S. HRG. 103–733

TAX TREATMENT OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES, AND EXCISE TAXES ON TOBACCO, GUNS AND AMMUNITION

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

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TAX TREATMENT OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES, AND EXCISE TAXES ON TOBACCO, GUNS AND AMMUNITION

THURSDAY, APRIL 28, 1994

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

The meeting was convened, pursuant to notice, at 2:05 p.m. in room SD-215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Rockefeller, Daschle, Conrad, Packwood, Dole, Danforth, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H-28, April 22, 1994]

FINANCE COMMITTEE SETS HEARING ON EXCISE TAXES ON TOBACCO, GUNS, AND AMMUNITION

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on excise taxes on tobacco products, firearms, and ammunition, and on the tax treatment of organizations providing health care services.

The hearing will begin at *10:00 A.M. on Thursday, April 28, 1994* in room SD-215 of the Dirksen Senate Office Building.

"Most of the major health care reform proposals before Congress contain significant increases in taxes on tobacco," Senator Moynihan said in announcing the hearing. "In addition, many Senators, including myself, have expressed a strong desire to see increased taxes on firearms and ammunition to help fund health care reform. Along with these issues, the Committee will also examine the tax treatment of hospitals and other organizations providing health care services, including the current 'community benefits standard' necessary for tax-exempt status."

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

The CHAIRMAN. A very good afternoon to our distinguished panelists and our welcome guests. The Committee on Finance continues the health care reform hearings that we have held from the beginning of this year.

Today we are going to discuss two subjects. The first, is the tax treatment of non-profit medical institutions, in the main, hospitals; and then we will discuss some other revenue measures, including the administration's proposal to increase excise taxes on cigarettes and tobacco products and proposals from our own Finance Commit-

tee to increase excise taxes on guns and ammunition. So, shall we get under way?

Monsignor, we welcome you, sir. Monsignor Charles Fahey, who is the director of the Third Age Center, Fordham University, is speaking on behalf of the Catholic Health Association; Dr. Hyman is from the University of Maryland Law School, effective July 1, 1994; Mary Nell Lehnhard, on behalf of Blue Cross and Blue Shield; John Martinez, who is executive director of the New York State Medical Care Facilities Finance Agency; and Jerry Phelan, who is consultant and former general counsel to the Kaiser Foundation Health Plan. We welcome you all. Your statements will be placed in the record as if read, and proceed as you like in accordance with the order of witnesses.

Senator Packwood, do you have a statement?

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

Senator PACKWOOD. I have just a very brief statement, Mr. Chairman.

Most of us do not like taxes just for the sake of taxes, and have no desire to impose them just for the fun of imposing them. They are not any fun.

Second, most of us, I think, would like, if we are going to tax, to tax similar entities similarly. But then you come to the question of non-profit, historically charitable hospitals, or non-profit HMO's. And in Oregon we are well familiar with HMO's, and certainly we are familiar with non-profit hospitals and charitable.

But Kaiser has been an immense presence, I would assume, Mr. Phelan, since World War II when the Kaiser shipyards were there and it has grown from that until it is one of the largest coverers of health in the State of Oregon; probably the largest.

I want to treat everybody fairly. I understand how now Blue Cross and Blue Shield is taxed because of what we did in 1986 and the slight difference between the way we tax them and we tax other insurance companies, and I understand Blue Cross' argument about those that they compete with that look more like insurance companies than they look like health providers.

But I just want to say at the outset that I have no desire to do any more damage to charitable hospitals and non-profit HMO's and others than we have done in the past. They provide a community service beyond belief, and there reaches a point where they cannot pass their costs on. We can succeed in driving them out of business, I suppose, if we are not careful. I hope, Mr. Chairman, we will be very careful.

The CHAIRMAN. And I am sure, with that injunction, we will be. There is nothing so distinctively American as the great hospitals which have grown up in our society. Tokeville would say, see, I told you so; this is the way they handle their affairs.

And, in our city of New York, Monsignor, as you know, Columbia Presbyterian was chartered by George, II, and New York Hospital by George, III, and Fordham came along shortly thereafter. So, whatever we do, we are not going to touch that arrangement.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. I do not have a statement. I look forward to the witnesses.

The CHAIRMAN. Well, good afternoon again. Monsignor.

STATEMENT OF MONSIGNOR CHARLES J. FAHEY, DIRECTOR, THIRD AGE CENTER, FORDHAM UNIVERSITY, NEW YORK, NY, ON BEHALF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Monsignor FAHEY. My name is Charles Fahey, and I teach at Fordham University. I used to be President of the National Conference of Catholic Charities, so I am well-rooted in the not-for-profit field. Today I am speaking on behalf of the Catholic Health Association.

We have three points that I would like to make. First, CHA strongly supports President Clinton's goal of extending universal health coverage to all Americans. We mean coverage, not universal access to insurance. We want to make sure people get the service. That is very important.

Second, we want to alert the committee that the not-for-profit mission in health care is being seriously threatened by the increasing commercial environment in which we find ourselves operating; a real commodification of health care, if you will.

The CHAIRMAN. Commodification of health care?

Monsignor FAHEY. Oh, yes. That's exactly what is happening.

The CHAIRMAN. Very good. Very good.

Monsignor FAHEY. From a service to a commodity, and very dangerous, I think, for the public well-being.

Third, community benefit standards, such as those in the President's legislation, are an important first step to better focus nonprofit providers on the communities they were established to serve. And, undoubtedly, part of our problem is some not-for-profits that lost their mission.

My first point in regard to universal access is that it does not mean universal coverage. Obviously, as health care wends its way through the Congress, the question of what is in the basic benefit is likely to erode to some extent. Not all persons will have insurance coverage for all needed services.

In cities like New York we are going to have hundreds of thousands of undocumented aliens with no insurance coverage. People in my neighborhood in the South Bronx just are not the informed consumer; they are going to need outreach and people that will work with them.

Health care itself is not really treating an arm or a leg, but, rather, we're dealing with families and neighborhoods that often are the cause of the ill health, as well as the people who will be returned to them.

So, there has to be creativity in delivering health care services. It is not just a simple, technical intervention in a person's life. So we see the absolute necessity of having the flexibility, not just funds for a particular treatment, but, rather, being able to deal with the person, the family, the neighborhood. Not profit, taxable exempt organizations have that creativity and flexibility. Indeed, I think one of the weaknesses—I was part of the Clinton Health Care Work Group on Ethics.

The CHAIRMAN. You can reveal that now?

Monsignor FAHEY. Yes, I can reveal it now. To some extent, there was not sufficient attention paid to the question of the delivery system in the work group. Those delivery systems are vitally important and should have responsibility for the health of populations, not just the health of individuals. The distinction, I think, is vitally important.

Second, the not-for-profit tradition is threatened because, the basic technique is being chosen for health reform is competition. There will be an extraordinarily strong dynamic at work, if you will. How do you take the relatively scarce health care dollars and allocate them to investors, keep the institutions going, and be an accountable health care plan or integrated delivery network?

Third, of course, is how do we get health care to individuals? That is going to set up an internal dynamic as we try to shrink the system that is going to be very difficult.

And, indeed, the point of our testimony here is that in the new kind of health delivery systems, at least some of these plans have a social mission and ought to be accorded the benefits of tax exemption so that they will be able to be of service to a community and to the health of populations.

Fourth, we think that the enforcement of prohibitions against private gain for insiders through intermediate sanctions, as proposed by Treasury, is a good idea. Also, we recommend granting tax exemptions for non-for-profit health care plans that meet the same enhanced community benefit standards as do individual providers.

Fifth, we feel that all tax-exempt health care providers ought to be required meet an explicit standard in regard to a community benefit.

The Catholic Health Association supports the community benefit standard in the President's legislative proposal. We have found that the standards for assessing community need and planning for community service help to focus our institutions on their community service tradition.

You may be aware that CHA has developed a social accountability budget that roughly 80 percent of our members now utilize. It was first used for public accountability, now is used ante factum to show how we use our resources in service of the community. I think this is a very valuable kind of thing that we ought to look at very carefully.

The CHAIRMAN. Monsignor, we have been putting together a lexicon of new terms as we go through here. What was that you said?

Monsignor FAHEY. Social accountability budget. Social accountability budget.

The CHAIRMAN. And the ante factum?

Monsignor FAHEY. Pardon?

The CHAIRMAN. Did you not use a Latin phrase there?

Monsignor FAHEY. No. It may have been my background slipped out, you know. Just those people I live with, and so on.

So we think that establishing statutory language is good, but the details should be left to regulation. We are not at all sure that having an actual number used to show what community benefit is would be useful.

We think there needs to be more flexibility especially for hard pressed hospitals. In New York State, for example, where hospitals are all existing on fumes at this moment there is not much of a bottom line because of the way we have crunched the system.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, indeed. That was a very important statement. The Treasury has not actually brought us intermediate sanctions language, have they? I do not think so. You are ahead of the curve in this regard.

Monsignor FAHEY. Yes. We think that we ought to be responsible. Right now I think Treasury is hamstrung to some extent. They have an atom bomb; take away tax exemption. What is needed is some intermediary things particularly aimed at those persons who would inappropriately benefit from the health care system services. That is foreign to our whole history and tradition of philanthropy.

The CHAIRMAN. Indeed. Thank you very much. We will get back to that.

[The prepared statement of Monsignor Fahey appears in the appendix.]

The CHAIRMAN. The once and future chairman, Mr. Packwood, says today is "Bring Your Daughter to Work Day." We have some daughters here. Mark's daughter, Sharell. I met Mark's daughter. Where is Sharell? And Julie James, whose daughter, Elizabeth, is in the audience. Where is Julie James? Hello. And here is Sharell. Say hello to Julie.

Ms. Kayle. Hello.

The CHAIRMAN. Thank you for coming. If we could keep all our testimony as succinct, we would do very well. [Laughter.]

The CHAIRMAN. Dr. Hyman, good afternoon, sir.

STATEMENT OF DAVID HYMAN, M.D., J.D., MAYER, BROWN & PLATT, CHICAGO, IL, ASSOCIATE PROFESSOR, UNIVERSITY OF MARYLAND LAW SCHOOL (EFFECTIVE JULY 1, 1994)

Dr. HYMAN. Mr. Chairman and members of the committee, my name is David Hyman. I am going to be an Associate Professor at the University of Maryland Law School starting this fall. I would like to make a number of points about tax exemption for various entities in the health care industry.

First off, the dollars at stake in providing for tax exemption are significant, although they are dwarfed by the magnitude of other tax preference issues relating to health care. Estimates of the value of tax-exempt status for hospitals range considerably, but somewhere between $6–10 billion seems to be a consensus number.

Only about half of this amount comes directly from the Federal FISC, but since most State and local jurisdictions take the Federal standard as their touchstone for exemption, the Federal standard has a broad sweep.

Second, since taxation is the rule, one needs to ask why we exempt anyone from sharing that burden. The analytical justification for tax exemption is usually made in terms of market failure. Market failure means that the market is not viewed as a sufficient supplier of the quantity or quality of some needed good or service.

Market failures result in clients seeking an entity they trust not to exploit them, that is, non-profit providers. Non-profit providers are viewed as more trustworthy than for-profit providers because of the non-profit's public purpose and the limitations on private benefit. As the Talmud put it, "we presume none sins unless he stands to profit by it."

Health care is usually viewed as one of the best examples of market failure.

The CHAIRMAN. Now, I am going to have to ask you to go by that Talmudic reference once more. The Talmud says?

Dr. HYMAN. "We presume none sins unless he stands to profit by it."

The CHAIRMAN. That seems to me a very shallow judgment about human behavior, but we will leave that. [Laughter.]

Dr. HYMAN. Health care is usually viewed as one of the best examples of market failure, since there are a host of informational asymmetries, few repeat players, involuntary participation with a certain randomness in where services are provided, great uncertainty about the quality of services actually provided, and staggeringly high costs associated with bad decisions.

In order to encourage the non-profit sector, our tax system provides an undifferentiated exemption from tax. This preference constitutes a subsidy whose precise value depends on the tax situation and profitability of the particular entity that receives it.

To qualify for an exemption, a hospital must have an anti-inurement provision to limit private benefit, and promote the health of a class of persons broad enough to benefit the community, commonly known as the Community Benefit Standard.

The scope of community benefit has never been articulated clearly. As such, it is difficult to be precise about what it is that hospital tax exemption is buying the Federal FISC, particularly in light of the growing penetration of for-profit hospitals in certain regions, many of which—by no means all—look similar in their operations to non-profit, tax-exempt hospitals down the street.

The Health Security Act, as drafted, eliminates the need for charity care by providing for universal coverage. Accordingly, charity care would no longer be available as a justification for exemption.

The CHAIRMAN. Universal coverage for legal immigrants.

Dr. HYMAN. Exactly.

The CHAIRMAN. And resident citizens.

Dr. HYMAN. Well, Senator, if you are doing to draft a health care plan that provides for coverage for certain people, do you want to use the Tax Code to indirectly subsidize health care for other people?

The CHAIRMAN. Go ahead, Doctor. You are both Dr. Hyman and Professor Hyman. I should note that. A J.D. and an M.D.

Dr. HYMAN. Thank you.

The Health Security Act continues the Community Benefit Standard and adds the requirement that the hospital annually survey the health needs of the community and formulate a plan for meeting those needs, although I note there is no requirement that the hospital actually institute that plan.

Ultimately, there is little in the way of theoretical, intellectual, or financial reasoning to maintain the current structure of hospital tax exemption, which provides for an undifferentiated subsidy.

Although market failure may be a viable justification for encouraging certain types of behavior in the health care industry, when the only constraint is a non-inurement provision, there are strong reasons to suspect the subsidy will be dissipated unproductively; that is, not serving the needs that Congress might prefer it to.

A shift to focused goals, whatever those might be, whether charity care or otherwise, would better serve the public interest and the public FISC.

With respect to the extension of exemption to other entities in the health care market, the Tax Court has upheld an exemption for one HMO and denied an exemption to another.

Since the fundamental reason for the non-profit form to be promoted is market failure and the basis for exemption is to encourage non-profits, the success of for-profit HMO's certainly suggest lots of people are comfortable receiving their care from a for-profit HMO, and there is no necessity to promote non-profits with a tax exemption. Indeed, it appears unlikely that HMO's compete for patients on the basis of whether they are a non-profit or for-profit enterprise.

Regardless, if you look at the structure of an HMO, it is a very effective response to market failure. It provides for a capitated fee structure, there is a periodic requirement for re-enrollment, and patients are typically bundled into groups, all of which minimize the potential for exploitation. Thus, the underlying rationale for exemption is simply not applicable to HMO's.

In addition, recall that HMO's exist to provide services to their members and not the general public, while exemption requires a public purpose.

Now, the Health Security Act provides that an HMO can qualify for exemption under 501(c)(3) if it meets all the other standards and is organized along a staff model. Independent provider involvement precludes an exemption. I cannot see a principled basis to discriminate among HMO's in their attempts to get an exemption, depending on the nature of their contracts with physician providers.

In closing, in light of the cost of exemption, we need to be clear-headed about the reasons why we have exemptions and we need to assess, on a continuing basis, whether they should be extended or curtailed.

The CHAIRMAN. Finish your statement.

Dr. HYMAN. I only have one more sentence.

The CHAIRMAN. Sure.

Dr. HYMAN. Although the Health Security Act will require hospitals to do more to earn their exemption, it does not address the logic of the exemption as such in light of the changes in the health care environment.

In addition, as I just noted, the discrimination among HMO's seeking exemption on the basis of their contractual arrangements with their physician providers simply defies analysis. Thank you.

The CHAIRMAN. Thank you, sir. Without being presumptuous, could I remind you that Holmes said that "the life of the law is experience, not logic." So we will get back to that.

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

The CHAIRMAN. We will hear from Mrs. Lehnhard, on behalf of the Blues.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, OFFICE OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mrs. LEHNHARD. Mr. Chairman, members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association, and I appreciate the opportunity to present our views. I am here representing the 69 independent Blue Cross and Blue Shield plans on the issue of taxation of health plans under health care reform.

We believe our position is straightforward. As part of reform, we urge you to establish a single tax rate for all accountable health plans, and let me explain this. Today, health insurance is conducted by a variety of different entities, and they are all taxed under different rules and, in some cases, they are not taxed at all.

At one extreme are the fully-taxed commercial insurance companies, and at the other extreme are the tax-exempt HMO's and hospitals that offer health insurance through organizations known as vertically Integrated Delivery Networks.

In the middle are Blue Cross and Blue Shield plans, all of which have been subject to Federal taxation since the 1986 Tax Reform Act. I will mention that we do have the benefit of a statutory reduction which lowers our rate to 20 percent of the AMT rate until we accumulate reserves to a certain level.

So, that is the range, 35 percent for commercial companies, 20 percent for a Blue Cross and Blue Shield plan if it qualifies for the deduction, and zero percent for many HMO's and hospitals which also have access to tax-exempt bond financing.

Let me explain why we think this variation in tax rates has to change under health reform. Today all of these entities are fundamentally in the same business; they promise to provide benefits for an illness or an injury in exchange for a premium or a capitation amount.

They are all engaged in the insurance business, whether these benefits are provided in the form of direct services, for example, through an employed physician in an HMO, or by making payments directly to a provider as most insurance companies in most HMO's do.

After reform, there will be virtually no distinctions between the business practices of plans. All will be required to meet the same set of detailed Federal standards in the marketplace.

At this point, health plans should be taxed the same. Without this change, there will be a significant competitive advantage in the health insurance business for tax-exempt HMO's and hospitals which form these accountable health plans, even though all of the practices are the same.

I want to emphasize, particularly with this panel, that our position would not change the tax-exempt status of hospitals for the di-

rect care patient services. We do believe, however, that if a hospital engages in the business of insurance, that business should be fully taxed. Also, an HMO that collects premiums in return for providing a defined set of benefits should be taxed on its premium income.

This concludes my statement, and I, of course, would be glad to respond to questions.

The CHAIRMAN. Thank you, Mrs. Lehnhard. We have several views already.

[The prepared statement of Mrs. Lehnhard appears in the appendix.]

The CHAIRMAN. Mr. Martinez is going to speak to us on behalf of the National Council of Health Facilities Finance Authorities. We welcome a New Yorker.

STATEMENT OF JOHN G. MARTINEZ, EXECUTIVE DIRECTOR, NEW YORK STATE MEDICAL CARE FACILITIES FINANCE AGENCY, NEW YORK, NY, ON BEHALF OF THE NATIONAL COUNCIL OF HEALTH FACILITIES FINANCE AUTHORITIES

Mr. MARTINEZ. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, my name is John Martinez and I am the executive director of the New York State Medical Care Facilities Finance Agency, and I am testifying today on behalf of the National Council of Health Facilities Finance Authorities, which I will call the National Council.

The National Council includes all of the 23 health care finance authorities that issue tax-exempt bonds on a Statewide basis. We do not represent specific hospitals or health care institutions. Rather, the National Council focuses its efforts on issues that directly affect the availability of tax-exempt financing to member authorities to issue bonds on behalf of public and not-for-profit hospitals.

Members of the National Council have issued over $55 billion of health care bonds to finance projects such as expansion and modernization of medical centers and clinics, the installation of computerized information systems that promote efficiency, the purchase of high technology medical equipment, and new construction of ambulatory care centers and hospital energy plants. The Council is concerned that current tax law, with respect to tax-exempt bonds, could work to impede the goals of health care reform.

As the providers of capital for health care facilities, members of the National Council play an integral role in America's health care system. We want the health care reform to work, but are concerned that current law restrictions on tax-exempt financings, if not reviewed, could cause difficulties in the implementation of health care reform.

To address the health care needs of the underserved, particularly in inner city and rural communities, non-profit 501(c)(3) health care institutions will need to provide health care in a more efficient and cost-effective manner.

One result of health care reform that is certain is the acceleration of the need to downsize the acute care system with hospitals and other health care providers, consolidating to reduce in-patient capacity, while filling other gaps in the system, such as continuing care for the elderly.

The goal of this retooling is to find innovative ways to serve consumers more efficiently. An important step towards accomplishing the related goal of cost reduction can be achieved by modifying certain restrictions on tax-exempt financing through impediments to consolidations, mergers, and innovative alternative health care programs.

We have identified four potential problem areas. I want to focus primarily on a $150 million institution cap, but I do want to say that other areas that are important are: the limitations on advanced refundings, the implications of redefining the 501(c)(3) status, and the need to include health care borrowers among the small issuers with access to the tax-exempt bond market via the initial cap's bank deductibility rule.

The $150 million cap is an obstacle to rationalizing the health care system. Most institutions which are important to the health care reform plan are not hospitals; as an example, non-profit health maintenance organizations, known as HMO's.

Yet, the current tax law limits these non-hospital facilities to $150 million per institution in outstanding tax-exempt bonds. As non-hospital facilities and hospitals form integrated delivery systems in response to health care reform, they will conceivably run into the limitations of the $150 million cap. This could impede the creation of integrated systems to provide a continuum of care in a variety of settings, not just acute care.

At a time when we are moving toward a non-hospital delivery system, the $150 million cap is an important disincentive to innovation. Currently, there are at least five States with an aggregate of 12 health care institutions that are at the $150 million limitation applicable to non-hospitals. In addition, there are another four health care organizations that are currently between $120–150 million in outstanding bonds.

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

Another example, is the Boise, Idaho chapter of the American Red Cross. Five years ago, the Boise chapter contacted the Idaho Health Facilities Authority to discuss a need to borrow so that they could expand, remodel, and equip their facility. Unfortunately, it was determined that the needed loan could not be obtained on a tax-exempt basis because the National Red Cross, which has a controlling interest in each State chapter, is already at the cap.

The Boise, Idaho chapter was forced to downsize its program and pay for it out of operating capital instead of devoting those funds to blood bank operations. As a result, just 1 month ago the Boise, Idaho Red Cross had to shut down completely because it is now behind in training and inspection programs and will probably be out of service for at least another month.

The National Council would like to promote the goal of health care reform by suggesting, in addition to the definition of hospital which is provided in the Anthony Commission Report, that the hospital definition should be expanded and include, on a conceptual

basis, at least, certain facilities that are currently encouraging more out-patient treatment and other cost-effective forms of care by expanding the exception for hospitals to include certain of these non-hospital health care facilities which would include things like a clinic, a health maintenance organization—should I go on with the list, sir?

The CHAIRMAN. Please.

Mr. MARTINEZ. A diagnostic treatment or surgical center, a comprehensive cancer center, kidney disease treatment center, a drug treatment center, alcohol treatment center, a hospice, skilled nursing facility, psychiatric hospital, or a community mental health center.

Well, we appreciate the opportunity to appear here. We would ask consideration that the $150 million per institution cap be lifted from not-for-profit health care projects that provide alternative care settings that will, of necessity, be a cornerstone of national health care reform. Thank you.

The CHAIRMAN. Thank you very much, sir, indeed.

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

The CHAIRMAN. Now, the last of our panelists, Mr. Jerry Phelan, who has had a distinguished career in this field, and is speaking, I think, for yourself, are you not?

Mr. PHELAN. No, I am speaking for Kaiser Foundation Health Plan, Inc.

The CHAIRMAN. Welcome, in either capacity.

STATEMENT OF JERRY J. PHELAN, CONSULTANT AND FORMER GENERAL COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HOSPITALS, WASHINGTON, DC

Mr. PHELAN. Thank you, Mr. Chairman. Mr. Chairman, members of the committee, I am Jerry Phelan. I recently retired as General Counsel for Kaiser Foundation Health Plan, Inc.

Kaiser Foundation Health Plan, Inc. and its 11 health plan subsidiaries are group practice health maintenance organizations that serve 6.6 million enrolled subscribers in 16 States throughout the country and the District of Columbia.

Medical services to health plan members are provided through 12 independent medical groups, and hospital services are provided or arranged through Kaiser Foundation Hospitals, which is a separate organization under common control with the health plan.

All of the health plans are group practice HMO's, all are qualified under the Health Maintenance Organization Act of 1973, and all are exempt from Federal income tax as charitable organizations under Internal Revenue Code Section 501(c)(3).

We believe there are important distinctions between conventional, commercial-type insurance companies and group practice HMO's. Risk transfer and risk distribution are the defining characteristics of health insurance. The defining characteristics of organizations on the health plan model, on the other hand, is assumption of responsibility for organizing and for providing health care.

It is, of course, true that health plans depend principally upon pre-payment to provide the funds necessary to support the health

care capability that Kaiser Permanente represents, and pre-paid dues from health plan subscribers resemble premiums charged by conventional insurers.

However, health plans differ from conventional insurers by using our members' pre-paid dues to establish and to maintain a health care structure that is available to serve the pre-paid membership, as well as the community generally, an undertaking that we think is foreign to the nature and the activities of commercial health insurance companies. Insurers accept and distribute the risk of the cost of health care; health plans undertake to organize and to provide care itself.

Throughout Kaiser Permanente, the regional health plan owns and sometimes leases medical office facilities where Permanente physicians and their supporting personnel conduct their office based practices, and provide out-patient services to health plan members. At the end of 1993, the book value of facilities and equipment owned by the health plans was $2.3 billion.

I believe it is apparent that our principal capital requirement is for the medical office facilities that serve health plan members. Our exemption permits the health plans to provide health care facilities at a lower cost than if the capital required to finance these facilities were derived from after-tax dollars.

Of course, organizations such as insurance companies that do not provide health care have no need for capital to build health care facilities. Congress, as the prior witness said, has imposed a $150 million limit on the amount of tax-exempt bonds that can be utilized by a tax-exempt organization for constructing and equipping out-patient facilities, and we can concur that this limit should be removed.

We believe that loss of exemption by health plans would have a disparate impact on health plans as compared with insurance companies because health plans require capital to construct health care facilities and to purchase health care equipment, and insurance companies do not.

A tax on health plans would be a tax on health care. Because insurance companies do not provide care, they simply pay for it, insurance companies receive a deduction from gross income for all amounts that they pay for health care.

We feel that a tax on health plans would be a targeted tax on a service that insurance companies do not perform, but which is the very essence of what health plans do, which is to organize, arrange, and provide care.

At the end of 1993, the Permanente Medical Groups included over 9,000 physicians, and medical groups and health plans employed over 37,000 licensed health care personnel. The health plans alone employ more than 17,000 of these licensed health care providers, and an additional 4,000 health care personnel who do not require licensing. Thus, health plans are substantial providers of health care.

As we understand the position of Blue Cross and Blue Shield, any organization that provides health care benefits on a pre-paid basis should be classified as an insurance company and pay tax on that basis. I believe that an unstated but necessary implication of their position is that a health care organization would not be ex-

empt unless it charges for its services under the fee-for-service method of payment.

I think there is widespread agreement that the fee-for-service method of payment, coupled with broad health care benefits, has resulted in pressure to increase costs because neither the provider nor the patient has an incentive to economize. We think that, in effect, enshrining the fee-for-service method of payment as a basis for exemption of a health care organization would be a mistake.

Finally, health plans extend benefits to vulnerable populations in many ways, such as through dues subsidy programs, the unlimited right to convert to individual membership upon loss of group eligibility, enrollment of individuals and small groups, guaranteed lifetime eligibility, irrespective of health status, absence of any limitation on any pre-existing conditions and a community-based rating system.

In conclusion, Kaiser Permanente and other group practice HMO's are models for the organization and delivery of health care in the United States. They are integrated health care organizations. They organize and deliver health care, as distinguished from Blue Cross and Blue Shield and insurance plans that pay claims.

The value of integrating the financing and delivery of health care for group and staff models of HMO's is well-known and generally understood in the health care community, and has been recognized in tax policy for some time. We suggest this recognition should be maintained.

The CHAIRMAN. Thank you, Mr. Phelan, indeed.

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

The CHAIRMAN. We have filled up now, so we want to be careful of our time. I will be brief. I mostly want to say to Monsignor Fahey that the "commodification of health care" is a remarkable phrase. The beginning of this century was involved in an enormous struggle and I think the Clayton Antitrust Act, as I recall, declared that labor is not a commodity.

Monsignor FAHEY. Right.

The CHAIRMAN. A lot of Fordham people were involved in that and it was a huge issue. Yet, we have heard testimony from all manner of persons, in effect, confirming your view.

A wonderful witness, as Senator Packwood will agree, Dr. Schultz, who heads the UCLA Hospital, described this phenomenon, in southern California. He commented that we now have a spot market in bone marrow transplants; someone says 80, someone else says 60. It is to be watched, because people are saying that medicine is a ministry.

Monsignor FAHEY. Well, it breaks my heart to hear him talk about industry rather than ministry.

The CHAIRMAN. Yes. Yes, sir. That is what we do.

Monsignor FAHEY. It is a disaster.

The CHAIRMAN. We are hearing you.

I would like to say to Mr. Martinez and Mr. Phelan that we are very much aware of the $150 million cap on, how do you say, nonhospital health care facilities, which is inhibiting some of the rationalization of health care delivery. The distinction is obviously artificial from the point of, what is health care, what happens in a

hospital, what happens in a community mental health center? They are essentially the same things, and we have heard that very well.

May I point out, just for the record, that Mr. Martinez has an attachment to his written testimony that lists the States with institutions that have reached their $150 million limitation, including California, Idaho, Massachusetts, New York, North Carolina, and South Dakota. Those who are approaching it include New Jersey, Colorado, Washington, and others cannot be far behind.

It is our practice to recognize the Majority Republican Leader first when he is on hand, and you are invariably on hand.

Senator DOLE. I will wait awhile.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. Ms. Lehnhard, let me make sure I understand what Blue Cross/Blue Shield is recommending. Let us just assume today that non-profits are not taxed and you are taxed $5 and normal commercial insurance companies are taxed $10, and that $5 was the outgrowth of the 1986—it was not in the bill here the law is putting in conference.

What you are saying is, you would be willing to give up your $5 status if everybody was taxed $8. Have I got it roughly right?

Mrs. LEHNHARD. Well, we are saying everybody should be taxed the $10. We are all in the same business, we are all doing the same thing. The gentleman from Kaiser—I am sorry, I have forgotten his name.

The CHAIRMAN. Mr. Phelan.

Mrs. LEHNHARD. Made a point about the difference in delivery systems. Well, if I am not mistaken, the legal basis for tax exemption has nothing to do with your delivery system, it is a test of community service.

So, the basis of your organization should not make any difference. What we are saying is that we are going to all be having open enrollment, a standard benefit package, accepting everyone, all the same rules, so we say we should all have the same tax rate.

Senator PACKWOOD. I did not mean to say you wanted everybody taxed at $8 versus $10, you just want them all taxed equally. I was assuming that——

Mrs. LEHNHARD. No. We do not care what the level is.

Senator PACKWOOD. But you would tax the hospital portion, the delivery portion of a non-profit hospital as if they were providing insurance.

Mrs. LEHNHARD. No. Think of a charitable hospital providing services, charity care. We do not want to touch that; that is not our issue. We are saying, to the extent that hospital, though, starts selling packages of benefits to employers for a premium, they are competing with every commercial company, they are competing with us, they are competing with Kaiser, and that business is all the same; it is all under the same rules.

And we should all have the same tax rules, but we would leave the hospital delivery system alone. If Kaiser has a tax-exempt hospital and they provide community services, we would not touch the tax-exemption of their hospital.

To the extent they are selling benefits on a capitation or premium basis, a package of benefits, they are doing the same thing we are and we feel they should be taxed like we are.

Senator PACKWOOD. Well, let me ask the Monsignor and Mr. Phelan. Is that an easily divisible item?

Monsignor FAHEY. No. I think this would be most unfortunate. I concur with the representative of Kaiser Permanente, that those of us who are involved with integrated delivery networks do not see ourselves primarily as insurers, but primarily as delivering services to folk and, therefore, providing community benefit.

You know, again, if I can just be a little philosophical for a moment——

Senator PACKWOOD. Sure.

Monsignor FAHEY.—in the just society as one in which we treat equals equally and unequals unequally in accord with capacity and need, and inherent in the notion of social justice, is both equity and adequacy.

And, in accord with the principle of subsidiary, if you will, the first rule of government is adequacy. How do we make sure that people who need services get it and get it in an economic fashion? It really is not the primary role of government to be involved with all the players to have an equal playing field if, indeed, that does not serve adequacy.

And I would argue strongly for the encouragement of integrated delivery networks, particularly those concerned with the health of populations whether they be in a rural area or whether they be in South Bronx, or Newark, or Patterson, or whatever the case may be. We ought to encourage that kind of behavior in the health reform package and offer incentives to those who follow the long tradition of this country to bring people together who offer services to folks.

Senator PACKWOOD. Mr. Phelan, is it easily divisible? Again, I used to be a labor lawyer representing employers, and we had a number of contracts with Kaiser in the late 1950's and 1960's. There is no question that we looked at it sort of like insurance for our employees. Would that be a fair description? I realize the medical services you provide, but would you admit that that is an insurance portion of the business?

Mr. PHELAN. We certainly concur that the principal financing is through pre-payment. We visualize ourselves principally as a health care delivery system, and the pre-payment is just a financing mechanic.

But we are in the health business and not in what we would call the conventional or commercial insurance business, which we think is principally limited to paying claims for health care rather than assuming direct responsibility for its actual provision.

Senator PACKWOOD. Ms. Lehnhard, do you want to comment?

Mrs. LEHNHARD. Senator, I think that overlooks how complex the market has become. We are merging with tax-exempt hospitals, we——

Senator PACKWOOD. Wait. We is Blue Cross/Blue Shield?

Mrs. LEHNHARD. Blue Cross/Blue Shield. We are buying hospitals, we are buying group practices, we are buying physician practices. Under health care reform we will have to publish an outcome status for our subscribers, how well we provide preventive care, how we are managing their illnesses, we will be gatekeepers. This is really direct management of an individual's full range of

health care, and we will be responsible for the outcome of their treatment.

So, I think the distinctions, even without health care reform, have blurred. And what is happening is, as you put together these integrated networks, you have combinations of profit/non-profit, and often the for-profit companies are riding the tax-exempt organization so that the whole entity itself becomes tax-exempt.

It is very confusing, and we think you can easily break out that part of a hospital's business that is a health insurance business. It is the exact same principle as the unrelated business income principle which is regularly administered by the IRS.

Senator PACKWOOD. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. In pursuit of our lexicon and enterprise, you went to law school at NYU and not at Fordham, but, even so, you will be afforded the opportunity to define the principle of subsidiarity. [Laughter.]

Senator PACKWOOD. In the mid-1950's, NYU did not attempt to make those kind of distinctions.

The CHAIRMAN. Subsidiarity is a principle—let's see if I get this right—that suggests that any activity of social purpose should be conducted at a level as close as possible to the community itself, and it is rarely the best idea to have the Federal Government run the hospitals.

Senator PACKWOOD. You may recall, I am familiar with the taxation of unrelated income. You may remember this, Mr. Chairman. NYU, the law school, actually, was given the Mueller macaroni company, the entire company. It was an immense profit center for the law school. First, there came an intra-university fight as to who was entitled to this money. Then it led to the whole issue of unrelated business income, because the law school was not really in the macaroni manufacturing business. [Laughter.]

That may have been the start of our decision as to what to do about unrelated business income, and we are perfectly familiar in this Congress with taxing unrelated business income. It is a perpetual battle. I think, in theory, Ms. Lehnhard is sort of saying, well, if this is unrelated to the direct business of providing health services, medical services, then it is unrelated business income.

Mrs. LEHNHARD. We are saying it is unrelated to the tax-exempt purpose, which is providing charitable, bad debt care.

The CHAIRMAN. And I observed that Senator Packwood was deft, indeed, in getting away from the subject of subsidiarity. [Laughter.] Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Chairman, I think that this hearing has pointed out, at least to me, some problems. When I came down here I thought, there are no problems with this situation. For example, we are not going to embark—at least I am not—in levying some kind of tax on St. Joseph's Hospital in Providence, Rhode Island, or Rhode Island Hospital, or Miriam Hospital. They are all 501(c)(3) institutions and provide tremendous care for the citizens of our State. So that is easy.

Then you get to the issues pointed out this morning. What happens if Rhode Island Hospital sets up a network and embarks on an HMO? You begin with a tax-exempt institution, and so everything seems to follow along that this new endeavor is also tax-ex-

empt, as opposed to somebody who was a for-profit insurance company that decided to start an HMO, and then gradually bought a hospital and came at it from the other direction. The development of these arrangements from each way leads to considerable confusion.

And, I must say, I came here, not thinking that Mrs. Lehnhard would have much of a point, but I am not so sure just how to handle this situation. I can understand Mr. Phelan's point, but what do we do? It does seem to me to end up with some extraordinary inequities.

If you start from the hospital end—and, regardless of what we do here it is going to happen anyway—the hospitals are going to set up networks with physicians, they are going to set up HMO's, they are going to have capitation situations, and it would all seem to follow that that should all be tax-exempt. But how do we resolve this?

This has been, I suppose, a disappointing day, Mr. Chairman, because I came down thinking there are few contentious issues here, and now we find one more set of problems. Mrs. Lehnhard.

The CHAIRMAN. And not an easy one.

Senator CHAFEE. Not an easy one, no. I mean, the old issue of, what do we do about sales taxes on the gift shop in the charitable hospital; that is easy compared to this one.

Mrs. LEHNHARD. I was going to make the point that, where your hospital engages in an HMO, they will have to go to the State Insurance Commissioner and become certified for that part of their business as an accountable health plan. The entire hospital will not be certified as an accountable health plan, the entire hospital cannot meet the solvency standards and all the other standards.

So we think most of the accountable health plan business will have to occur in a subsidiary of the hospital in the first place. Even if it did not, I made the point before you came in, the whole principle of taxation of unrelated business income where that business is not the same as the purpose for which the institution was granted tax exemption is a well-established practice. Given that, however, we think hospitals are going to have to put the health plan business into a subsidiary, that has been the practice in the marketplace to date.

Senator CHAFEE. Then, Mr. Chairman, we run head-on into the $150 million limitation that we discussed here.

The CHAIRMAN. Monsignor Fahey wanted to say something.

Senator CHAFEE. I would be glad to hear it.

Monsignor FAHEY. Could I make a comment in regard——

Senator CHAFEE. Monsignor, can you help us out on this a little bit?

Monsignor FAHEY. Well, just a real-life example from Oregon. How is that?

Senator PACKWOOD. Good.

Monsignor FAHEY. Or from California, too. There is a remarkable development in health care of older persons called the "On Lok" experience, or PACE, On Lok illustrates this. It started out from a social institution, a day care center really, not a health care institution at all.

They have established a risk-based Medicare HMO, in effect, that is now being replicated throughout the United States. The distinction points out, that they are not primarily an insurer.

They do, indeed, accept premiums, but they are in business, if you will, to be in ministry and to help older people, and they are doing it extraordinarily effectively. It would seem as if they are doing it so effectively that they are worthy in that instance, or situations that would be analogous to it, to be granted tax exemption. It is a very economic way, a very humane way, a truly dramatic way to change the delivery of health care.

Senator CHAFEE. Could I ask one more quick question?

The CHAIRMAN. Please.

Senator CHAFEE. Mrs. Lehnhard, would not one way of drawing the difference—now, Blue Cross falls into a never-never land in a way, but take a for-profit insurance company, Aetna, or Mutual of Omaha, whomever it might be, and then they extend down the chain; they set up an HMO, they then buy a hospital, and so forth.

Could we not say that, well, they should be taxed because they are for-profit, whereas the extension, working the other way upward from, say, Kaiser, starting with a hospital, or Rhode Island Hospital whomever it is, starting upward and starting an HMO that, just as Monsignor Fahey said, their objective is never to make a profit. If they make any money it does not go to shareholders, it goes back into the system, reducing the costs, caring for the poor.

Mrs. LEHNHARD. Senator Chafee, we made that exact argument in 1986 and we lost our exemption, we argued that we do not have stockholders, we do not make profit, it all goes back into the reserves.

And Congress said, if you are in the commercial insurance business and they defined it broadly, you should not be tax-exempt. And that is what we are saying, that any entity that sells a defined set of benefits for a premium is in the business of insurance.

It used to be that maybe if you took individuals without medical underwriting or small groups you had an argument for tax exemption. Under health care reform we are going to all be taking everyone, we will all have open enrollment, we will all accept the people who are already sick. There will be no differences in our market practices. The only difference will be that some organizations that have had the exact same practices are not only tax-exempt, but they have access to the tax-exempt bond market.

Senator CHAFEE. Thank you.

Senator PACKWOOD. Let me give you a bit of history, John, as to how this happened; Ms. Lehnhard will remember. Taxing Blue Cross/Blue Shield was not in the Senate bill. It was put in in conference; Congressman Stark insisted upon it. Kaiser is not included. Kaiser is headquartered in his district.

The CHAIRMAN. That is the principle of subsidiarity. [Laughter.] Senator Baucus.

Senator BAUCUS. Thank you. Thank you, Mr. Chairman.

I would like to explore this distinction, if I could, a little bit more. Monsignor, are you saying that non-charitable care revenue should be tax-exempt?

Monsignor FAHEY. Would you say that a little bit more, please? I am not sure I understand.

Senator BAUCUS. Yes. What I am really getting at is, should income that a hospital receives not directly related to charitable care be tax-exempt?

Monsignor FAHEY. Non-related business income certainly should be taxed.

Senator BAUCUS. So you do think that the unrelated business income provisions are sound?

Monsignor FAHEY. Oh, sure. Absolutely. And I think we have got to keep the not-for-profit pure. I mean, I think part of our problem is where there have been abuses.

Senator BAUCUS. All right. The next question then is, is insurance income charitable care or is it more in the nature of unrelated business income?

Monsignor FAHEY. Well, again, I think it is out of the motivation of why you are in the business of getting premiums. If it is to have profit to go back to folks that are investing in the organization, I think that that is taxable.

On the other hand, if the organization is receiving a premium and it is not being redistributed to anyone, and there is not an inappropriate kind of inurement to an individual but it is all being invested in the care of a population, the care of the enrollees, I think it is worthy of tax exemption.

Senator BAUCUS. Ms. Lehnhard, what is your reaction to the Monsignor's position?

Mrs. LEHNHARD. Yes. I think you could have a charitable hospital that had every good intention in the world, and they are selling insurance to three people—GM, IBM, and Kodak—for a full premium.

And we are saying, where they do that, wall that off from the charitable activities of the hospital—it is not related to the charitable purpose of the tax exemption—and tax that as unrelated business income.

Senator BAUCUS. Your answer, Monsignor?

Monsignor FAHEY. Well, again, I think in the integrated delivery network kind of situation we are talking about, it ain't that simple. Of course, one of the things we are trying to avoid in all this is the very notion of cherry picking and cost shifting, which cause all kinds of problems. I think, if I heard it right, that is just what we are talking about at this moment.

What we are trying to do is to get everybody in the same tent. We are trying to enable providers of service to have the tools to be able to do what they ought to do in a local community.

If, indeed, GM or whomever is able to come in and get a discount, that is going to get shifted someplace else and somebody else is going to pick it up, or that the providers of service are not going to be able to fulfill their charitable mission. A great concern within the Catholic healthcare system, is we do all kinds of cost shifting with everybody else.

Senator BAUCUS. Right.

Monsignor FAHEY. We try to do it on the basis of taking care of poor people.

Senator BAUCUS. Now, on a related point here, as a practical matter—and this is Dr. Hyman's point—why should non-profits who are presently providing charitable care continue to receive tax-

exempt status under, say, the President's plan when they will be providing much less charitable care?

That is, a large portion of that care will be care where the hospitals are receiving income because this will be compensated care. That is, under the President's plan, theoretically, there should be much more compensated care. If that is the case, why should a hospital still be able to have total non-profit characterization and be tax-exempt?

Monsignor FAHEY. Well, just a couple of quick comments. The fact question, all I can say is, I hope you people are good enough to have a comprehensive health care benefit in which that reality that you are speaking of is realized. But I am not the least bit sanguine that we are going to develop a universal coverage program of a comprehensive benefit that is going to meet the needs of the people.

Senator BAUCUS. On that point, what if the plan is essentially successful and the vast majority of patients to whom you are now providing charitable care, in fact, become compensated care patients?

Monsignor FAHEY. First of all, it is awfully hard—I am not an attorney—to deal in hypotheticals. But, on the other hand, I think in the delivery of health care, to a large extent, we are talking about dealing with populations, we are talking about areas, we are talking about neighborhoods, we are talking about families.

The way in which the health care system works now is to drive the costs down and to pay for an individual unit of service; the whole idea of the DRG's, for example. And what we are saying, in our view of health care, that reductionist approach, highly technical, is a most unfortunate one.

And if, indeed, we are going to deal with the health of the people in the South Bronx, or people in Rossberg, Oregon, or someplace else, that health care providers have to be involved with public health, they have to be involved with a variety of community affairs that either caused the illness or will sustain people out of the——

Senator BAUCUS. All right.

Dr. Hyman, your reaction to all this?

Dr. HYMAN. Well, I think the point you made is really the correct one; if you relieve the burden you have to ask why you are going to continue the exemption, what is the logical reason for doing that? And I cannot think of one.

Senator BAUCUS. Perhaps one. There are some parts of the country where, with inner city hospitals and most particularly rural hospitals, if they have to close there is no alternative, there is no other health care.

Under the DRG prospective payment theory, the most efficient survive, the inefficient do not, but no big deal because if the inefficient fails there is a nearby efficient. That theory does not apply in rural America.

Dr. HYMAN. Obviously, the system works better in downtown Chicago where I am than it does in rural areas. At the same time, I think, to throw the question back to you, is an undifferentiated subsidy the best way to ensure the provision of health care in the rural areas? If you want to provide that, go for a targeted credit.

Senator BAUCUS. Thank you, Mr. Chairman.

The CHAIRMAN. All right. I notice that nobody asked Monsignor Fahey what he intended by the term reductionist, which is a very important proposition about the DRG's. It does leave out a population as you start getting concentrated on details.

Monsignor FAHEY. Yes. Far more, we define health care very narrowly. You know, the sociologists go one way as saying, health, disease, cure, is a social event. The way the health care system goes, it is more and more technical: we deal with an arm, a leg, a kidney, or whatever it is; get them in, get them out; do not worry about how they get there, do not worry about them after they leave the hospital.

The CHAIRMAN. Yes.

Monsignor FAHEY. And what we have to do, again, is somehow see health as a community event. I must say, I do not think we are paying enough attention to the performance of the health care system in terms of how it interacts with neighborhoods, families, and a variety of other things.

What we tend to concentrate on, even in the President's plan, how do you pay for discrete services in a very specific, concrete way? Frankly, in the long haul, that is wrong. We are going through an epidemiological transition from the provision of care that is acute care to basically chronic long-term care. All of us who are living longer all have chronic illnesses which will require the continuing support in a whole variety of different ways.

Reductionist, technical, narrow intervention, as good as it is, does not adequately describe or define the question of how health care especially chronic long-term health care ought to be delivered in this country.

The CHAIRMAN. May I just say, before we go any further, that whatever else happens, we are not going to finance universal health care by taxing St. Joseph's Hospital in Providence, Rhode Island. [Laughter.]

Senator CHAFEE. I can assure you, you will not, as long as I am around. [Laughter.]

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. It looks like St. Joseph's is pretty safe on this side.

Mr. Phelan, how would you respond to Ms. Lehnhard's assertion that all health plans—the HMO's, Blue Cross/Blue Shield, commercial insurance companies, and the new integrated networks—are essentially all in the same business and ought to be treated the same for tax purposes.

Mr. PHELAN. We think they are not in the same business, at least we think that Kaiser Permanente is in the health care business and pre-payment is simply a mechanism to finance that activity. And Blue Cross/Blue Shield's position, as I understand it, is that any health care organization, to be exempt, must operate on a fee-for-service basis rather than a pre-payment basis.

I think that, in response to that question and the question that Senator Chafee raised, that the central inquiry is whether the dominant aspect of the organization in question is health care orientation or simply a financing orientation.

As our testimony says, the principal value of health plans' exemption is developing the capital to build health care facilities. That is a need that Blue Cross or Blue Shield does not have, or Aetna does not have, it is a need that only health care organizations have.

Senator CONRAD. Ms. Lehnhard, would you like to respond to that?

Mrs. LEHNHARD. First of all, I would say that over 33⅓ percent of our enrollment is in network products, either HMO's or PPO's, and they are not fee-for-service, they are capitation. Second, I would say that we have a tremendous need for capital.

We have to maintain, say, reserves at a level to pay 3 months' worth of claims; Kaiser does not have to have that kind of solvency standard. We also have to spend millions and millions for claims systems and, as I said, we are purchasing hospitals, physician practices, group practices.

We are doing the same things they are, with the same kind of delivery systems. Under health care reform we will have the same benefits, same market practices, same delivery systems, and there will be no difference. That is our point. We have many Blue Cross and Blue Shield plans that have HMO's that look very much like Kaiser.

Senator CONRAD. I would like to ask any members of the panel who want to respond for your take on the following proposition. When the Finance Committee had its retreat, we heard from economists representing a broad range of ideological perspectives.

Virtually all of them, in my recollection, said that, providing for tax deductibility above at least a certain cap is giving inappropriate results. It is leading to utilization patterns which are not appropriate, it is having a whole series of effects in the system that add to cost.

When I think of the tax exemption that is provided for hospitals and I think of occupancy levels in my home town of 55 percent, two hospitals a few blocks apart, tremendous facilities, I must say it makes me at least ask the question, is there not a possibility that the tax-exemption has encouraged the over-construction of facilities, that we have got too much capacity in the system, partly because we have got a tax exemption?

Mr. Phelan, do you want to respond to that?

Mr. PHELAN. Well, I will respond only on behalf of Kaiser Permanente. And that is, in our system, we build only the hospitals that we need to take care of our members. We do not have that particular problem.

Of course, in most of our regions we utilize community hospitals and, to that extent, relieve any over-supply of beds in the community rather than building our own. Our principle hospital networks are in California.

Senator CONRAD. Monsignor?

Monsignor FAHEY. Well, I do not think there is any question but that the country has to wring out excess capacity and redistribute capacity as well, one way or another. Again, obviously, the administration's general approach to it at this moment is through competition. I do not know whether people realize it or not, getting out

the excess capacity is going to bring excruciating choices to a number of communities.

I am from a State, of course, that has gone into highly regulated situation, both in terms of capacity and in terms of payment. However we are going to get there. We have to wring out excess capacity in buildings. We have to shift into out-patient, which is more humane, more economic.

I think the tax-exempt question may be of some historical interest, but it is really the future that we are concerned about. We need some approach, either regulatory or competitive, that is going to wring out unneeded capacity without having social Darwinism, in which efficiency is only defined as—again, hear the words that are being used here: business, return on equity; a whole variety of things.

Many of the least efficient providers are going to be those that take care of the poor, are in rural areas. By their very nature they are non-competitive in a strictly commercial business industry approach. I do not think we can afford as a nation, to lose them.

Senator CONRAD. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. All right. Now, social Darwinism.

Senator CONRAD. I think we are against that. [Laughter.]

Monsignor FAHEY. And for subsidiarity.

The CHAIRMAN. I think we have also heard a lot of testimony to indicate that the surplus hospital capacity is the result of advances in medicine. The problem is, how do you deal with the side effects of good events?

Senator Bradley, do you want to help us on that subject?

Senator BRADLEY. I am sorry. Senator Rockefeller was diverting me from paying attention to the Chairman.

The CHAIRMAN. How do you deal with the unanticipated consequences of progress?

Senator BRADLEY. No.

The CHAIRMAN. No. All right. Get that down.

Senator BRADLEY. If I could think a little bit any kind of reform that we pass, it seems to me it is going to put pressures on non-profit hospitals to essentially reduce those things that are revenue losers, and that could mean reduced charity care.

And, as you know, before 1969, the IRS explicitly required charity care in order to maintain and qualify for the benefits of tax-exempt status, those being the charitable contribution, the bonds, 501(c)(3), et cetera.

I recognize that not all non-profits would be in this category, but it seems to me that in a reformed environment that there would be significant pressures for non-profits to reduce charity care because that is the best way they are going to make money.

So, my question is, would you agree that there be reinstituted a Federal requirement that non-profits, in order to qualify for non-profits, have to provide a certain percent of charity care?

Monsignor FAHEY. Well, in the testimony that I gave earlier, the Catholic Health Association, in effect, says, certainly, to qualify as a non-profit charity, you have to demonstrate community benefit in an effective manner, and we would call for that just as we would call for intermediate sanctions to deal with any private inurement.

Now, the specific technique in which this would be written, we think, would be better in the IRS code rather than in a statute, because if you freeze something in a statute, you are stuck with it in how you deal with it. You do not make a difference between Rossberg, Oregon, or Harlem Hospital, or St. Joseph's——

Senator BRADLEY. St. Joseph's.

Monsignor FAHEY [continuing]. Or Patterson, or whatever. There would be different ways in which these hospitals would fill their responsibilities, and I think we should recognize some way of doing it. It would be a real trick to do it, but I think the regulatory realm of the IRS would be best.

Senator BRADLEY. But would you agree that the current standard in this new environment should be made more explicit and strengthened so that it is clear that entity that has non-profit status has it because they are doing something that others are not doing, such as providing charity care.

Monsignor FAHEY. Absolutely. And you will see in our written testimony we have a number of suggestions.

Senator BRADLEY. Good.

Monsignor FAHEY. We concur wholeheartedly.

Senator BRADLEY. And, Mr. Phelan, tell me how you feel about it in terms of standards for community benefit for tax-exempt HMO's.

Mr. PHELAN. Certainly there should be a requirement of a community service obligation. Whether it should be quantified and how it should be quantified, I do not know, or whether there should be any quantification at all or left, as I think the Monsignor suggested, to administration.

Senator BRADLEY. Well, the benefit is clearly quantifiable with tax-exempt status, so if you are going to quantify one of the criteria for designation, it seems there is kind of a parallelism there. I mean, if you were a tax-exempt entity you would not be able to receive charitable contributions, you would not be eligible for tax-exempt bonds, et cetera.

Mr. PHELAN. That is certainly true. I was only suggesting that I am uncertain whether a strict mathematical measure is the necessary or the best way to identify the manner in which an organization can provide community benefit.

As I said earlier in the testimony, many insurance organizations have pre-existing condition limitations, or, if you get sick, they kick you out. We do not have those limitations. We think that those provisions are extremely beneficial to the community, but it is, we think, impossible to quantify them.

Senator BRADLEY. If the committee and the Congress wanted to strengthen what is required of tax-exempt HMO's in terms of standards of community benefit, what recommendations would you make to strengthen that?

Mr. PHELAN. Well, the Internal Revenue Service, when it acquiesced in the Sound Health Decision in 1981, issued a General Counsel's memorandum. And that, together with Sound Health, identified, I think, up to 20 or 22 factors that the IRS, under present practice, weighs to determine whether or not an organization meets standards for exemption.

Senator BRADLEY. Do you have anything else to add to that?

Mr. PHELAN. No, I think it is a fairly comprehensive list.

Senator BRADLEY. Mr. Chairman, I heard the bell.

The CHAIRMAN. No. You may ask another question.

Senator BRADLEY. I think that it would be very important for us to have the thinking of those who are responsible non-profits, both in the HMO area and in the genuine non-profit charitable area on this line of thought. It would be very helpful to me to make sure that we understand and we can make sure that non-profits are doing what we have given the tax-exempt status to do.

Mr. Chairman, I am not sure I am going to be around. I will try to be around the for the next panel. But, if I could just make a very brief comment.

The CHAIRMAN. Yes.

Senator BRADLEY. I know we are going to have testimony on tobacco and on guns, and I know that you have your proposal for taxes on ammunition. I have some taxes on guns, and certainly I think that the tax on tobacco—I really hope that the tobacco representative will explain to the committee in great detail why, if he does think that tobacco is not addictive, why he thinks it is not addictive. And, if he says it is addictive, I would like to know why it should not be passed.

The CHAIRMAN. Why do you not give us some questions, if that is the case, and we will put them in the record?

Senator BRADLEY. I certainly will. But I want to say that I agree with all of those.

The CHAIRMAN. Yes.

Senator BRADLEY. But I also profoundly would suggest that we need to look at the tax deduction for advertising of tobacco because there are minors in this country today that are getting very elaborate Joe Camel advertisements through the mail promising that if they buy X amount of Camels, just enough to buy more Camels, that they will get a free subscription, and all kinds of little trinkets. So I would hope that the committee, as we consider where we are going to get revenue sources, would look to that source for revenue in addition to the taxes.

The CHAIRMAN. Very clearly said. That is the Senator's right, and, in this case, a very important one. Perhaps you can stay; perhaps you cannot.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

I would like to revisit a couple of the answers that some of you have already provided in response to members' earlier questions.

Mr. Phelan, Senator Conrad was asking you about the tax-exempt status of Kaiser Permanente, and you answered that you felt your tax exemption was based upon the fact that you prepay. And I guess I would like you to elaborate, if you could. Does that mean that tax exemption is a function of when one pays?

Mr. PHELAN. No. I think it was the other way around. That is, I think that we are a health care delivery system and we finance that delivery system through prepayment rather than through fees for services.

And I am suggesting that a non-profit health care delivery system should not be punished, as it were, if that is the right word,

for utilizing prepayment as the mechanism for funding its activities as opposed to fee-for-service funding of activities.

Senator DASCHLE. But that is a reiteration, I think, of the point that you made to Senator Conrad.

Mr. PHELAN. Yes.

Senator DASCHLE. I guess I am wondering why it is that prepayment ought to be the criteria one judges for tax exemption. Ms. Lehnhard was commenting earlier that at least 30 percent of their business is also on a prepayment basis, for which there are no tax-exemptions.

Mrs. LEHNHARD. I would say that all of our business is prepayment. We do not see any difference between prepayment and a premium.

Senator DASCHLE. That is my point. How would one differentiate, if you were in our position, between your situation, which is prepayment, and Blue Cross, which is also prepayment but in a different form?

Mr. PHELAN. Well, I would differentiate it, again, on the difference between simply financing and providing. When the Blues get their subscribers, their policyholders' payments in the mail, I assume they put the money in the vault and wait for the claims to come in. When we get our subscribers' dues payments, they are immediately applied to sustain a health care capability that is there.

Senator DASCHLE. Let us pursue that a little bit. Does that mean that every time somebody prepays, immediately somebody walks in the door who has just made that payment to demand the services rendered as a result of that payment? I mean, do you not also keep the money, as would an insurance company, and wait for that person to come in at some later date, or use the money that that person paid for services somebody else may be obtaining?

I mean, you do not do this on a personal basis, do you? You collect the funds, you pool those resources, you use the resources for anybody who may subscribe to your services regardless of whether it was their resources or somebody else who may have paid in; is that not right? So, is that not, in a sense, an insurance function?

Mr. PHELAN. There is a risk distributing function with respect to the health plan. There is no question about it. However, predominantly we are, again, a health care system and we have, as I said, billions of dollars in facilities, we have many thousands of health care personnel who are there and who have to be paid for with those dues; conventional insurers have none of that.

Senator DASCHLE. Well, if I were answering my own question it would seem to me that what you are suggesting is that you do not have an intermediary; you take the money from your subscribers and pay directly to the service providers and the care-givers, without going through a contractor, which, in this case, would be an insurance company.

Blue Cross/Blue Shield is doing that more and more as well, as I understand it, although there still is an intermediary for maybe two-thirds of the business they do. But isn't that really the difference, that in your case you do not have that intermediary?

Mr. PHELAN. Well, also, there is an element of the manner in which the money is applied. Kaiser Permanente has substantially

fixed costs. The hospitals are there, and they have to be maintained, and staff has to be paid irrespective of utilization, and the same with respect to the physicians. The medical groups are paid on a per capita basis, and those payments are made to medical groups irrespective of utilization.

Ms. Lehnhard, earlier, mentioned that they have substantial reserves, and we do not have substantial reserves; we are not required to have substantial reserves under State law, and that is perfectly true. The reason that we do not have to have reserves is because we maintain health care capability to provide benefits, whereas insurance companies have to have the dollars to pay benefits.

Mrs. LEHNHARD. Senator.

Senator DASCHLE. Ms. Lehnhard.

Mrs. LEHNHARD. Senator, one comment on the structure of Kaiser. It is not unlike many Blue Cross and Blue Shield HMO's. Columbia Medical Plan is a Blue Cross and Blue Shield HMO.

Kaiser, for example, is a holding company. It has a for-profit group practice as the physician part. It is for-profit, taxable. And, in many places, they own a hospital, in other places they pay hospitals fee-for-service. In the District I think Kaiser pays hospitals fee-for-service. We are saying there is no difference.

Senator DASCHLE. I am sufficiently confused, but thank you. Thank you.

The CHAIRMAN. I think you are.

Senator Rockefeller, clear this up for us, would you, please?

Senator ROCKEFELLER. Mr. Chairman, I have no questions.

The CHAIRMAN. No questions.

Senator Danforth?

Senator DANFORTH. I apologize to the panel for not being here for your testimony. Mr. Martinez, you had one point to make which I think is a very important one, and it had to do with the $150 million cap on tax-exempt bond financing. It is my understanding that you believe that, because that cap does not apply to hospitals but does apply to other kinds of health care facilities, it is disadvantageous to those particular facilities, clinics, and out-patient health care facilities of various kinds. Could you just reiterate for me the basic point that you are making?

Mr. MARTINEZ. Very clearly, if we take a look at the need in the urban areas and the rural areas to try to get people out of the emergency rooms being their primary health care provider and into community-based health care facilities, the way that we can most effectively provide the financing is through a tax-exempt provision of bonding.

The CHAIRMAN. If I could just interrupt to say that Mr. Martinez used the term "non-hospital health care facilities."

Mr. MARTINEZ. Many of the facilities that we are talking about will not be actually run by a hospital. They may have an affiliation with a hospital, but it will be a tax-exempt organization that will go out and provide the actual service in the community.

Increasingly in New York, as an example, we are seeing a strong need to have many more diagnostic and treatment centers developed, not only in New York City in the five burroughs, but in the

upstate area, which is primarily more rural, because we do not have the delivery system.

Our State is one in which the reimbursement system pays the capital cost of providing these types of facilities and it does not make sense to us to have that reimbursement system which is paid partly by the Federal Government, by the State Government, and by local government, paid at a higher capital rate, which is what happens when you are doing it on a taxable basis as opposed to tax-exempt. We want to facilitate that access by ensuring that the $150 million cap, as we move forward, will not be an obstacle to providing that type of facility.

Senator DANFORTH. Is it an obstacle today?

Mr. MARTINEZ. We are just moving in that direction. We anticipate it is going to become an obstacle because many of the non-profit, non-hospital entities that were going to become involved in this are already at their cap, or soon will be at the cap of $150 million.

Senator DANFORTH. Now, our Chairman has taken the position in the past that the bond cap, where it applies to research institutions, is really a disservice, it is contrary to the National interest and we should eliminate that cap.

You would not argue that we should retain it for everybody else, would you? In other words, if we went further than you are advocating and applied it not only to health care facilities other than hospitals, but also to universities and those that do research.

Mr. MARTINEZ. I am only suggesting that the cap be removed as it relates to the non-hospital health care providers.

Senator DANFORTH. I know. But you would not argue against us making it more broad, though.

The CHAIRMAN. That answer, Mr. Martinez, is that you would not. [Laughter.]

Go ahead.

Senator DANFORTH. Well, obviously I am using this to give a little commercial to something that Senator Moynihan and others, including myself, have taken an interest in in the past, especially with respect to our research universities and some of our great institutions in this country. They have reached the bond cap.

This is not a question of something in the future, they have reached it. We have taken a position in our tax law that, too bad for them. But their needs are for facilities, their needs are for equipment, some of which is very expensive. The bond route just is not there, the tax-exempt bond route is not there.

Of course, what I fear is that we will start taking, instead of one type of facility such as yours, taking that out from this general problem that we have, and, therefore, the pressure will be less for solving the whole problem.

And I was simply making the point that I would hope that, instead of trying to save our own skins and forget about everybody who is disadvantaged by this bond cap, maybe we can deal with the whole problem.

Mr. MARTINEZ. Actually, we do see a logical linkage because many of the health care facilities are associated with many of the institutions of higher education, and there is a symbiotic relationship there. But, because I only deal with financing for health care

facilities, I do not try to assume that I should be able to speak on behalf of the educational facilities.

Senator DANFORTH. Thank you.

The CHAIRMAN. Thank you, Senator Danforth.

We want to express great thanks to this panel who has presented us with new information.

Senator PACKWOOD. I need to clarify one thing.

The CHAIRMAN. Yes, sir.

Senator PACKWOOD. I made one misstatement. What was your principle? Sub-what?

The CHAIRMAN. Subsidiarity.

Senator PACKWOOD. Well, it turns out that Kaiser is not in Mr. Stark's district, it is next door to Mr. Stark's district. Where does that fit in the principle?

The CHAIRMAN. That would do. All politics is mostly local, or near local.

Senator PACKWOOD. And, indeed, I want to emphasize he was not out to save Kaiser, he was just out to do in the Blues, as I recall. [Laughter.]

Senator PACKWOOD. But I do want to ask one thing about Kaiser, because I do not want to leave a misimpression. It has been 30 years since I bargained in the collective bargaining contracts. In those days, when an employer picked Kaiser, we always had an opt out; the employee could go someplace else if they wanted. I was always quite amazed with the satisfaction of the employees; most of them stuck with Kaiser and stayed there.

I want to know if you still follow a policy that you had then. When you took a group you did not attempt to exclude anybody in the group. It was, in essence, open enrollment regardless of pre-existing condition in the group. Is that right?

Mr. PHELAN. That is correct.

Senator PACKWOOD. And you have groups as small as two?

Mr. PHELAN. I know it is three. I do not know if we go to two, or not. But we, of course, have individual enrollment as well.

Senator PACKWOOD. Yes, I understand that. And you had a community rating system where you did not vary much more than, I would say, about 5 percent of a big group or small group.

Mr. PHELAN. Well, for many, many years we had a pure community rating system under which all groups with the same benefits paid the same rate. A few years ago we went to a method that is contemplated by the HMO Act called Adjusted Community Rating. It is still community rating based, and there are limits on increases from year to year.

Senator PACKWOOD. And it is a very small variance among the groups even, as I recall.

Mr. PHELAN. I am sorry, Senator. I do not know the precise variance.

Senator PACKWOOD. All right. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

As we thank our panel, let me just say that one of the things that we have learned—certainly I have learned—in the course of this year is we are, in fact, in the heroic age of medical discovery; at the beginning of the century it was physics, at the end of the

century it is medicine. Everyday we learn of something new. What Senator Danforth was saying about the role of research universities and institutions—most of the things you read, you would not have been able to compose a sentence about 30 years ago.

This morning on the front page of the Washington Post, "Mice Making Human-Like Antibodies—Medical Implications Called Stupendous." Scientists have produced a genetically altered strain of mouse that makes antibodies identical to those made in humans, and these are the proteins that seek out and destroy microbes.

The implications for a whole range of viruses, tumors, and faulty immune cells is extraordinary. Day by day this happens, and we want to make sure we do not put an end to these discoveries as we rationalize health care and do all the things that many of you have been talking about.

This is just to say thank you. Thank you very much, indeed. I think Dr. Hyman has views he did not fully express. We would particularly like to hear from you on these subjects. Thank you again.

[The letter of Senator Wendell Ford appears in the appendix.]

The CHAIRMAN. Now we are going to have a panel that will discuss two aspects of taxation. One of the more distinctive elements of our hearing so far has been the question of financing this new system, so we are going to hear from Michael K. Beard, who is the president of the Coalition to Stop Gun Violence. Mr. Beard, good morning. Mr. Beard is bearded.

And Richard J. Feldman, who is General Counsel of the National Police Athletic Leagues. Mr. Feldman, we welcome you. I was a member of the Police Athletic Leagues in New York City in the 1930's.

Dr. Robert Tollison, who is a professor of economics and director of the Public Choice Center at George Mason University, a distinguished institution nearby.

And Dr. Kenneth Warner, who is professor and chair of the Department of Public Health Policy and Administration at Ann Arbor at the University of Michigan, who is appearing on behalf of the American Cancer Society, the American Heart and the American Lung Associations.

Mr. Beard, you are first. We welcome you all. Each statement will be placed in the record, and off we go.

STATEMENT OF MICHAEL K. BEARD, PRESIDENT, COALITION TO STOP GUN VIOLENCE, WASHINGTON, DC

Mr. BEARD. Thank you very much, Mr. Chairman. On behalf of the 40 national organizations and the over 120,000 members of the Coalition to Stop Gun Violence, I would like to thank you for inviting us to testify today.

The coalition fully supports increasing the tax on handguns and handgun ammunition and using the increased tax revenue to pay for health care for two primary reasons.

First, the overall fiscal impact of gun violence, especially to health care providers, is negative. The Nation loses more than $20 billion a year treating gun violence victims. Under the present system, these costs are borne primarily by the taxpayers; 86 percent, according to the most recent study.

The Coalition to Stop Gun Violence believes that it is entirely appropriate to tax those who make, sell and buy handguns to cover some of the costs. Those involved in the handgun trade must acknowledge their responsibility in the violence which inevitably results from the use of this most dangerous consumer product.

Second, increasing the tax will dissuade, hinder, or perhaps prevent some people from purchasing handguns. Handguns represent a public health danger to both their owners and to society at large. The fewer people who purchase handguns, the fewer people who will be killed with handguns, especially children.

I am not talking simply about handguns used in crimes. Handguns in the home represent a danger to family and to friends. In my written statement, I go into some detail about the research which has been conducted to validate this position.

But let me just state, as I have so many times in the past that I have forgotten whom I have stolen this line from, if handguns made us safe, the United States would be the safest society in the world.

I would like to address a couple of important points. The legislation we are discussing in no way affects hunting, hunters, or other legitimate sports shooters. We have drawn a distinction between handguns and long guns, shotguns and rifles, for the simple reason that handguns are more likely to be misused than long guns.

Although handguns comprise only about one-third of the private arsenal in the Nation, they are used in more than eight out of 10 of the gun deaths, and in a majority of all murders.

Between 1987 and 1992, the number of murders increased by more than 3,000, an increase comprised entirely of handgun murders, as murders by all other uses declined over that same time period.

If anyone is concerned that the assault weapon language in Senator Bradley's bill will somehow affect sporting weapons, that is simply a smoke screen and, hopefully by next week, will be a moot point as well.

As you know, the Senate has already approved, as part of the crime bill legislation, a ban on assault weapons. At the same time, the legislation specifically exempts more than 650 sporting firearms currently on the market. Obviously, the U.S. Senate has no intention of interfering with legitimate sport shooting activities.

I urge you to consider for a minute the impact that gun violence has on our economy. Schools, which spend large portions of their budget on metal detectors and security officers, are not spending that money on books and teachers. The students whom these schools graduate are not as likely to obtain the education needed to be productive members of a work force as others.

Housing officials who spend precious resources to remove guns from public housing complexes are using up resources that should be used in less violent settings to build more and better housing.

Foreign tourists who are afraid to travel to the U.S. spend their money elsewhere, and U.S. citizens who are afraid to travel to New York City, or Newark, or any of our major urban areas, are keeping their money instead of spending it as tourist dollars.

In Florida, we know that car rental companies are no longer placing their decals on cars for fear that they mark the cars as a

target for armed carjackers. Too many businesses and other establishments—restaurants, office buildings, courtrooms, shopping malls—are forced to spend large amounts of money on security and other measures to prevent gun violence. Gun violence is a problem the rest of the developed world does not worry about. In short, gun violence is not good for American business.

If this legislation displaces some of the small number of workers who derive their income from handguns, then we believe the government should assist in retraining them to find other work, just as tobacco growers might be given assistance in growing other, more useful crops. Workers who derive their livelihood from sport shooting will not be affected by these taxes.

Thirty years ago, this Nation awoke to the dangers of tobacco, and today tobacco use has declined dramatically. We must now realize that handgun violence has reached a similar dimension as a public health crisis.

We must educate Americans to the danger of handgun ownership and enact laws which make it more difficult for individuals to purchase handguns. The time has come to shift the societal burden of gun violence to those who make, sell, and buy handguns and away from the general public.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Beard.

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

The CHAIRMAN. Mr. Feldman, I think, is arguing otherwise.

STATEMENT OF RICHARD J. FELDMAN, ESQ., GENERAL COUNSEL, NATIONAL POLICE ATHLETIC LEAGUES OF AMERICA, EXECUTIVE DIRECTOR, AMERICAN SHOOTING SPORTS COUNCIL, INC., ATLANTA, GA

Mr. FELDMAN. Thank you, Mr. Chairman. Let me clarify, I am here today representing the American Shooting Sports Council. I am the General Counsel of the National Association of Police Athletic Leagues.

The CHAIRMAN. Exactly so.

Mr. FELDMAN. And we will be having our 50th anniversary this year in Hophog, New York. I would like to invite you to attend.

The CHAIRMAN. My God, that is upscale for the PAL. But, good.

Mr. FELDMAN. On behalf of the American Shooting Sports Council, representing the firearms industry, it is a pleasure to be here today. The ASSC represents the manufacturers, importers, distributors, retailers, independent representatives, publications, and other service-related entities within our industry.

The American firearms industry represents a $24 billion segment of the Nation's economy. We employ hundreds of thousands of American taxpayers, support additional hundreds of thousands of American dependents, and play a vital role in the economic health of numerous other sectors in the American economy, from steelmakers, to over-land common carriers. We are not just another industry, we are the quintessential American industry.

Our customers represent half of all the households in America, and include in their numbers doctors, lawyers, union workers, single parents, housewives, and, yes, even United States Senators. In short, they are everyday citizens who happen to own firearms.

They commit no crimes and make no headlines; they represent mainstream America.

As every law student has been taught and every historian to cite, the power to tax is truly the power to destroy. Several years ago, Congress passed a luxury tax on boats. Prior to that tax, the boating industry was a robust industry with a substantial economic impact on the U.S. economy. In the few years following the imposition of that tax, the boating industry declined to near extinction.

By raising the cost of factory ammunition beyond the reach of the average American shooter, this tax will destroy an important segment of America's economy. First, it will cost jobs: lots and lots of jobs. Second, it will prevent tens of millions of your constituents who participate in the shooting sports from doing so easily and safely.

Third, it will harm conservation efforts because it will lower excise tax revenues, not increase them. Fourth, it will diminish firearm safety training due to lower funding, which increases the number of firearm accidents in direct contradiction to raising monies to provide for health care.

Finally, the bill will not reduce crime, nor criminals' misuse of our products and no fair-minded individual outside the Beltway thinks it would.

Just in the States represented by the members of this committee, there are over 239,000 jobs and $6.2 billion which are placed at risk by this bill. Once again, no crime would be prevented.

In addition, this bill adversely impacts the environment. The firearms and ammunition industries fought for and supported the existing 10 and 11 percent excise tax on firearms and ammunition because it was earmarked for conservation purposes. Those funds are currently used for wildlife preservation and safety training.

In conclusion, this tax is a scapegoat for the failings of the criminal justice system and a health care system run amuck. It is farcical to believe it would lower criminal violence, and comical to think that the American people are so gullible as to buy into these bait-and-switch tactics. The collateral damage done to the American economy and its citizens will not go unnoticed, nor easily forgiven.

Mr. Chairman, we made the funds——

Senator ROCKEFELLER. Mr. Feldman, can I interrupt you?

The CHAIRMAN. Of course you can, Senator Rockefeller.

Senator ROCKEFELLER. Was that a threat?

Mr. FELDMAN. No, sir.

Senator ROCKEFELLER. Well, could you repeat your statement, the sentence you just read?

Mr. FELDMAN. People, when they lose their jobs——

Senator ROCKEFELLER. Well, you were reading. Read what you said.

Mr. FELDMAN. I would be happy to, Senator.

The collateral damage done to the American economy and its citizens will not go unnoticed, nor easily forgiven.

Senator ROCKEFELLER. By your organization?

Mr. FELDMAN. By the American people, your constituents, sir.

Senator ROCKEFELLER. I see. The tenor of the way you are giving your testimony seems to me that you are very angry.

Mr. FELDMAN. Oh. No, sir. I am——

Senator ROCKEFELLER. Is there an aura of retribution that you wish to put forward. Am I wrong?

Mr. FELDMAN. You are, sir. I am sorry if you came to that conclusion from my remarks. It was certainly not intended that way whatsoever.

The CHAIRMAN. That helps, Mr. Feldman. You were not getting anywhere with the chairman of this committee, and had the distinguished Senator from West Virginia not spoken, it would have fallen to me to do so.

Now, smile once more for the camera and finish your testimony; we have interrupted you.

Mr. FELDMAN. Thank you, Mr. Chairman.

We made the guns that Americans used to make this country free. We made the guns that Americans used to fight tyranny and genocide all over the globe. We make the guns and ammunition that protect law enforcement and honest citizens from criminal violation.

Unless this Congress taxes us out of existence, we will continue to make the guns and ammunition that Americans will use to keep America free and secure today, tomorrow, and forever.

Mr. Chairman, members of the committee, I would like to thank you for this time and the opportunity to present our views.

The CHAIRMAN. We thank you, Mr. Feldman.

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

The CHAIRMAN. Now we will go to the second subject of our panel, which is the proposed taxation on tobacco, and then we will get back to questions about all of them.

Now we turn to Professor Tollison. I wonder if it would not be better to hear, in the pattern we have done here, Dr. Warner and then hear Dr. Tollison in the mode of rebuttal. I think that probably is more useful.

Dr. Warner, good afternoon, sir. We welcome you. You are speaking on behalf of the American Cancer Society, the American Heart Association, and the American Lung Association.

STATEMENT OF KENNETH E. WARNER, PH.D., PROFESSOR AND CHAIR, DEPARTMENT OF PUBLIC HEALTH POLICY AND ADMINISTRATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN, ANN ARBOR, MI, ON BEHALF OF THE AMERICAN CANCER SOCIETY, THE AMERICAN HEART ASSOCIATION, AND THE AMERICAN LUNG ASSOCIATION

Professor WARNER. Thank you, Mr. Chairman, members of the committee. I am Kenneth Warner. I am an economist at the University of Michigan School of Public Health. I have studied the economic and public health aspects of tobacco for nearly two decades at this point.

In 1989, I served as the Senior Scientific editor of the 25th anniversary Surgeon General's report, and, in 1992, I chaired a panel of 26 experts convened by the National Cancer Institute for the purpose of assessing the impacts of tobacco taxation.

I am pleased to be here on behalf of the three organizations that the Chairman noted. They are united in the form of the Coalition

on Smoking Or Health, and, with 100 other health and civic organizations, they are supporting a very major increase in the cigarette excise tax, on the order of $2 per pack.

In support of this objective, I would like to offer the following observations. First, a major increase in tobacco taxes is sound health policy. Based on a wealth of economic and epidemiologic analysis, we estimate that President Clinton's proposal to raise the cigarette tax by 75 cents per pack would reduce consumption by approximately one-eighth, and would discourage some 3.7 million Americans from smoking. This would eventually result in 900,000 fewer premature deaths.

A $2 tax increase would reduce consumption by nearly one-quarter, would encourage well over seven million Americans not to smoke and, ultimately, would reduce the number of premature deaths associated with smoking by almost two million people.

The second point. A major increase in tobacco taxes is good health care policy. Current and former smokers consume half a trillion dollars in excess lifetime health care costs. Reductions in smoking can be expected to decrease health care expenditures.

Third. Tobacco taxes are a highly reliable source of significant revenue, and they will be for the foreseeable future. While tobacco taxes will decrease consumption, they will do so in a proportionate manner considerably less than the increase of the tax rate itself.

The Joint Committee on Taxation, the Congressional Budget Office, and the Department of Treasury concur that a 75 cent cigarette excise tax increase will generate $10–11 billion in net revenue gains over each of the next 5 years, and beyond. If you look at a $2 per pack tax, you are talking about revenue gains, again, net, on the order of about $100 billion over the next 5 years.

Fourth. It is fair to single out tobacco as a source of revenue for health care reform. We are talking about a unique product here. Tobacco kills hundreds of thousands of Americans each year; indeed, it kills more than all other consumer products combined.

Its most important ingredient, nicotine—which, by the way, is an insecticide—is highly addictive. Significantly, virtually all new tobacco users are children, and the health burden of smoking is experienced disproportionately by the poor. A major tax increase would be expected to reduce smoking most dramatically among young people and in low-income communities.

Fifth. Tobacco taxes are a popular financing mechanism for health reform. A recent national poll shows that two-thirds of the American public support a $2 per pack increase in the cigarette excise tax. And, I might note, this includes 65 percent of voters in the tobacco States, and fully one-third of smokers who support a $2 increase.

Before offering a concluding observation, I want to comment, briefly, on three arguments that are raised by opponents of a tax increase. More detailed responses are presented in my written testimony.

First, the tobacco industry claims that a tax increase will cause major job losses. The industry is knowingly grossly exaggerating the magnitude of job losses, if, in fact, any will occur on balance. Our own research demonstrates that in a non-tobacco State, decreases in tobacco consumption will increase employment.

Money not spent on tobacco products is, instead, spent on other goods and services, thereby generating employment in other industries. I should note that one of the Tobacco Institute's own economic consultants made this observation to the institute in a report written in the mid-1980's.

Second. Economists who oppose a cigarette tax increase on economic theory grounds predicate their entire argument on the conventional model of rational economic behavior. That model assumes that adults make free, fully-informed consumption decisions. Not one of these assumptions holds in the case of tobacco use.

Young children make the all-crucial initial consumption decision, not adults. Thereafter, nicotine addiction means that decisions are not made freely and consumers are certainly not fully informed. The standard model of rational economic behavior simply does not apply here; therefore, neither do these economists' conclusions.

Third. In addition to the flawed conceptual starting point, economists who take this approach use gross under-estimates of the external costs of smoking when they argue that smokers already pay their own way through existing taxes.

To note only one example, there is some very impressive recent research that suggests that the mortality toll associated with environmental tobacco smoke may be more than 10 times as high as the numbers that these economists are using in their analyses.

Clearly, members of the committee, there is a very appealing conceptual tie between taxing the leading cause of preventable illness and restructuring health care delivery and finance.

I want to make one point very emphatically, however. Please note that a substantial increase in the cigarette excise tax would constitute significant health care reform all by itself, simply by virtue of the enormous health benefits it would produce and the associated decrease in the Nation's health bill that would follow. In addition, of course, it would be raising billions of dollars to help finance the Nation's remaining health care expenses.

I think you have before you an extraordinary opportunity to do some public health good while doing some fiscal good at the same time. I hope that you will avail yourselves of that. Thank you.

The CHAIRMAN. Thank you, Dr. Warner.

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

The CHAIRMAN. And now, to conclude our panel, Dr. Tollison, who is a Duncan Black Professor of Economics in a hotbed of rational expectation at George Mason University, and you are appearing on behalf of the Tobacco Institute. We welcome you, Doctor.

STATEMENT OF ROBERT D. TOLLISON, PH.D., DUNCAN BLACK PROFESSOR OF ECONOMICS, AND GENERAL DIRECTOR, PUBLIC CHOICE CENTER, GEORGE MASON UNIVERSITY, FAIRFAX, VA, ON BEHALF OF THE TOBACCO INSTITUTE, WASHINGTON, DC

Dr. TOLLISON. I am, indeed. I thank you and the distinguished members of the committee. My name is Bob Tollison. I am a Professor of Economics at George Mason University, and I appear today on my own behalf at the request of The Tobacco Institute.

I was going to read my statement, but I think I can just go down the points that Professor Warner raised so as to——

The CHAIRMAN. Your statement will be in the record.

Dr. TOLLISON [continuing]. Join the debate, perhaps, a little more efficiently than if I simply read a summary statement.

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

Dr. TOLLISON. Point number one. I think it is not correct to single out tobacco as a product that uniquely has risk associated with its consumption. I think that model and the incumbent model of taxation that goes with it can be expanded to a wide variety of lifestyles and commodities in the economy, and I am certainly willing to say more about that if you want in the discussion.

Second, my understanding of this bill is that it is a finance bill, so the second point that Professor Warner raised is really important: will this tax increase health care costs in the long run, or will it reduce them? He says it will reduce them.

I do not think there is very much credible evidence that that is true, and I think studies by OTA and other agencies of the Congress attest to the fact that the tax on smoking would very likely in the long run increase health care costs and other unfunded social transfer liability programs of the Federal Government.

Senator BRADLEY. Because people would live longer, right?

Dr. TOLLISON. Under their assumption, yes.

Senator BRADLEY. Right.

Dr. TOLLISON. Right. Do we want to go into this at this point?

Senator BRADLEY. Unbelievable.

The CHAIRMAN. Sure. You tell us what you think.

Dr. TOLLISON. Well, it seems to me there are two points, Senator Bradley. At whatever time and for whatever reason people expire, we are not all guaranteed our 4 score and 7 years, they stand in some net relationship to the government.

They are either "givers" or "takers" with respect to their fiscal relationship to the government. It seems to me, if one wants to articulate a theory that certain lifestyles expire early, then that is a magnitude that ought to be counted in their favor in that regard.

Senator BRADLEY. Could I interrupt you there? And that means that all the rest of us have to pay for it too, because it is our tax dollars that are going to take care of these people who are exercising the free choice to expire at a young age because they are smoking.

Dr. TOLLISON. No, quite the contrary. I think the implication of the argument is that if you assume that smokers expire early, this tax is going to make them expire later, according to the calculations. They are going to live——

Senator BRADLEY. So, basically, your argument is that it will cost taxpayers more because people will be living longer and drawing more Social Security and more Medicare, and it, therefore, should be the policy of government to try to not discourage those things that allow people to live longer. Now, I mean——

Dr. TOLLISON. Is it not a fact that the predominant health care costs come at the extremely elderly ages? Is that not a fact? Is this not a finance bill? I mean, the question——

Senator PACKWOOD. Well, let me interrupt now. I think I know what Bill is driving at. Indeed, in terms of reducing costs in Medicare if we encourage more smoking, we will reduce the Medicare cost. [Laughter.]

Senator BRADLEY. Well, no, no. By this analogy we should not have seat belts, by this analogy we should have no safety at airports, by this analogy we should have nothing that could deny somebody the right to die earlier by their personal choice.

Senator PACKWOOD. I think Dr. Tollison is dividing this into purely economics, if I understand what you are saying.

Dr. TOLLISON. I am simply accepting the assumptions that undergird the point that Professor Warner made. You need to know whether this tax is going to increase health care costs or reduce them in the long run.

Senator PACKWOOD. Then let me follow-up Bill, if I can, for just a second. "Mice Making Human-like Antibodies." Now, if this works we are talking about extending people's lives extensively with these mice, and are going to cause more health care costs because we are going to extend them to a longer age. Would the logic be that we should think of these things like tobacco in the sense of, are they going to cause us increased costs?

Dr. TOLLISON. Indeed. I am trying to follow out the assumptions of the argument. This is not my only argument against the excise tax.

Senator BRADLEY. Let me just ask one more question; I know the Chairman is giving me the opportunity.

Then by this logic, you think that it is better not to intervene toward the end of someone's life in order to further that person's life, and, indeed, you agree with Mr. Kevorkian and all the others who want to end life early.

Dr. TOLLISON. I do not see what that has to do with the discussion. That is not on the table at all.

Senator BRADLEY. Well, if you did not deny them they would live life longer and cost all of us more money.

Dr. TOLLISON. You are asking me my position about the way individuals should be allowed to behave in their private lives and the economy. I believe in liberty. I believe that they ought to be able to consume things, under a well-informed state——

Senator BRADLEY. Right.

Dr. TOLLISON [continuing]. Such as tobacco and take other such risks as may lead to health care costs in the future over some horizon. That is what I believe.

Senator BRADLEY. Do you believe that they have a right for a tax subsidy to do that? Do you believe that the companies who promote the use of tobacco by young people have a right to a tax subsidy on advertising?

Dr. TOLLISON. Is that the question?

Senator BRADLEY. Yes.

Dr. TOLLISON I think that tobacco is a legal product and is entitled to that advertising treatment, as other companies who advertise are. I think that the Tax Code is complicated enough. You were a well-respected and revered champion of broad-based, clear, uncomplicated taxation in the mid-1980's, and I would assume that that proposal would go in an opposite direction.

Senator BRADLEY. So that, from your standpoint then, there is no underlying tax theory argument, it is that, you know, whatever is in the Tax Code is in the Tax Code; some things are in, some things are out.

If you choose not to allow a deduction for advertising, people say, this is a right of free speech. This is not a free speech right, this is an issue of, do you have a right to a tax deduction. And my view is, you do not have a right to the tax deduction if your activity is luring 16-year-olds into the consumption of a product which will shorten their lives.

And the issue of free choice, when you are 15 years old and you get a big Joe Camel advertisement that comes into your house and promises you, you can get shirts, you can get trinkets, just smoke Camel cigarettes, from my standpoint, that is a matter of conditioned choice.

The CHAIRMAN. Well, let us, even so, hear what it is from Dr. Tollison's standpoint. And I did note that he comes from a hotbed of rational expectation theory, and a very distinguished faculty it is, too. Proceed, sir.

Dr. TOLLISON. All right. Let me proceed to Professor Warner's third point, just in the interest of trying to join this debate a little further. He says that the tobacco tax is a reliable tax.

I think two points are relevant in that regard. I think the estimated revenues of this tax are about twice too high. The price of tobacco products is in the CPI. It gets nicked up by this tax increase by about a percent. The federally mandated programs that are——

The CHAIRMAN. By about a percent?

Dr. TOLLISON. About a percent.

The CHAIRMAN. Wait. One full percent to the CPI?

Dr. TOLLISON. Yes.

The CHAIRMAN. Instead of 3.1, 4.1?

Dr. TOLLISON. No, I am sorry. The weighting of tobacco products——

The CHAIRMAN. The weighting will go up. Yes.

Dr. TOLLISON [continuing]. Is such that this 75-cent tax increase translates to about a percent increase in the CPI. That is my calculation. I would be happy to——

The CHAIRMAN. Send them over, will you?

Dr. TOLLISON. I would be happy to provide them.

Senator BRADLEY. A percent increase. One percent.

The CHAIRMAN. It is what we call counter intuitive at this point, but, listen, we have great respect for that operation across the river.

Dr. TOLLISON. Well, let me just check this. I have a calculation at .7 percent.

The CHAIRMAN. Very interesting, indeed.

Dr. TOLLISON. In, fact, I had an op-ed——

The CHAIRMAN. Which has associated cost increases in other matters.

Dr. TOLLISON. Yes. Which must be netted out against the extra revenues. In fact, I had an op-ed in the Washington Times on the subject, so I would be happy to provide the calculations.

The CHAIRMAN. We would appreciate it, Dr. Tollison.

[The information appears in the appendix.]

The CHAIRMAN. And Dr. Warner will have a chance to comment.

Dr. TOLLISON. Absolutely.

The fifth point. The tax is a regressive tax. I do not think you can kid yourself that you are not taking $400 a year away from low-income, working class smokers by passing this bill. Now, maybe there will be other effects through the health care reform system that would restore that in some manner or fashion, and Professor Warner talks about those in his statement.

But I think the only sure thing you are doing here is taking $400 a year from low-income smokers. That is for sure. The rest of it, you really do not know if it will translate and go through in exactly the way it has been discussed.

The next to last comment, is the good, economic theorists who have attacked this problem, Tom Schelling of the University of Maryland, Joe Newhouse of Harvard, Winfred Manning of the RAND Institute.

The CHAIRMAN. Surely, Tom Schelling is at Harvard.

Dr. TOLLISON. No, he moved to the University of Maryland, sir.

The CHAIRMAN. I am sorry. Thank you, sir.

Dr. TOLLISON. And these studies are reviewed in this Congressional Research Service report to the Congress. This is an excellent review of those studies. Every one of these people who carefully apply economic methodology to the issue of taxing smoking come to one simple conclusion: the tax is already too high. It is too high by about 25 cents.

The CHAIRMAN. Too high for what purpose?

Dr. TOLLISON. It is too high to cover the so called external costs, the social costs, that smokers impose either through the health care system, or through passive smoking, or through any other mechanism that is deemed relevant in those analyses.

Senator BRADLEY. And that is because, after a certain tax increase, there is less revenue coming in; is that it?

Dr. TOLLISON. No, I am sorry. The art form is to calculate what those external costs are and compare them to the prevailing level of excise taxation. The art form is to get the excise tax——

The CHAIRMAN. But that does not exclude that we use it just purely for revenue purposes.

Dr. TOLLISON. Right.

Senator BRADLEY. How would you price out 400,000 lives?

Dr. TOLLISON. They do, sir.

Senator BRADLEY. What is the cost in your theory, on the 400,000 lives that are lost every year because of smoking?

Dr. TOLLISON. It is not my theory. They parse out what cost of the act of smoking are, in fact, borne by smokers.

Senator BRADLEY. Well, what is the cost of a life?

The CHAIRMAN. We had Monsignor Fahey here earlier, and I think we really ought to—

Dr. TOLLISON. Thank you. Thank you very much.

The CHAIRMAN. Dr. Tollison is an economist.

Senator BRADLEY. He is only a specialist in reductionism. [Laughter.]

The CHAIRMAN. Why do you not wrap up, sir, so we can go on to questions?

Dr. TOLLISON. All right. Well, I will end with that. I think that those are the best analyses that exist. They are summarized in this Congressional Research Service document. I would recommend that the committee read that, if they have not.

The CHAIRMAN. We will place it in the record at this point.

[The Congressional Research Service document appears in the appendix.]

Dr. TOLLISON. Thank you. I will cease and desist.

The CHAIRMAN. Dr. Warner, did you want to say something?

Professor WARNER. I simply want to make some factual corrections if I may, because Professor Tollison has made some statements that are not accurate and I would simply like them corrected for the record, if I may. Would that be permissible?

The CHAIRMAN. Surely. But do so with some expedition so Senator Chafee and Senator Baucus can ask questions, and Senator Rockefeller.

Professor WARNER. I will try to be as concise as possible.

Concerning the issue of whether smoking cessation reduces or increases health care costs, I used to at least contemplate the issue the way that Dr. Tollison does, although I hope not as callously. There is an analysis in the Milbank Quarterly in 1992 that is far and away the most thorough, best analysis of this issue. It concludes that because smokers cost so much more in each of their years of shortened life, on balance, they end up costing more to the health care system, including, by the way, for men, during the Medicare years.

The CHAIRMAN. We had better watch this. We are going to end up asking, what is the cost of a new baby and can we afford one?

Professor WARNER. In point in fact, in response to Senator Bradley's question, Professor Tollison said that each of the studies he mentioned included the value of the 400,000 lives lost. There is zero value attributed to those lives. There is value attributed to productivity and health care costs, but there is no value to life per se whatsoever.

And, by the way, in at least one of those studies Professor Tollison cites the author agrees that, had he used what are now believed reasonable estimates of the effects of environmental tobacco smoke, the tax would have to be a great deal higher; that is the Manning study.

Professor Tollison made the statement that the estimates of revenue that we provided do not account for issues like the adjustment of the Consumer Price Index. This is not accurate, once again. The organizations that make these estimates specifically have a substantial reduction in their estimates, which I believe to be too large, to allow precisely for those kinds of things.

The CHAIRMAN. All right. Now, no one is going to question good motives and good intentions here, we are trying to get the facts, which are elusive.

Did you want to say one thing before we go to general questions?

Dr. TOLLISON. I just wondered if Manning has recanted this in writing.

The CHAIRMAN. Well, we will get Mr. Manning in and find out. Thank you, gentleman.

Senator Packwood?

Senator PACKWOOD. I want to ask Mr. Beard and Mr. Feldman, because there are two statements here that seem contradictory to me. Mr. Beard, you say, "in an earlier study, Dr. Kellerman found that for every self-defense killing with a handgun, 43 friends and family members were shot to death," and then you go on with some other language.

Now, Mr. Feldman, this is not your statement, it is from the National Rifle Association before the House Ways and Means, but it is another study. "Indeed, it has been estimated by Professor Kleck, of Florida State University, that there are approximately 1.4 million instances annually of the defensive uses of firearms in the United States; 645,000 of them involve handguns. Professor Kleck has noted the possibility—the possibility—that more lives are saved by protective use of firearms than are taken in suicide, homicide, and accidental misuse together; certainly numerous injuries which would otherwise require medical care are prevented by lawful gun ownership."

Those two studies seem somewhat in conflict to me, although I realize Professor Kleck says, possibly. But, still, Mr. Beard's 43 to one ratio as opposed to Mr. Kleck's possibility seems in conflict. Are either of you familiar with Professor Kleck's study? Mr. Beard, are you familiar with it, too?

Mr. BEARD. Yes.

Senator PACKWOOD. Can you comment on both of those for me?

Mr. BEARD. Yes, sir. Senator, first of all, the Kleck study was based on a public opinion poll that was done about 18 years ago. The question was posed as to whether or not people had used a gun in self-defense. It did not ask if it was against an animal, or if there was a person there. It did not make any distinction.

It simply said, have you ever used a gun in self-defense. He then took that poll and extrapolated it to reflect current statistics and current ownership. He then made a lot of assumptions. So, it is not a scientific survey which determined specific incidences of where pulling a gun has saved lives or prevented someone becoming a victim.

Senator PACKWOOD. What you are saying is, it is not really a study, it is a poll.

Mr. BEARD. It is not really a study.

Senator PACKWOOD. All right.

Mr. BEARD. It is a study of a poll that was done by a gun control organization in Massachusetts over 18 years ago. So it is, I think, a very suspect poll. Dr. Kleck has done some more recent research and, again, it goes against what the rest of researchers looking at this issue has said. Dr. Kellerman's study, which was in the New England Journal of Medicine concluded that handguns in the home increases chances of homicides, 13 times and suicides, 5 times.

In addition, there has been, as you probably know, a study of studies done by Wright and Rossi where they looked at all of the studies and concluded that the evidence was not clear, and what was needed was another study.

Senator PACKWOOD. Mr. Feldman.

Mr. FELDMAN. Well, I can tell you a poll that was done on April 18th by the Terrence Group, which asked a question, do you know anyone who has ever had to use, but not necessarily fire a gun, in

order to protect themselves or their family? Twenty-eight percent of the adult population said yes. That does not go to the immediacy of how many people, that is just how many people know someone who has.

I have, twice in my life, taken out a sidearm and pointed it at someone when I felt my life was in immediate danger. I did not have to fire that gun in order to use that gun. I prevented myself and the woman I was with at the time from being victims of a mugging, so I am one of those statistics. Neither I, nor the perpetrators were injured in the attack; they turned around and fled. But that is an ad hominem. When you want to look at the statistics——

The CHAIRMAN. No, Mr. Feldman. That is not ad hominem, that is anecdotal.

Mr. FELDMAN. Anecdotal. The issue is one that you can look at statistics from both sides and you can use those statistics in a number of ways. Clearly, someone who does not own a gun cannot have a gun they do not own used against them. I own guns. They are in Georgia, I am here in Washington, DC. Obviously, if I was attacked, my ownership of those guns here in the District would be of no use, they would be of no value. I cannot use them to protect myself, my companions, or anyone else.

So, the fact is that well over half of the citizens in this country, or the households in this country, have a firearm in them. The vast majority of people use guns lawfully. It is the criminal element, Mr. Chairman. We are all on the same side. We want to take guns out of the hands of criminals. They do not belong there. And we have all got to do a better job in getting rid of those criminals with guns.

Senator PACKWOOD. Let me ask Dr. Tollison a question. You make the statement that tobacco taxes are regressive. Of course, all excise taxes are regressive, I think, except maybe excise taxes on furs over $10,000.

The CHAIRMAN. Yotz. That was a good idea he had.

Senator PACKWOOD. Yotz. Is JB still here? Yes, he is. He did not hear that.

So, what? Are you saying, ipso facto, if a tax is regressive it is, therefore, bad?

Dr. TOLLISON. I think that is consistent with the history of theories of public finance that I know, that the State should strive to finance itself with broader based progressive levies, than with specific levies on specific products.

Senator PACKWOOD. Well, then let me give you a for instance. Let us say, in adopting a health care reform bill, we would say a basic package, we estimate, costs $200 a month, and anything over that we are going to tax. That also would be regressive, because it is going to hit everybody equally, and the executive making $100,000 with the same company policy will pay less in terms of progressivity than the janitor making $15,000.

Dr. TOLLISON. As, indeed, the Social Security taxes, as Senator Moynihan has long noted, is also an extremely regressive——

Senator PACKWOOD. It is, although the pay-out in it is progressive.

Dr. TOLLISON. It is.

Senator PACKWOOD. But, on the health care benefits, the pay-out is about the same. But should we oppose any kind of limitation because it is a regressive tax; should we oppose any kind of a tax cap because it is regressive?

Dr. TOLLISON. I would have to say, being consistent with my background in public finance, that you should oppose it, that these things should be financed through broad-based, progressive taxes.

Senator PACKWOOD. Progressive taxes. But then that leaves us the problem that there are not enough rich and we cannot raise enough money for long-term care, and prescription drugs, and picking up the retiree benefits of the auto workers just with taxes on the rich. Then what do we do?

Dr. TOLLISON. Well, you are obviously asking me for my personal and professional opinion. I thought you guys were on the right track in the mid-1980's in which you were broadening the base, removing loopholes, and lowering rates. Obviously, the level of rates is a matter of debate and contention, but the broadening phenomenon would bring more income to the government.

Senator PACKWOOD. While the 1986 code was slightly more progressive, even though we had lowered the rates—progressivity depends upon the base and the rates. For all of the 90 percent tax rates we had, there are lots of people that paid no taxes, despite the 90 percent rate. But the 1986 act made it slightly more progressive—slightly, even though we reduced rates tremendously. But the evidence from the Joint Tax Committee was, it was a slightly more progressive code by the time we were done.

But, is that your standard for everything we are going to finance? No matter where we are in time—it is now 1994—any new taxes should be progressive and if we pass some progressive taxes now, in 1995 that should be the base, and any new taxes should be progressive from 1995 and so on.

Dr. TOLLISON. Something like that would seem reasonable.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Chairman, it seems to me that the efforts that are being discussed here—the taxation of cigarettes and of ammunition—are not solely revenue measures, but are health care measures.

Thus we are not necessarily seeking an equalization between the income that is received and the costs that are incurred by the item involved. Mr. Tollison, in his statement, makes the point that they are being over-taxed. As I understand his point, it is that the amount of revenue that is now coming in is adequate to pay for the damage that cigarettes do. Is that your point?

Dr. TOLLISON. Yes, sir.

Senator CHAFEE. But that is not the total objective of the exercise here. The objective of the exercise is to prevent, to the greatest extent possible, the damage that is done. It is not just to put some price tag on a life, or the harm done to a non-smoker when he or she is subjected to secondary smoke.

As far as the handguns or the ammunition situation goes, it seems to me that Mr. Feldman's point is that you are going to lose a lot of jobs here, so we should not do it. He does not talk at all about the pain and suffering that has occurred. He does not even

get into the cost of gunshot wounds; at least I did not see it in your statement, Mr. Feldman.

Now, the tax you provide on ammunition, Mr. Chairman, am I correct in believing that your tax is nearly all—or maybe entirely—on handgun ammunition.

The CHAIRMAN. Exclusively on handgun ammunition.

Senator CHAFEE. Exclusively on handgun ammunition. So the points that you make in your statement, Mr. Feldman, do not apply to the proposal before us. In other words—well, you do not number your pages, which is unfortunate. You are not the only one, I might say.

I have battled with my staff ever since I have been here to please date their memos, say who they are from, and please number the pages. And I am not totally successful on any of the scores. [Laughter.]

But you spend a good deal of time talking about, on page 4, I guess it is, the more than 25 million hunters who spend in excess of $480 million just for licenses and on their sport. But jobs in travel, hotel, and shipping—those are not jobs that are affected by a tax on handgun ammunition. I suspect that the greatest portion by far involve hunting. And what do hunters use? They use shotguns and they use rifles. There are not many people who go hunting with handguns.

Mr. FELDMAN. Well, 48 States in this country allow handgun hunting.

Senator CHAFEE. Oh, I do not doubt that they allow it. I am saying that when you get into jobs, related to hotels, shipping, guide services, taxidermists, recreational vehicles, that a tiny, tiny percentage of that, I believe you would concede, is associated with handguns.

Mr. FELDMAN. No. When it comes to target shooting, and awful lot of people——

Senator CHAFEE. No, no, no. You do not need a taxidermist for target shooting. [Laughter.]

Mr. FELDMAN. No, of course not. But you do need to ship the ammunition from the manufacturer to the distributor, from the distributor to the retailer. Lots of States—and New York State is one of them—allow for handgun hunting and it is a separate season on handgun hunting. And there are a lot of rifles that take handgun rounds, .22 caliber, .45 caliber. I have a .45 caliber carbine that is a handgun round, yet it is a rifle.

Senator CHAFEE. Well, we do not propose to touch the .22 caliber rounds.

Mr. FELDMAN. My point is that lots of handgun ammunition is capable of being fired through rifles that are chambered in that caliber.

Senator CHAFEE. I think that it is worth noting that you have a .45 caliber carbine, because there are so few of them around.

Mr. FELDMAN. Oh, you would be surprised, Senator.

Senator CHAFEE. Well, maybe I would be.

Mr. FELDMAN. I can assure you.

The CHAIRMAN. Mr. Feldman.

Mr. FELDMAN. Yes, sir.

The CHAIRMAN. You are talking to a U.S. Senator who was at Guadal Canal. Would you show a little respect, please?

Mr. FELDMAN. Certainly, and not meaning any disrespect, Mr. Chairman.

Senator CHAFEE. But, Mr. Chairman, it seems to me that what we have got to face up to is, we have brought this panel here as a health care panel. Health care is the subject we are dealing with. Indeed, we have been given some pretty powerful testimony by Mr. Beard, whom I have had the privilege of working with in the past.

And the fundamental question here, Mr. Chairman, it seems to me, is this: the argument against doing anything about handguns and ammunition is that it will not affect crime, that criminals will still get guns. But does that mean we are to continue on the path we are now, which does nothing about it? Oh, yes, we have made steps forward—the waiting period for one. But that does not address the proliferation of these weapons. Somehow, we have got to turn off the spigot.

It is no coincidence that other countries of the world that are so called civilized countries—I am referring to Canada, to the Scandinavian countries, to Germany, to France, name any of them—do not come anywhere close to the number of handgun deaths that occur in this country. Nowhere near.

As for those who say, well, criminals will still get guns—well they will not get them after awhile. The good people may turn guns in, the criminals may not. But the first step is to turn off the spigot that pours these guns into our society cut back on the abundance of these weapons.

The second step, then, is to begin to collect these weapons that are out there now—obviously with the exception of those used by policemen, law enforcement officials, and the military. Somehow we have got to take these steps.

It does not do any good to end up with a statement—like your stirring statement at the end—that the tax is a scapegoat for the failings of the criminal justice system and a health care system run amuck. I frankly do not know what you mean by either of those statements. We are working on the criminal justice system all the time. But many of the crimes that are committed with handguns are not done by hardened criminals by a long shot. And I do not know what you mean by the health care system run amuck.

Mr. FELDMAN. Senator, there are millions of people in this country that use handguns to protect themselves. And far more people use handguns than law enforcement does to protect themselves.

I do not know. Perhaps you have some ideas on how you would like to confiscate those guns from American citizens. I think it would be a very difficult task and it is one that, with 225 million lawfully owned firearms out there, I do not think very many police that I know would enjoy trying to achieve.

Senator CHAFEE. Well, again——

Mr. FELDMAN. With these buy-back programs, Senator——

Senator CHAFEE. It is very, very facile, I think, to mingle in rifles and shotguns with handguns, and it is just not accurate. It is not accurate for my legislation, and it is not accurate for the Chairman's bill. There is a world of difference, and no one knows it better than you do.

Mr. FELDMAN. Approximately one-third of all firearms are handguns in this country.

Senator CHAFEE. That is right. And that is what we are focussing on. We are talking about the 70 million handguns out there, with 2 million more being added to them every year. We are not touching rifles, we are not touching shotguns.

Mr. FELDMAN. How would you differentiate between ammunition that is fired through a rifle and the handgun caliber?

Senator CHAFEE. No one knows better than you that duplication in those areas is very modest as part of the total.

Mr. FELDMAN. How would you suggest that these guns be confiscated?

Senator CHAFEE. In the Chairman's legislation, what he proposes is an increased tax on the ammunition for handguns.

Mr. FELDMAN. But you talked about confiscating guns.

Senator CHAFEE. In my bill, which of course is not before the committee today, we have a grace period of 6 months in which we pay either the fair market value, or $25, whichever is greater, for handguns that are turned in. The only way to start on this is to start. It does no good to say it is impossible. We cannot continue the system we have in this country now.

Mr. FELDMAN. But that is what is at issue——

Senator CHAFEE. My time is up. Thank you.

Mr. BEARD. Mr. Chairman, could I add a point?

The CHAIRMAN. Quickly, because Senator Baucus has to go.

Mr. BEARD. Under your bill, S. 1616, the excise tax would be placed on the basis of length, not caliber. Mr. Feldman keeps talking about caliber. Your bill deals with any ammunition less than 1.3 inches.

The CHAIRMAN. Exactly, sir.

Mr. BEARD. And the Bureau of Alcohol, Tobacco and Firearms has said that is the dividing line between ammunition for handguns and any other legitimate sporting weapon. That is a very important difference that Mr. Feldman is trying to blur here.

Mr. FELDMAN. Any ammunition that is over one inch would be capable of being a destructive device.

The CHAIRMAN. Thank you, Mr. Beard. Mr. Feldman, would you please reserve a moment?

Senator Baucus is next.

Senator BAUCUS. Thank you, Mr. Chairman. This is obviously not an easy issue. I would like to begin by saying that I supported the Brady Background Check bill, I supported the Feinstein Ban on Assault Rifles, and am the first member of the Montana Congressional Delegation to support anything to de-categorize gun control since I think Senator Mike Mansfield did in 1967 or 1968.

And I can tell you, I did it because I thought it was the right thing to do. I can also tell you that a lot of folks in my home State are not terribly happy with those two votes.

But the real question now is—and this is a legitimate question that a lot of legitimate sportsmen have—in Montana, anyway, the sportsmen say, I do not like the background check bill, I do not like the ban of assault rifles, but I can live with it. But what is next? That is the legitimate question on their minds: what is next?

Well, here we are, we are faced with the potential, what is next? And there can be a lot of what is next here in this committee and on the floor. So, the next question is, well, which of these what nexts is right and which of these what nexts are not right?

The question I have is, the degree to which an ammunition tax really gets at crime. I do think, first of all, that the causes of crime are varied and they are complex and they are very fundamental.

In my judgment, frankly, the causes of crime are, first, excessive violence on television. I think there is way too much violence on television in America today, which I think desensitizes Americans.

It makes Americans less sensitive to the sensibilities of people and human values, and Americans are more casual, therefore—some people, anyway, are—about crime and violence and they are more likely to commit crime and acts of violence.

I think there is another cause of crime in this country, and that is drugs—excessive drugs in this country. A lot of people resort to crime to support the habit in one variation or another. That causes crime.

You can add to that lack of economic opportunity. Many people in America just do not see good, sufficient economic opportunity, in some of the inner cities, for example. They see the short-cut, easy way is crime.

I do also think that another cause of crime—and that is why I supported the Brady Background Check bill as well as the Feinstein Ban on Assault Rifles—is there are too many of the wrong kinds of guns that get too easily in the hands of the wrong kinds of people. I do think that is another cause.

So are Brady and Feinstein a solution to crime in America? No, they are not the solution to crime in America, there are lots of other necessary solutions. Are Brady and Feinstein going to go a long way to solving the problem? No, I do not think they are going to go a long way to solving the problem, but I do think they will go a partial way to solving the problem and that is why I supported them.

Now, I see how there is a direct nexus between a background check and catching criminals. In fact, even in my State just recently—I think it was in Butte—because of the Brady bill, the police in Butte, Montana apprehended somebody.

I do not know what the total figures are nationwide, but there are thousands of people who have been stopped, and I guess thousands have even been apprehended as a consequence of background checks. And that is good, that has worked.

The next question, to me, anyway, is this tax going to really do much to stop crime? I was struck with an analysis just a few days ago. This is in D.C., particularly. A lot of law enforcement officials believe that most crime is caused by kind of a hard core group of people with a lot of repetition, sort of recidivism. It is just finding out who these people are who are cause for a lot of the repeat crimes in the District.

So, when we passed the Crime Bill here in the Congress, umpteen billions of dollars for prisons, and boot camps, and mandatory sentences, and more capital crimes and so forth, I think that has some effect on addressing the problem, although most crime is enforced by State law enforcement, not Federal.

But I am having a hard time, frankly, seeing the connection between a ammunition tax and stopping crime, given, if we are honest with ourselves, all of the causes of crime in this country.

So I am just asking you, Mr. Beard, what is the direct connection here? As you know, the 10–11 percent tax on, I think it is rifles and ammunition, whatever, under the Pittman-Robertson Act, goes basically back to the States for wildlife conservation measures, and so forth.

And there is a connection there, because most people who buy guns and use guns are sportsmen and they very much appreciate that the tax that they are paying goes back to wildlife conservation and education kinds of programs.

I have a hard time seeing the connection here, frankly, between the ammunition tax and really stopping crime, if we are really honest with ourselves, what the problem really is. Would you just address that, please?

Mr. BEARD. Certainly, Senator. You asked two very important and distinctly different questions. The first, was about sports and sportsmen in your State. I would remind you again that neither the Chairman's bill, nor Mr. Bradley's bill would affect sports ammunition at all. These taxes are on handgun ammunition, not on legitimate rifle, shotgun, or other ammunition. So it is not a question of affecting sportsmen.

Senator BAUCUS. I do not mean to be argumentative here, and I am trying not to be.

The CHAIRMAN. You are not.

Senator BAUCUS. But a lot of sportsmen use handguns. They just do. It is easier to get in the woods, particularly thick woods, with a handgun when you are out hunting. If you have a higher caliber handgun you can use it for big game, for example, under certain circumstances.

A lot of hunters take a higher caliber rifle to knock down a deer and elk, then sometimes they use their handgun to finally kill the animal to get it out of its suffering or pain if it is not yet killed. I mean, these are legitimate uses of handguns.

And I do not know where you are from, but if you were to spend time in western States, in Rocky Mountain States, in my State of Montana, I think you would have a real appreciation for this. These are the questions that honest people, good people are asking.

They are asking, what in the world is going on here? They want to do something about crime, you know. They say, all right, the Brady bill. I see that. I do not like it so much, but that is all right. And the ban on 19 out of 600 rifles, you know, they can kind of see that, too.

If you start to tax ammunition, particularly to this amount, and when they are really paying the brunt of it, and when they say, basically correctly, that if someone's going to use a gun to commit a crime, a 30 percent tax on ammunition is not going to make a difference one way or another, it is just going to happen anyway. So I just cannot understand it. Even though we are talking about handguns here and ammunition for handguns here, they have an awfully hard time doing the right thing in making this connection.

Mr. BEARD. Well, first, let me say that I was born in West Virginia and raised in Ohio, and I spend half of my time now in West

Virginia in the panhandle in the mountain area. Most of my friends, and almost all of my family are hunters and I spend a lot of time talking about this issue with them, and I understand what you are saying about the sporting use of some handguns.

With the small percentage of people who use handguns for sporting and hunting purposes compared to what happens to our society, the 36,000–38,000 lives a year that are lost, plus the billions of dollars is costs us, is——

Senator BAUCUS. Yes. But you are making the connection that those lives will be saved if this 30 percent ammunition tax is passed. That is a very big leap. That is what I am trying to focus on, is that connection. I am saying these people have a hard time seeing this connection.

Mr. BEARD. Well, I think Senator Chafee made the point very clear, that it is not just a crime issue that we are talking about, we are talking about a public health issue. Of those 36,000–38,000 people who died last year from handgun violence, or from gun violence, the majority of them—close to three-quarters of them—were not killed by criminals and not killed in any criminal activity. Half of them killed themselves.

Senator BAUCUS. I am sorry, sir. It is the same point because we try to make the connection between the tax and abuse of the gun. If it is crime, it is crime; if it is health related, it is health related. So, it is the same issue.

The issue is, what is the connection between the 30 percent on the one hand, and the handgun not used on the other, or the ammunition not used for criminal purposes. That is just the question I am trying to find the answer to.

Mr. BEARD. Well, it seems to me it is the same question we are asking about with tobacco and some other consumer products. If the use of that particular consumer product—and that is all a handgun is, is a unique consumer product—is costing society billions of dollars, should not the people who manufacture, sell, and use that product bear some of the cost? It seems to me that is the only real question.

Senator BAUCUS. Well, there is a real difference there because every cigarette harms somebody, not every bullet fired does. In fact, by far, most do not. There is a major difference. Major. Every cigarette has a detrimental effect on health, every single one that is smoked. Every one. Most bullets fired do not, most handguns used do not.

Mr. BEARD. I got involved in this issue in 1968. And, from 1968 to 1972, the number of firearms in the United States doubled in that four-year period. Starting at that same time, the homicide and suicide rates also doubled; they have now tripled.

It seems to me that there is a direct relationship between the easy availability of guns and the deaths, the accidents, and the injuries in our society, and the change that has taken place in our society because of easy access to firearms.

I do not understand why it is wrong to require those people who manufacture that deadly consumer product to pay some of the costs, the people who purchase that deadly consumer product to pay some of the cost to society.

As I said in my statement, the estimate is, it is roughly $20 billion a year. Senator Chafee has an estimate of $4 billion a year just in emergency care cost, 86 percent of which has to be paid for by the taxpayers.

Senator BAUCUS. Yes. Again, obviously, manufacturers of handguns and ammunition should pay some tax. You can use figures like $20 billion, but the real question, again, is the causal connection. I mean, it is a bit irresponsible, to put it mildly, to just use figures like that without addressing the core question, which is the cause. I think the real issue here is the degree to which there is a cause and effect. That is really what we are trying to establish here. And I submit that that is a part of the cause of crime.

But I also tend to think that there are many other reasons that are causing crime in America, and if we are really directly honest with ourselves we should address those as well with as much focus and as much intensity. And, frankly, I think one of them, as I said, is violence on television. I just think there is way too much violence on television still in America today, and I do think that tends to desensitize the American population to ordinary, proper values.

The CHAIRMAN. Now, will you let me say, first of all, a friendly word? You have caused me to come up with the idea of the returnable cartridge. For every .45 round used to dispatch an elk, you send it in and back comes the two cents tax. Well, it is a thought. [Laughter.]

Senator BAUCUS. It is a thought.

The CHAIRMAN. Different places, different problems.

Senator BAUCUS. Well, we will apply the tax in New York, but not in Montana.

The CHAIRMAN. All right. I would settle for that. We probably take about twice as many deer in New York as they take in Montana. We do, you know. You have got nothing to eat out there, Senator. [Laughter.]

We are in deerslayer country.

But about 10 years ago—this is no longer the case—I had a bill in to heavily tax/ban the manufacture of .25 caliber and .32 caliber rounds. One-third of the rounds fired at New York City policemen were .25 caliber and .32 caliber. They are the Saturday night specials. No sportsman would go near them. They have snub-noses three inches long, they are accurate at maybe 10 yards, and useless, thereafter.

From an epidemiological point of view, you often go where you least suspect. We spent years telling people, drive carefully. But, when you have 99 million people with automobiles and some are 16—which, by definition, means you are not going to be careful—and some are 76—which, by definition, means you probably do not have the best depth perception you ever had—it turned out seat belts were a better answer.

And to get seat belts in automobiles you had to change the behavior of four people: the presidents of GM, Chrysler, Ford, and American Motors. That is much easier than changing the behavior of 99 million people.

We have a two century supply of handguns, we have a three-year supply of ammunition. And epidemiologists would automatically say, you go to that particular triad. On some of the rounds we are

talking about, I would like to ask Mr. Feldman. In 1986, we managed to ban that particular Teflon-coated round which penetrates body armor. Surely, you would have supported that bill, would you not?

Mr. FELDMAN. Absolutely.

The CHAIRMAN. Yes. So, once you have made that concession, you said we could talk about others as well. And we will not settle this here, but Senator Chafee is very serious about this matter. If you have spent a lot of time with guns, you are very careful of these things. I was a gunner in the Navy and I took very great care with how I handled a gun. They go off.

Mr. FELDMAN. When you pull the trigger.

The CHAIRMAN. Or, you drop them.

Mr. FELDMAN. It should not.

The CHAIRMAN. You have never been a gunner.

Mr. FELDMAN. No, I have not.

The CHAIRMAN. Yes. Well, I have been.

Mr. FELDMAN. I am the Navy.

The CHAIRMAN. All right.

Senator Chafee?

Senator CHAFEE. Well, Mr. Chairman, with regard to the argument as to whether they go off when they are dropped, you know, in the Marine Corps we spent a good deal of our time on accidental discharges, and trying to trace them.

The CHAIRMAN. You are right.

Senator CHAFEE. And the individual's defense always was, oh, I never pointed it at him, I just dropped it and it went off.

But, in Mr. Feldman's testimony, he talks about the failings of the criminal justice system. That is something we are wrestling with now. I mean, in the recently-approved Crime Bill, as you know, everything but overtime parking now receives capital punishment. [Laughter.]

Senator CHAFEE. And with this crime bill we are going to build a lot more prisons and have more policemen.

The CHAIRMAN. Do not get Tollison going, he will estimate the savings from capital punishment. [Laughter.]

Senator CHAFEE. So, Mr. Chairman, I think this clearly is far deeper than the failings of the criminal justice system. But my bill is a subject for another day. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

I want to thank our panel. Drs. Tollison and Warner are going to send us some additional data.

I want to thank you all for a very helpful and informative afternoon. With this, we do not dispose of our subject, but we do conclude our panel.

[Whereupon, at 4:52 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted

Prepared Statement of Michael Beard

On behalf of the 40 national organizations that comprise the Coalition to Stop Gun Violence and our 120,000 members nationwide, I want to thank chairman Moynihan for allowing us this opportunity to testify here this afternoon.

Handgun violence has become a major public health concern. More than 38,000 Americans were killed by gunshot wounds in 1991, the last year for which complete statistics are available. Tens of thousands more were wounded but survived. The cost to our society, our economy and our health care system is tremendous.

In a report published this winter in *Health Affairs* two researchers at the University of California, San Francisco Dorothy Rice and Wendy Max, estimate that in 1990 the societal cost of gun violence totaled over $20 billion. A large portion of that loss was born by the health care system. Health care costs alone have been reported by Senator Chafee to total more than $4 billion a year.

Who is paying these costs? We all are. A study in the *Journal of the American Medical Association* several years ago reported that up to 86% of the costs of treating gunshot victims is born by the public. The cost of giving uncompensated care has forced nearly 100 trauma centers to close since the late 1980's.

Trauma center closings adversely affect us all not just victims of gun violence. As more trauma centers close more Americans are unable to obtain the care they need when they become victims of trauma.

The coalition to stop gun violence believes strongly that a portion of the cost of treating gunshot victims should be shifted from the general public to those who make, sell and use handguns. Although, we support Senator Chafee's legislation to ban handguns, that is not the purpose of the tax legislation being discussed today. It is simply a matter of shifting costs.

The current Federal excise tax on handguns is earmarked for a little known program that primarily assists sport shooting programs in the fifty states. The same is true of the current tax on shotguns and rifles. We feel it is entirely appropriate for the tax on sporting weapons to be used for these purposes. Shotguns and rifles, although they comprise a majority of the privately owned guns in the U.S., are far less likely to be misused than handguns.

Handguns are the weapon of choice for those who commit gun violence in our society. Handguns are used in the majority of all murders in the U.S. They are also used in a majority of suicides. Unintentional shootings are almost always committed with a handgun.

If we continue to look at gun violence and particularly handgun violence as simply a crime issue we will never solve the problem. Most incidents of gun violence still occur in suicides and among family members and friends. Dr. Arthur Kellerman of Emery University in Atlanta reported last year in the *New England Journal of Medicine* that the presence of a handgun in the home increases the likelihood of a murder occurring in that home by a factor of three. Suicides are five times more likely to occur in homes with handguns.

In an earlier study Dr. Kellerman found that for every self-defense killing with a handgun, forty three friends and family members were shot to death. What the American people need to realize is that handgun ownership is a bad bargain. This brings us to the other benefit of this legislation.

If the tax on handguns and handgun ammunition is raised fewer people will purchase handguns and fewer people will therefore be killed. In the past opponents of a handgun tax have argued that such a tax would disarm only the poor. This argument is built on the fallacy that poor people or any other Americans are better off

with more handguns. We know this is not true. On a recent weekend in Chicago one public housing complex reported more than 300 shootings. The residents of the Robert Taylor homes are nearly unanimous in demanding an end to the gunfire which makes their lives the equivalent to living in a war zone. Does anyone honestly believe that more handguns are the answer to violence in our inner cities?

Specifically, the coalition to stop gun violence supports both Senator Moynihan and Senator Bradley's proposals. Each proposal distinguishes between handguns and other firearms. Neither would adversely affect hunting or other sporting uses of firearms. This is a very important point. Taxing handguns and handgun ammunition to pay for health care makes sense because the overwhelming majority of gun shot injuries result from handguns not legitimate sporting weapons. Senator Moynihan's tax on handgun ammunition employs an effective definition of handgun ammunition which will not affect ammunition for shotguns and rifles.

Senator Bradley's legislation would be particularly effective in raising revenues and preventing manufacturers from circumventing the excise tax. Two years ago *The Wall Street Journal* reported on the Jennings family of California which has cornered the market on Saturday night specials—small easily concealed, inexpensive and poorly made handguns which Congress barred from importation in 1968. The *Journal reported:*

> According to federal officials familiar with the IRS probe, the alleged excise scheme was simple: The 10% excise tax is levied only on the price charged by the gun maker, not the wholesaler. So Calwestco and Byrco allegedly skirted the normal tax amount by charging artificially low prices when they sold their guns to Jennings firearms. Then, Jennings firearms in its role as wholesaler but not gun maker, sharply increased the price and resold the pistols to other wholesalers, paying no excise tax and reaping big profits.

Incidentally, since the *Journal* article ran, the Lorcin company, which was also criticized in the article have run advertisements featuring that day's *Journal* with several bullet holes in the paper.

Senator Bradley's proposal eliminates this loophole by applying the 30% tax at each transfer prior to the retail sale. S. 1798 also raises the fee for selling guns from the current $200 to $1000 a year. Many of the quarter of a million gun dealers, especially those who do not operate actual gun stores, would choose not to stay in the business of selling guns. The ATF has estimated that, in fact, a majority of the current licensees would not reapply if the fee was raised.

If the number of licensed dealers were to decline to a more manageable number, ensuring compliance with a handgun and ammunition tax would be made much easier.

Thirty years ago the nation began to understand the health risks posed by tobacco. Over the past three decades smoking and tobacco use have declined dramatically. Now we are faced with another public health crisis.

Gun violence is not just a crime problem. It is not just a matter of a few bad apples spoiling everyone ease's fun. Gun violence is a public health problem which touches all Americans.

Gun violence is also detrimental to our economy—not just in the actual costs listed above, but in a myriad of other ways. When foreign tourists are afraid to travel to the U.S. our economy suffers. When American school children spend hours in line each morning passing through metal detectors, they are falling behind their foreign counterparts who spend that time learning. Our economy is hurt by losing more than 30,000 citizens each year to gun violence. I can assure you that nowhere else in the developed world is this a problem.

Everyone who makes, sells or purchases a handgun has to understand his or her responsibility as part of a problem which is uniquely American. Paying an increased tax to compensate victims of gun violence is a relatively small price to pay for the privilege of owning a handgun, especially when compared to the price paid by so many victims.

In six states, including New York and Louisiana, gun deaths now outnumber traffic fatalities. The CDC estimates that by early in the next decade this will be true for the country as whole. Taxing handguns and handgun ammunition will not eradicate gun violence. Increasing the tax will send the message that gun violence is more than just a crime problem—it is a public health and economic problem which adversely affects us all.

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Tax my sins, but tax guns, too

By Matthew Reese

Over the past several months there has been a lot of talk around Washington about sin taxes, and after living in Washington for the past 30 years, if there is one area in which I am an expert, this is it.

Most of the discussion thus far has focused on two sins of which I am altogether too familiar—alcohol and tobacco. All I can say about these is a wish the tax on them had been higher when I was younger, then maybe I wouldn't be so old now. If raising the tax on cigarettes and alcohol will prevent some kid from smoking like I do and drinking like I did, then it is a tax I wholeheartedly support.

But, if my sins are going to be taxed so should others. Undoubtedly, tobacco and alcohol use cause a significant strain to our health care system. Those who use these products should be prepared to pay for these costs. I am. Still, tobacco and alcohol are not the only products that have detrimental effects on health care.

Specifically, I would like to see an increase in the tax on handguns—a big tax. Sen. John Chafee (R-R.I.) reports that handgun violence accounts for an estimated $4 billion a year in health care costs. That's one reason Chafee wants to ban handguns. I agree with Chafee—handguns have no place in a civilized society which has dedicated itself to ensuring "domestic tranquility." Unfortunately, most in Congress don't yet see it that way. So, if Congress is not going to get rid of handguns, they should at least tax handguns sufficiently to pay for its associated health care costs.

Congress, in fact, did hold hearings on the gun tax earlier this week. Among those who testified in favor of a "sin" tax on guns were the American Medical Association, the National Association of Public Hospitals and a representative from the Schwab Rehabilitation Center in Chicago. The only witness to oppose the tax was the representative of the National Rifle Association.

Right now the current tax on handguns is actually less than that on long guns—shotguns and rifles—even though handguns are far more likely to be used in crimes. Handguns comprise only one third of the guns in private hands in the U.S., yet are used in more than 85 percent of gun murders and an equally overwhelming majority of other gun crimes. Handguns are taxed at 10 percent while long guns and ammunition are subject to an 11 percent excise tax, applied only to the initial sale of the weapon by the manufacturer.

At present, the excise tax is used to fund something called the [illegible] program which distributes money to state agencies responsible for maintaining public hunting areas. That may have made sense at one time, but with gunfire now taking more than 33,000 American lives each year and wounding approximately seven times that number, hospitals, not hunters, should be the beneficiaries of an increased handgun tax.

Chicago's Rep. Mel Reynolds (D-Ill.) has introduced legislation that would double the excise tax and earmark the funds for hospitals hardest hit by the gun violence epidemic. Reportedly Hillary Rodham Clinton is considering including such a proposal in her health care package. She should.

But the tax should be raised even more. Last year the firearms tax brought in about $100 million. Even doubling this amount falls well short of Chafee's $4 billion cost estimate.

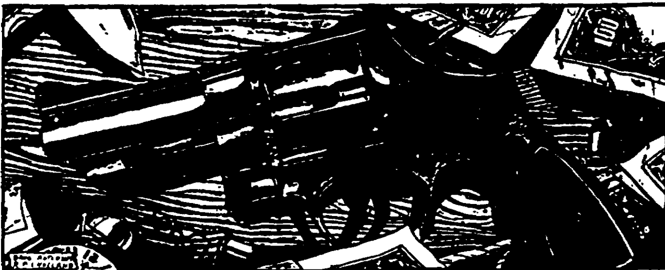
Therefore, if the tax on cigarettes is going to be a monster, then the handgun tax ought to be a killer. Such a killer tax would greatly increase the price of handguns, thereby raising more revenue at the very time it would decrease consumption. Sen. Patty Murray (D-Wash.) has introduced legislation that would raise the handgun tax to 25 percent and extend the tax to all transactions—from manufacturer to distributor through retailer to consumer.

Such an increase would virtually double the cost of a handgun and bring in about 10 times as much revenue for the federal government. For instance, a handgun manufactured for $100 which raises just $10 under the current excise tax, would under this plan increase the eventual cost to the consumer to at least $195 of which $95 would be tax. Which is still not a lot of money for a product whose primary use is to kill people.

An additional potential benefit of applying the handgun tax to sales between private individuals would be to allow the IRS to police illegal handgun sales. Under current law the Bureau of Alcohol, Tobacco and Firearms (I like that combination) is hamstrung in its efforts to stop the flow of illegal handguns. This is largely a result of the National Rifle Association's past influence over the writing of the nation's gun laws, which forbid the ATF from computerizing its gun records. If the ATF is not allowed to police illegal handgun sales, than why not turn over the job to zealous IRS agents and prosecute gun traffickers for tax evasion?

For years the NRA has claimed to represent law abiding gun owners. If so, these gun owners should be willing to pay additional taxes to cover the health care costs associated with gun violence in order to retain the privilege of owning handguns. As a smoker, I am willing to help pay for the health care costs caused by my sin. Gun owners should do the same.

Matthew Reese is a retired political consultant serving on the senior advisory committee of the Coalition to Stop Gun Violence.



Richard Mitchell/Los Angeles Times Syndicate

PREPARED STATEMENT OF MONSIGNOR CHARLES J. FAHEY

The Catholic Health Association of the United States is pleased to present views on the continued need for tax exempt hospitals after health care reform.

The Catholic Health Association is a national organization of over 1,200 Catholic hospitals and long-term care facilities, their sponsoring organizations and systems. Throughout our seventy-eight year history, CHA has taken a leadership role in advocating high standards of health care for all persons. Care and services to the poor—whether it be in inner cities, in rural areas, or elsewhere—has been of particular concern to this association and our membership.

Since 1986, the Catholic Health Association has been a consistent advocate for universal coverage in a redesigned health care system. Our health care reform proposal, *Setting Relationships Right: A Proposal for Systematic Health Care Reform,* includes many of the features of the President's "Health Security Act."

CHA's proposal is anchored in six fundamental values which are rooted in the Judeo-Christian tradition:

- Health care is a service, not a mere commodity to be exchanged for profit.
- Public policy must serve the common good.
- Every person is the subject of human dignity.
- The needs of the poor should receive special priority.
- There must be effective stewardship of resources.
- Tasks should be performed at appropriate levels of organizations.

Applied to the discussion of the Committee today, these values lead to the following principles:

- Public policy should encourage the service orientation of the health care system.
- Focusing on the common good, not-for-profit health care providers should respond to broad community needs, not solely the needs of an enrolled population.
- Every person has the right to access high quality health care services.
- There will continue to be a need for mission-driven health care providers who view the provision of services to the poor as a moral priority.
- Local community members are in the best position to evaluate whether their health care organizations fulfill a charitable purpose.

The Catholic Health Association has also taken a leadership role in advocating that tax exempt, not-for-profit health care facilities be accountable to their communities. In 1989, CHA published *The Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint.* It has been widely used within and beyond Catholic health care. We also developed, with the American Association of Homes for the Aging, a version of the document for nonprofit long-term care facilities.

Last year, after consultation with Catholic and other not-for-profit health care leaders, CHA developed and distributed "Standards for Community Benefit," calling for development of community benefit plans that describe how the facility will address community needs and problems, particularly those of the poor, frail elderly, minorities and other underserved and disadvantaged persons. These voluntary standards are attached to this testimony.

THE CATHOLIC HEALTH ASSOCIATION'S POSITION ON CONTINUING TAX EXEMPTION FOR NOT-FOR-PROFIT HOSPITALS

The Catholic Health Association believes that the promise of health care reform for near-universal access to health care services and elimination of most uncompensated care does not alter the appropriateness or necessity of granting federal tax exemption to not-for-profit health care organizations that provide substantial community benefits. We urge this Committee to recommend retention of tax exemption for qualified not-for-profit hospitals.

Our testimony will describe three primary reasons for the continued tax exemption of community benefit health care organizations.

- **Health care is traditionally and ideally a service,** not a commodity that responds well to competition and commercial forces. Tax exemption helps preserve the service orientation of health care organizations.
- Not-for-profit hospitals will continue to have a role in serving **the poor and disadvantaged.** Even in a most generously designed health care system, some individuals and communities (especially rural and inner-city locations) will not be well served. They will remain dependent on not-for-profit providers establishing services in their areas.

- **The community benefit role of not-for-profit hospitals goes beyond free care to the poor.** Programs and services for the broader community will continue to be characteristic of these institutions as they work both independently and in collaboration to address community-wide health problems and needs.

SEALTH CARE AS A SERVICE

The history of hospitals is one of religious and community leaders responding to needs of communities by creating services and shelter for the poor, sick, dying, and elderly. The first hospitals were mission-driven in the truest sense of the term. There was little or no compensation for services, and members of communities supported these early institutions with financial and volunteer assistance.

As the health care system changed in the types of persons served, services provided, and the availability of government and private financing, health care remained and is today, fundamentally a service. It is performed best, we believe, by mission-driven organizations carrying out their mission in contemporary terms.

CHA shares the concern of many that commercial values and the competitive environment in which health care facilities have operated in recent years have had a negative effect on the essential service and community orientation of many not-for-profit health care providers.

We believe that health care reform could aggravate this competitive environment and further encourage commercial behavior by not-for-profit health care facilities. Health care reform, as currently being discussed, shifts financial risk from purchasers of health care (government and employers) to providers. Health care plans and providers would be forced to compete on the basis of cost as well as quality and services. While it is hoped that these developments will result in the desired lower cost and higher quality, they also present threats to the service and community orientation of providers.

CHA recognizes that increasing economic discipline in the delivery of health care services is essential, but intense price competition in some communities could unleash commercial influences that overwhelm the professional and service ethos in American health care. Unless health care reform and related policies retain and improve incentives for a strong service orientation, the result could be excessive commercialization and an inadequate focus on the needs of persons and communities.

Tax exemption, with its requirements for community benefit and prohibitions against private inurement and private benefit, is one safeguard against commercial values overtaking the professional and service orientation of individual not-for-profit facilities and the health care system as a whole.

HOSPITALS' CHARITABLE PURPOSE CONTINUES: CARE OF THE POOR

The "charitable purpose" basis for tax exemption has historically had a dual interpretation: relief of poverty and community benefit. The Catholic Health Association believes that not-for-profit tax exempt health care organizations should and will continue to demonstrate that they serve a charitable purpose under both interpretations.

CHA believes that there will be a continuing role and responsibility for not-for-profit, tax exempt health care organizations to serve the poor and disadvantaged. This is because it is unlikely that even the most generously designed reform package will address all needs of all people, especially those who have historically been underserved.

Aside from persons outside of the new health care system, we believe that universal coverage will not necessarily mean *universal access* to health care services, nor will it mean *universal care* for all health care needs.

Persons who are poor and others currently going without health care services may fail to properly use the new system. Lack of an ability to cope with government bureaucracies and other struggles of daily living prevent many low income, low literacy and other troubled persons from taking advantage of programs and benefits available to them now. Under-enrollment in the Special Supplemental Food Program for Women, Infants, and Children (WIC), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and Medicaid give evidence of this phenomenon. It will be necessary for health care providers to reach out to these persons and families, enroll them into the health care system, and teach them how to use health care services in a more effective way than they have in the past.

Another problem that will persist for persons struggling with poverty and other hardships is that some providers may not wish to treat them, despite more equitable financing and other safeguards designed to avoid discrimination. Today, and predictably in the future, some providers will shun persons who are poor, are part of minority groups or have certain physical or mental disabilities. Their reason may be

outright prejudice or the belief that such persons present language, literacy or other problems that take excessive resources.

In fact, our experience shows that many low income and multiproblem persons and families *do* require additional attention and services to adequately address their needs. We have found that not all providers are prepared or willing to respond to these needs. Therefore, our communities will continue to need charitable health care organizations driven by community needs, with an historical mission of service to the disenfranchised and particular expertise in reaching out and providing services to these populations. We support provisions of the Health Security Act that call for tax exempt providers to assess the health care needs of their communities and develop plans to meet those needs.

It is also likely that enrolled persons will not have all health and health related needs met in the new system of care. Even a fairly comprehensive benefits package may not include needed over-the-counter medicines and appliances, transportation to health services, counselling, and some desired, but not life saving, procedures and treatments. Low income persons enrolled in a network are likely to continue to need some free and discounted services and supplies.

Finally, the new health care system will likely not cover undocumented aliens who will also need care.

HOSPITALS' CHARITABLE PURPOSE CONTINUES: COMMUNITY BENEFIT

The parallel definition of "charitable" is providing benefits to the broad community. This too, can characterize a tax exempt health care organization in a reformed health care system because the community benefit role of not-for-profit hospitals goes beyond serving the poor and disadvantaged.

The Catholic Health Association believes that communities will continue to need the type of community benefit services not-for-profit tax exempt hospitals provide when they respond to community need and help build community-wide responses to those needs. Such services not only affect the poor and other special needs persons, but the broader community as well. These benefits to the broader community include policies and programs that:

- Improve the health of persons in the community; and
- Improve the overall health of the community, preventing widespread disease and injury and acting on societal problems that tend to cause disease and injury.

Not-for-profit tax exempt facilities will continue to work directly, in collaboration with partners in their health networks or other health care providers and with local and state health departments to address these community-wide issues. Some examples of community benefit services that will continue to be provided by not-for-profit health care organizations include:

- Being part of community-wide efforts to decrease infant mortality and morbidity, to protect children against vaccine preventable disease, to address the problem of violence in the community and to help homeless families.
- Reaching out to minorities, the poor and other underserved persons, whether or not they are enrolled. This could include providing multi-lingual information on child health or offering employment opportunities to persons who are developmentally disabled.
- Implementing programs that promote health and avoid injury and illness through campaigns to decrease teen drinking, promoting the use of car seats for toddlers, and instituting surveillance systems for detection of unusual incidence of cancer, certain infection or other possible indications of systemic community health problems.

STATUTORY GOALS

As we noted above, we support provisions in the President's bill that call for tax exempt providers to assess the health care needs of their communities and develop plans to meet those needs. Some have questioned whether additional standards concerning community benefit will be necessary. If this Committee considers additional requirements, we encourage you to develop flexible standards that will allow providers and the Internal Revenue Service to adapt the rules to the consistently-changing nature of the health care delivery system:

- For example, CHA believes that in addition to assessing a community's needs and developing a plan to meet those needs, that tax exempt providers should also be required to provide outreach and other programs to address these needs.

- The Committee may also wish to consider requiring tax exempt hospitals to look beyond their immediate community to assist in addressing the needs of the medically underserved in the region. Such a requirement would serve to encourage providers in communities with less severe needs to share resources with areas of greater need.
- In addition, the Committee could codify a marked distinction between nonprofit, tax exempt providers and for profit providers. As you know, nonprofit hospitals are not established to serve shareholders interested in receiving a monetary return on their financial investment. The Committee could reinforce this charitable commitment of nonprofit providers by requiring tax exempt hospitals to use all revenues not needed to deliver health care services (or for reasonable reserves) to improving their facilities or equipment, patient care, medical training, education or research, or to programs designed to address community needs.
- Nonprofit tax exempt hospitals also could be required to treat individuals (such as undocumented aliens) not covered under health reform legislation on an emergency basis. Perhaps, this could be extended to required provision of impatient and outpatient services for such persons. Such a more stringent requirement would have to be coupled with a financial ability standard that recognized that there are limitations on a hospital's resources to provide such an open ended commitment).

CHA strongly opposes, however, any requirement that charitable institutions spend a particular dollar amount or percentage of revenues for one or more enumerated charitable purposes. The needs of each community vary too widely to set a singular federal monetary standard. Such a standard would: (1) serve to shift the nature of charitable activities toward the type of activity that met the quantifiable standard, and (2) send a signal that achievement of a numerical goal was sufficient to dispense with the organization's overall obligations to its community. Goals set as minimums too often become the ceiling for an overall effort. Furthermore, such an approach could tend to reward high cost, inefficient community programs and discourage highly effective programs that may have lower costs through the use of volunteers or efficient management, and may provide substantial savings in terms of reduced future health care costs.

A critical aspect of not-for-profit health care organizations is that they are indeed organized and operated as not-for-profit entities. The Internal Revenue Service has testified that the current prohibitions against inurement and private benefit are difficult to enforce because the only recourse available in cases of violations is complete withdrawal of tax exemption. For this reason, CHA supports the Treasury Department's proposed intermediate sanctions on all tax exempt organizations and "insiders" that engage in private inurement or private benefit activities.

Some have questioned whether not-for-profit health care plans, both existing plans and those emerging as the health care system is restructured, should be eligible for tax exemption. CHA believes that tax exemption must be available to those organizations that are organized and operated as nonprofit and that meet standards of community benefit and other requirements that may be imposed on tax exempt hospitals and other providers. The presence of not-for-profit organizations accountable to the community will have desirous effect on health care systems and the health of persons they are designed to serve.

As the health care system continues to evolve, we urge the Internal Revenue Service continue scrutiny of tax exempt health care provider business practices and continue to provide guidance in the form of General Counsel Memoranda and other issuances that give direction to health care providers and others in the formation of not-for-profit health care networks and plans.

SUMMARY

Even with the welcome introduction of systemic health care reform with universal access to comprehensive health care services and improved delivery of services through integrated networks of providers, the need for community oriented, charitable health care organizations will not be eliminated.

Not-for-profit, tax exempt hospitals demonstrate that they fulfill a charitable purpose by continuing their founders' tradition of service, reaching out to the poor and underserved and by exhibiting concern for the broad community. As the health care system changes, this service orientation and community benefit role should continue to be a dominant characteristic both for the American health care system and the not-for-profit hospitals organized to serve it.

CATHOLIC HEALTH ASSOCIATION
STANDARDS FOR COMMUNITY BENEFIT

As members of the Catholic Health Association of the United States, we share a historical mission and tradition of community service. In order to continue our tradition of providing benefit to the community, we affirm that:

1) The organization's mission statements and philosophy should reflect a commitment to benefit the community and that policies and practices consistent with these documents, including:

   - Consideration of operational and policy decisions in light of their impact on the community served, especially the poor, the frail elderly and the vulnerable.
   - Adoption of charity care policies that are made public and are consistently applied.
   - Incorporation of community healthcare needs into regular planning and budgeting processes.

2) The governing body should adopt, make public, and implement a community benefit plan that:

   - Defines the organization's mission and the community being served.
   - Identifies unmet healthcare needs in the community, including needs of the poor, frail elderly, minorities and other medically underserved and disadvantaged persons.
   - Describes how the organization intends to take a leadership role in advocating community-wide responses to healthcare needs in the community.
   - Describes how the organization intends to address, directly and in collaboration with physicians, other individuals and organizations:
     - particular or unique healthcare problems of the community
     - healthcare needs of the poor, the frail elderly, minorities, and other medically underserved and disadvantaged persons.
   - Describes how the organization sought the views of the community being served and how community members and other organizations were involved in identifying needs and the development of the plan.

3) The healthcare organization should provide community benefits to the poor and the broader community that are designed to:

   - Comply with the community benefit plan,
   - Improve health status in the community,
   - Promote access to healthcare services to all persons in the community,
   - Contain healthcare costs.

4) The organization should make available to the public an annual community benefit report that describes the scope of community benefits provided directly and in collaboration with others.

Approved by the CHA Board of Trustees April 30, 1992

PREPARED STATEMENT OF RICHARD J. FELDMAN

Mr. Chairman and members of the Committee, I am Richard Feldman, Executive Director of the American Shooting Sports Council, Inc. or ASSC. The ASSC represents the manufacturers, wholesalers, importers, retailers, independent representatives, publications, and any other service related organizations involved with firearms, hunting, and related activities.

As every law student has been taught and every historian can cite, the power to tax is the power to destroy.

A few years ago, Congress passed a luxury tax on boats. Prior to the tax, the boating industry was a robust industry with a substantial economic impact on the United States Economy. In the few years following the imposition of this tax, the boating industry declined to near extinction. several boat builders and many boat dealers went out of business. It is my understanding that some boat builders survived by selling high performance boats to smugglers. The proposed excise tax increase will be even more devastating to the firearms industry.

By raising the cost of ammunition beyond the reach of the average American shooter, this tax will destroy an important segment of the American industry. This legislation, however, will have a number of intended as well as unintended consequences. First, it will cost jobs and lower revenues to your states and to the federal treasury. Second, it will prevent tens of millions of your constituents, who participate in the shooting sports from doing so easily and safely. Third, it will harm conservation efforts because it will lower excise tax revenue, not increase it. Fourth, it will diminish firearms safety training due to lower funding which increases the number of firearm accidents, a direct contradiction to raising monies to provide for health care. Finally, the bill will not reduce crime or criminals misuse of our products and no fair-minded person, outside the Beltway, thinks it would.

In the United states, over 25 million hunters spend in excess of 480 million dollars just for licenses and 14.1 billion dollars just on their sport. The 28 million U.S. target shooters spend a similar sum on their sport. The impact of gun collectors, law enforcement, and military sales have not been adequately measured. Over 700,000 jobs are supported by this industry. More jobs in the travel, hotel, shipping, guide services, taxidermists, recreational vehicle, and other industries are added because of the activities of hunters and target shooters. *Fortune* magazine has said that the impact of hunting is felt more by small towns off the interstates, often making the difference between success and bankruptcy. The economic multiplier effect of hunting and shooting sports raises the impact on the national economy to well over 100 billion dollars annually.

Just from this committee's majority members' states, 153,947 jobs and over 4 billion dollars annually would be lost. On the minority side, over 2 billion dollars and 85,383 jobs would be lost. Thus in the states represented on the Senate finance Committee 239,330 jobs and 6.253 billion dollars would be lost—and not one crime would be prevented.

In addition, this bill would adversely impact the environment. The Firearms and Ammunition industries fought for and supported the existing 10 to 11 percent excise tax on firearms and ammunition because it was earmarked for conversation purposes. Those funds are currently used for wildlife preservation. This bill would confiscate all of those funds and transfer them to the Health Care Trust Fund. How long would the wildlife of the country continue to flourish?

In conclusion, this tax is a scapegoat for the failings of the criminal justice system and a health care system run amok. It is farcical to believe it would lower criminal violence and comical to think the American people are so gullible as to buy into these bait and switch tactics. The power to tax is truly the power to destroy. The collateral damage done to the American economy and its citizens will not go unnoticed nor easily forgiven. Therefore, the firearms industry of America strongly opposes this proposed excise tax increase. Thank you for your time and this opportunity to testify.

Name	Jobs	Economic benefits
Majority:		
Moynihan, NY	34,109	$890,245,000
Baucus, MT	8,179	213,462,000
Boren, OK	8,767	228,806,000
Bradley, NJ	7,014	183,061,000
Mitchell, ME	5,166	134,837,000

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Name	Jobs	Economic benefits
Pryor, AR	13,946	363,982,000
Riegle, MI	43,649	1,139,249,000
Rockefeller, WV	8,514	222,221,000
Daschle, SD	4,876	127,262,000
Breaux, LA	17,191	448,692,000
Conrad, ND	2,537	66,227,000
Minority:		
Packwood, OR	13,816	360,590,000
Dole, KS	6,536	170,596,000
Roth, DE	1,451	37,876,000
Danforth, MO	18,620	485,987,000
Chafee, RI	1,618	42,220,000
Durenberger, MN	13,276	346,493,000
Grassley, IA	19,506	509,094,000
Hatch, UT	6,579	171,714,000
Wallop, KY	3,981	103,907,000

PREPARED STATEMENT OF DAVID HYMAN

Overall, the United States spends in excess of $2700 per citizen per year, or more than 14% of the GDP, on health care. Approximately 40% of health-related payments go to hospitals, and 45% of these hospitals are tax-exempt, nonprofit institutions. HMOs and various group practice entities capture a substantial proportion of the balance. Estimates of the value of tax exempt status for hospitals ranges from $6 - $10 billion per year, if one combines the benefits received from federal, state, and local tax exemption.

The analytical justification for tax exemption is usually made in terms of market failure. Market failure means that the market is not viewed as a sufficient supplier of the quality or quantity of some needed good or service. Market failures result in clients seeking an entity they trust not to exploit them, i.e. nonprofit providers. In order to encourage the nonprofit sector, our tax system provides an undifferentiated exemption from tax. This tax preference constitutes a subsidy, whose precise value depends on the tax situation and profitability of the entity that receives it.

I.R.C. § 501(c)(3) requires an exempt entity to be organized and operated exclusively towards a charitable end. The organizational aspect of this test is met by having an anti-inurement provision. For hospitals, with respect to the operational aspect, prior to 1969 the standard for exemption was the provision of charity care. Since 1969, the law has been that a hospital promoted health, and thus provided sufficient community benefit to qualify for exemption, by operating an emergency room open to all, and providing inpatient services to those who could pay. This is commonly known as the "community benefit" standard.

Because community benefit has never been defined, hospitals were left to their own devices to decide what it was they should do to benefit the community, and thus justify the exemption. Not surprisingly, hospitals started doing different things, consistent with their individualized understanding of the needs of their community. Some hospitals continued to provide charity care, while others found different avenues to serve the needs of their community.

Because of concern about the choices made by particular hospitals, and whether particular hospitals, in fact, provided a community benefit, there have been periodic exposes, attempts to revoke exemptions, proposals for intermediate sanctions, and proposals for guidelines of what constitutes community benefit. One should also recall that for-profit hospitals are in the market as well, and many of them look similar in their operations to the nonprofit tax exempt hospital down the street. Even were there better standards for what constitutes community benefit, the fact that the for-profit hospital is in the market makes it more urgent to address the question of what differentiates a nonprofit hospital from a for-profit hospital, sufficient to justify an undifferentiated subsidy of the magnitude previously mentioned.

The Health Security Act, which provides for universal coverage, eliminates the need for charity care. Accordingly, charity care would no longer be available as a justification for exemption. However, the Health Security Act continues the community benefit standard and adds the requirement that the hospital annually survey the health needs of the community and formulate a plan for meeting those needs -- although, I note there is no requirement that the hospital institute that plan.

Some hospitals will probably do things that deserve a big subsidy, while others will do relatively little, yet both will get the subsidy. The determination of whether the hospital has adequately assessed and served its community is also dependent on the hospital being audited -- an unlikely event. Finally, should the hospital be audited, the dètermination of community benefit will be made by a revenue agent with little experience or expertise in medical matters.

In practice, for-profit hospitals don't appear to be that much different from nonprofit hospitals, and an inurement constraint alone should not be sufficient to make an entity tax exempt. Ultimately, there is little in the way of theoretical, intellectual, or financial reasoning to maintain the current structure of hospital tax exemption. Although market failure may be a viable justification for encouraging certain types of behavior in the health care industry, when the only constraint is a non-inurement provision, there are strong reasons to suspect the subsidy will be dissipated unproductively. A shift to focused goals, and away from an undifferentiated subsidy, would better serve the public interest by encouraging obviously desirable conduct. Tax subsidies are not costless. They distort the market and they place a greater burden on non-exempt taxpayers. Certainly, the inability to be specific about the operational differences that distinguish a nonprofit from a for-profit hospital should give one pause.

A few words about the extension of exemption to other entities in the health care market is appropriate. To date, the Tax Court has upheld an exemption for one HMO, and denied an exemption to another. Remember that the fundamental reason for the nonprofit form is market failure, and the basis for exemption is to encourage nonprofits. The success of for-profit HMOs certainly suggests most people aren't all that concerned about market failure, and are comfortable with receiving their health care from a for-profit HMO. It appears unlikely that HMOs compete on the basis of whether they are nonprofit or for-profit. Regardless, if you look at the structure of an HMO, it is a very effective response to market failure. Thus, the underlying rationale for exemption is simply not applicable to HMOs. In addition, recall that HMOs exist to provide services to their members -- and not the general public, while exemption requires a public purpose.

The Health Security Act provides that if an HMO's physicians are on staff, the HMO can qualify for exemption if it meets the other standards for exemption. But, if the physicians are not on staff, and contract with the HMO to provide fee-for-service at a piecework rate, the Health Security Act disqualifies the HMO from receiving an exemption, based solely on the contractual relationship between the HMO and its physician-providers. Thus, the Health Security Act only makes things worse, because it discriminates among HMOs in their quest for a tax exemption, depending on the nature of their contracts with physician-providers. There is no principled basis for this distinction.

Given the cost of exemption, one should be clearheaded about the reasons why exemptions are granted, and assess whether they should be continued, extended, or curtailed. Although the Health Security Act will require hospitals to do more to earn their exemption, it does not address the logic of the exemption as such. In addition, the Health Security Act discriminates among HMOs seeking exemption, depending on their contractual arrangements with physician-providers, for reasons that defy analysis. Neither of these positions are optimal.

PREPARED STATEMENT OF MARY NELL LEHNHARD

Mr. Chairman and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association, the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million Americans. I appreciate the opportunity to present our views to you on how the Health Security Act would affect the tax treatment of health care organizations.

Blue Cross and Blue Shield Plans have a firm and longstanding commitment to comprehensive health care reform. We support the fundamental goal that all Americans should have affordable, comprehensive health insurance and that the unacceptable increase in health care costs must be restrained.

I cannot emphasize strongly enough our support for what we believe is the most fundamental feature of health care reform: the enactment of a single set of federal standards that will govern all health plans in the reformed marketplace, forcing uniform and fair competition on the basis of price, quality, service and sound management. This change alone will correct much of what is wrong today with our health care system and will respond to what Americans most want health care reform to accomplish. It would open the doors of all health care plans to anyone who chooses to enroll, regardless of their health care status. It would eliminate volatile changes in premiums from year to year. Most important, it would guarantee that health benefits cannot be taken away because of an illness or a change of jobs. These are the first order changes that any health reform legislation must accomplish.

THE NEED FOR A NEW TAX POLICY

Health care reform will be a bold, fresh departure from the past and it will be incomplete without an equally fundamental and comprehensive change in the taxation of health care plans. The time has come to move beyond the patchwork pattern of tax policies and rates for commercial insurance companies, Blue Cross and Blue Shield Plans, HMOs and others. These tax policies have served their purposes and now need to be replaced. We need a new approach.

We propose that a single tax policy and a single tax rate be established for all accountable health care plans, whether for profit or nonprofit. This new policy should contain no exceptions, no special preferences, no hidden features and no subsidies. It should be guided by the simple premises that all health care plans will be held to the same set of standards in the marketplace regardless of how they are structured—and that the reformed marketplace will provide universal insurance coverage.

Make no mistake, our position also provides no exception for Blue Cross and Blue Shield Plans. We will support the phase out of the special tax status of Blue Cross and Blue Shield Plans as part of the enactment of a uniform set of market standards for all accountable health plans. Our position underscores our firm commitment to the enactment of health reform. We are prepared to accept an end to our special tax status to achieve something far more important to Blue Cross and Blue Shield Plans and our subscribers, a reformed health care system that relies on vigorous and fair competition between health plans to control health costs.

The other major effect of our proposal would be the elimination of tax exemption and the access to tax-exempt bond financing for all nonprofit health plans, including nonprofit HMOs and health care plans organized by nonprofit hospitals.

Let me be clear that this does not mean we are advocating the repeal of tax exemption for nonprofit hospitals or their access to tax-exempt financing. Our position also would not preclude hospitals or other groups of health care providers from forming accountable health plans. What we propose is that the health plan business of any organization, including an exempt hospital or HMO, should be taxed. This is consistent with the principle of current law that a business activity of an exempt organization is taxable if it is unrelated to the tax-exempt purpose of the organization. There is no reason that the extension of this well-established tax principle to the business of health financing should threaten in any way the quality of the services provided by those who deliver health care.

TAX CHANGES IN THE HEALTH SECURITY ACT

The Admmistration's proposals for the taxation of health plans run the full gamut from tax exemption to full taxation with no consistent policy rationale or compelling guiding principle to explain the differences in tax treatment. It is this unsupportable variation that we believe must be changed.

Beginning in 1997, the Health Security Act would repeal the special tax status of Blue Cross and Blue Shield Plans. Under provisions of the Tax Reform Act of 1986, Blue Cross and Blue Shield Plans lost their tax exemption. Plans have been allowed to deduct a portion of their additions to their reserves and these amounts are then subject to the alternative minimum tax (AMT) rate of 20%. Commercial insurance companies are required to pay the full corporate 35% tax rate on comparable additions to their reserves. Blue Cross and Blue Shield Plans were also allowed to continue to deduct 100% of their additions to reserves for unearned premiums while other insurance companies were only entitled to deduct 80% of these amounts.

Under the Health Security Act, BCBS Plans that met strict standards before the 1997 effective date of the repeal of their special tax status would be entitled to continue the lower AMT tax rate on their reserves for an additional two year period.

The Health Security Act would allow nonprofit HMOs to continue to qualify for tax exemption. Staff model HMOs presently qualify for exemption under section 501(c)(3) which allows them access to tax-exempt bonds to meet their capital needs. Most other forms of HMOs have been classified under section 50 1(c)(4) which exempts them from the payment of federal taxes but does not allow them access to tax-exempt financing. To retain exemption, the Act would require that an HMO meet two tests: the HMO could not offer substantial open ended benefits outside of its network and a section 501(c)(3) organization would be required to assess the health care needs of its community and determine how to satisfy them.

Delta Dental Plans are exempt from taxation under current law and no change would be made in their tax status by the Health Security Act.

Finally, the Act would treat for profit HMOs—and nonprofit HMOs that do not qualify for exemption—as taxable insurance companies which would clarify that they are in the business of insurance and are entitled to the same insurance reserve deductions that are available to other insurers.

In summary, rather than rationalizing tax policy for all health plans into a coherent whole, the Health Security Act would merely substitute a new and less rational patchwork policy for the one we already have, squandering the opportunity to craft a consistent tax policy that complements the objectives of health care reform. Perhaps even more disturbing is that this approach is likely to cost the federal government billions of dollars in unexplained subsidies for certain types of health plans.

THE PRINCIPLES THAT SHOULD GUIDE TAX CHANGES

As the committee considers the changes needed in the tax code to accompany health care reform, we recommend that you be guided by several principles.

1. Uniformity of Treatment

We believe this committee and the Administration will conclude, as we have, that all health plans—HMOs, Blue Cross and Blue Shield Plans, commercial insurance companies and the new integrated networks and partnerships being organized by health care providers—are fundamentally in the same business.

All health care plans are in the business of financing health care services for individuals who have transferred their risk of an illness or accident to the health plan.

That risk is then distributed among all others who are enrolled in the same plan. Risk transfer and risk distribution are the defining characteristics of health insurance, without regard to the almost endless number of ways that different organizations have been formed to manage those two tasks. This business is the same whether the health plans are for profit or nonprofit companies, as Congress and the IRS have already concluded in the case of nonprofit Blue Cross and Blue Shield Plans and commercial insurance companies.

All health plans protect their enrollees from losses resulting from an illness or accident either by making payments for the services they receive or by providing the services directly to the enrollee. Whichever route they choose makes no difference to the insurance principle of indemnifying an individual for his or her loss. It is still the transfer and distribution of risk.

After the enactment of health care reform, the similarity among health plans only will be greater than it is today. They will be required to offer identical benefits, open enrollment, community rating and meet cost containment and quality standards. Tax subsidies to encourage these same practices will no longer be needed. Unless all tax distinctions are eliminated, a nonprofit, tax-exempt health plan would have a tax subsidized advantage over other companies which are engaged in the same business under the same standards. That subsidy would equal 35% of a company's taxable income. In addition, the capital costs of staff model HMOs would continue to be subsidized by tax-free bond financing. This outcome is neither acceptable nor Justified.

2. Separate Tax Treatment for Health Care Financing and Delivery

We also believe that the tax code must make a clear distinction between the business of health care financing and health care delivery. This is particularly important if Congress intends to retain tax exemption for the care provided by nonprofit hospitals. Unless Congress separates these two activities, exempt health provider organizations that are rapidly entering the field of health financing will cause a significant drain on federal revenues after the enactment of health care reform. In addition, there would be significant and unwarranted competitive advantages held by these tax-exempt organizations.

3. Changes Coincide with Health Care Reform

Our support for fundamental change in the tax code is linked directly to the enactment of health care reform legislation that achieves a level playing field among all health plans no matter how they are structured. To state our case clearly, we support health reform legislation that establishes a level playing field among all health plans with respect to their market conduct and we will not support a tax policy that falls short of the same standard.

This is a singular and important opportunity for Congress to address the irrational variation in the tax treatment of health care financing organizations. Without a consistent and complementary tax policy to accompany the establishment of uniform standards for all accountable health plans, there can be little prospect that the promise of health care reform—the vigorous, fair competition among all health plans in the market—can be realized.

4. Moratorium on Tax Exemptions for Insurance Activities of Integrated Delivery Systems

One of the most troublesome developments in the taxation of health plans are five recent rulings by the IRS that nonprofit hospitals can acquire medical practices and compete against HMOs and health insurers in the health financing business with the benefit of tax exemption for both their health delivery and health financing activities. These emerging arrangements, known as integrated delivery systems (IDS), not only gain the advantage of tax exemption, they have also become eligible for raising capital through tax-exempt financing.

It is clearly essential that Congress sort out these kinds of issues now as you address health care reform. For example, we believe tax-exempt bonds, which are only available to 501(c)(3) organizations, should not be used to finance the construction of facilities for the health plan itself. Until issues like this are clarified, we urge you to take appropriate actions to put a temporary halt on the further granting of tax exemptions for the health financing activities of these integrated delivery systems. This, of course, does not mean that hospitals could not continue to be granted tax-exempt status as they are today for their medical service business.

5. Appropriate Transition Provisions

Blue Cross and Blue Shield Plans are well aware of the difficulty caused by making the change from tax exempt to taxable status and we understand the importance of appropriate transition provisions when an organization's tax status is changed.

Many of the technical transition provisions that would be required for exempt health plans that become taxable could be modeled after provisions provided to Blue Cross and Blue Shield Plans in the Tax Reform Act of 1986. Any transition rules should not, however, undermine the essential principle of achieving a level tax playing field for all health plans.

Similarly, Blue Cross and Blue Shield Plans will require transition rules as they move toward fully taxable status. Two provisions are particularly important. First, the phase out period for Plans should be gradual and available to all Blue Cross and Blue Shield Plans. Second, Blue Cross and Blue Shield Plans and all other health plans should be entitled to a 100% deduction for additions to premium stabilization reserves just as life insurance companies are now allowed to take this deduction for their health insurance business.

CONCLUSION

In summary, the Blue Cross and Blue Shield Association urges the committee to approach the taxation of health plans on the same principled basis as the rest of health care reform. The old ways of financing and structuring health care are changing every day and the change is rapid and irreversible. We need a tax policy that looks ahead to these changes. That policy must recognize that although health plans of the future may take many different forms, they will all be in the same business and should play by the same set of rules. None of these health plans should

be subsidized by federal tax revenues. These are the principles that we urge you to support as you consider health reform legislation.

PREPARED STATEMENT OF JOHN G. MARTINEZ

Mr. Chairman and members of the Committee, my name is John G. Martinez, and I am the Executive Director of the New York State Medical Care Facilities Finance Agency. I am testifying today on behalf of the National Council of Health Facilities Finance Authorities (the "National Council").

The National Council includes all of the 23 Health Care Finance Authorities that issue tax-exempt bonds on a state-wide basis.[1] We do not represent specific hospitals or health care institutions; rather, the National Council focuses its efforts on issues that directly affect the availability of tax-exempt financing to member authorities that issue bonds on behalf of public and not-for-profit hospitals.

Members of the National Council have issued over $55 billion of health care bonds to finance projects such as the expansion and modernization of medical centers and clinics; the installation of computerized information systems that promote efficiency; the purchase of high-technology medical equipment (e.g., fixed CT scanners, OR/lasers, and mammography equipment); and new construction of ambulatory care centers and hospital energy plants.

THE NATIONAL COUNCIL IS CONCERNED THAT TAX-EXEMPT BOND LAW COULD WORK TO IMPEDE THE GOALS OF HEALTH CARE REFORM

As the principal providers of capital for health care facilities, members of the National Council play an integral role in America's health care system. We *want* health care reform to work but are concerned that current law restrictions on tax-exempt financing, if not reviewed, could cause difficulties in the implementation of health care reform.

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

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

An important step towards accomplishing the related goal of **cost-reduction** can be achieved by modifying certain restrictions on tax-exempt financing that are impediments to consolidations, mergers, and innovative alternative health care programs. Based on the impact the current law on tax-exempt bonds has had on financing decisions by health care facilities, the National Council has extrapolated potential problems that should be addressed under any plan for health care reform.

We have identified four potential problem areas, although the balance of this testimony focuses on the $150 million per institution "Cap." The other three areas relate to limitations on advanced refundings that inhibit hospital mergers and consolidations; the implications of redefining 501(c)(3) status; and the need to include health care borrowers among the small issuers with access to the tax-exempt bond market via the "initial Caps bank deductibility" rule; we would be pleased to work with the committee to explore solutions for addressing these problems as well as that posed by the $150 million dollar Cap.

THE $150 MILLION CAP IS AN OBSTACLE TO RATIONALIZING THE HEALTH CARE SYSTEM

Many institutions important to the health care reform plan are not "hospitals" (*e.g.*, non-profit health maintenance organizations or "HMOs"), yet current law limits these non-hospital facilities to $150 million per institution in outstanding bonds.

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[1] In addition to the City of Philadelphia, the following states are members of the National Council:

Arizona; California; Colorado; Connecticut; Idaho; Illinois; Indiana; Louisiana; Maine; Maryland; Massachusetts; Michigan; Missouri; Montana; New Hampshire; New Jersey; New York; North Carolina; Rhode Island; South Dakota; Vermont; Washington; Wisconsin

As non-hospitals and hospital systems form integrated delivery systems in response to health care reform (e.g., long-term care facilities or free-standing ambulatory care facilities) they will conceivably run into the limitations of the $150 million Cap. This result will impede the creation of integrated systems that provide a continuum of care in a variety of settings, not just acute care facilities.

As stated in the Anthony Commission Report (at page B-3) the definition of "hospital" for purposes of the $150 million Cap is virtually unworkable in today's medical environment and is contrary to the policy of encouraging more outpatient treatment and other less intensive forms of care: "Hospital" should become "Healthcare."

CURRENT DATA SUGGESTS THE IMMEDIACY OF THE PROBLEM CAUSED BY THE $150 MILLION CAP

At a time when we are moving towards a "non-hospital" delivery system, the $150 million Cap serves as an important dis-incentive to innovation. Currently, there are at least five states with an aggregate of 12 health care institutions that are at the $150 million limitation applicable to non-hospitals. In addition there are another four health care organizations with between $120 to $150 million in outstanding bonds (See Attachment A).

As an example of the perverse action of the $150 million Cap, the New York State Association of Retarded Persons ("NYSARC")—the Nation's largest provider of non-profit community-based care—is now at the Cap, and thus cannot issue any more tax-exempt bonds for new community facilities. This state of affairs exists at a time when NYSARC is also coping with the consequences of the State of New York's court-ordered mandate to de-institutionalize!

Another example is the Boise, Idaho Chapter of the American Red Cross. Five years ago, the Boise Chapter contacted the Idaho Health Facilities Authority to discuss the need to borrow for expanding, remodeling, and equipping their facility. Unfortunately, the Idaho National Council member determined that the needed loan could not be obtained on a tax-exempt basis, because the National Red Cross (which has a controlling interest in each state chapter) is at the Cap! The Boise, Idaho Chapter was forced to downsize its program and pay for it out of operating capital (instead of devoting those funds to blood bank operations). As a result, just one month ago, the Boise, Idaho Red Cross had to shut down completely, because it is now behind in training and inspection programs—it will probably be out of service for at least another month!

Health Care Reform will undoubtedly encourage the development of alternative health care facilities (such as HMOs, family clinics, more long-term care and continuing research, and other collaborative efforts between hospitals and non-hospitals) and thereby increase the need for bond issuances by non-hospitals. Further, National Council members have been approached by hospitals planning to extend their operations into non-acute care functions such as neighborhood diagnostic and treatment facilities; medical equipment acquisitions entities; ambulatory care centers; nurse recruiting services; and long-term residential care facilities.

In order to access capital in a cost-effective way, these new facilities would benefit from affiliations with or ownership by hospitals that have healthy balance sheets. Hospitals that might wish to lend their credit to an otherwise risky or lower-rated venture have a limited ability to do so because of the $150 million Cap. As a result, the National Council is concerned that more non-hospitals will approach the $150 million Cap.

THE CAP AS A BARRIER TO HOSPITAL MERGERS

While current health care delivery is based on stand-alone hospitals and multi-hospital systems, health care reform is expected to result in a major restructuring in which independent hospitals will be forced to merge with or acquire others to compete in the post-reform environment. The Administration has focused on the potential anti-trust issues presented by hospital mergers; attention should also be paid to tax exempt bond limitations that may inhibit mergers.

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

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

THE NATIONAL COUNCIL PROPOSES TO PROMOTE THE GOALS OF HEALTH CARE REFORM, BY ADDING OTHER DESIRABLE "HEALTH CARE FACILITIES" TO HOSPITALS THAT ARE OUT OF THE $150 MILLION CAP:

The following "conceptual" definition is based on state law that defines the purposes for which health bonds can be issued. The National Council would propose to promote the policy of encouraging more out-patient treatment and other cost-effective forms of care by expanding the exception for hospitals to include certain out-patient "non-hospital" health care facilities (without regard to their physical location):

1. a clinic,
2. a health maintenance organization,
3. a diagnostic, treatment, or surgical center,
4. a comprehensive cancer center,
5. a kidney disease treatment center,
6. a drug treatment center,
7. an alcohol treatment center,
8. a home health agency,
9. a hospice agency,
10. a skilled nursing facility,
11. a psychiatric hospital, or
12. a community mental health center;

CONCLUSION

The National Council appreciates this opportunity to raise this tax-exempt finance/health care issue presented by the $150 million Cap "on the record," and looks forward to working with you to insure that current law does not have the unintended result of impeding the implementation of Health Care Reform.

Specifically, in order to have an orderly evolution of health care by promoting cost-effectiveness and efficiency, the National Council offers the following proposals for your consideration:

1. Lift the $150-million-per-institution Cap from not-for-profit health care projects that provide alternative care settings that will, of necessity, be a cornerstone of national health care reform.

ATTACHMENT A—FACILITIES AT $150 MILLION LIMITATION

State	Description of facility at limitation
California	Health maintenance organization
	Four Long Term Care Facilities
Idaho	American Red Cross
Massachusetts	Health maintenance organization
	Medical Research facility
New York	Health maintenance organization
	Non-profits which provide services to mentally retarded and mentally ill
	Mount Sinai Hospital and the Medical School
North Carolina	Intermediate care facility for mentally retarded
South Dakota	A multi state nursing home

FACILITIES BETWEEN $120 MILLION AND $150 MILLION WITH NON-HOSPITAL BONDS

State	Description of facility at limitation
New Jersey	One hospital at $140 million
Colorado	One community provider at $130 million issued bonds for projects for abused children, mentally retard, retirement communities, and alzheimer patients

FACILITIES BETWEEN $120 MILLION AND $150 MILLION WITH NON-HOSPITAL BONDS—Continued

State	Description of facility at limitation
Washington	One HMO could do a refunding of a bond issue but that would put them above the $150 million limitation One clinic could do a refunding which would put them above the $150 million limitation

PREPARED STATEMENT OF SENATOR MITCH MCCONNELL

Thank you Mr. Chairman and Members of the Committee. I appreciate the opportunity to give you my views on the proposed excise tax increase on tobacco products in the President's health care proposal.

I feel compelled to inform my colleagues on the Committee of the disastrous consequences of such a tax increase, not only on tobacco, but on a whole way of life.

All too often in the debate over tobacco, it is the farmer who is the forgotten part of the industry. People criticize the tobacco industry and its "powerful" lobby, and broadly state "let's end the government's involvement in the tobacco industry" *without any regard to what happens to our tobacco farmers. The tobacco farmers in my state have few other options.*

Whatever an individual's personal views are on tobacco, the economic importance of this crop is undeniable. In addition to 2.5 million jobs for American workers, the sale of tobacco products generates nearly $20 billion in tax revenue, contributes over $40 billion to the Gross National Product, and provides a trade surplus of about $6 billion. A single tobacco plant generates *only 61 cents in gross farm income,* but it amounts to $3.24 in federal taxes, $3.51 in state tax revenue, and more than $23 in retail product value.

Tobacco is one of the Southeast's leading industries. Leading tobacco states like Kentucky, North Carolina, and Virginia are not the only states whose economies benefit from tobacco. Tobacco is grown on an estimated 136,000 farms in 22 states and in Puerto Rico. Tobacco *provides jobs* to countless Americans. The hundreds of thousands of people involved in the tobacco industry buy cars built in Michigan, refrigerators built in Iowa, computers from California, and insurance from New York companies. *Also, the billions of tax dollars supplied by the many facets of the tobacco industry support schools, pay for roads . . . help build America . . . and sustain the history we are all proud of. In our own United States Capitol Building, the small Senate Rotunda has its columns adorned with tobacco leaves.* There is no denying its importance.

Tens of thousands of Kentuckians earn a living from the growing, harvesting, manufacturing, and marketing of tobacco products. Additionally, nearly $130 million of Kentucky's tax revenue relates to tobacco production, and local governments receive approximately $5.5 million in property taxes from the value of the quota system alone. Tobacco is a $3 billion industry in the state and accounts for more than one-half of the total farm income received from crop sales. *Any tax increase will have a devastating effect on both the state and the 60,000 farm families who count on tobacco for much of their income.*

For over 200 years, tobacco has played an integral role in Kentucky's history and economy. More burley tobacco is grown in Kentucky than anywhere in the world. The average farmer grows less than three acres of tobacco, and *there is no other crop which provides the income tobacco does on such small acreage.* The economics of this intensively managed crop do not transfer to soybeans, peanuts, or corn. There have been attempts to replace tobacco production with other crops; however, almost none are economically sustaining.

It's time to put away the crystal ball and get down to reality. In Kentucky, the reality of a 75 cent per pack increase in the excise tax on cigarettes would reduce tobacco income by $58.8 million, the equivalent of *losing* 3,285 jobs. Under this scenario, gross tobacco income would be reduced by more than one million dollars in each of 16 counties, equivalent to eliminating 50 to 90 jobs in each of these counties.

It takes a tobacco farmer about 275 man-hours of labor to grow and harvest one acre of tobacco. By comparison, it takes about three man-hours to grow and harvest an acre of wheat. I get *hundreds* of letters per day from farmers who are pleading for their lives. These families have been farming tobacco for generations. A constituent in Hodgenville explained to me that her teenage sons' college education depends on their father's job. However, their father's job would be lost if the tobacco tax went through, and with the lost job would be the lost chance for two young men to receive a college education. A tobacco farmer in Murray stands to lose his home. A tobacco farmer in Princeton would lose his barns and equipment. A young farmer in

Allensville is working his way through college and he is paying for it with money he makes by growing tobacco. Tobacco is his *primary source of income* from his farm; he is a junior in college and doesn't want to have to quit because he is taxed out of business. I could go on and on about the countless number of letters I receive every, single day which say that tobacco feeds their families, clothes them, educates them, houses them, the list is endless.

Tobacco is one of the most economically productive crops for the type of soil we have in Kentucky, and researchers are yet unable to find a viable alternative. Forcing farmers to leave tobacco for an unsuitable crop is irresponsible and will cause irreparable damage to thousands of Kentuckians.

We have too many "big-picture economists" and self-appointed experts who say farmers can find something else to grow, and not one of them has been to a tobacco farm to even know what it looks like. If they would go with me to Morgan, Owsley, or Wolfe Counties, where over three-fourths of their farm income comes from tobacco, it becomes very clear why I say there are not many alternatives. *Twenty-three counties, all in Eastern Kentucky, rely on tobacco for more than one-half of their farm income.*

Owsley County—88% of farm income is from tobacco
Wolfe County—80% of farm income is from tobacco
Morgan County—75% of farm income is from tobacco

If they could diversify they would. In Western Kentucky, where the land is flat, they are growing tomatoes and peppers. In Central Kentucky, they have beef and dairy cattle. But in Eastern Kentucky, where the choices are coal, tobacco, or welfare, the options simply are not there, no matter what the experts say.

Beyond the farm gate, tobacco farming is immensely important to hundreds of small rural communities. Without the tobacco program the value of farmland would fall dramatically, local tax bases would be wiped out and the loss of income from leasing the tobacco quota or growing the crop would reduce the standard of living dramatically across my state. Nearly 160,000 families derive income from tobacco production, and thousands more people earn their living in the marketing and manufacturing process. This income does not provide a lavish lifestyle. It is used to put food on the table, keep the children in school, and to pay the taxes.

The real travesty of an excise tax increase would be the impact on family farmers who have been helping to stabilize and revitalize our rural communities. In Bath County nearly 50% of all personal income comes from tobacco sales. *That means it keeps a steady flow of money going into the community.* Bath County School Superintendent Bill Morgan said the district depends on the revenue from tobacco farms. Morgan said if farmers were forced to give up tobacco for a less profitable crop, the county's tax base would decrease, and that would mean less money for schools. It would even mean less money in the collection plate at the church in Bath County.

If this tax goes through, how are tobacco farmers going to pay the local truck dealership, the farm equipment store, the seed and fertilizer store, the local independent bank, and all the other important elements in the community?

There is just no disputing the fact that Kentucky burley brings in far more money than any other crop raised in the state. There are tobacco quotas in 119 of Kentucky's 120 counties, and it is actually grown in all but five of those counties. The 1992 tobacco crop was valued at $959.7 million dollars, two times the yield of the number-two crop in the state which, is corn.

The bottom line is this: the tobacco tax is an attempt to control people's actions and thoughts about tobacco. However, we must remember that the decision to use tobacco products is up to the individual, and I do not think it is acceptable for the government to impose additional hardships on those who do. I think the President is wrong in singling out tobacco as the main source of revenue in efforts to pay for health care reform.

While, I do not personally use tobacco products, the proposed excise tax increase will impact me and every non-smoker across the country. The excise tax on tobacco products, as proposed by the President, will have a dramatic impact: jobs will be lost, sales and income tax revenues will be lost, unemployment will increase, businesses will shut down, and family farmers will go bankrupt and that will affect every one of us.

In summary, it's often been pointed out, first by the Supreme Court, that the power to tax is the power to destroy. However, we cannot allow taxes to be used as a blunt weapon to destroy a way of life. We cannot stand by and watch a tax take away a family's home, bankrupt their farm, and rob their children's dreams and opportunities. There are one hundred and sixty thousand burley families—hardworking, patriotic, taxpaying, God-fearing—who are guilty of only one thing: producing a legal commodity by the sweat of their brow that creates net economic benefits

for their communities, their states, and their Nation. We cannot forget the tobacco farmers—and we cannot allow a tax to take away their way of life.

[Submitted by Senator Moynihan]

DESCRIPTION AND ANALYSIS OF PROPOSALS RELATING TO THE TAX TREATMENT OF HEALTH CARE ORGANIZATIONS AND EXCISE TAXES ON TOBACCO PRODUCTS AND FIREARMS AND AMMUNITION

[Scheduled for a Hearing Before the Senate Committee on Finance on April 28, 1994. Prepared by the Staff of the Joint Committee on Taxation, April 28, 1994, JCX-5-94]

INTRODUCTION

The Senate Committee on Finance has scheduled a public hearing on April 28, 1994, on the tax treatment of health care organizations and excise taxes on tobacco products and firearms and ammunition. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of present law and proposals and also a brief discussion of related issues.

Part I of the document relates to the tax treatment of health care organizations; Part II relates to excise taxes on tobacco products; and Part III relates to excise taxes on firearms and ammunition.

I. TAX TREATMENT OF HEALTH CARE ORGANIZATIONS[2]

A. Background and Present Law

Tax-exempt organizations generally

Code section 501(a) provides that certain organizations listed in sections 501(c) and (d) are exempt from Federal income tax. Among the organizations listed in section 501(c) are those organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual (sec. 501(c)(3)), and civic leagues and organizations not organized for profit which are operated exclusively for the promotion of social welfare (section 501(c)(4)).

Charitable organizations described in section 501(c)(3) are classified either as public charities or private foundations. In general, an organization will be classified as a public charity if it (1) receives significant support (generally more than one third) in the form of contributions from the general public or (2) is a church, school or hospital. In addition, section 509(a)(3) provides that public charities include certain "support" organizations which are organized and operated exclusively to benefit one or more specified public or publicly supported charitable organizations. Public charities are not subject to the special rules applicable to private foundations, such as a prohibition against self-dealing and tax on net investment income, and contributions to public charities are subject to more liberal deduction rules than are contributions to private foundations.

Charitable organizations exempt under section 501(c)(3) receive four major tax benefits: (1) exemption from Federal income tax; (2) ability to accept tax-deductible contributions; (3) ability to benefit from tax-exempt financing; and (4) exemption from certain State and local taxes.[3] In contrast, social welfare organizations exempt from Federal income tax under section 501(c)(4) cannot accept tax-deductible contributions or use tax-exempt financing, and generally are not exempt from State and local taxes.

Hospitals as tax-exempt entities

Although Code section 501(c)(3) does not specifically mention furnishing medical care and operating a not-for-profit hospital, such activities have long been consid-

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[1] This document may be cited as follows: Joint Committee on Taxation, *Tax Treatment of Health Care Organizations and Excise Taxes on Tobacco Products and Firearms and Ammunition* (JCX-5-94), April 28, 1994.

[2] This description and discussion is principally derived from the previous Joint Committee pamphlet: Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600. S. 1757. and S. 1775 ("Health Security Act")* (JCS-20-93), December 20, 1993.

[3] The extent to which an organization is eligible for exemption from State and local taxes depends on the laws of the local jurisdiction; while local exemption is frequently conditioned upon Federal exempt status, it does not flow automatically from such status.

ered to further charitable purposes.[4] However, the mere provision of not-for-profit medical care is not, by itself, sufficient to allow an organization to qualify for exemption under section 501(c)(3). Rather, an organization must demonstrate that its activities are targeted to a charitable class. The precise nature of that charitable class has been and continues to be a source of controversy.

In 1956, the Internal Revenue Service (IRS) issued Revenue Ruling 56–185, 1956–1 C.B. 202, setting forth the conditions that a not-for-profit hospital must satisfy to qualify for recognition as a tax-exempt charitable organization under section 501(c)(3). The IRS ruled that a hospital would be exempt if it met the following four conditions: (1) it must be organized as a not-for-profit organization for the purpose of operating a hospital for the care of the sick; (2) it must be operated, to the extent of its financial ability, for those not able to pay for the services rendered and not exclusively for those able and expected to pay; (3) it must not restrict use of its facilities to a particular group of physicians; and (4) its earnings must not inure, directly or indirectly, to the benefit of any private shareholder or individual (this last requirement merely restated a restriction generally applicable to all organizations under section 501(c)(3)).

With respect to the "financial ability" requirement, the IRS noted that:

> The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

Three years after publication of Revenue Ruling 56–185, the Treasury Department significantly revised its regulations interpreting section 501(c)(3). The amended regulations provided that:

> The term "charitable" is used in section 501(c) (3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions.[5]

Relying upon the amended regulations, the IRS issued Revenue Ruling 69–545, 1969–2 C.B. 117, which considered whether two nonprofit hospitals qualified for Federal tax exemption. In establishing the so-called "community benefit" standard, the IRS noted that the promotion of health is "one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community. " The IRS specifically modified Revenue Ruling 56–185 to eliminate the requirement relating to caring for patients without charge or at rates below cost.

The "community benefit" standard, which remains the principal standard applied by the IRS today, focuses on a number of factors which indicate that the operation of a hospital benefits the community rather than serving private interests. In Revenue Ruling 69-545, the IRS determined that the standard was satisfied by a hospital that operated an emergency room open to all persons and provided hospital care in non-emergency situations for everyone able to pay the cost thereof, either themselves, or through third-party reimbursement.[6] The hospital also had a board of directors drawn from the community, an open medical staff policy, treated persons paying their bills with the aid of public programs (such as Medicare and Medicaid),

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[4] Although not-for-profit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some may also qualify for exemption as "educational organizations" because they are organized and operated primarily for medical education purposes.

[5] Treas. Reg. sec. 1.501(c)(3)–1(d)(2).

[6] In Rev. Rul. 83–157, 1983–2 C.B. 94, the IRS clarified that the operation of an emergency room was not a prerequisite for hospital exemption, if a State health planning agency made an independent determination that the operation of an emergency room would be unnecessary and duplicative, and provided that other factors set forth in Rev. Rul. 69–545 were present indicating that the hospital promoted the health of a class of persons broad enough to benefit the community.

and applied any surplus receipts to improving facilities, equipment, patient care, and medical training, education and research.

The community benefit standard was challenged in a class action by various health and welfare organizations and several private citizens on the grounds that it failed adequately to identify a charitable class. In *Eastern Kentucky Welfare Rights Organization* v. *Simon,* 370 F. Supp. 325, 338 (D.D.C. 1973), a Federal District Court sustained the challenge, and concluded that Congress intended to restrict the term charitable to its narrow sense of relief of the poor. The United States Court of Appeals reversed the District Court, however, and upheld the IRS' broader interpretation of "charitable" reflected in Revenue Ruling 69-545.[7] The Court of Appeals explained that the term "charitable" is "capable of a definition far broader than merely the relief of the poor." The Court also noted that the community benefit standard did not supplant the "financial ability" requirement of Revenue Ruling 56-185, but rather represented an alternative method whereby a not-for-profit hospital could qualify as a tax-exempt charitable organization.

Health maintenance organizations (HMOs) as tax-exempt entities

The same community benefit standard for determining whether a hospital is a tax-exempt charitable organization applies in determining whether a health maintenance organization ("HMO") qualifies for tax-exempt status under section 501(c)(3). In this context, the IRS has developed a fairly comprehensive list of characteristics that distinguish tax-exempt charitable HMOs from other HMOs. Although an HMO seeking exemption as a social welfare organization under section 501(c)(4) is not required to possess all of the same characteristics as an HMO that qualifies for exemption under section 501(c)(3), its activities must generally satisfy a community benefit standard similar to, but less exacting than, that imposed on charitable HMOs.[8]

In general, HMOs represent one form of managed health care delivery organization. Although there is case law regarding the tax treatment of HMOs, the Code does not define an HMO.[9] In general, HMOs have structured their delivery of medical care in accordance with four basic models: (1) a "staff model" HMO employs its own doctors and staff and serves its members at its own central location; (2) a "group model" HMO contracts with an existing group of physicians to perform services at the HMO's central location; (3) an "IPA model" HMO contracts with physicians, often through an individual practice association ("IPA"), to provide care to HMO members at the physicians' own offices; and (4) a "network model" HMO provides care to its members through a network of independent medical groups.[10]

The IRS initially took the position that, while HMOs could qualify for tax-exempt status as social welfare organizations under section 501(c) (4), they could not qualify as charitable organizations under section 501(c) (3) because the preferential treatment provided to members/subscribers represented private, rather than public, benefit. However, the United States Tax Court rejected this position in *Sound Health Association* v. *Commissioner,* 71 T.C. 158 (1978). The Court held that the programs and facilities of the staff model HMO benefited the community because its membership class was so open as to be practically unlimited; where possible membership is so broad, benefit to the membership constitutes benefit to the community.

In response to the *Sound Health Association* decision, the IRS issued several GCMs identifying certain factors which differentiate HMOs exempt under section 501(c)(3) from other HMOs.[11] In GCM 39828 (August 30, 1990), for example, the IRS stated that the characteristics of an HMO eligible for tax-exemption under section 501(c) (3) include: actual provision of health care services and maintenance of facilities and staff; provision of services to nonmembers on a fee-for-service basis;

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[7] *Eastern Ky. Welfare Rights Org.* v. *Simon,* 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds,* 426 U.S. 26 (1976).

[8] See GCM 39829 (August 30, 1990) which reviews the IRS' position regarding HMOs and considers the extent to which HMOs customarily act as providers of health services or insurance.

[9] Both State and Federal law regulate the operation of HMO. For Federal purposes, the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, codified as amended at 42 U.S.C. 300e-300e17, defines a health maintenance organization and prescribes the manner in which such organizations must be organized and provide health services to be qualified under the Act and eligible for certain Federal developmental loans, grants and guarantees. In GCM 39829, the IRS suggested that an HMO's qualification under the Act could be considered as evidence of community benefit, noting that the Act imposes requirements in the areas of quality assurance, community rating and continuation of coverage that tend to suggest that the HMO's operations would benefit the community.

[10] See GCM 39829 (August 30, 1990).

[11] Although general counsel memoranda may not be relied upon as precedent, these documents are made public under section 6110 of the Code and may be indicative of the IRS' position on particular issues.

care and reduced rates for the indigent; care for those covered by Medicare, Medicaid or other similar assistance programs; emergency room facilities available to the community without regard to their ability to pay (and communication of this fact to the community); a meaningful subsidized membership program; a board of directors broadly representative of the community; health research programs; health care providers who are paid on a fixed-fee basis; and the application of any surplus to improving facilities, equipment, patient care, or to any of the above programs. The IRS noted, however, that these factors are not all-inclusive, nor is the absence of any one determinative of the lack of a charitable operation.[12]

More recently, in *Geisinger Health Plan* v. *Commissioner,* 985 F.2d 1210 (3rd Cir. 1993), the Court of Appeals for the Third Circuit applied the factors set forth in *Sound Health Association* and held that Geisinger Health Plan (GHP), a network model HMO, did not qualify for tax-exempt status under section 501(c)(3) because its activities did not primarily benefit the community. GHP did not provide any health services directly, but contracted to provide health services with other health care providers (which typically were other entities related to GHP). In addition, the Court noted that operating a subsidized dues program for 35 otherwise medically underserved individuals did not benefit the community sufficiently to overcome GHP's primary purpose of providing benefits only to its members.[13]

HMOs as taxable entities

In fact, the majority of HMOs are not organized as tax-exempt entities. At the beginning of 1990, there were 575 HMOs nationwide, approximately two-thirds of which were organized and operated as taxable, for-profit businesses.[14] The primary issue for such taxable HMOs concerns their ability to deduct additions to reserves established out of premium payments to cover accrued liabilities (so-called "incurred but not reported" or "IBNR" claims). In general, accrual method taxpayers are not entitled to deduct expenses until all events necessary to fix and determine the taxpayer's obligation have occurred (the "all events" test). In addition, section 461(h) imposes an economic performance requirement which, in general, postpones deductions until payment.

Property and casualty insurance companies are entitled to deduct IBNR reserves without regard to the "all events" test or the economic performance requirement. Such reserve deductions are, however, subject to certain limitations. For example, reserve deductions by an insurance company must be discounted on a pre-tax basis to take account partially of the time value of money, and unearned premium reserve deductions must be reduced by 20 percent.[15] Thus, the tax treatment of a taxable HMO depends largely on the extent to which it qualifies as an insurance company.[16]

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[12] See, e.g.., GCM 38735 (May 29, 1981) (concluding that staff model HMOs that have truly open membership, directly provide services to members and nonmembers, maintain an open emergency room, and treat patients regardless of ability to pay may be exempt under section 501(c)(3)); and GCM 39057 (Nov. 9, 1983) (ruling that an IPA model HMO which arranged for health care services through an affiliated, physician-owned IPA that controlled the HMO does not qualify for exemption under section 501(c)(3)). In GCM 39057, the IRS explicitly expressed no opinion as to whether the HMO in question could qualify for exemption under section 501(c)(4).

[13] The Court of Appeals remanded the case to the Tax Court for a determination of whether GHP could qualify for 501(c)(3) status as an "integral part" of an exempt organization. The integral part theory set forth in Treas. Reg. sec. 1.502-1(b) provides generally that an organization is entitled to exemption as an integral part of a tax-exempt affiliate if its activities are carried out under the supervision or control of an exempt organization and could be carried out by the exempt organization without constituting an unrelated trade or business. The Tax Court noted that a taxpayer may qualify for exemption under the integral part theory if the taxpayer performs an essential service directly to its affiliates, but not if it provides such services to unrelated organizations. Alternatively, the taxpayer may provide services on behalf of its exempt affiliates directly to the class of charitable beneficiaries of such affiliates. The Tax Court concluded GHP did not qualify for tax-exempt status under the integral part theory. *Geisinger Health Plan* v. *Commissioner,* 100 T.C. No. 26, filed May 3, 1993.

[14] See, T.J. Sullivan, "The Tax Status of Nonprofit HMOs After Section 501(m)," *Tax Notes,* January 7, 1991.

[15] Present law also provides that property and casualty insurance companies are eligible for exemption from Federal income tax if their net written premiums or direct written premiums (whichever is greater) do not exceed $350,000; and further provides that a company with such premiums in excess of $350,000 but less than $1.2 million may elect to be taxed only on taxable investment income (and thus, generally to exclude underwriting income from tax) (sec. 501(c)(15)).

[16] Under Treas. Reg. sec. 1.801-3(a), to constitute an "insurance company," a company must be one whose primary and predominant business activity is the issuing of insurance or annuity contracts or the reinsurance of risks underwritten by insurance companies.

Insurance activities of tax-exempt organizations

Under section 501(m), an organization described in section 501(c)(3) or 501(c)(4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance. Commercial-type insurance generally includes any insurance of a type provided by commercial insurance companies, subject to certain exceptions. For example, commercial-type insurance does not include insurance provided at substantially below cost to a class of charitable recipients. In addition, section 501(m)(3)(B) provides that commercial-type insurance does not include incidental health insurance provided by an HMO, of a kind customarily provided by an HMO.[17]

Special rules applicable to certain taxable insurance companies

When section 501(m) was enacted in 1986, special rules were added to benefit certain organizations that no longer qualified as tax-exempt organizations and became subject to tax as insurance companies under subchapter L. Section 833, enacted concurrently with section 501 (m), provides special relief for Blue Cross and Blue Shield organizations existing on August 16, 1986, which were exempt from tax for their last taxable year beginning before January 1, 1987, and which have experienced no material change in their structure or operations since August 16, 1986. In addition, section 833 provides special relief for certain other organizations, substantially all of the activities of which involve the provision of health insurance, that meet certain community-service-related requirements.[18]

Section 833 provides three special rules for organizations within its scope. First, eligible organizations are treated as stock insurance companies. Second, section 833 exempts eligible organizations from the rule (referred to above) that is generally applicable to property and casualty insurance companies, requiring a 20-percent reduction in the amount a company can deduct for any increase in unearned premium reserves.[19] Thus, eligible organizations are not required to reduce the deduction for increases in unearned premium reserves. Third, eligible organizations are entitled to claim a special deduction with respect to their health business in an amount equal to 25 percent of claims and expenses incurred during the taxable year, less adjusted surplus at the beginning of the year.

The transition rules in section 833 provide that no adjustment was to be made on account of a change in such an organization's method of accounting for its first taxable year beginning after that date. The transition rules also provide that, for purposes of determining gain or loss, the adjusted basis of any asset of such an organization held on the first day of the taxable year beginning after December 31, 1986, was treated as equal to its fair market value as of such day. Rules were also provided to limit adjustments to surplus that could affect the amount of the special deduction, and to treat reserve weakening after August 16, 1986, as occurring in the organization's first year as a taxable organization.[20]

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[17] See GCM 39829 (August 30, 1990) for a discussion of the legislative history of the enactment of section 501(m) and the HMO exception in section 501(m)(3)(B).

[18] These community service requirements are: (1) substantially all the activities of the organization involve providing health insurance; (2) at least 10 percent of the health insurance is provided to individuals and small groups (not taking into account Medicare supplemental coverage); (3) the organization provides continuous full-year open enrollment (including conversions) for individuals and small groups; (4) the policies covering individuals provide full coverage of pre-existing conditions of high-risk individuals without a price differential (with a reasonable waiting period), and coverage is without regard to age, income, or employment status of individuals under age 65; (5) at least 35 percent of its premiums are community rated; and (6) no part of its net earnings inures to the benefit of any private shareholder or individual.

[19] The 20-percent reduction requirement was added by the 1986 Act, effective for taxable years beginning after December 31, 1986. The 1986 Act also required the inclusion in income ratably, over the ensuing six-year period, of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1987. The inclusion was required at the rate of 3⅓ percent of such outstanding unearned premium reserve in each of the first six taxable years beginning after December 31, 1986.

[20] Because increases in reserves are generally deductible by a taxable insurer, a reduction in reserves (so-called "reserve weakening") immediately prior to the time a tax-exempt organization becomes a taxable insurer could allow the organization to claim a bigger deduction than it would otherwise be entitled to after it becomes taxable.

B. Description of Bill (S. 1757—Sen. Mitchell and others and S. 1775—Sen. Moynihan (The "Health Security Act") (secs. 7601-7603 of bill)

Tax-exempt status of hospitals, HMOs, certain parent organizations and regional alliances

The bill would establish certain new requirements applicable to nonprofit health care providers (hospitals and HMOs) seeking to qualify as tax-exempt charitable organizations under section 501(c)(3).

In particular, the bill would amend the Code specifically to require that, in order for the provision of health care services to constitute a charitable activity for purposes of section 501(c)(3), the organization providing such services must periodically assess the health care needs of its community and develop a plan to meet those needs. Such assessment and plan development must take place at least annually and must include the participation of community representatives.

In addition, the bill would provide that an HMO seeking tax-exempt status under section 501(c) (3) must furnish health care services to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization.

The bill would further provide that organizations which serve as parent holding companies for hospitals or medical research organizations constitute public charities rather than private foundations. Thus, the bill would add to the list of organizations described in section 509(a) any organization which is organized and operated for the benefit of, and which directly or indirectly controls, (1) a hospital, the principal purpose or function of which is the provision of medical or hospital care or medical education or medical research; or (2) a medical research organization if such organization is directly engaged in the continuous active conduct of medical research in conjunction with a hospital and, during the calendar year in which the contribution is made, such organization is committed to spend such contribution for medical research not later than the beginning of the fifth calendar year beginning after the date such contribution is made.

Finally, section 7603 of the bill would add the to-be-established regional alliances described in section 1301 of the bill to the list of tax-exempt organizations set forth in Code section 501(c)

Effective date.—The provisions regarding the definition of charitable activities of medical service providers and HMOs would be effective January 1, 1995. The provision regarding the exempt status of regional alliances would apply to taxable years beginning after the date of enactment. and the provision regarding the treatment of parent organizations of health care providers would take effect on the date of enactment.

Insurance activities of tax-exempt organizations

Under the bill, health insurance provided by an HMO would be treated as commercial-type insurance if such insurance relates to care which is not provided pursuant to a pre-existing arrangement between the HMO and a health care provider (other than emergency care provided to a member of such organization at a location outside such member's area of residence). Under this rule, commercial-type insurance would include plans under which an HMO member can select any health-care provider, the HMO pays a portion of the costs of such provider, and the member is obligated to pay the remaining portion. Such arrangements are commonly referred to as providing "point of service" or "fee-for-service" benefits (i.e., the member decides which medical provider to use at the point at which service is required). However, the provision of emergency care, even if on a point of service basis, to HMO members outside their area of residence would not constitute commercial-type insurance.

The bill would specifically identify four types of health insurance provided by an HMO that would not be treated as commercial-type insurance and, thus, would not jeopardize the organization's tax-exempt status. Such non-commercial-type health insurance coverages generally address emergency situations and situations in which a health care provider has a pre-existing relationship with an HMO whereby the HMO exerts control over either the fee charged by the service provider or the member's use of such provider's services.

First, insurance relating to care provided by an HMO to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such HMO would not constitute commercial-type insurance. Such arrangements are characteristic of "staff model" or "group model" HMOs which hire health care providers (as employees or independent contractors) to provide services to members on an exclusive basis.

Second, insurance relating to primary care provided by a health care professional to a member of an HMO on a basis under which the amount paid to such professional does not vary with the amount of care provided to such member would not constitute commercial-type insurance. This rule addresses situations in which an HMO pays health care providers on a "fixed" or "capitated" basis for primary care services rendered to members. Although such fees may be based on the number of members served by such provider, they may not be based on the extent of services provided to a member.

Third, insurance which relates to the provision of services other than primary care, if provided pursuant to a pre-existing arrangement with an HMO, would not be commercial-type insurance. This exception is intended to address situations in which an HMO member is referred by his or her primary care provider to a specialist who is a member of an HMO's so-called "provider network," even if the amount paid to the specialist varies with the amount of care provided. Unlike the "point of service" situation described above, the HMO in these cases, rather than the member, controls the decision regarding the appropriate health care provider.

Fourth, insurance relating to emergency care provided to a member of an HMO at a location outside such member's area of residence would not constitute commercial-type insurance. This exception would apply, for example, when an HMO reimburses health care providers for the provision of emergency care to HMO members, outside of their area of residence, irrespective of whether such providers have a pre-existing arrangement with the HMO.

Effective date.—These provisions would be effective on the date of enactment.

Definition of taxable property and casualty insurance companies

In general, the bill would redefine the scope of organizations treated as taxable property and casualty insurance companies. Under the bill, any organization that is not tax-exempt, is not a life insurance company, and whose primary and predominant business activity during the taxable year falls in one of three categories, would be treated as a property and casualty insurance company. The three categories of activities are: (1) issuing accident and health insurance contracts or reinsuring accident and health risks; (2) operating as an HMO; or (3) entering into arrangements to provide or arrange for the provision of health care services in exchange for fixed payments or premiums that do not vary depending on the amount of health care services provided. The bill would modify the "primary and predominant" requirement in the case of organizations that have, as a material business activity, the issuing or reinsurance of accident and health insurance contracts. For such organizations, the administering of accident and health insurance contracts would be treated as part of such business-activity for purposes of determining whether the organization's activities fall within the scope of category (1) above.

Effective date.—This provision would be effective for taxable years beginning after December 31, 1996.

Special rules applicable to certain taxable insurance companies

The bill would repeal the special rules provided under section 833 to Blue Cross and Blue Shield organizations and other eligible organizations, and would provide transition rules for organizations that become subject to section 833 after the effective date (generally, taxable years beginning after December 31, 1996). The provision would treat such organizations as insurance companies, but would not specify that such organizations be treated as stock companies.

The bill would repeal the special exception to the 20 percent reduction with respect to unearned premium reserves. The bill would require inclusion in income ratably, over a six-year period following the effective date, of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1997. The inclusion would be required at the rate of 3⅓ percent of such outstanding unearned premium reserve in each of the first six taxable years beginning after December 31, 1996.

The bill would also repeal the special deduction for 25 percent of claims. A special phase-out rule would apply to an organization that meets the community-service-related requirements of present law for each of its taxable years beginning in 1995 and 1996. For such organizations, the deduction would be phased out at a specified rate over the organization's first two years following the effective date; 67 percent of the otherwise allowable amount of the special deduction would be allowed for such an organization's taxable year beginning in 1997, and 33 percent would be allowed for its taxable year beginning in 1998. As under present law, the deduction would not be allowable during the phase-out period in determining the organization's alternative minimum taxable income.

The bill would provide transition rules for organizations that become subject to section 833, as amended, after the effective date (generally, taxable years beginning after December 31, 1996). For an organization that is not tax-exempt for its last taxable year beginning before January 1, 1997 (and is taxed other than under the property and casualty insurance company regime for taxable years beginning in 1992 through 1996), the amendments to section 833 would be treated as a change in method of accounting, and all adjustments required to be taken into account under section 481 would be taken into account in one taxable year, i.e., the company's first taxable year beginning after December 31, 1996. No special transition rule would apply to organizations that treat themselves as subject to tax under the property and casualty insurance company regime for taxable years beginning in 1992 through 1996.

For an organization that is tax-exempt for its last taxable year beginning before January 1, 1997, no adjustment would be taken into account under section 481 or any other provision for the company's first taxable year beginning after December 31, 1996, on account of a change in method of accounting required by the amendments to section 833. In addition, for purposes of determining gain or loss, the adjusted basis of any asset held by such an organization on the first day of its first taxable year beginning after December 31, 1996, would be deemed equal to the fair market value of the asset on that date.

The bill would also specify that the above amendments do not affect the adjusted basis of any asset determined under the transition rule provided for existing Blue Cross and Blue Shield organizations in the 1986 Act (i.e., generally, that basis equalled fair market value as of the first day of the organization's taxable year beginning after December 31, 1986). In addition, the bill would eliminate the requirement that existing Blue Cross and Blue Shield organizations not experience any material change in their operations or structure to be eligible for the basis adjustment, and would further provide that, on January 1, 1997, such basis adjustment is made permanent.

Effective date.—These provisions would generally be effective for taxable years beginning after December 31, 1996, subject to the special income inclusion rule (with respect to the repeal of the 20 percent reduction), the phase-out rule for certain organizations (with respect to the repeal of the special deduction for 25 percent of claims), and the transition rules described above.

C. Discussion of Issues

Tax-exempt status of certain organizations

In general, tax exemption is a form of subsidy administered through the tax system (sometimes referred to as a "tax expenditure"). It is granted to, among other organizations, certain private organizations that conduct activities which Congress deems to further worthy public objectives.

As a threshold matter, it is important to assess whether the subsidization of the operation of hospitals and HMOs, as well as regional health alliances, through tax expenditures, rather than through direct outlays or other means of finance, is appropriate. In general, such subsidization means that the true cost of such activities appears understated in relation to the cost of other goods and services because they do not appear as outlays in budget reporting. In addition, such tax expenditures are not subject to the annual appropriations process.

The desirability of tax exemption also must be evaluated in the context of the overall health care proposal. As described above; under present law, the provision of medical care and operation of a nonprofit hospital in a manner that satisfies the "community benefit" standard is considered to further "charitable" objectives. Although this community benefit standard evolved in response to the expanded Federal role in health care financing through programs such as Medicare and Medicaid, payment for medical care remained largely the province of the private sector.

The system of *universal* health care coverage envisioned under the bill represents a significant quantitative, and perhaps also qualitative, expansion of Federal participation in financing health care. Accordingly, it may be appropriate to reexamine the circumstances under which the provision of medical care would constitute a charitable function in such a system. Presumably, teaching institutions could continue to be eligible for tax exemption as educational organizations. However, if all Americans have access to health care, what other activities would distinguish a nonprofit from a for-profit health care provider? For example, would nonprofit hospitals provide charity care where gaps exist in the system of universal coverage?

These questions are particularly apt in light of the significant financial benefits for which charitable organizations are eligible. It is not clear, for example, that allowing such organizations continued access to tax-exempt financing is appropriate in a system in which the Federal Government provides considerable direct subsidies

(for example, the Federal payments to alliances outlined in Title IX, Subtitle B of the bill). With respect to regional and corporate health alliances, section 7902 of the bill would provide that regional and corporate health alliances be treated as private businesses that are not eligible for tax-exempt financing. This raises the further question of why such alliances should be treated differently than other medical service providers exempt under section 501(c) (3).

Finally, it is not clear whether the community needs assessment and plan development requirements set forth in the bill are intended to replace or supplement present-law standards for exemption. In addition, the scope of organizations subject to the requirements is unclear. The bill states that the requirements apply to hospitals, HMOs and "other entities providing health care services." A wide variety of organizations exempt under section 501(c)(3) provide an equally wide range of health care services. For example, a half-way house for alcoholics, a blood bank, a childbirth education organization, a clinic to aid drug victims, an organization that provides home health care, homes for the elderly, and nursing homes all have qualified for exemption under section 501(c)(3). Do the community needs assessment and plan development requirements apply to all of these organizations, as well as to hospitals and HMOs?

Insurance activities of tax-exempt organizations

Similarly, it may be appropriate to reexamine the characterization of certain forms of insurance provided by HMOs as commercial- or non-commercial-type insurance. The bill generally appears to codify positions developed by the IRS with respect to various payment arrangements established by HMOs under a health care system very different from the one proposed in the bill.

In addition, the provisions regarding characterizing insurance arrangements as commercial or non-commercial appear somewhat inconsistent with other provisions of the proposed health plan. For example, the bill would characterize "point of service" or "fee-for-service" plans offered by HMOs as commercial-type insurance. However, section 1402(d) of the bill would require certain health plans (e.g., those that offer enrollees the lower cost sharing schedule described in section 1132 of the bill) to offer fee-for-service coverage. If participants elect such coverage to the extent that it constitutes a substantial portion of such HMO's activities, the HMO could lose its tax-exempt status.

Definition of taxable property and casualty insurance companies

The bill would expand the definition of taxable property and casualty insurance companies to include organizations that are not tax-exempt, are not life insurance companies, and that meet one of three tests. The first is insurance or reinsurance of accident and health risks (a traditional activity of insurance companies). The second is operation as an HMO, and the third appears to encompass arrangements similar to those which an HMO might enter into, whether or not it purports to be an HMO (i.e., arrangements to receive fixed payments as consideration for providing or arranging to provide health care services, regardless of the amount of health care services provided). Thus, the bill would treat taxable HMOs and taxable organizations that operate like HMOs as property and casualty insurance companies.

However, it is not self-evident that all taxable HMOs should be taxed as property and casualty insurance companies. The underlying presumption appears to be that if an HMO is not tax-exempt, its activities involve the provision of insurance services as opposed to medical services. This presumption is based on what traditionally has been a key distinction between HMOs and hospitals; HMOs deliver prepaid benefits whereas hospitals are paid on a fee-for-service basis.

Several issues are raised in determining whether a taxable HMO (for example, an HMO that is not tax-exempt because it is organized on a for-profit basis) sufficiently resembles a property and casualty insurance company to be taxed as one. One is whether deductions for reserves are appropriate to the operation of an organization that directly provides medical care.

A central issue in determining whether an HMO should be taxed as a property and casualty insurer is the method of accounting for premium payments received. In general, property and casualty insurance companies are entitled to deduct increases in reserves which affect premium income. Organizations that are not insurance companies, by contrast, are not entitled to deduct increases in reserves but rather, generally account for deductions in accordance with the all events test and the rules for determining when economic performance has occurred. The allowance of a deduction for Federal income tax purposes with respect to reserves of property and casualty insurance companies generally reflects the fact that payments (premium income) are generally received in a taxable year earlier than the year in which the loss is incurred or paid.

If an HMO receives payments that resemble the premiums received by insurance companies in these respects, it appears appropriate to tax them under the regime applicable to property and casualty insurance companies. On the other hand, if an HMO receives prepayments for medical services it directly provides, reserve deductions are arguably inappropriate, and the organization should not be treated as a property and casualty insurance company. Because the manner of organization and operation of HMOs varies and may change rapidly with business trends, consideration should be given to whether one rule is appropriate for all taxable HMOs. On the other hand, it may not be administratively feasible to distinguish among types of payments received by HMOs.

With respect to treatment of reserves, some taxable HMOs take the position that they are subject to taxation as property and casualty insurance companies. Others, however, may take the position that, although they may be subject to State regulation and financial reporting requirements as insurance companies, they are not taxable as property and casualty insurers. Such organizations nevertheless may claim tax deductions for reserves on the theory that the risk of loss has shifted to them. These organizations may argue that, because they are not taxable as property and casualty insurers, they are not subject to the limitations on reserve deductions imposed on property and casualty insurance companies. Thus, as a practical matter, the regime prescribed under the bill may represent a significant change only for taxable HMOs that take the position that they are not taxable as property and casualty companies.

An additional issue relates to the operation of the property and casualty company tax regime. Treating HMOs as property and casualty insurers could be criticized on the ground that the present-law regime for taxing such entities is flawed in certain respects. For example, present law provides for a pre-tax method of discounting loss reserves of property and casualty insurance companies which only partially takes account of the time value of money. It is arguable whether taxpayers not explicitly subject to this regime should be made explicitly subject to it without addressing its failure to take account fully of the time value of money. Further, some might assert that the regime of complete or partial tax exemption for small property and casualty companies may not be appropriate for HMOs that fail to qualify for tax-exempt status under 501(c)(3) or 501(c)(4).

As a technical drafting matter, the statutory structure set forth in the bill appears redundant in defining both criteria for tax-exempt status and criteria for taxable status. Rather than simply characterizing all organizations that are not tax-exempt as taxable, the bill would set forth one standard for tax exemption and another, different, standard for taxability. Conceivably, some organizations could fail to meet either set of criteria. In addition, the taxability standards themselves could be criticized as vague. Because neither present law nor the bill defines an HMO, the second standard ("operating as an HMO") is difficult to apply at best

The bill would also require that the three enumerated activities constitute the primary and predominant business activity of an organization. This standard is similar to a rule set forth in Treasury regulations that describes an insurance company as one whose primary and predominant business activity is the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies, and has been variously interpreted in judicial decisions. While the bill does state that administering accident and health insurance contracts is treated as part of the activity of issuing accident and health insurance contracts or reinsuring accident and health risks (for an organization that has issuing such contracts or reinsuring such risks as a material business activity), the bill would not specify the nature and amount of other activities that a company may conduct and still be treated as a property and casualty insurance company. Because this standard does not provide a bright-line test, without further clarification, it could be criticized as an inadequate basis for determining the tax status of an organization.

Finally, because the effective date of this provision would be deferred until taxable years beginning after 1996, additional rules may be needed to forestall opportunities for manipulation of accounting items for organizations that become taxable under the bill (or whose accounting method is changed) and, thus, become subject to the provision. For example, the bill does not contain a rule comparable to that provided in the Tax Reform Act of 1986 (the "1986 Act") to limit reserve weakening by organizations immediately prior to the point at which they become taxable.

Special rules applicable to certain taxable insurance companies

Some might argue that the present-law special rules under Code section 833 (enacted in 1986) for Blue Cross and Blue Shield organizations that became taxable was intended merely to ease the transition from tax-exempt to taxable status and should now be repealed. It could be argued that sufficient time has elapsed since

the 1986 Act changed the tax status of these organizations for them to adjust to operation as taxable entities, and that repeal of the special deduction, as provided by the bill, is now appropriate. Others might assert that this purpose was not stated in the legislative history, and, in fact, the provision was not temporary when enacted.

II. EXCISE TAXES ON TOBACCO PRODUCTS

A. Present Law

Tax rates

Excise taxes are imposed on the manufacture or importation of cigarettes, cigarette papers and tubes, snuff, chewing tobacco, and pipe tobacco. The present-law tax rates are as follows:

Cigarettes:	
Small cigarettes (weighing no more than 3 pounds per thousand)[21].	$12 per thousand (i.e., 24 cents per pack of 20 cigarettes).
Large cigarettes (weighing more than 3 pounds per thousand)[22].	$25.20 per thousand.
Cigars:	
Small cigars (weighing no more than 3 pounds per thousand).	$1.125 per thousand.
Large cigars (weighing more than 3 pounds per thousand).	12.75 percent of manufacturer's price (but not more than $30 per thousand).
Cigarette papers and tubes:	
Cigarette papers[23]	0.75 cent per 50 papers.
Cigarette tubes[24]	1.5 cents per 50 tubes.
Snuff, chewing tobacco, pipe tobacco:	
Snuff	36 cents per pound.
Chewing tobacco	12 cents per pound.
Pipe tobacco	67.5 cents per pound.

[21] Most taxable cigarettes are small cigarettes.
[22] Large cigarettes (measuring more than 6½ inches in length) are taxed at the rate prescribed for small cigarettes, counting each 2¾ inches (or fraction thereof) as one cigarette.
[23] Cigarette papers measuring more than 6½ inches in length are taxed at the rate prescribed, counting each 2¾ inches (or fraction thereof) as one cigarette paper. No tax is imposed on a book or set of cigarette papers containing 25 or fewer papers.
[24] Cigarette tubes measuring more than 6½ inches in length are taxed at the rate prescribed, counting each 2¾ inches (or fraction thereof) as one cigarette tube.

Exemptions; use of revenues

No tax is imposed on tobacco products exported from the United States. Exemptions also are allowed for (1) tobacco products furnished by manufacturers for employee use or experimental purposes; and (2) tobacco products to be used by the United States. In addition, no tax is imposed on tobacco to be used in "roll -your-own" cigarettes.

Revenues from the tobacco products excise taxes are retained in the general fund of the Treasury. Revenues from taxes on tobacco products brought into the United States from Puerto Rico and the American Virgin Islands are transferred ("covered over") to those possessions if the products satisfy a domestic content requirement with respect to the possession from which they are received.

B. Description of Bill (S. 1757—Sen. Mitchell and others and S. 1775—Sen. Moynihan (The Health Security Act) (secs. 7111-7113 of the bill)

Rate increases; extension of coverage

The bill would increase the tax rate on all tobacco products by approximately $12.50 per pound of tobacco content, and would extend the tax to tobacco to be used in "roll-your-own" cigarettes. The new tax rates would be:

Cigarettes:	
Small cigarettes (weighing no more than 3 pounds per thousand).	$49.50 per thousand (i.e., 99 cents per pack of 20 cigarettes).
Large cigarettes (weighing more than 3 pounds per thousand.	$103.95 per thousand

Cigars:	
Small cigars (weighing no more than 3 pounds per thousand.	$38.625 per thousand
Large cigars (weighing more than 3 pounds per thousand	52.594 percent of manufacturer's price (but not more than $123.75 per thousand).
Cigarettes papers and tubes:	
Cigarette papers	3.09 cents per 50 papers
Cigarette tubes	6.19 cents per 50 tubes
Snuff, chewing tobacco, pipe tobacco, "roll-your-own" tobacco:	
Snuff	$12.86 per pound
Chewing tobacco	$12.62 per pound
Pipe tobacco	$13.175 per pound
"Roll-your-own" tobacco	$12.50 per pound

Exemptions; administrative provisions

The bill would repeal the present-law exemptions for tobacco products provided to employees of the manufacturer and for use by the United States.

The bill also includes several administrative and compliance provisions. First, the exemption for exports would be limited to products that are marked or labelled under Treasury Department rules designed to prevent the diversion of such products into the domestic market Second, re-importation of tobacco products previously exported without payment of tax (other than for return to the manufacturer) would be prohibited and a new penalty, equal to the greater of $1,000 or five times the amount of tax imposed would be assessed against all parties involved in any prohibited re-importation. All tobacco products and cigarette papers and tubes, as well as all vessels, vehicles, and aircraft used in such re-importations, would be subject to seizure by the United States.

Third, the bill would extend current manufacturer inventory maintenance, reporting requirements, criminal penalties, and forfeiture rules to importers of tobacco products.

Fourth, the bill would repeal the present-law exemption for books or sets of cigarette papers containing 25 or fewer papers.

Fifth, the bill would limit the cover over of tobacco product revenues to Puerto Rico and the Virgin Islands to present-law tax levels.

Effective date

The provisions would be effective for tobacco products removed after September 30, 1994. A floor stocks tax would be imposed on taxed tobacco products held on the effective date.

C. Discussion of Issues[25]

Statistics relating to incidence of tobacco use

The United States National Institute on Drug Abuse estimates that, in 1991, 27 percent of the United States population currently smoked cigarettes and that 3.4 percent of the population currently used smokeless tobacco.[26] Medical research has linked the use of tobacco products to a number of diseases—including cancer of the lungs, mouth and throat, emphysema, chronic bronchitis, and heart disease.[27] In addition, smoking is believed to be a contributing factor to low birth weight babies. The public's increased awareness of these health hazards has led to substantial declines over the past 30 years in the percentage of the United States population that currently uses tobacco products. The incidence of smoking among males 20 years old or older has fallen from approximately 50 percent in 1965 to approximately 31 percent in 1988. Over the same period, the incidence of smoking among females 20

[25] The following discussion draws substantially on the analysis presented in Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")* (JCS-20-93), December 20, 1993.

[26] "Current" use of cigarettes or other tobacco products is defined as use of the product within the last month. The estimate is based on a household survey. Bureau of the Census, United States Department of Commerce, *Statistical Abstract of the United States. 1992.*

[27] Department of Health and Human Services, *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General,* DHHS Publication No. (CDC) 89-8411 (prepublication version, January 11, 1989).

years old or older has shown a similar though smaller decline. Table 1 details the incidence of cigarette smoking for selected years between 1965 and 1988.

Table 1.—INCIDENCE OF CIGARETTE SMOKING, BY MALE AND FEMALE, SELECTED YEARS 1965 TO 1988

[Percentage of individuals 20 years old and older]

	1965	1970	1976	1980	1985	1988
Female	31 9	30 8	31 3	29 0	28.0	23 3
Male	50 2	44 3	42 1	38 5	33.2	30 9

Source Bureau of the census, United States Department of Commerce, *Statistical Abstract of the United States. 1992.*

The incidence of smoking varies by age, gender, race, level of education, and other demographic factors. Individuals with more education tend to have a lower incidence of smoking than those with less education. For example, the incidence of smoking among individuals with college degrees was 15.6 percent in 1988, while the incidence of smoking among individuals with less than a high school diploma was 32.8 percent.[28] The incidence of smoking among blacks is modestly greater than the incidence of smoking among whites.[29] The incidence of smoking has fallen among all groups.

The incidence of smoking in developed countries, including the United States, has declined over the past 20 years. While the incidence of smoking in the United States is not substantially different from that of other developed countries,[30] it is generally conceded that health care costs in the United States exceed those abroad. Such aggregate data do not reveal the extent to which United States expenditures on health care are, or are not, attributable to tobacco-related health problems.

Table 2.—INCIDENCE OF CIGARETTE SMOKING IN CERTAIN FOREIGN COUNTRIES, 1986

[Percentage of individuals 20 years old and older]

	Great Britain	Australia	Norway [1]	Sweden [2]
Female	31.0	30 6	32.4	30.0
Male	35 0	32.9	43 8	24.0

[1] Ages 20 to 70 only

[2] Ages 18 to 70 only

Source John P. Pierce, "International comparisons of Trends in Cigarette Smoking Prevalence," *American Journal of Public Health*, 79, February 1989

Many countries tax cigarettes at a higher total rate than does the United States. Some of this higher total tax is due to other countries' use of value-added taxes which generally tax all consumption items. However, when the effect of value-added or general sales taxes is removed, the cigarette taxes in the United States remain relatively low. Table 3 shows cigarette excise taxes as a percentage of retail prices in selected OECD countries for 1987.

Table 3.—CIGARETTE EXCISE TAXES (EXCLUDING VALUE-ADDED AND GENERAL SALES TAXES) AS A PERCENTAGE OF RETAIL CIGARETTE PRICES IN SELECTED OECD COUNTRIES, 1987

Country	Tax a percentage of price
United States	30 1
Australia	32.3
Belgium	64.4
France	49.2
Germany	59.8
Portugal	58.0
Spain	32.8

[28] *Statistical Abstract of the United States. 1992.*

[29] *Ibid.*

[30] See Table 2 below.

Table 3.—CIGARETTE EXCISE TAXES (EXCLUDING VALUE-ADDED AND GENERAL SALES TAXES) AS A PERCENTAGE OF RETAIL CIGARETTE PRICES IN SELECTED OECD COUNTRIES, 1987—Continued

Country	Tax a percentage of price
United Kingdom	61.3

Source: Congressional Budget office, "Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels," June 1990.

Federal excise taxes on tobacco products are imposed in nominal terms, that is, they do not rise with inflation of the general price level. Cigarette taxes, imposed at eight cents per pack in 1951, remained unchanged until 1983. Subsequent increases under the Omnibus Budget Reconciliation Act of 1990 have increased the tax to 24 cents per pack, or three times the nominal 1951 level. The general price level today is more than five and one half times that prevailing in 1951, implying a substantial decline in the real (inflation-adjusted) burden of tobacco excise taxes. On the other hand, it may be inappropriate to compare tax rates prevailing today with those imposed during the Second World War or the Korean War.

Health policy and control of tobacco

In general

The medical research cited above has motivated many public health analysts to advocate greater governmental action to help reduce the use of tobacco among the population. Such non-tax action could range from increased expenditures on public service announcements detailing the risks associated with tobacco use to increased penalties for sales of tobacco products to minors. Some analysts advocate increasing tobacco taxes to provide a market incentive to individuals to reduce their consumption of unhealthy products. The higher prices of tobacco products resulting from increases in tobacco excises taxes would be expected to reduce consumption by consumers of tobacco products. Some consumers may cease using such products altogether, while others moderate their current level of consumption. Among smokers, some smokers may maintain their current rates of smoking by substituting discount brands of cigarettes for more expensive brands.[31] Among smokers who crave nicotine, some may reduce the number of cigarettes they consume but switch to cigarettes with higher levels of nicotine.

Taxes on the consumption of specific products, as opposed to broadly imposed consumption taxes, distort consumer behavior by disfavoring certain goods in the economy relative to other goods. Generally, market price distortion through taxes reduces consumer well-being because the change in relative prices introduced by the tax causes consumers to choose a less preferred good than they would have in the absence of the tax. This general economic analysis is based on assumptions that consumers are fully informed about the product and that consumption of the product imposes no externalities, i.e., additional costs on society as a whole. Some public health analysts question the validity of these assumptions in the case of tobacco use.

In addition, some public health analysts observe that, as a major provider of health care, the Federal Government has an interest in controlling health costs, and that tobacco use may overly contribute to the Federal Government's health and welfare costs.

Informed versus uninformed choice

Some proponents of higher taxation of tobacco products argue that consumers are not fully informed about the true costs and benefits of the use of tobacco products, and that consumers do not fully account for the harm such products can have on their health. They argue that the higher prices that increased taxation will produce are necessary to help potential consumers see the true cost of tobacco products. They argue that this particularly may be the case among younger individuals who do not recognize the addictive power of nicotine or who otherwise might be expected to be less informed about the potential health dangers of tobacco use. There is evi-

[31] The market share of discount brands has grown in recent years and now accounts for nearly one third of the cigarette market. Michael Grossman, Jody L. Sindelar, John Mullahy, and Richard Anderson, "Policy Watch: Alcohol and Cigarette Taxes," *Journal of Economic Perspectives*, 7, Fall 1993.

dence that younger individuals may be more likely than the population at large to reduce their consumption of tobacco products if the price rises.[32]

There is some survey evidence, however, that both smokers and nonsmokers overestimate the probability of death and illness from tobacco use. Moreover, that survey suggested that teenagers attach a higher risk to smoking than do adults.[33] Opponents of higher tobacco taxes also argue that if the primary concern is to reduce the demand by young individuals who may be uninformed, a tax increase is inefficient because the tax also imposes large costs on older, informed individuals who derive pleasure from tobacco products. They argue that more targeted remedies such as greater penalties for sales to minors may be more efficient. Some argue for both higher tobacco taxes and greater penalties for sales to minors.

Externality

Economists say that an externality arises when the consumption (or production) of a good by one individual imposes a cost (or benefit) on society as a whole. For example, emissions of volatile organic compounds from automobiles contribute to urban smog, which imposes health and other costs on society at large. When all such external costs (or benefits) are not accounted for by the individual purchaser/user, there is too much (or too little) of the good produced and consumed. Recent medical research suggests that "second-hand smoke," that is, the smoke from smokers inhaled by nonsmokers, creates health risks and costs for nonsmokers.[34] Thus, while potential health damage of smoking is a direct cost to the smoker, second-hand smoke creates a cost for nonsmokers for which the smoker does not account in making the decision to smoke. Such costs are referred to by economists as negative externalities.

Economists often propose corrective taxation as a remedy for existence of a negative externality.[35] The idea is that if a tax is imposed on the product that creates the externality at a rate equal to the additional harm created by the externality, then the market price will fully reflect all benefits and Costs to society from the production and consumption of the product. Assuming that second-hand smoke is an externality, a tax on smoking tobacco could improve economic efficiency. However, the difficulty is in choosing the correct level of the tax. Too great a tax could reduce economic efficiency by discouraging more tobacco use than the harm caused by second-hand smoke might justify. Critics of increases in tobacco taxes contend that there are no good measures of the value of possible external harms from tobacco products.

Some suggest that current pricing practices for medical insurance may create a negative externality. Whereas life insurance policy premium rates often vary based upon whether the consumer is a smoker or a nonsmoker, medical insurance premium rates typically are the same regardless of tobacco use by the consumer. If tobacco users have greater insured medical expenses than other consumers,[36] then some of the increased health costs of tobacco use may be borne, not by the tobacco user, but by all consumers in the form of higher insurance premiums.[37] By reducing the incidence of tobacco use, increased tobacco taxes would reduce the magnitude of this problem; however, given the current pricing practices for health insurance, the problem will exist as long as anyone uses tobacco.

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[32] Department of Finance, Canada, *Tobacco Taxes and Consumption*, June 1993 ("*Tobacco Taxes and Consumption*"). Also see, Eugene M. Lewit, Douglas Coate, and Michael Grossman, "The Effects of Government Regulation on Teenage Smoking," *The Journal of Law and Economics*, 24, December 1981. Because nicotine is addictive, the price response of addicted consumers should be less than that of nonaddicted consumers. It is probable that older smokers are more likely to be addicted than would younger smokers.

[33] W. Kip Viscusi, *Smoking: Making the Risky Decision*, (London: Oxford University Press), 1992.

[34] Department of Health and Human Services, *The Health Consequences of Involuntary Smoking. A Report of the Surgeon General*, DHHS Publication No. (CDC) 87-8398, 1986.

[35] These taxes often are called "Pigouvian taxes" after economist Alfred Pigou who first proposed such a policy. In the case of a beneficial externality, a subsidy would be provided instead of a tax to encourage the behavior producing the beneficial externality.

[36] See the discussion in the paragraph below titled "Tobacco-related expenditures on health care" for evidence relating to medical expenditures by smokers versus nonsmokers

[37] The pricing of many employer-provided retirement annuities has an effect opposite that of the pricing of health insurance. When a retirement annuity is valued based on average life expectancy after retirement, on average, nonsmokers benefit at the expense of smokers, because smokers have a shorter life expectancy. In the case of retirement annuities, such pricing of annuities would overcharge smokers and undercharge nonsmokers. (See the discussion of social security below.)

Tobacco-related expenditures on health care

Researchers have found that smokers of all ages require more medical care than those who have never smoked.[38] While the life expectancy of smokers is less than that of nonsmokers, their cumulative lifetime medical expenditures exceed that of those who never smoke. One estimate places this excess at $2,500 over the smoker's lifetime.[39] Some advocates of higher taxes on tobacco products have argued that, by reducing the demand for tobacco products, the Federal Government will reap savings in its provision of health care. On the other hand, some have observed that when the Federal Government's entire budget is examined, tobacco use may not impose a net burden on the government. They observe that to the extent that tobacco users have shorter life expectancies than nonsmokers, the Federal Government has lower overall costs in the long run by making lower Social Security payments.[40]

It is difficult to measure the magnitude of such health costs and savings from reduced retirement expenditures across individuals' lifetimes. One study has attempted to measure the net external cost of smoking.[41] This study included costs of additional medical expenditures, the lost production from additional sick leave taken by employees who smoke, higher costs of group life insurance (from increased mortality rates), costs from fires attributable to smoking, and lost tax revenues from the earlier age of death of smokers. The study measured savings to society as reductions in pension payments and reduced use of nursing home care. The study concluded that the net costs of smoking were less than present combined Federal and State tobacco taxes. The study has been criticized for its failure to account for potential costs from second-hand smoke and other potential external costs such as increased litter from cigarettes or annoyance on the part of nonsmokers. With all such calculations, the results may be sensitive to the choice of the discount rate.[42]

Other issues related to tobacco taxation

Excise taxes are perceived as imposing a larger burden on lower-income families (relative to income) than on middle- and higher-income families. Some economists argue that family expenditures may be a better measure of ability to pay than is annual family income. Measured against expenditures, tobacco taxes appear less regressive than when measured against income.[43] Tobacco excise taxes also have a varying impact on families with similar incomes, because the incidence of tobacco use varies across families.

If increases in tobacco excise taxes succeed in reducing consumption of tobacco products, the domestic tobacco industry may be expected to contract.[44] To the extent that the farming of tobacco and production of tobacco products is geographically specialized, reduction in demand may lead to at least short-term economic dislocations in these geographic areas. For example, unemployment may rise among those currently employed in tobacco farming and tobacco product manufacturing. The severity of this economic dislocation would depend in part on the ability of the affected individuals to gain employment in different industries. Finding new employment may require some individuals to relocate to another region and/or undergo substantial retraining. The major tobacco growing States are North Carolina, Kentucky, and South Carolina, followed by Virginia, Georgia, and Tennessee.[45]

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[38] C. Stephen Redhead, "Mortality and Economic Costs Attributable to Smoking and Alcohol Abuse," Congressional Research Service (CRS) Report for Congress, 93–426 SPR, April 20, 1993. These findings do not necessarily mean that the smoking causes all the additional medical expenditures. Individuals predisposed to smoke may be predisposed to certain other unhealthy behavior, such as other drug use (alcohol, marijuana, etc.).

[39] *Ibid.*

[40] John B. Shoven, Jeffrey O. Sundberg, and John P. Bunker, "The Social Security Cost of Smoking," National Bureau of Economic Research, Working Paper No. 2234, Cambridge, MA., May 1987.

[41] Willard G. Manning, Emmett B. Keeler, Joseph P. Newhouse, Elizabeth M. Sloss, and Jeffrey Wasserman, *The Costs of Poor Health Habits, A RAND Study,* (Cambridge, MA: Harvard University Press), 1991.

[42] A recent Congressional Research Service report reviews both the study and criticisms of its results in more detail. See, Jane G. Gravelle and Dennis Zimmerman, "Cigarette Taxes to Fund Health Care Reform: An Economic Analysis," CRS Report for Congress, 94–214E, March 8, 1994.

[43] United States Congress, Congressional Budget Office, *Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels,* June 1990.

[44] Some tobacco products are produced for export. Generally, exported tobacco products would be exempt from proposed increases in domestic excise taxes. The extent of production for export would mitigate the extent of contraction of the industry.

[45] Gravelle and Zimmerman, "Cigarette Taxes to Fund Health Care Reform" reviews recent estimates of potential employment effects that may result from increased taxation of tobacco products.

In addition to possible economic dislocations in tobacco producing States, substantial reductions in tobacco consumption may be expected to reduce the revenues of all State governments, as all States impose tobacco taxes at the State level. At the present, tobacco taxes are a more important revenue source for States than for the Federal Government. In 1989, States collected $5 billion in tobacco tax revenues, representing 1.8 percent of all State tax receipts. By contrast, the Federal Government collected $4.5 billion in tobacco tax revenues in 1989, representing less than one half of one percent of Federal tax receipts.[46]

Higher tobacco prices should induce fewer people to begin to use tobacco products. Thus, even if no existing tobacco users altered their behavior through time, a smaller percentage of the population would use tobacco products. Therefore, an increase in tobacco taxes could be expected to reduce the incidence of tobacco use in the long run, by a greater amount than any reduction achieved in the short run.[47] In the past, in the United States, population growth generally has made up for a reduced incidence of smoking such that the revenue yield of tobacco taxes has increased through time.[48] However, if higher prices induce substantial declines in the incidence of smoking, the short-run revenue yield may overstate the long-run revenue yield. If the tobacco taxes are earmarked for certain programs, the potential for lower revenue in the long run than in the short run may be an important consideration for Government policy.

III. EXCISE TAXES ON FIREARMS AND AMMUNITION

A. Present Law

Ad valorem excise taxes

A 10-percent excise tax is imposed on the sale of pistols and revolvers by a manufacturer, producer or importer thereof. Other firearms and shells and cartridges are subject to an 11 percent excise tax (Code sec. 4181).[49]

An exemption is provided for sales of firearms and ammunition for use by the United States Department of Defense. In addition, no excise tax is imposed on sales by manufacturers, producers or importers: (1) for use by the purchaser in further manufacture, or for resale by the purchaser for use by the second purchaser in further manufacture; (2) for export, or for resale by the purchaser to a second purchaser for export; (3) for use by the purchaser as supplies for vessels or aircraft; (4) to a State or local government for their exclusive use; or (5) to a nonprofit educational organization for its exclusive use. In general, the effect of the State and local government exemption is to exempt sales to State and local police departments.

Amounts equivalent to revenues from these excise taxes fund the Federal Aid to Wildlife Program for use in making grants to support State wildlife programs.

Transfer and making taxes; special occupational taxes

Transfer and making taxes.—Present law also imposes making and transfer taxes on certain firearms and other destructive devices. A transfer tax of $200 is imposed on each "firearm" transferred, and a making tax at the rate of $200 is imposed on each firearm made (Code secs. 5811 and 5821).[50] The ad valorem excise taxes described above do not apply to firearms subject to these making and transfer taxes.

Firearms subject to the making and transfer taxes are machine guns, short-length or short-barrelled rifles or shotguns, pen guns, handguns with smooth bore barrels, firearms silencers, mufflers or suppressors, silencer parts, machine gun receivers

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[46] Tax Foundation, *Facts & Figures on Government Finance,* (Baltimore: The Johns Hopkins University Press), 1991. Some local governments assess additional tobacco taxes which produced approximately $200 million in 1988. These revenues also would be expected to be reduced by reductions in tobacco consumption.

[47] The Canadian study finds that the price elasticity, that is the behavioral response to price changes, is greater in the short run than in the long run. The study attributes this to the habitual nature of tobacco and argues that at first smokers quit, but that they eventually start smoking again. (See, *Tobacco Taxes and Consumption*). This analysis does not appear to account for long-run aggregate behavior, such as fewer new-starting tobacco users.

[48] This is absent an accounting of tax rate increases. However, if the downward trend in the incidence of smoking continues, lower rates of population growth in the future could cause tobacco revenues to fall in the absence of change in tobacco tax rates.

[49] A reloader of shells or cartridges is not considered a manufacturer for purposes of the ad valorem excise tax if, in return for a fee and expenses, the reloader reloads shells or cartridges submitted by customer and returns the reloaded shells or cartridges, with the identical casings provided by the customer, to that customer (Treas. Reg. sec. 53.11).

[50] A $5 transfer tax applies to articles defined as "any other weapon" under Code section 5845(e).

and parts designed to convert a weapon into a machine gun (generally, firearms subject to regulation under the National Firearms Act ("NFA")).

In general, Federal, State and local governments are exempt from the making and transfer taxes. In addition, transfers between persons subject to the special occupational tax (described below) are exempt from the transfer tax, as are transfers of unserviceable firearms and exported firearms.

Special occupational tax.—All importers, manufacturers and dealers in NFA firearms are required to register with the Secretary of the Treasury. Importers and manufacturers are subject to a special occupational tax of $1,000 per year (small importers and manufacturers are eligible for a reduced rate of tax); dealers are subject to a special occupational tax of $500 per year (Code sec. 5801).

An exemption from the special occupational tax is available for persons who conduct business exclusively with or on behalf of the United States.

Other regulation of firearms and ammunition

Firearms and ammunition also are subject to regulation under the Gun Control Act of 1968 and the Arms Export Control Act of 1976, as amended. In general, the Bureau of Alcohol, Tobacco and Firearms ("BATF") administers the Gun Control Act of 1968 and the National Firearms Act (Code secs. 5801-5872). The United States Postal Service administers the prohibition against mailing firearms (18 U.S.C. 1715).

The Gun Control Act of 1968 ("GCA"), as amended, regulates interstate and foreign commerce in firearms. Under the GCA, manufacturers, importers, dealers and certain collectors are licensed and must maintain various records regarding manufacture, import, receipt, and disposition of firearms. Manufacturers and importers of ammunition are licensed under the GCA. The GCA also prohibits the disposition of firearms and ammunition to certain proscribed categories of persons, e.g., felons. The "Brady Law" is also contained in the GCA. The GCA sets forth various civil and criminal penalties and forfeiture provisions.

The Arms Export Control Act of 1976 ("AECA") regulates the importation and exportation of arms, ammunition and implements of war. The AECA contains registration and permit provisions, and provides civil and criminal penalties and forfeitures. The BATF administers the importation provisions and the Department of State and Customs Service administers the exportation provisions.

B. Description of Bills

None of the comprehensive health care proposals introduced in the 103rd Congress contain proposals for modifying the tax treatment of firearms and ammunition. However, several other bills have been introduced that would increase Federal taxes on firearms and ammunition.

The following is a brief description of the bills that provide for increases in the present-law excise and special occupational taxes. Many of these bills also contain extensive non-tax provisions amending the Federal regulation of firearms and ammunition through increased licensing fees, criminal penalties and other requirements. Some of these provisions may interact with the current excise and special occupational tax regimes contained in the Internal Revenue Code; however, a complete description of these bills is beyond the scope of this document.

1. S. 32 ("Violent Crime Control Act of 1993") and S. 179 ("Real Cost of Ammunition Act")—Senators Moynihan, Chafee, and Simon

The bills would increase the rate of the present ad valorem excise tax on certain ammunition—9 millimeter, .25 caliber and .32 caliber ammunition—to 1,000 percent.

2. S. 868 ("Firearm Victims Prevention Act")—Senators Murray, Bradley, Simon, Kerry, Moseley-Braun, Mathews, and Bingaman

The bill would increase the rate of the present ad valorem excise tax on handguns, assault weapons, large capacity magazines, and shells and cartridges used in handguns and assault weapons to 25 percent.

The bill also would impose a 25-percent retail excise tax on the sale, transfer, or other disposition of a handgun, assault weapon, large capacity magazine, or shells and cartridges used in handguns and assault weapons. Where the manufacturers' tax was paid, the retail tax would not be imposed until after the first retail sale of the article.

Revenues from the 25-percent excise taxes would be used to fund a new Health Care Trust Fund.

3. S. 1616 ("Real Cost of Handgun Ammunition Act")—Senator Moynihan

The bill would increase the ad valorem excise tax rate on certain handgun ammunition. Centerfire cartridges with a cartridge case of less than 1.3 inches in length and cartridge cases of less than 1.3 inches in length would be taxed at 50 percent. A 10,000-percent rate would apply to (1) jacketed, hollow point projectiles which may be used in a handgun and are designed to produce, upon impact, evenly-spaced sharp or barb-like projections that extend beyond the diameter of the unfired projectile; and (2) cartridges with a projectile measuring 0.500 inch or greater in diameter which may be used in a handgun.

The bill also would impose a special occupational tax on each importer and manufacturer of handgun ammunition of $10,000 per year.

4. S. 1798 ("Gun Violence Health Care Costs Prevention Act")— Senator Bradley

The bill would increase the ad valorem excise tax rate to 30 percent on handguns, semiautomatic assault weapons and shells and cartridges used in handguns and semiautomatic assault weapons.

In addition, the bill would impose a 30-percent transfer tax on any subsequent sale, transfer, or other disposition of a handgun, semiautomatic assault weapon or shells and cartridges used in handguns and semiautomatic assault weapons. The 30 percent tax would not be imposed on any such article taxed under the revised Federal manufacturer's level excise tax.

Revenues from the increased tax rates would be dedicated to a new Gun Violence Trauma Care Trust Fund.

5. S. 1878 ("Gun Violence Prevention Act of 1994")—Senators Metzenbaum, Bradley, Chafee, Kennedy, Lautenberg, Boxer, and Pell

The bill would increase the ad valorem excise tax rate on handguns to 30 percent and the tax rate on handgun ammunition to 50 percent.

Revenues derived from the excise tax on handguns and handgun ammunition would be used to fund a new Health Care Trust Fund.

C. Discussion of Issues

The taxation of firearms and ammunition

Rationale for increased taxation of firearms and ammunition

Some portion of health care expenditures is incurred to treat victims of gunshot wounds. Because public funds often are expended to treat gunshot wounds, it may be appropriate to charge those who purchase firearms and ammunition for the additional public expenditures resulting from such wounds. In this way, theoretically, these purchasers would bear a greater portion of the costs of their behavior and the purchase and misuse of firearms would be discouraged.

On the other hand, taxes on the consumption of specific products, as opposed to broadly imposed consumption taxes, may distort consumer behavior by disfavoring certain goods in the economy relative to other goods. Generally, economists believe that market price distortion through taxes reduces consumer well-being because the change in relative prices introduced by the taxes causes consumers to choose a less preferred good than they would have in the absence of the tax. In addition, excise taxes applied to all purchases of firearms and ammunition for the purpose of accounting for the costs that arise from gunshot wounds arguably may be inefficient because such taxes impose costs on consumers whose use of firearms and ammunition does not lead to gunshot wounds or public expenditures. The majority of firearms and ammunition sales are to consumers who purchase these goods for sport (hunting, skeet, and target shooting) or for their personal protection.

Advocates of increased taxation argue that even firearms and ammunition purchased for sporting or personal protection purposes are the source of many suicide attempts and may result in accidental gunshot wounds, and some enter the supply of illegal weapons.[51] In addition, firearms increasingly are being used in homicides and other criminal activities. Advocates of higher taxes on firearms and ammunition argue that such taxes not only generate needed revenue to finance health care reforms or other policies, but also further the goal of firearms control.

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[51] Under this view, taxes on firearms and ammunition might be interpreted, in part, as insurance premiums to cover costs that arise from caring for gunshot wound victims (because any firearm may potentially lead to such wounds).

The economic effects of increased taxation of firearms and ammunition

The higher prices of firearms and ammunition resulting from increases in excise taxes could be expected to reduce purchases by consumers of these products. To maximize this effect, it would be necessary to increase existing excise taxes applicable to the purchase of new firearms and ammunition, but also to tax subsequent transfers. Firearms are durable goods. There is a substantial market in used firearms, and sales of those firearms generally are beyond the application of current Federal excise taxes.

By increasing the price of new firearms, the market value of existing firearms could be expected to rise as well, as consumers substitute the purchase of old firearms for new firearms. For advocates of taxation as a means of firearms control, such an outcome would have the positive effect of making the existing stock of firearms more expensive to obtain,[52] as well as reducing the flow of new firearms into society. On the other hand, by increasing the price of firearms, self-manufacture and the smuggling of weapons, where possible, may become more attractive. The extent of any increase in such illegal activities would depend upon their cost compared to increased price of legal firearms.

In practice, some ammunition also is a durable good. Certain types of ammunition can be reloaded (the spent shell casings may be recovered and repacked with a bullet or pellets, powder, and primer); such reloading can occur several times, although not indefinitely. Reloaded ammunition is exempt from Federal excise taxes under certain conditions (as described above in "Present Law"). As with firearms, increasing the price of new ammunition through an increased excise tax would be expected to increase the price of reloaded ammunition as well, as consumers increase their use of tax-free reloaded ammunition. It would also be possible to tax reloading tools and materials. Higher prices also would make the illegal manufacture or importation of ammunition more attractive.

The overall effect of increased taxation of firearms and ammunition on health care expenditures will depend on the effect of higher firearm and ammunition prices on the use of firearms in legal activities (which can be the source of accidental gunshot wounds and suicide attempts) and illegal activities (which also can be the source of gunshot wounds). Increases in price should reduce the purchase of these goods for legal activities and reduce the flow of these goods to illegal activities. However, there is little evidence on how levels of legal and illegal activities would respond to changes in the price of firearms and ammunition.

The overall effect of increased taxation of firearms and ammunition on health care expenditures also depends on the extent to which firearms currently contribute to health care expenditures.

Issues in targeting the taxation of firearms and ammunition

The observation that the majority of uses of firearms and ammunition are legal and have little or no adverse medical consequences has led some analysts to explore ways to target the taxation of firearms and ammunition at firearms and ammunition perceived to be most responsible for additional health care costs and most likely to be used in illegal activities. These types of firearms or ammunition, or both, could be singled out for increased taxation. Targeting certain firearms and ammunition may further health and law enforcement policy objectives. The effectiveness of any targeting efforts that rely on increased Federal taxes depends in large part, however, on whether the measures are administrable and enforceable. Certain issues in this regard are discussed further below.

Generally, there are four types of firearms: handguns; shotguns; rifles; and machine guns.[53] Firearms also can be characterized as non-automatic, semi-automatic, and fully automatic.[54] Ammunition generally is characterized by its caliber (diameter of the cartridge),[55] the length of the cartridge ("long," "short," or "intermediate"), and by whether it is rim-fire or center-fire.[56]

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[52] Price increases also would be expected in "black market" sales of firearms as such weapons are substitutes for firearms purchased legally.

[53] Under present law, it is illegal to own machine guns unless one is a licensed collector.

[54] A weapon that fires each time one pulls the trigger and uses the force of the prior shot to automatically reload the chamber is characterized as "semi-automatic." A revolver technically is not semi-automatic because it requires mechanical force to bring the next round to the chamber after each shot. A machine gun, or fully automatic firearm, is a firearm that fires more than one round at the pull of the trigger.

[55] "Gauge" in the case of shotgun ammunition.

[56] A rim-fire cartridge is fired by crushing the rim of the shell casing to ignite the gunpowder inside the shell. A center-fire cartridge is fired by striking a center-mounted primer to ignite the gunpowder inside the shell. Rim-fire cartridges cannot be reloaded. Center-fire cartridges generally permit a more powerful charge and can be reloaded a limited number of times.

Targeting the taxation of firearms

Any proposal to increase the excise tax on a defined subset of firearms must address certain administrative and compliance issues. First, as discussed above in the case of increasing the excise tax on all firearms, increasing the tax on firearms may shift firearms transactions from licensed gun dealers to unlicensed or illegal sellers. Currently, a substantial number of the firearms used in criminal activities are illegally obtained. Although increased taxes on particular classes of firearms will increase the cost of such firearms, whether obtained legally or illegally, they also may encourage additional smuggling and illegal sale of these highly taxed items, further exacerbating law enforcement problems with unlicensed firearms dealers. To the extent this shift in purchases occurs, a disproportionate share of those who bear the burden of the tax arguably may be law-abiding consumers, rather than those involved in criminal activities.[57]

Second, restricting the tax to those firearms associated primarily with criminal activities and gunshot wounds, as opposed to those used in recreational endeavors, may raise difficult definitional issues. Some experts note that it is difficult to distinguish firearms used for sporting purposes from those that would be subject to an increased tax rate. For example, while handguns are not generally used in hunting, they are used in target shooting competitions; they are also often used in criminal activities. Similarly, rifles may be used in both hunting and target shooting, as well as in criminal activities. For instance, many hunting rifles are semi-automatic, a feature that makes them popular for criminal use.

One way to distinguish among firearms is their caliber. However, this method does not distinguish effectively firearms used for hunting from those used for other purposes by their caliber. Firearms of many caliber sizes are used for hunting. Generally, small caliber firearms are used for small game and larger caliber firearms are used for larger game. In addition, characteristics other than caliber are important in distinguishing firearms. The caliber of the popular .22 hunting rifle is essentially the same as that of the United States' military M-16. Further, as new weapons of different calibers are manufactured, it would be necessary to determine whether each weapon would be subject to tax.

Another way of distinguishing "street" weapons from sporting weapons is by their style or appearance, or by the size of the magazine the firearm accepts. However, differential tax rates for firearms (e.g., higher tax rates on assault rifles[58] or higher rates on firearms with larger magazines) may create enforceability questions, especially if the tax rate differentials are large. For example, while it may be possible to distinguish a handgun from a rifle, it is more problematic to between semi-automatic and automatic rifles. Some experts state that it is a simple procedure to convert semi-automatic weapons to automatic-fire weapons. For instance, gun enthusiast magazines carry advertisements for kits to convert semi-automatic fire weapons to automatic fire.[59] As a result, what by outward appearances is a hunting rifle becomes the equivalent of an assault rifle.

Such convertibility may make it difficult to enforce a tax that imposes a higher tax rate on weapons capable of automatic fire than on semi-automatic fire weapons. This problem could be addressed by subjecting such "conversion kits" to tax; however, some experts state that, in many cases, conversions can be made with "off-the-shelf" parts. Similarly, small magazines often are easily replaced with larger magazines in a straightforward procedure. In general, defining the tax base by the outward appearance of firearms could create a secondary "conversion" market in which it is difficult to collect the tax, and may require repeated reactions to minor marketplace changes to ensure accurate administration of the tax. Although the tax base of any tax may change as the marketplace changes, the narrower the defined tax base, the more likely it is that revisions will be required.

Targeting the taxation of ammunition

As in the case of defining a subset of firearms to be subject to a higher rate of tax, defining a subset of ammunition to be subject to a higher rate of tax raises administrative and enforcement issues. In some cases, differential taxation of ammunition would be expected to lead to a substitution of lower tax ammunition for high tax ammunition. This would tend to increase the price of all ammunition, implying

[57] In addition, to the extent that the firearms targeted for taxation are substitutes for firearms not subject to taxation, one would expect the tax to increase the price of the untaxed firearms as would-be buyers substitute untaxed firearms for taxed firearms.

[58] In military parlance, an "assault weapon" is a shoulder-fired, select-fire (ability to choose single fire or fully automatic) weapon that fires an intermediate cartridge.

[59] It is currently illegal to convert semi-automatic fire weapons to automatic fire.

that part of the burden of the tax would fall on consumers of non-targeted ammunition.[60]

Typically the firing chamber of a firearm is designed to accept only one type of cartridge. Therefore, it is possible to impose a higher rate of tax on ammunition designed for a specific subset of firearms. For example, "short" ammunition generally is used only in handguns.[61] The Federal Bureau of Investigation reports that, in 1992, of the 15,377 murders due to firearms, 12,489 (81.2 percent) were due to handguns.[62] A tax targeted at handgun ammunition may reduce the use of such weapons.

However, just as firearms can be put to a variety of uses (i.e., handguns can be used for sport, personal protection, or crime), so too can a wide variety of firearms be put to the same use (i.e., both rifles and handguns can be used for sport or in illegal activities). This interchangeability means that it is difficult to identify types of ammunition that are used in *all* criminal activities or that are responsible for *all* gunshot wounds. Substitutability also may make it difficult to predict future patterns of ammunition use. On the other hand, if specific types of ammunition cause substantial public health expenditures because of the severity of the wounds inflicted or the frequency of occurrence of such wounds, an increased rate of tax on those types of ammunition could reduce public health expenditures by reducing demand for, and use of, the specified ammunition.

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[60] To the extent that firearms require specific ammunition, differential taxation of ammunition also would affect the demand for, and hence price of, different types of firearms. The demand for firearms using lightly taxed ammunition would increase relative to the demand for firearms using heavily taxed ammunition. Thus, purchasers of firearms may also bear some of the burden of the ammunition tax. However, because firearms purchasers are also ammunition purchasers, this potential shifting of the tax burden may not be deemed important.

[61] Some guns designed for long ammunition can accept short ammunition; the reverse is not true.

[62] U.S. Department of Justice, Federal Bureau of Investigation, *Crime in the United States*, Washington, D.C., 1992. Figures reported include data from all States except Maine.

WENDELL H. FORD
KENTUCKY

COMMITTEES
COMMERCE, SCIENCE, AND TRANSPORTATION
ENERGY AND NATURAL RESOURCES
RULES AND ADMINISTRATION

United States Senate
WASHINGTON, DC 20510-1701

April 27, 1994

The Honorable Daniel Patrick Moynihan
Chairman
Senate Finance Committee
Washington, D.C. 20510

Dear Mr. Chairman:

It is my understanding that on April 28th, the committee will conduct hearings on potential sources of financing for health care reform legislation, including excise taxes on tobacco and tobacco products. I have a strong interest in this matter, and would ask that this letter be made part of the committee hearing record on this issue.

It is no secret that tobacco means jobs in my state and in many other states in this country. Kentucky has more than 60,000 family farms which produce tobacco. Although it involves less than two percent of the farmland in my state, it generates approximately one-fourth of farm income. Tens of thousands of additional jobs are involved in this industry as well, from warehouses to processing to manufacturing to distribution and retail sales. Many of these individuals have been communicating to me their fears and anxieties over their jobs generated by recent events in Washington, D.C. It is my hope that these concerns will not be ignored by the Committee.

Excessive increases in excise taxes have generally been rejected in the past out of concern for the impact on lower income Americans. Excise tax increases remain among the most regressive means used for raising revenues, running directly contrary to the principles underlying the Budget Reconciliation legislation passed last year. In fact, for working class Americans with a smoker in the family, a proposed 75 cents per pack cigarette tax increase will more than consume any tax benefits from last year's law, including the highly commendable expansion of the Earned Income Tax Credit. It is my hope that the Committee will not ignore the regressive nature of excise taxes -- an obvious consequence which has been absent from the debate so far.

Contrary to the claims of certain groups, tobacco already is an extremely heavily taxed and regulated commodity. I would be interested to see evidence of greater governmental burdens being placed upon any other single commodity or product. Taxes imposed on tobacco products at the federal, state, and local levels exceeded $14 billion in 1993. The Department of Agriculture inspects and grades tobacco. The Environmental Protection Agency registers all pesticides used on tobacco. The Federal Trade Commission has jurisdiction over advertising. Of course, this involves only those forms of advertising which are not already banned. The FTC also collects information on tar and nicotine levels in tobacco products. Federal law requires that rotating

warning labels be placed on all packaging for tobacco products. The Department of Health and Human Services collects information on all ingredients which are added in the manufacture of tobacco, and reports annually to Congress. The Bureau of Alcohol, Tobacco and Firearms has jurisdiction over the collection of taxes derived from tobacco products. An Interagency Committee on Smoking and Health also issues an annual report to the Congress.

In recent weeks, a handful of Members of Congress and other individuals have mounted an unprecedented series of attacks on the tobacco industry, and have successfully generated a significant amount of media attention. To do so, a change in their strategy has been required. In recent years, many of these same individuals argued for more taxation and regulation of tobacco products on the grounds that individuals in this country were not capable of making an informed decision on whether to use tobacco products. This approach only went so far with most Americans, many of whom believe they have sufficient information to make such personal decisions.

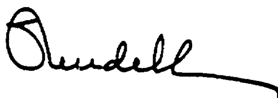
Now, these same opponents of tobacco have been attempting to create the impression that individuals using tobacco products are helpless to control their personal decisions. These same individuals also argue with a straight face that tobacco is currently underregulated. I am convinced that certain individuals and groups would prefer to modify our laws to enact Prohibition on the use of tobacco and tobacco products, but public opinion polls suggest that this would be a poor strategy. The enactment of a variety of punitive measures appears to be the next best strategy.

Americans are generally skeptical when their government practices paternalism. Whether generated by the political right or left, paternalistic efforts have generally failed in the past. One editorialist commented on the recent House hearings on tobacco, writing that "the Capitol Hill inquisition masquerading as legislative hearings reminds me of nothing so much as a witch hunting Joe McCarthy." Another commentator suggested that "they are going after tobacco with a special vengeance -- almost the way homophobes go after gays."

It is my sincere hope that the Committee will approach the issue of tobacco excise taxes with a sense of objectivity. I also hope the committee will not ignore the regressive impact of excise tax increases on lower income Americans, as well as the severe impact which a proposed tax increase will have on employment in my state. I do not believe it is fair or equitable to single out one industry or region to finance a health care reform proposal designed for the benefit of the entire nation.

Because of the obvious economic harm which an excessive tobacco excise tax proposal will have on my constituents, I will be unable to support any health care reform proposal which includes a punitive level of taxation on tobacco and tobacco products.

Sincerely,



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Senator Daniel Patrick Moynihan
Chairman, Senate Finance Committee
Dirksen Senate Office Building, rm. 205
Washington, DC 20510-6200

May 13, 1994

Dear Senator Moynihan:

I had the privilege of testifying on the cigarette excise tax on behalf of the Coalition on Smoking or Health at the Committee's April 28th hearing on health care reform financing. The Tobacco Institute's representative, Professor Robert Tollison, testified that the work of three prominent economists, Thomas Schelling, Joseph Newhouse, and Willard Manning, supports his position that the cigarette excise tax should not be increased.

As you will see from the enclosed letters, these three prominent economists disagree with this interpretation of their work and specifically disavow Professor Tollison's inappropriate use of their work. Each notes his support of the proposed cigarette excise tax increase.

As the Committee continues to deliberate on an increase in the cigarette excise tax, I trust that you will find it noteworthy that the three scholars whose work is specifically cited by the Tobacco Institute's consultant as opposing that tax increase in fact support it.

Sincerely,

Kenneth E. Warner
Professor and Chair

UNIVERSITY OF MARYLAND AT COLLEGE PARK

SCHOOL OF PUBLIC AFFAIRS

May 2, 1994

Senator Daniel Patrick Moynihan
U. S. Senate
Washington, DC

Dear Senator Moynihan:

It has been reported to me that Professor Tollison, in testimony before the Senate Finance Committee, identified me as a professionally qualified economist who had publicly taken a position against any increase in the Federal excise tax on cigarettes. It occurred to me that the statement may have puzzled you, and because I directed for five years an Institute for the Study of Smoking Behavior and Policy at Harvard University my opposition to the taxation of cigarettes might be taken seriously. So I am writing to correct the record.

As Director of that Institute I convened a conference in April of 1985 on the subject of the cigarette excise tax. (Frank Cantrel, Tax Consul to the Senate Finance Committee, was a participant.) Until that time I had not made up my mind on the issue. There are arguments in both directions that have to be weighed against each other to arrive at a judgement, and I had not taken the time to sort out the arguments and arrive at a considered, judgement. But having sponsored and chaired the conference I had given up any excuse for not having made up my mind.

I reached two conclusions. One is that the arguments in favor outweigh the arguments opposed. The second is that the relative weight of the arguments in favor is greater, the higher the tax. In 1985 the immediate issue was whether the modest tax of 16 cents per pack should be allowed to revert to an even more modest 8 cents per pack, and I couldn't see that that difference would have much affect on smoking, especially among children. Taxes higher by an order of magnitude are now widely discussed, and the arguments in favor of the tax take on much more added weight than any arguments against.

I am sure I have not at any time expressed opposition to taxation of cigarettes and I am at a loss to understand how Professor Tollison thought that I had.

Sincerely yours,

Thomas C. Schelling

HARVARD UNIVERSITY

DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION

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May 2, 1994

Senator Daniel Patrick Moynihan
Chairman
Committee on Finance
United States Senate
Washington, DC

Dear Senator Moynihan:

I understand from Professor Kenneth Warner that Professor Robert Tollison, in a hearing before the Finance Committee, cited my work with Manning, Keeler, and others as suggesting that cigarette taxes should not be raised. This is a misreading of our work. At most our work shows that at current levels, cigarette taxes cover the costs a smoker imposes on others (especially medical and pension costs, the latter being negative because smokers die sooner). We, however, are explicit in our Harvard Press book (W.G. Manning et al., The Costs of Poor Health Habits, 1991) that this finding is not a sufficient reason for not raising cigarette taxes and in fact say on page 20:

> "If the primary concern in taxing cigarettes and alcohol is the revenue-raising effect, then there is a strong economic argument for such taxes..."

As I hear the current debate, that is exactly the situation we are in; we are looking for additional revenues to finance health care reform.

Our estimates of external costs are not updated for recent literature on the effects of second-hand smoke; although it is clear that this would increase our estimates of external costs, I do not know the magnitude of the increase. In any event, our analytical findings are not conclusive in favor of Professor Tollison's position, and I personally favor an increase in the cigarette tax.

Sincerely yours,

Joseph P. Newhouse

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May 10, 1994

Senator Daniel Patrick Moynihan
Chairman
The Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Moynihan,

I understand that in testimony before the Senate Finanace Committee on April 28th, Dr. Robert D. Tollison cited the research on the external costs of smoking and alcohol use that I published with colleagues in the late 1980's and early 1990's. Our research on the costs of smoking apparently was quoted out of context, and cited for propositions that my colleagues and I do not support. Important limitations and sensitivities of the findings to modeling assumptions that are discussed in detail in both our paper and our book were apparently not mentioned, and were dismissed when raised by Dr. Warner.

I take issue with any treatment of our work that suggests that it supports the view that there are not significant external costs associated with smoking, or that a case could not be made for higher cigarette taxes. Because of some important qualifications on our work, we were careful not to draw broad conclusions. Some of those qualifications are summarized here. First, we were unable to document the dollar or human external costs of passive smoking, due to the state of research at the time we conducted the study. Given the recent evidence on the effect of passive smoking, a revised analysis of the external costs of smoking would clearly indicate a substantially higher level of external costs than we were able to document. Second, the original article omitted the smoking induced costs of low birthweight babies. This omission was corrected in the book (pages 83-84), increasing our estimates of the costs of smoking by from two cents per pack (for Neonatal Intensive Care Unit costs) to 16 cents per pack (including the cost of premature mortality), in 1986 dollars. Third, taking inflation into account, especially medical care price inflation, would change our results considerably if the estimates were translated into current (1994) dollars from the 1986 prices we used.

One of the important points that we discussed in both publications was the fact that our primary focus, external costs, is only one of several rationales for taxing tobacco. As we noted, there are other considerations that could suggest even higher taxes. The examples include:

1. **Addiction.** Smoking is an addiction acquired by teenagers for which their adult selves pay the price in health and life-expectancy. Because teenagers heavily discount the future, they tend to undervalue the future adverse consequences of today's smoking. Some have argued that one could use tobacco taxes to induce teenagers to do what they as adults would chose to do -- not smoke.

2. **Underestimation of Risk.** To the extent that individuals underestimate the risks associated with smoking, one can use a tax (as well as educational and warning activities) as a way to correct for incorrect subjective probabilities.

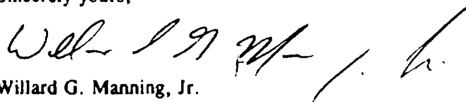
3. **Raising Revenue.** Tobacco taxes can raise substantial revenues to pay for a variety of public programs, including health care reform. Given the price inelastic demand[1] for an inessential commodity (tobacco), an excise or sales tax on cigarettes is a particularly appealing revenue source.

For a fuller discussion of some of these issues, see the last two pages of the article in the *Journal of the American Medical Association*, and the relevant sections of Chapter 1 of our book from Harvard University Press.

In light of these concerns about the misreporting of our earlier results, I hope that this letter will remedy the incorrect impression left by Dr. Tollison's testimony. Personally, I feel that the other reasons are more than sufficient to argue for a much higher tax on cigarettes than we currently see in the U.S. As a member of the Tobacco Tax Coalition for a Healthy Minnesota, I have been arguing for an increase in the state's excise tax. Higher state and national cigarette taxes should deter many children and young adults from initiating a very addictive and destructive habit, as well as encouraging some existing smokers to quit.

If I can be of any further assistance to you in this or related matters, please feel free to call.

Sincerely yours,



Willard G. Manning, Jr.
Professor

References:

Manning, W.G., E.B. Keeler, et al., "The Taxes of Six: Do Smokers and Drinkers Pay Their Way?" *Journal of the American Medical Association* 261(11):1604-1609, March 17, 1989.

Manning, W.G., E.B. Keeler, et al., *The Costs of Poor Health Habits*, Harbard University Press, Cambridge, MA, Fall 1991.

cc: Dr. Dwight Lee, Consultant, The Tobacco Institute
Samuel D. Chilcote, Jr., President, The Tobacco Institute
Dr. Robert D. Tollison

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[1] A ten percent increase in tobacco taxes would probably generate a four to six percent fall in tobacco consumption.

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May 26, 1994

The Honorable
Daniel Patrick Moynihan
Chairman, Finance Committee
U.S. Senate
Washington, D.C. 20510

Dear Senator Moynihan:

I am in receipt of a copy of Dr. Kenneth Warner's letter to you of 13 May 1994, as well as copies of the letters he solicited from Professors Schelling, Newhouse, and Manning. With all due respect, Professor Warner is just playing a cute little game with you and your colleagues on the Finance Committee.

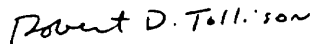
First of all, I did ***not*** suggest ***anything*** with respect to Professor Schelling's position on the cigarette tax. I cited him as an economist who had not fallen into common errors in the economic analysis of smoking. Here, I refer specifically to his paper in *Preventive Medicine (1986).*

Secondly, Professors Newhouse and Manning may very well ***personally*** favor an increase in the cigarette tax, but their published research on the issue cannot be ***read*** that way. It can be read as I stated in my testimony -- by their calculations, the present tax on tobacco is *too high* with respect to estimates of the external costs imposed by smokers. And, of course, these authors are welcome to suggest how their results would work out if redone now. This, however, they have not (to my knowledge) done, and pending such work, I suggest to you that the Congressional Research Service (CRS) Report of March 1994, entitled *Cigarette Excise Taxes to Fund Health Care Reform: An Economic Analysis,* is the best guide with respect to how issues such as "passive smoking" would play out in a reworking of the Newhouse, Manning, type of analysis.

So in the end, you do not have to take my word for it or Professor Warner's word; you can simply read the *CRS Report,* which states -- if environmental tobacco smoke has any effects at all, the effects "would be quite small" (*CRS Report*, p.13).

I hope this will at least set the record straight with respect to the points raised in Dr. Warner's letter to you. There is no case for an increase in the cigarette excise tax that can be made with a respectable economic model.

Sincerely,



Robert D. Tollison
Duncan Black Professor of
Economics, and Director
Center for Study of Public Choice

RDT/cr

cc: Samuel Chilcote, Jr., President, Tobacco Institute
Professor Warner
Professor Schelling
Professor Newhouse
Professor Manning

Boston Sunday Globe

SUNDAY, APRIL 24, 1994

Victim, society pay price for bullets fired in anger

By Tom Mashberg
GLOBE STAFF

The bullet that cut down Mark Fulks last October costs 19 cents at the average ammunition store; today, $91,000 later and counting, Fulks is just beginning to stand up on his own.

A graduate of Hyde Park High with a mellow drawl and a muscular stride, Fulks, in his 20s, often walked from his $450-a-month apartment in Mattapan to his $9-an-hour job in Cambridge. Saving $1.70 in T fare made sense before he was "smoked" – paralyzed, nearly killed – by a slug from a $499.95 handgun. Now, each of his trips by ambulette to a spinal clinic cost Massachusetts Medicaid $125.

The bullet, .45 caliber, pierced a $200 wooden door, then ripped up Fulks' new $300 winter coat; it also cracked his backbone and bloodied his spine. He missed Game 4 of the '93 World Series. Instead, he took a $350 ambulance ride to Boston City Hospital, two $18-an-hour paramedics with him, two $25 saline sacs plugged into his veins.

Fulks spent 16 days at City Hospital ($22,484), and 60 more at Boston University Medical Center ($63,676); for 16 weeks now, he has sweated three hours a day, three days a week, at a spinal injury center ($5,200 and counting), rediscovering how to walk.

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After 6½ months his bills are approaching six figures – all paid for by the public. Nationwide, new data show, the annual cost of treating thousands of victims like Fulks, as well as their lost productivity, is about $21 billion – about the amount being debated in Congress for an anticrime package designed to last 10 years.

"That's 19 cents for the bullet, $91,000 for the care, and hardly a penny for prevention," said Dr. Susan Pauker, director of the Harvard Community Health Plan Foundation and a specialist in the societal costs of violence. "That's $91,000 times God-knows-how-many victims that you, me, all of us must pay to pick up the pieces. When will we invest more money up front, to keep bullets from wrecking the lives of people like Mark Fulks?"

Along with 80 percent of his fellow victims of gunfire – the increasingly random, increasingly routine plague of poorer urban areas around the country – Fulks' medical bills are absorbed by the taxpayers, and by the hospitals that continue to treat him.

As with so many of the others, Fulks has gone from productive citizen to strain on system.

"I was no angel coming up, but I wasn't a gangster either," Fulks says. "Just a Boston boy. I love my city. I could never be like those folks sitting around on welfare, taking government money. Now I'm in this chair, with bills the rest of my life."

The bills for so much violent crime ricochet across American society like the bullet that smashed two ribs and a vertebra in Fulks' upper thorax. Over a lifetime, his wounds and his rehabilitation and his aches and pains could cost $250,000 to remedy, making his case costlier than most.

But injuries like his are more common now among city dwellers ages 13 to 35, the Americans most often felled by bullets. Last year, according to the National Center for Injury Prevention, 22,000 crime victims were killed by a bullet or a knife, 250,000 were wounded and 75,000 of those were hospitalized for at least a night. In Massachusetts, 2,066 were wounded and 1,860 hospitalized. In Boston alone, the numbers are 1,338 wounded and 1,150 hospitalized.

In Mission Hill and Mattapan, in East New York and South Los Angeles, survivors of bullets, often seated in wheelchairs or stumbling on steel canes, are familiar sights. Fulks often runs into Joe Green, a friend from the neighborhood, now paralyzed, when the two visit their rehabilitation clinic in the South End. Both will need weeks of therapy at $156 an hour, new $1,800 wheelchairs and $65 aluminum walkers; neither will be able to work full time for months, perhaps years.

"When you combine response and treatment with long-term care and lost work hours, you have costs most people haven't begun to comprehend," said Dorothy P. Rice, a professor of health policy at the University of California at San Francisco and one of the first researchers to put a price tag on the injuries resulting from violent crimes.

"And frankly, we're shooting in the dark," she said. "So many woundings go unreported that the costs are probably much higher. No question, this is a national health-care calamity."

The story of Mark Fulks of Boston – city kid, high school grad, reformed thief, forklift operator, gunshot victim – is the story of the calamity that one 19-cent bullet can create.

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Shot by a stranger

Mark Fulks' bullet was the cheap kind, a soft tipped plug that bursts inside its target. The pricier metal-jacketed models tear all the way through. More than likely the bullet was made in the USA, most [illegible]-caliber bullets used here are. It was fired by a stranger, from a semiautomatic handgun. It was meant, everyone now knows, for the other guy.

There were loud footfalls on a landing that night, the long third-floor hallway at 760 Cummins Highway in Mattapan, a boxy family apartment complex. Two men were running, calling out for someone. A man Fulks had just met.

Fulks was arriving, in new clothes, on a night off from work to watch the Series. Three couples – three women and two other men – were all barely in the door. A woman looked over Fulks' shoulder and saw the running men. "Lock the door," Fulks heard her say.

"So I'm closing the door, they're kicking at the door, I'm putting my weight against it, trying to lock it," Fulks said. "As I was trying to shut it and lock it, a bullet come through the door and hit me in my right shoulder. And that was that."

The meter on Fulks' life was ticking. Blood ruined his coat.

Fulks made $340 a week on the assembly line at a Kendall Square firm, American Engineering Components. He paid $20.23 weekly in state taxes, $44 in federal. Over a work life spanning 33 years, averaging $13 an hour and raising two children, someone like Fulks might have paid out $80,000 in federal taxes, $40,000 in state and $20,000 in Social Security taxes; a total of $140,000, according to IRS estimates.

Shooting-related bills and public aid for Fulks could hit $140,000 for the first year alone.

Everything is being covered by Medicaid or by the hospitals. When a victim cannot pay his bills, Medicaid and the hospitals will split the total, with the costs passed on to paying customers and taxpayers.

"I've seen the bills; I got my bills all over the house," Fulks said. "I know that the state is taking care of them. I didn't ask for no bullet, didn't deserve no bullet. Right now, I'm a man on a mission: a mission to get up out of this chair."

Simply weaning Fulks from his $1,800 wheelchair to a $200 set of leg braces costs $156.60 an hour in physical therapy; for now, he is taking 10 hours a week. Keeping his pain in

check and his bowels moving smoothly costs $40 a month in medication.

The wheelchair van that ferries him from his mother's place on Mariposa Street in Hyde Park to the Boston University Medical Center in the South End costs $125 round trip. The ramp being built outside his mother's building will cost about $5,000.

He needed a new winter coat. It cost him another $200.

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The costs of violence

When Dorothy Rice of the University of California sat down to figure out the costs of gunshot and stabbing injuries related to violent crime, she started with the emergency response and ended with lost income and tax revenues as a result of recuperation – for an annual national total of $21 billion.

She excluded those wounded accidentally by gunfire, about 100,000 people, and in suicide attempts, about 20,000 more.

That was for the living. She has other numbers for the dead.

Her results, published in the medical journal Health Affairs, add a fresh burden to an already swollen health care budget.

Hillary Rodham Clinton has mentioned treatment of violence, especially among poorer Americans, as a growing part of the US health-care crisis. Surgeon General M. Joycelyn Elders, during a recent visit to Boston, said: "Violent crime among younger men, especially young men of color, is a national health epidemic. It puts an enormous burden on our national health-care system."

According to Rice and others who know the data, health and welfare costs for a single year's violence break down this way:

- Immediate costs, like the emergency surgery and intensive care that Fulks needed at City Hospital, total $2.5 billion.
- Less direct costs, like the physical and emotional therapy that Fulks has needed since then, run about $2 billion.
- Lost productivity and taxes, and welfare payments and other set-asides for those disabled in a crime, total $16.5 billion.

Rice has another estimate, more intricate: the lifetime costs that result from a year's worth of wounded people. Year 1 is the costliest to the individual, because of immediate expenses such as the treatments that have already pushed Fulks' bills toward $100,000.

But society must still pay over that person's lifetime. Fulks will not match his pre-injury earnings for many years. Rice says that all the people wounded in 1993 alone will cost society an extra $47 billion in their lifetimes.

Rice says those killed by violence in a single year, about 25,000, represent a loss in earning potential of $150 billion.

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Making a living

Mark Fulks is single and was trying to learn a trade; in the 14 years before he was wounded, he was arrested five times – three times for breaking and entering, and twice for assault. Police records show he spent six months in prison in the 1980s.

"I had my bad times, but God gave me a second chance," he said. "I have a head for business, and that was my new goal."

Fulks was high up on the list of solid temporary workers at the Sterling-Olsten Employment Agency. Because of his size and strength (5 feet 8 inches, 200 pounds), he spent his weekends on double shifts at American Engineering, pushing a wheelbarrow of metal plugs across a factory floor, sometimes boxing components as they came off the assembly line. His pay was $9 an hour.

"I used to call Olsten in the middle of the night and leave voice mail saying I was available for the morning," Fulks said. "You have to be aggressive when you want work. They liked that about me. They liked it that I'd work nights and weekends."

Tom Courtney, an administrator at American Engineering, said Fulks had a good work record and was

popular in the factory.

But the livelihood Fulks might have made, even as a full-time employee, would never have begun to soak up his medical bills. Even now, as he pushes and sweats to walk again, working harder than he ever has before, Fulks knows that the best he might do is some light filing for a minimal wage – maybe $15,000 a year.

Nationally, according to the National League of Cities, the average costs of treating any single gunshot wound is $14,500.

On the criminal justice side, the costs are enormous, too.

Catching, prosecuting and imprisoning the people who shot Fulks and the thousands of other victims – no arrest has been made in Fulks' case – has helped double the national criminal justice budget in real terms since 1982, according to the Bureau of Justice Statistics. About 3.5 cents of every federal dollar, and 7 cents of every state and local dollar, goes to expenses related to criminal justice. The combined total in 1992, the Justice Department says, was $74 billion.

It is money Fulks says he would just as soon not see spent on him. "Why relive this at trial?" he asked. "Don't need it."

* * *

'Maybe I won't die'

Living with what he went through on the night he was shot is hard enough for Fulks, whose once-powerful football legs are stiff and gimpy and barely able to prop up his bulk.

"I never took walking for granted," he says. "I loved to walk. I could walk for miles. Boston is a walking town."

He remembers feeling the sensation drain out of them after the soft-nosed 19-cent bullet knocked around inside his chest.

He remembers thinking, "If I just stay awake, if I just stay awake, I won't die. I will not die, just maybe I won't die."

He didn't feel the paramedics carrying him down the stairs, naked on a gurney, his new clothes cut to ribbons, even his sneakers cut from his feet. Later, the landlord at 760 Cummins Highway would have to spend about $200 to re-tile the blood-stained kitchen floor.

He didn't feel the potholes when the paramedics raced him up Blue Hill Avenue, toward Columbia Road, then down to Mass. Ave. and finally into Boston City Hospital. He didn't know that they had roared right past the Shields Funeral Home, where

> **'I got bills all over the house. I know that the state is taking care of them. I didn't ask for no bullet.'**
>
> ***- Mark Fulks***

many young men wind up for $4,500 services, and past the Boston city morgue, too, where autopsies run about $300.

Working with his therapist, Regina Mouradian, at the spinal clinic at University Hospital, Fulks thought about life, about death, about what he might do now that he has cost so much and lost so much, about what he might do with 30 more good years.

"I want to give it back, to volunteer here," he said, flopping himself over for 25 solid push-ups. "To talk about the stupidity of violence. About making something of yourself."

Mouradian smiled. Fulks has been an enormous inspiration, up on his feet faster than anyone she can remember, chatting with all the patients, honest about his injury and his experiences, pushing everyone there to try harder to walk. An inspiration.

"I don't like to be so needy, nobody does," he said. "The people around here are kind of like my crew now. We all came in together, and we're all progressing together. These injuries are so complicated that you just have to be patient and confident."

Love the pain, Fulks tells his crew when they wince. Pain is free. Love the pain and enjoy feeling that if nothing else.

Fulks was also feeling hungry on his way out the door last week, now that he can eat almost anything again. He was craving a movie and dinner, but on a few hundred dollars a month in Social Security Disability Income, he cannot do it.

He said he might ask his ambulette drivers to stop by a local food distribution center on his way home to pick up some of the free cheese that the government still hands out. For now, he has rejected his $90 monthly allotment of food stamps. Pride can be wounded only so much.

"I'd like to start working again," he said. "Light filing, organizing, that sort of thing. Pay my taxes. I'm ready now."

Fulks can reach back with his right arm and feel his 19-cent bullet just under the chocolate skin, right beside his left shoulder blade. It's a hard lump, half the size of a golf ball.

His doctors tell him that the bullet might grow its way out, right through his skin, and drop at his feet in the shower, or roll out of his bed one morning when he wakes up. Now that he's getting some feeling back, they might even give him some local anesthesia and remove it with a scalpel, although letting it grow out naturally would save everyone a $250 surgical procedure.

"I'd like to show it to the guy who shot me," Fulks said.

Then, thinking thoughts of peace, thinking about the button on his cap that reads, "Stop the Killing, Save the Children," thinking about the long walk back onto his own two legs, Fulks said: "Naw. Actually, I'd like to show it to the guy what made it. Wouldn't that be something, to show the guy his bullet?"

Prepared Statement of Jerry J. Phelan

I. INTRODUCTION

Mr. Chairman and members of the Committee, I am Jerry Phelan. I recently retired as General Counsel of Kaiser Foundation Health Plan, Inc.

II. KAISER PERMANENTE

Kaiser Permanente is a group practice prepayment program conducted by closely cooperating organizations in 12 geographic regions in the United States. Kaiser Foundation Health Plan, Inc. or one of its 11 Health Plan subsidiaries ("Health Plans") enters into Membership Contracts with individuals and employer groups to arrange or provide comprehensive prepaid health care services for enrolled members. Except for emergencies, benefits are received from Kaiser Permanente providers or through referrals made by Kaiser Permanente providers.

All of the Health Plans are group practice HMOs; all are qualified under the Health Maintenance Organization Act of 1973; and all are exempt from federal income tax as charitable organizations under I.R.C. §501(c)(3).

In each Region, Health Plan satisfies its obligations under Membership Contracts through two major contracts:

Kaiser Foundation Hospitals ("Hospitals"), a California nonprofit public benefit corporation, undertakes to provide or arrange hospital and related services for Health Plan members. Hospitals also is exempt from federal income tax as a charitable organization under I.R.C. §501(c)(3). Kaiser Foundation Health Plan, Inc. and Hospitals have common Boards of Directors.

One of 12 Permanente Medical Groups undertakes to provide or arrange professional and related services to Health Plan members. The Medical Groups are legally separate organizations that derive approximately 98% of their revenue from serving Health Plan members. The income of Medical Groups and Permanente physicians is solely in consideration of their professional medical and related services.

The Health Plans have more than 6.6 million voluntarily enrolled members in the following states: California, Colorado, Connecticut, Georgia, Hawaii, Kansas, Ohio, Oregon, Maryland, Massachusetts, Missouri, New York, North Carolina, Texas, Washington, Virginia, and the District of Columbia. In addition to Kaiser Permanente's 12 Regions, exempt group model HMOs include, among others, Health Insurance Plan of Greater New York; HIP/Rutgers Health Plan; George Washington University Health Plan; Health Alliance Plan of Michigan; and HealthPartners (Minneapolis).

Risk transfer and risk distribution are the defining characteristics of health insurance. The defining characteristic of health plans on the Kaiser Permanente model, on the other hand, is assumption of responsibility for organizing and providing health care. It is of course true that Kaiser Permanente depends principally upon prepayment to provide the funds necessary to support the health care capability that Kaiser Permanente represents, and prepaid dues from Health Plan subscribers resemble premiums charged by conventional insurers. However, Health Plans differ from conventional insurers by using members prepaid dues to establish and to maintain a health care structure that is available to serve the prepaid membership as well as the community generally, an undertaking that is foreign to the nature and activities of conventional health insurance companies. Insurers accept and distribute the risk of the *cost* of health care. The Health Plans accept responsibility to organize and to provide care itself.

Throughout Kaiser Permanente, the regional Health Plan owns (and sometimes leases) medical office facilities where Permanente physicians and their supporting personnel conduct their office-based practices and provide outpatient services to Health Plan members. In addition, hospitals owned and operated by Hospitals include substantial medical office facilities. At the end of 1993, the value of facilities and equipment owned by the 12 Health Plans totaled over $2.3 billion. This figure does not include the value of medical office facilities owned by Hospitals. The figure does include some administrative property, but the overwhelming proportion of property owned by Health Plans is devoted to directly providing health care. No Permanente Medical Group or Permanente physician has any ownership interest in any facilities or equipment used to serve members.

Because Health Plans are nonprofit and do not attempt to maximize revenue, their only need for revenue is to support Kaiser Permanente's financial requirements, including current expenses and capital requirements. Health Plans' principal capital requirement is for the medical office facilities where Permanente physicians serve Health Plan members. Health Plans' exemption permits Health Plans to provide health care facilities at a lower cost than if the capital required to finance these

facilities were derived from after-tax dollars. Of course, organizations such as insurance companies that do not provide health care have no need for capital to build health care facilities and thus they have no need for an exemption that would permit them to accumulate the capital free from tax to build health care facilities.

Congress has imposed a $150 million limit on the amount of tax exempt bonds that can be utilized by a tax exempt organization for constructing and equipping outpatient facilities. We believe this limit should be removed.

Loss of exemption by Health Plans would have a disparate impact on Health Plans as compared with insurance companies because Health Plans require capital to construct health care facilities and to purchase health care equipment, and insurance companies do not. A tax on Health Plans would be a tax on health care. Because insurance companies do not provide health care (they only pay for it), insurance companies receive a deduction from gross income for *all* amounts they pay for health care. However, the cost of capital assets must be amortized over the useful life of the property, and therefore such a deduction for Health Plans would be available with respect to the cost of health care facilities only over time as a depreciation deduction. But under Kaiser Permanente's capital programs, non-deductible capital requirements always' will exceed the current depreciation deduction for past capital expenditures. A tax on Health Plans would be a targeted tax on a service that insurance companies do not perform but which is the very essence of what Health Plans do. What they do is organize, arrange and provide health care.

Although the Permanente Medical Groups are legally separate from Health Plans, they have exclusive responsibility to provide or arrange all medical services for Health Plan members. With minor exceptions, the personnel who support Permanente physicians in their office-based practice are employed by Health Plans in all Regions outside of California. In California, these personnel are employed by the Medical Groups.

At the end of 1993, the Permanente Medical Groups included over 9,000 physicians, and Medical Groups and Health Plans employed over 37,000 licensed allied health personnel whose virtually exclusive professional endeavor, like that of the physicians they support, is service to Health Plans members. The Health Plans alone employ more than 17,000 of these licensed health care providers and an additional 4,000 health care personnel who do not require licensing. Thus, Health Plans are substantial providers of health care.

Kaiser Permanente's financial requirements are satisfied principally through members' prepaid dues, and the dues rate is based on the expected cost of serving the members. The expected cost of personnel and facilities are principal components of the budget and the dues rate. Thus, each Permanente Medical Group's budget becomes part of the regional Health Plan's budget, as does the expected cost of Health Plan's and Hospitals' personnel and facilities. Unlike an insurance company's revenues, which are applied to pay claims, Kaiser Permanentes revenues are directly applied to support a health care capability. It is true that some services, principally the services of referral physicians and hospitalization in the smaller Regions where Kaiser Foundation Hospitals does not own facilities, are not provided directly by the Kaiser Permanente organizations, but all these services ultimately are performed through referrals by Permanente physicians, and Permanente physicians are responsible for monitoring and managing care at all levels.

Under the Agreement between Health Plan and Medical Group in each Region, the principal payment to Medical Group is a prospectively determined per capita payment, which shifts the risk of the cost of physician care to the Medical Group. Other Medical Group costs, such as the cost of specified fringe benefits, principally retirement benefits for physicians, commonly are reimbursed on a dollar-for-dollar basis. Other compensation provisions adjust Medical Group's compensation based on overall regional and Medical Group financial results in relation to forecast. The Medical Groups' professional liability' costs and the costs of their principal fringe benefits programs, as well as Medical Groups' compensation, is provided through their contractual arrangements with Health Plans.

Health Plans extend benefits to vulnerable populations in many ways, such as through dues subsidy programs; unlimited right to convert to individual membership upon loss of group eligibility; enrollment of individuals and small groups; guaranteed lifetime eligibility irrespective of health status; absence of any limitation on pre-existing conditions; and a community rating based rating system. Moving beyond enrollment and rating practices, an HMO can provide community benefits in many other ways, as the Health Plans do, such as through sponsoring health education programs, research, care for persons covered by Medicare and Medicaid and other public assistance programs, and in various other ways.

III. CONCLUSION

Kaiser Permanente and other group practice HMOs are models for the organization and delivery of health care in the United States. They are integrated health care organizations. They organize and deliver health care as distinguished from Blue Cross, Blue Shield and insurance plans that pay claims. The value of integrating the financing and delivery of health care through group and staff model HMOs is well known and generally understood in the health care community and has been recognized in tax policy for some time. This recognition should be maintained.

PREPARED STATEMENT OF ROBERT D. TOLLISON

Mr. Chairman and distinguished members of the Committee, my name is Robert D. Tollison. I am Duncan Black Professor of Economics at George Mason University. I have published numerous articles and books in the field of economics, including *The Economics of Smoking* (1992). I have served as a Senior Staff Economist on the Council of Economic Advisers and as Director of the Bureau of Economics at the Federal Trade Commission.

I am appearing here today on my own behalf at the request of the Tobacco Institute to comment on the Administration's proposal to increase the excise tax on cigarettes in connection with health care reform. I testified before this Committee in May 1990 on issues related to the "social costs" of smoking. Although I am appearing at the request of The Tobacco Institute, the views I am expressing are my own.

President Clinton has stated that his purpose in proposing to increase the federal cigarette excise tax is solely to help finance his health care program—not to reduce smoking. At a press conference last November, the President stated in answer to a question from Andrea Mitchell:

> "I didn't want to raise any money from anybody to do anything other than to pay for the health care program, although I think that higher tobacco taxes [would] discourage use and that's a good thing. But that wasn't what was behind it."

Accordingly, I will focus on whether the proposed cigarette excise tax increase is justified as a means of financing health care reform. I should state, however, that I am strongly opposed, on philosophical grounds, to increasing the cigarette excise tax as a means of reducing smoking. Use of the tax code to induce conformity with socially approved norms of personal behavior is totalitarian in its implications.

My statement has two parts. As I will explain in the first part, it would be unfair to make smokers, and only smokers, pay through increased excise taxes for any health care "costs" that they may impose by virtue of their chosen lifestyle, and in any event smokers already are more than paying their way at current tax levels. The Congressional Research Service, in a report to Congress released last month, reached the same conclusion:

> "An increased cigarette tax as a method of financing health care reform appears questionable on efficiency, budgetary, and equity grounds. The most straightforward justification for linking the two—that smokers impose financial costs on nonsmokers—probably has already been corrected by existing cigarette excise taxes. The revenue from the tax will be substantial but will decline over time relative to budget-window estimates and will finance an increasingly smaller share of health care costs. The cigarette tax will fall on a small share of the population and will disproportionately burden lower-income individuals compared to almost any other revenue source."[1]

CRS stated that "[b]ased on the criterion of matching tax revenue to net external costs, the data indicate that cigarettes are overtaxed and alcohol is undertaxed." (CRS–6) And CRS concluded that even if a "passive-smoking cost" were to be considered appropriate for inclusion as an external cost, that cost "would be quite small, and unlikely to raise the estimate of spillover effects above the level of the current tax." (CRS–13) CRS and the Office of Technology Assessment, both assuming that an excise tax increase, by reducing smoking, would thereby increase life expectancy, have suggested that reducing smoking could *increase*, not decrease, health care and other government costs in the long run.[2]

As I will explain in the second part of my statement, the proposed tax increase, by reducing consumption and thereby decreasing production, would result in increased unemployment nationwide, with the Southeastern states being especially hard hit. The proposed tax increase also would reduce state revenues and trigger

additional federal spending that would substantially offset the $10.4 billion in "new" revenues that proponents of the proposed tax increase project.

I.

Fairness. Let us assume, for the purpose of discussion only, that smokers impose health care "costs" on society by virtue of their smoking, and that smokers are not already paying their fair share of any such "costs" at current levels of taxation. It would be unfair nonetheless to increase the federal cigarette excise tax for at least three reasons.

First, as Professor Dwight R. Lee of the University of Georgia has noted, making smokers pay through higher taxes for the health care "costs" they supposedly incur implies that we want our health care system to operate on a pay-as-you-go basis, in which Americans are taxed according to the health care costs that they are thought to incur as individuals, by virtue of their particular behaviors and lifestyles.

If indeed this is how we want our health care system to operate, it would be arbitrary and unfair to single out smokers. Let Congress tax every American on the basis of the health care costs he or she may incur as an individual. Needless to say, this user-fee approach would be hopelessly at odds with the "community rating" principle that underlies the Administration's health care package.

Second, even if the justification for increasing cigarette excise taxes were to reduce health care costs by promoting "healthier" lifestyles and behaviors—a justification that the President has disavowed—it still would be arbitrary and unfair to focus solely on smokers. Fairness and consistency would require the targeting of a long list of "risky" lifestyles.

The First Lady has dismissed this point by suggesting that smoking is the only "risky" lifestyle that is practical to target through excise taxes. This suggestion is obviously wrong. Poor diet, which the Surgeon General has estimated is responsible for 1.4 million premature deaths per year, easily can be targeted. One simply need select those foods that have been identified as risk factors for disease—be it coffee, butter, red meat or "snack food"—and then impose an excise tax on those products. In the case of alcoholic beverages, an excise tax already is imposed.

Third, cigarette excise taxes, like all excise taxes, are inequitable. A 75-cent-per-pack increase in the cigarette excise tax would increase the yearly tax burden of a typical smoker by $400. But as CRS noted:

> "The cigarette tax is not horizontally equitable; it imposes higher taxes on smokers than on nonsmokers of equal income. The tax also is regressive, imposing larger taxes as a percent of income on lower-income individuals." (CRS–iii)

The Congressional Budget Office reported in 1987 that a cigarette excise tax increase would hit lower-income families more than six times harder than higher income families. CBO, which studied the distributional effects of excise tax increases on beer, wine, liquor, tobacco, gasoline, airfare and telephone services, concluded that "[a]n increase in the excise tax on tobacco would be the most regressive of all."[3] A Congressional Black Caucus Task Force report released by Congressman Mervyn Dymally (D–Cal.) stated that even a modest increase in excise taxes would "considerably magnify the incidence, prevalence and the enormity of poverty in the United States."[4]

Economic considerations. To the extent that smokers do impose any health care "costs" on society by virtue of their smoking, they already are paying more than their fair share of any such costs at current levels of taxation. As noted, CRS and the Office of Technology Assessment has suggested that reducing smoking could increase, not decrease, health care and other government costs in the long run.

A. SMOKERS ALREADY ARE PAYING THEIR FAIR SHARE.

1. Health Care

a. Costs to Government

In a report released in May 1993 and reaffirmed in November 1993, OTA estimated that smokers "cost" federal, state and local governments $8.9 billion in health care expenditures because of illnesses viewed as smoking-related.[5] Assuming the validity of this estimate for the sake of discussion—an estimate that I believe is fundamentally flawed[6]—the fact is that smokers currently pay federal, state and local governments $11.3 billion in cigarette excise taxes and another $2 billion in sales taxes—a total of $13.3 billion. Only smokers pay this $13.3 billion. Nonsmokers do not.

Thus, through excise and sales taxes, smokers currently are paying $4.4 billion *more* to federal, state and local governments than the $8.9 billion that OTA claims smokers "cost" all levels of government in health care expenditures. OTA estimates the federal government's share of these government "costs" at $6.3 billion. This translates to 24 cents per pack of cigarettes sold—the current level of the federal cigarette excise tax. Clearly, with respect to government costs, smokers are more than "paying their own way" at current tax levels.

b. Private Medical Costs

OTA estimates that smokers also generate $11.9 billion in health care costs that are not borne by the government—that is, health care costs that are paid by smokers individually or through private insurance. For purposes of accurate calculations, even this $11.9 billion estimate must be reduced to $7.5 billion by the $4.4 billion in excess taxes that smokers pay. There are, however, more fundamental problems with OTA's estimate.

By definition, health care costs paid by smokers are not "external" costs. Such health care costs include co-payments, deductibles and other costs that are not covered by insurance. These costs cannot properly be included in any tabulation of "external costs" that smokers are thought to impose. As CRS has pointed out (CRS–52), OTA never attempted to calculate or disaggregate these costs that are paid by smokers.

Thus, OTA has no basis to claim that smokers do not also pay their way in the private insurance market. In this connection, the Surgeon General has stressed the paucity of "actuarial data to document that nonsmokers incur fewer health care costs" than smokers.[7]

It is, in any event, inappropriate to view private health insurance premiums paid by others as an "external" cost. The premise of insurance is the sharing of risk. It would defy this premise to isolate smokers as a "high risk" group for purposes of financing health care reform. It also would perpetuate a discriminatory feature of our current health care system, a feature that the Administration's reform package seeks to eliminate.

2. Foregone Wages and "Lost" Productivity

OTA suggests that smoking results in $40.3 billion in foregone wages and $6.9 billion in "lost" productivity. Even assuming for the sake of discussion that these estimates were accurate, they do not represent "external costs"—a point stressed by CRS in its critique of the OTA analysis (CRS–52). And since these "costs" are not related to health care, it is inappropriate in any case to consider them in determining whether a proposed federal cigarette excise tax increase may be justified as a means of financing *health care.*

Foregone wages are, by definition, costs borne directly by the employee. They cannot be considered costs incurred by anyone else. Thus, the $40.3 billion that OTA assigned to foregone wages cannot be viewed as an external cost that justifies any increase in the cigarette excise tax. And "lost" productivity, as Professor Lee has observed, cannot be considered a cost at all—unless one assumes that society somehow is entitled to maximum productivity from its members, so that anything less than maximum effort is a social "loss."

This is, in Dr. Lee's words, "an absurd conception." As Dr. Lee stated:

> "When a person is absent from work for whatever reason—to go on vacation, have a tooth pulled, serve on a jury, or attend a child's school play—there is no "cost" to society. The fact that someone does something other than work does not represent a *social* loss unless we view ourselves as 'owned' by society and society is viewed as having the power to determine how we spend our time based on its own criteria of value. This is not my vision of America or any other free society."

It has not been established, in any event, that smokers, as a group, are less productive than nonsmokers when all relevant factors are taken into account. The large majority of studies that report an association between smoking status and increased employee absenteeism acknowledge that factors other than smoking may account for the apparent association. As James Athanasou, an antismoking advocate, stated in an early review article:

> "Sickness absence is a complex behavioral phenomenon in which a multiplicity of health, social and psychological factors are involved. * * * Most investigators have implicitly assumed that the only difference between a non-smoking and a smoking group is their tobacco habit and that any other personal factors are equally distributed within these groups. * * * None of the reported studies has considered the additional effects on sickness ab-

sence of job satisfaction, attitudes to work, personality, other psychosocial or socioeconomic variables and the urban factor in conjunction with the effects of smoking."[8]

In our own book on the subject, Kichard E. Wagner and I likewise noted that smokers and nonsmokers are not identical in all respects other than smoking. Among other things, smokers have an above-average representation in blue collar occupations, they also consume on average an above-average amount of alcohol, and they generally exercise less than nonsmokers. In assuming that people are identical except for their smoking, various diseases and their associated costs are improperly attributed to smoking.[9] Professor Richard Ault of Auburn University and several colleagues similarly have noted that the failure to consider other differences between smokers as a group and nonsmokers as a group has resulted in "spurious conclusions about the relationship between smoking and absenteeism."[10]

B. A TAX INCREASE COULD INCREASE DEMAND FOR HEALTH CARE.

It generally is assumed that health care costs would be reduced by raising the cigarette excise tax to the level suggested by the Administration, given the decline in smoking that would be expected to result. I am aware of no hard data on this point. However, a number of experts and government authorities assume that smokers would live longer and make greater demands on the health care system if they did not smoke, and thus believe that reducing smoking might well increase, not decrease, health care costs.

OTA stated in its May 1993 report, for example, that the reduction or elimination of smoking:

"may not lead to savings in health care costs. In fact, significant reductions in smoking prevalence and the attendant increase in life expectancy could lead to future increases in total medical spending, in Medicare program outlays, and in the budgets of the Social Security and other government programs.

For similar reasons, CRS has suggested that "reduced smoking would add to the [federal] deficit." (CRS-32)

As an economist, I am in no position to assess the validity of the assumption that reducing smoking would increase life expectancy. But if the assumption is accepted, the conclusion that reducing smoking could increase health care costs over the long run seems self-evident. The point here is not that any premature death assumed to result from smoking should be regarded as a "benefit"—it obviously should not—but that proponents of a federal cigarette excise tax increase cannot justify such a tax increase as a means of reducing the nation's escalating health care costs.

II.

There is no dispute that the proposed tax increase would reduce consumption and would thereby decrease production. This and other effects of reduced consumption would increase unemployment, especially in the Southeastern states, even under the conservative calculations of the Congressional Research Service. Reduced consumption—as well as smuggling and cross-border sales from Mexico—also would substantially offset the $10.4 billion in additional federal revenues that proponents of the tax increase project, and depress state revenues.

Job losses. According to Price Waterhouse, there are approximately 681,000 jobs in the U.S. tobacco sector of the economy.[11] The tobacco sector includes tobacco growing and manufacturing, the distribution and retailing of tobacco products, and the industries that supply these sectors.

The Administration estimates that the proposed 75-cent-per-pack cigarette excise tax increase would result in a 12–15 percent reduction in demand. Price Waterhouse estimates that this would cost about 82,000 tobacco sector jobs. Along with these lost jobs would be a payroll loss of approximately $1.9 billion. Through an inevitable ripple effect, this payroll loss would generate a loss of nearly 192,000 jobs throughout the economy.

The South would be particularly hard hit by these job losses. It is estimated that nearly 40,000 tobacco sector jobs would be eliminated in 12 Southeastern states. In the six major tobacco producing states of Georgia, Kentucky, North Carolina, South Carolina, Tennessee, and Virginia the tobacco sector job losses are estimated to come to approximately 33,500 jobs.

The Congressional Research Service has suggested that the "ripple effect" projected by Price Waterhouse is overstated because money not spent on tobacco would be spent on other products. (CRS-35) The ripple effect described by Price

Waterhouse, however, encompasses the effect of unemployment in the tobacco sector on employment in dependent sectors. Consumers may spend their money on other things if they do not spend it on tobacco, but the effect of such substitutions would be too diffuse to offset the effects directly felt in the tobacco sector and those dependent on it.

CRS also suggests that the impact of a tax increase on employment would be short-lived because, "[i]n the long run, workers will shift to new jobs." (CRS-35) This may prove true to some extent, but not all of the lost jobs will be replaced and few of the new jobs will pay as well as the old ones. And it is small comfort in any case to know that some of the lost jobs will be replaced "in the long run." In the words of Harry Hopkins, President Roosevelt's close friend and New Deal advisor, "people don't eat in the long run—they eat every day."

Increased federal spending. The proposed tax increase would trigger a significant increase in required federal spending as well. Increases in federal spending would be required as tobacco workers become unemployed because of decreased production. A reasonable estimate of these losses is $1.72 billion.

In addition, a 75-cent increase in the cigarette excise tax is bound to have a pronounced effect on the Consumer Price Index. Last year, the Producer Price Index (PPI) *fell* .6 percent because of the price reduction for branded cigarettes by about 40 cents per pack. Increasing the excise tax on all cigarettes—branded and generic—would boost the CPI even more than the price reduction for branded cigarettes cut the PPI.

The tobacco component of the CPI is 1.7458 percent. A 75-cent increase in the price of all cigarettes would increase the CPI by .7 percent. That in turn would require a .7 percent increase in federal spending on all indexed federal programs, such as the Social Security, food stamps, and federal pension programs. At 1993 spending levels, this would amount to $3.92 billion in additional obligated federal spending.

The total quantitative losses come to $5.64 billion, which leaves only $4.76 billion net revenue from the proposed 75-cent excise tax increase. This is less than half the gross estimate proponents claim the proposed tax increase actually would raise. When the multiplier effect takes effect, the net revenue from the proposed tax increase is reduced even further. The problem of increased federal spending would be aggravated further if, as some antitobacco advocates urge, the federal cigarette excise tax is indexed to inflation.

Acknowledging this problem, some antitobacco advocates have proposed removing tobacco products from the CPI for the purpose of indexing federal programs. Rep. Mike Andrews in fact has introduced legislation (H.R. 1246) to that end. Such a "solution" has an Alice-in-Wonderland quality—removing from the "basket of goods" used to compute the CPI a product consumed by 25 percent of the adult population, solely to negate the impact on the CPI of a huge increase in the price of the product!

The CPI should not be politicized in this manner. Moreover, although such a ploy might avoid the impact on government spending produced by increases in the cigarette excise tax through the CPI, this maneuver could not avoid the impact on public or private sector contractual spending obligations linked to the existing product mix used to compute the CPI.

Smuggling. The foregoing calculations do not reflect the further reduction in federal revenues that is sure to result from smuggling. As the recent Canadian experience shows, a large cigarette tax increase leads to an initial decline in domestic consumption that is replaced with smuggled cigarettes from abroad. Domestic tax revenues and production, and retail sales, would suffer further as a consequence.

The 2,000 mile U.S.-Mexico border offers a significant potential for smuggling and cross-border sales of lower-priced Mexican cigarettes. Mexican premium-category cigarettes, which include most U.S. top brand names, currently sell for $1.35 per pack, inclusive of Mexican taxes. After a U.S. tax hike of 75 cents per pack, smugglers could save $9 per carton for such brands in Mexico. At this price differential, a truck-load of cigarettes from Mexico could show a gross potential profit of $500,000 in the U.S.

Effect on state revenues. It also should be recognized that reduced cigarette sales from the proposed federal excise tax increase will reduce state cigarette excise tax revenues. These revenues are currently around $6.7 billion per year. The Congressional Research Service has suggested that the states will lose about $1 billion in revenues in the first year as a result of a 75-cents-per-pack federal cigarette tax increase, and that this loss would grow to about $3.6 billion per year decades hence. (CRS–33) Some of this loss to the states undoubtedly would have to be made up by the federal government. This would represent yet another source of erosion of the net revenue the federal government would receive from the proposed cigarette excise tax increase.

Increasing the federal cigarette excise tax is simply not justified from an economic standpoint. As CRS confirms, smokers already more than "pay their way" at current levels of taxation. Making them pay more would be discriminatory and unfair. In addition, OTA's recent report suggests that reducing smoking actually could *increase* health care costs over the long run rather than reduce them. Finally, the proposed excise tax increase would trigger additional federal expenditures that would substantially offset the new tax revenues and impose significant unemployment costs on the economy, particularly in the South.

For all of these reasons, the proposal to increase the federal cigarette excise tax to help finance health care reform should be rejected.

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George Mason University
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May 4, 1994

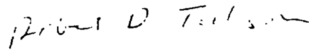
The Honorable
Daniel Patrick Moynihan
U.S. Senate
Washington, D.C.

Dear Senator Moynihan:

It was a pleasure and honor to testify before the Senate Finance Committee on April 28, 1994. As we discussed during my testimony, tobacco products are included in the products that make up the Consumer Price Index (CPI). Thus, an increase in the excise tax will increase the CPI by a stipulated amount based on the weighting given to tobacco products. And an increase in the CPI will lead to an increase in mandated federal spending will reduce the net revenues from an increase in the excise tax. The background and basis of this argument are given in the attached items.

All the best and good luck in all respects.

Sincerely,



Robert D. Tollison
Duncan Black Professor of
Economics, and Director
Center for Study of Public Choice

ROBERT TOLLISON

Revenues down in smoke?

As the details of the Clintons' health care reform proposals take shape, one feature seems clear — a primary financing instrument in the proposed plan is a substantial increase in so-called "sin" taxes. Most discussed in this regard is an increase in the excise tax on cigarettes on the order of magnitude of $1 a pack. Various authors and economists have claimed various additional revenues from a $1 a pack increase, most of these estimates fall in the range of $12-15 billion a year.

Unfortunately, all such estimates are gross overestimates of the additional revenue to be garnered by the federal government from an increase in the cigarette excise tax. The reasons are simple, straightforward and indisputable. Consider the following logic.

First, the tobacco component of the Consumer Price Index (CPI) is about 2 percent (1.7458 percent). This may not appear to be much, but it is sizable enough so that a large increase in the cigarette excise tax could lead to a significant increase in the CPI.

To follow out this reasoning, a rough and ready calculation suggests that a $1 pack increase in the cigarette excise tax could boost the CPI by as much as 1.3 percentage points. The calculations here are not exact, but they are close enough to be realistically suggestive of how the increase in tobacco prices as a result of an increase in the excise tax would impact on the CPI. Just last week, for example, it was announced that the Producer Price Index (PPI) had fallen 0.6 points because of the fall in the prices of certain brands of tobacco products. If a 40 cent reduction on the price of branded tobacco products has such a prounounced impact on the PPI, think of what a $1 a pack increase in the price of all cigarettes, generic and branded would do by comparison. In this respect, a 1.3 percent estimate of the impact on the CPI of an increase in the cigarette excise tax seems quite reasonable.

Finally, and this is the important point, if the CPI increases by 1.3 percent, all federal entitlement programs tied to the CPI would also increase by this amount. These programs, among others, include Social Security, federal pensions and food stamps. Obviously, to obtain the *net* increase in federal revenues from an increase in the cigarette excise tax, you have to deduct these automatic spending increases from the additional revenues generated by the increased excise tax. I have not done a careful study of exactly what the relevant figures are, but the net additional federal revenues from an increase in the excise tax on cigarettes are clearly much lower than $15 billion. By the time all is said and done, the net additional revenues could fall to less than $10 billion and maybe even as low as $6 billion. This is not nearly as much net revenue as is normally forecast and certainly not enough to fund the Clintons' health care plans.

The key point is that such a tax increase will not raise federal revenues nearly to the extent advertised because of it potential impact on federal spending obligations.

The moral of the story is that there is no free lunch. Taxing tobacco will impact the CPI, which will increase automatic spending in the federal budget. This is not presented as a theory of inflation, it is just simple arithmetic, which will come into play as a result of the increase in the excise tax. So at least the Clintons should be aware that the cigarette excise tax is not the goose that lays the golden (albeit regressive) eggs to fund their schemes. Such a tax is a bad tax for a host of other reasons which will not be gone into here. But the key point is that such a tax increase will not raise federal revenues nearly to the extent advertised because of it potential impact on federal spending obligations.

Robert D. Tollison is a professor of economics and director of the Center for the Study of Public Choice at George Mason University.

NEWS RELEASE

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TOBACCO TAX HIKE MEANS HIGHER INFLATION, MORE GOVERNMENT SPENDING

Arlington, Va.-- New warning signs from Canada suggest that while President Clinton's plan to raise cigarette taxes may provide a few new tax revenues, the cost to the U.S. economy will be measured in higher inflation and government spending.

"Canada's high excise tax on tobacco failed to produce the expected tax revenue or reduce Canadian tobacco consumption relative to that in the United States. Instead, the tax increase led to massive cigarette smuggling from the U.S. and higher inflation," said Cesar Conda, executive director of the Alexis de Tocqueville Institution, a non-profit, non-partisan public policy organization which studies economic and tax policy issues.

"In the wake of a major cut in Canada's tobacco taxes enacted in February, the Canadian government reports that inflation has plunged to 0.2 percent in February, the lowest level since 1962."

"Moreover, lower tobacco taxes will help reduce the Canadian budget since many Canadian entitlement spending programs -- like those in the U.S. -- are pegged to the consumer price index for inflation," Conda said.

The contrast between Canadian and U.S. public policy regarding tobacco taxes is rather stark, he said. "And so are the implications for the U.S. economy and the Federal budget."

Drawing upon a recent analysis of the tobacco tax increase by Professor Robert Tollison of George Mason University, Conda said that President Clinton's proposed 75 cent per pack tax increase would result in a significant one-time boost in inflation. "Here's how it works: The U.S. tobacco component of the CPI is about 2 percent. The proposed 75 cent excise tax would raise the price of a pack of cigarettes about 40 percent, boosting the CPI by .7 percentage points."

"As the CPI goes up, inflation-adjusted federal entitlement spending programs -- Social Security, food stamps, pension programs and so forth -- will automatically rise," said Conda

- more -

"The proposed excise tax is expected to raise about $10.4 billion in the first year. But the higher entitlement spending and lower revenues from tax indexing will take about $5.6 billion away, thereby shrinking the net gain to a paltry $4 8 billion."

"When it comes to increasing the tobacco tax, U.S. policy-makers have chosen to ignore the lessons from Canada and the weight of academic studies. In fact, a key House Ways and Means subcommittee has even one-upped Mr. Clinton's original tax hike plan, approving a cigarette tax increase of $1.25 per pack. Such a dramatic tax hike would cause the CPI to jump 1.3 percentage points.'

"During the 1980s, President Ronald Reagan's low-tax and anti-inflation policies ended the 'stagflation' of the late 1970s and early 1980s, slashing inflation from 10.3 percent in 1981 to only 1.9 percent in 1986 and sparking the longest peacetime recovery in post-war history. Lower inflation meant lower prices for consumer goods and higher real family incomes," Conda said.

"Today, however, inflation is heating up. Gold prices and long-term interest rates are rising which is indicative of the market's growing fear of future inflation. President Clinton's income tax rate increases on labor and capital, which took effect at the beginning of this year, will eventually increase inflationary pressures because the existing supply of money will be chasing a dwindling supply of goods and services in the economy -- a sure-fire recipe for higher prices."

"To keep the inflation genie in the bottle, the Federal Reserve Board should adhere to a strict anti-inflation monetary policy. And the Congress ought to shelve the President's tobacco tax increase plan because it would simply add fuel to the smoldering fires of inflation," Conda concluded.

# # #

For more information, contact Cesar V Conda, Executive Director of the Alexis de Tocqueville Institution, 2000 15th Street North, S. 501, Arlington, Va. 22201. Phone: (703) 351-4969, Fax: (703) 351-0090.

The Impact on the Consumer Price Index and Federal Spending of a 75-Cent Cigarette Excise Tax Increase

There are various estimates of the additional revenues that would accrue to the federal government from a 75-cent increase in the cigarette excise tax. The most widely used estimate is $10.4 billion. This is an estimate of the net additional revenues from such a tax increase. Actual revenues would be considerably less than half this amount. This is why:

The tobacco component of the Consumer Price Index (CPI) is about two percent (1.7458 percent). Therefore, a 75-cent tax increase on cigarettes would translate into a one percent increase in the CPI, given the current price of cigarettes. A one percent increase in the CPI will lead to a one percent increase in all indexed spending at the federal level -- Social Security, food stamps, federal pension programs and so on. At 1993 spending levels, this would amount to $5.6 billion in additional obligated federal spending and loss of revenue from income tax indexing.

Various additional increases in federal spending would occur as tobacco workers are displaced by a cigarette tax increase, and as a result receive unemployment benefits and pay less income taxes. (There also would be less state excise tax revenue as cigarette consumption declines.) A reasonable estimate of these losses is $2.46 billion.

Therefore, actual federal revenues from a 75-cent cigarette tax increase would be: $10.4 billion - $8.06 billion = $2.34 billion. This is less than half of the estimated gross revenues.

There has been some discussion of taking tobacco products out of the CPI for the purpose of indexing federal programs. This makes no sense whatsoever. In fact, Patrick Jackman, the chief economist for the CPI division of the Bureau of Labor Statistics, recently indicated that the bureau is opposed to measures that would remove tobacco from the CPI. According to Jackman, "The CPI is supposed to represent expenditure patterns. You can't just unilaterally exclude something here if people are still spending their money on tobacco."

The marketbasket of goods for computing the CPI is longstanding and widely followed by the economics profession and financial markets as a reliable indication of inflation. Its administration has been consistent, professional and credible. Indeed, during the recent spate of cigarette price reductions, government officials proudly touted the fall in the Producer Price Index (PPI) as a result of a decline in cigarette prices. To include tobacco in the PPI when it produces good news and to exclude it when it produces bad news would be the height of hypocrisy and would politicize and seriously devalue an economically objective standard.

CRS Report for Congress

Cigarette Taxes to Fund Health Care Reform: An Economic Analysis

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and

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March 8, 1994

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Cigarette Taxes to Fund Health Care Reform: An Economic Analysis

Executive Summary

A cigarette excise tax increase of 75 cents per pack has been proposed to finance part of the President's universal health care program. The tax enjoys considerable public support, would raise about $11 billion per year, and would be relatively simple to administer because it would increase an existing manufacturer's excise tax. The President's fiscal year 1995 budget stressed that the tax would help pay for the additional health care costs of smoking, and would discourage individuals, particularly young people, from smoking.

This report discusses these rationales, as well as other effects of and concerns about the tax, organized into the topics of market failure as a justification for the tax (i.e., economic efficiency); potential for revenue; equity; and the job loss the tax might cause in tobacco growing regions.

One reason economic theory suggests selective excise taxes generally are not desirable is that they distort individual choices among goods and services in the market and impede efficient resource allocation. Circumstances may exist, however, in which the efficiency case against selective excise taxes is stood on its head: should market failure be present, such taxes may actually be the preferred policy instrument to achieve economic efficiency. Such market failures may exist for cigarettes for two reasons: spillover effects and imperfect information. A cigarette tax is efficient if it forces smokers to pay for costs they impose on nonsmokers (external costs or spillover effects) or if it raises smokers' costs to compensate for the effect that incomplete information has on their judgment about the cost to themselves (internal costs).

An initial question is whether the spillover effects alone are sufficient to justify the proposed increase in the excise taxes (Federal and State), which currently average 50 cents per pack. Estimates of per-pack spillover effects require information on smoking-related health care costs, sick leave costs, life insurance costs, costs of fires, foregone tax revenue, costs of pensions, and costs of nursing homes. Many of these components are subject to considerable uncertainty due to often conflicting scientific evidence, the less-than-perfect data used for measurement, and the presence of some nonquantifiable factors.

These uncertainties produce a wide range of estimates of per-pack spillover effects. Mid-range estimates based upon likely assumptions suggest net external costs from smoking in the range of 33 cents per pack in 1995 prices, an amount that by itself is too small to justify either current cigarette taxes or the proposed tax increase. An upper-bound estimate of net external costs would justify current cigarette taxes and some or all of the proposed 75 cent tax increase. A lower-bound estimate suggests smoking does not impose external costs on nonsmokers, but rather provides net external savings to the nonsmoking population (primarily because smokers' early death leaves their Social Security and pension contributions unused and available to reduce future financing demands on nonsmokers).

One controversial component of the spillover effect calculation is passive smoking. The epidemiological evidence on the health effects of passive smoking is far less certain than evidence on the effect of active smoking. In addition, any effects may be more likely to occur within families (and on spouses rather than children). This leaves two critical issues unresolved: the magnitude of the passive smoking effect; and whether the effect should be classified as an internal or external cost. If one resolves these and several related conceptual and estimating issues in favor of the option that would produce the largest passive-smoking effect, external costs from passive smoking would be approximately 21 cents per pack. Resolving these issues in a manner that weighs the uncertainties of both overestimation and underestimation would produce external costs from passive smoking as low as zero to four cents per pack.

Considering passive-smoking effects to be external costs raises an additional policy issue if a tax is used to compensate for the external costs of smoking. Available evidence suggests the majority of smokers will not be deterred by the tax. As a result, the majority of spouses and children of these undeterred smokers will not benefit from reduction of passive-smoking effects, but will be penalized because the tax will reduce their disposable family income. In this case, the tax would accomplish the opposite of what was intended.

These estimates of spillover effects are confined to effects that can be quantified—they do not account for factors such as the general distaste many individuals feel for smoking. Regulation rather than taxation might be best suited to deal with these spillover effects. No value of "distaste" exists to provide guidance on the correct magnitude of the tax, the tax must be paid for smoking even when no repelled observers are present, and it is relatively easy to separate smokers and nonsmokers in many business and social settings. In fact, it is arguable that a more efficient outcome may occur if private business regulates smoking without formal government regulation.

Some argue these estimates of net external costs are inaccurate because they do not account for the intangible costs of premature death (e.g. the grief of family and friends). On the efficiency grounds being discussed here, the relevance of this issue depends upon whether the individual accurately values the effect of this risk on his family and friends. There is no compelling reason to believe individuals, on average, undervalue this risk. In any case, a policy that assigned an arbitrary value for the underassessment of intangible cost of premature death would have far-reaching implications. It would imply imposition of the rights and preferences of groups relative to those of individuals, a policy that could be viewed as inconsistent with certain basic political and economic values of society. Pleasure driving, many recreational activities, some dietary practices, and some occupations, to name just a few activities, involve the same actuarially-validated risks of premature death and grief. In fact, we do not impose taxes on these activities. Taxing such activities involves value judgments that are beyond the scope of economic analysis.

A tax also may be justified on grounds of market failure if smokers have imperfect information about the health hazards of smoking or about the

difficulty of quitting in the future. Although surveys suggest that some smokers are not aware of or do not accept the health hazards of smoking, available data indicate the average smoker is aware of, or overestimates, the health risks of smoking. Thus, there is considerable evidence that smokers seem to make their smoking decision with knowledge about the health risks of smoking.

Evidence on the adequacy of information about the difficulty of quitting is mixed. The major policy concern with this aspect of market failure is its effect on young people who are less capable of making informed decisions. Imposition of a tax to correct for their lack of understanding of the habit-forming nature of smoking would likely be effective in reducing their participation; it also would penalize a much larger number of adult smokers. Non-tax mechanisms, such as educational programs and strengthened enforcement of laws restricting sales to minors, might be better suited to deal with the problem.

While the available evidence will not support precise findings or conclusions, the proposition that efficiency improvements justify the proposed tax is subject to question: existing taxes exceed some reasonable estimates of the social cost of smoking; and the average smoker appears to have made the smoking decision while in possession of adequate information, at least with regard to health hazards. For those smokers who make poor decisions because of inadequate information, such as the young, increased education and regulation might be more effective market corrections and have fewer undesirable economic effects than a tax.

The cigarette tax would provide a significant source of revenue. However, the unindexed cigarette tax will finance a continually smaller share of health care costs. Even if the tax is indexed, the relatively high sensitivity of youth smoking rates to the tax increase will cause the total smoking participation rate to fall gradually over time. This declining total smoking participation rate will cause long-term cigarette tax revenue to fall gradually over time. After fifteen years revenue would be about ten percent less than the initial $11.4 billion annual budget-window estimate. Without further increases in the tax rate, after many years, the revenue would decline to about two-thirds of the budget-window estimate. This effect on revenue is separate from the effect that would result should there be a continuation of the long-term downward trend in smoking participation rates that is attributable to non-tax-related causes.

Equity is also an important consideration in the evaluation of tax proposals; this issue has been addressed extensively with respect to tobacco taxes in other studies. The cigarette tax is not horizontally equitable; it imposes higher taxes on smokers than on nonsmokers of equal income. The tax also is regressive, imposing larger taxes as a percent of income on lower-income individuals.

The publicized claim of 273,000 lost jobs from the cigarette tax in the health care proposal includes job losses from the export share of the market that will not be affected by the tax, losses that would be offset by Government spending, and losses from workers who shift to new jobs. After eliminating job

losses from these sources, tobacco-related job losses are estimated to be: about 7 percent of total tobacco-related jobs in North Carolina, 0.2 percent of total State employment; about 8 percent of total tobacco-related jobs in Kentucky, 0.3 percent of total State employment; and about 9 percent of total tobacco-related jobs in Virginia, less than 0.1 percent of total State employment. Even large regional multipliers would be unlikely to increase these total shares of State employment beyond one percent. Short-term regional job losses should not necessarily determine national policies, although losses can be significant in local areas, and some transition assistance or phase-in of the tax might be justified.

If the Congress is interested in exploring alternatives to cigarette tax financing, several are available. An alcohol tax would appear to be more efficient and more equitable: the best estimate of alcohol's net external cost exceeds current tax levels; alcohol taxes are also regressive but less so than cigarette taxes. Increased income tax rates or base broadening would be more equitable, and a base-broadening option such as taxing employer-paid health care premiums also would promote economic efficiency in the health care market. Elimination of some spending provisions in the health care proposal could reduce the need for revenue and promote economic efficiency, e.g., the small business subsidies for mandated premiums.

The President's budget proposal stressed the adoption of a cigarette tax to decrease youth participation as one of its rationales. Recent research suggests increased regulation and increased enforcement of existing regulations against sale of cigarettes to minors might be effective, and would avoid the adverse economic consequences that cigarette taxation imposes on the mature smoking population. Should taxation remain the preferred deterrent, greater reductions in smoking might be obtained if the tax was cut loose from the health care program and its revenue earmarked for increased antismoking regulatory and education efforts, perhaps including a system of grants to the States. Such earmarking was a feature of California's 25 cent per-pack tax that was enacted in 1989.

Cigarette Taxes to Fund Health Care Reform: An Economic Analysis

President Clinton presented a comprehensive plan for universal health care in September 1993. Among the sources of financing proposed in this plan is an increase in taxes on tobacco products at a rate of $12.50 per pound of tobacco content. Virtually all of the tax (96 percent) would be collected on cigarettes. If adopted, this tax would raise the Federal cigarette tax by 75 cents per pack, from the current 24 cents to 99 cents. The tax increase is about 42 percent of the current price (inclusive of existing Federal and State-local taxes).

The tobacco tax, expected to raise around $11 billion a year, will finance a significant portion of the President's proposed health care plan as presented in the FY 1995 budget, particularly in the first year or two. It is a relatively simple tax to administer, as it increases a currently existing manufacturer's excise tax. The tax enjoys considerable public support and may be viewed by some to be the most politically feasible alternative available. Reasons given in the budget document for including the tax are the additional health care costs of smoking which the tax will help pay for and the desire to discourage individuals, particularly young people, from smoking.[1]

This report discusses these rationales as well as several concerns that have been raised about this proposed tax. First, selective excise taxes normally are not rated as desirable revenue sources because they distort consumption decisions. A cigarette tax, however, may be desirable if it compensates for burdens that smokers impose on others or because smokers make their smoking decision without adequate information to assess the health costs of smoking. In fact, the choice of a tax on tobacco to finance health care may have been motivated by both of these links between smoking and poor health. If smokers generate additional health costs, some of which nonsmokers pay, why not impose a tax on smokers to offset the burden they impose on nonsmokers? And if smokers make inadequate risk assessments, shouldn't they be discouraged from smoking? Whether these conditions, or market imperfections, are present is an empirical question addressed in section I.

Second, the health care program is to be a permanent program and the permanence of its financing sources is of interest. Section II investigates the effect of several factors on the long-term adequacy of cigarette tax revenue: the lack of indexing of the tax; the long-term deterioration of smoking participation rates; and per capita income growth.

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[1] *Budget of the United States Government, Fiscal Year 1995*, Washington, D.C.: United States Government Printing Office, p. 187.

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A third issue is the potential loss of jobs in the tobacco industry and the concentration of these lost jobs in regions of the country that are heavily dependent on the growing of tobacco and the manufacture of tobacco products. Section III discusses the conceptual and empirical foundation for these industry and regional effects.

A fourth issue is the regressivity of this excise tax (that it takes a higher fraction of income of lower-income individuals) and that it also tends to impose different amounts of tax on people who, by virtue of having equal income, are generally considered to be equals. These effects are well documented by numerous studies, and this equity issue is discussed briefly in section IV.

Section V discusses policy implications arising from the analysis. Appendix A discusses the evidence on passive smoking, Appendix B compares the estimating procedures for various studies of the external costs of smoking, and Appendix C explains the model used to calculate long-term cigarette tax revenue.

I. MARKET IMPERFECTION AS A JUSTIFICATION FOR TAXING TOBACCO

One reason economic theory suggests selective excise taxes generally are not desirable is that they distort individual choices among goods and services in the market and impede efficient resource allocation. Circumstances may exist, however, in which the efficiency case against selective excise taxes is stood on its head: should market failure be present, such taxes may actually be the preferred policy instrument to achieve economic efficiency.

This section discusses two conditions that, if present, make a selective excise tax on cigarettes and other tobacco products a correction for market failure and consistent with economic efficiency: spillover effects and imperfect information. First, cigarette smoking might impose a financial burden on the rest of society (spillover effects). Second, people might make their smoking decision without complete information about the negative consequences of these products; that is, they may make a rational decision based on imperfect information that would be irrational given complete information.

SPILLOVER EFFECTS

It is a generally accepted fact that smoking damages the smoker's health. The term "health costs" is a broadly defined measure which includes medical expenditures, lost productivity from sickness and disability, and early death. These health costs are divided into two types—those that burden the smoker himself (internal costs) and those that burden society (external costs).[2] If the smoker possesses complete information about the relationship between smoking and his own health, he already takes internal health costs into account in making a decision, and no tax is justified to obtain economic efficiency. It is, therefore, the external health costs that might justify cigarette taxation. This section deals with the magnitude of external costs, or spillover effects. The following section deals with the issue of whether imperfect information about internal costs justifies a tax.

To the extent that others in society must pay part of these health costs—increased medical expenditures (which are largely pooled through insurance), and increased job absences covered by sick leave payments—a tax may be justified because the cigarette price does not cover the true economic cost of smoking. And the external costs of smoking are not limited to the health costs of smokers. For example, smoking contributes to fires whose costs may be borne by others if premiums on fire insurance are raised for everyone.

This brief discussion suggests two conclusions from standard economic theory. First, smoking-related costs that are incurred by the smoker

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[2] These issues are also discussed in Michael Gross, Jody L. Sindelar, John Mullahy, and Richard Anderson, "Policy Watch: Alcohol and Cigarette Taxes," *Journal of Economic Perspectives*, Vol. 7, Fall 1993, pp. 211-222.

directly—such as his share of medical expenditures or actual lost wages from sick days— are internal costs that do not justify a tax on spillover grounds. Second, costs imposed on the nonsmoking population (external costs) can justify a tax on spillover grounds. This conceptual case for cigarette taxation does not, however, provide information about how large the tax must be to compensate for the external costs. For that, it is necessary to review the literature that measures the magnitude of these external costs.

The Manning Study

A thorough analysis of spillover effects from smoking must include a lifetime profile of both the external costs smokers impose on nonsmokers and the external savings smokers provide to nonsmokers. While there has been considerable research on the overall health costs of smoking (medical expenditures, lost productivity from sickness and disability, and early death), only the study by Manning, Keeler, Newhouse, Sloss, and Wasserman (hereafter referred to as the Manning study) measures both the lifetime external costs and savings that are needed to gauge the efficient excise tax.[3] Their study uses data on health costs of smokers (both current and former) and lifetime nonsmokers (referred to as never-smokers) to develop the estimates.

The Manning study found that the net external costs (external costs minus external savings) of smoking are small—smaller than the current combined Federal and State taxes on cigarettes. Part of the reason for this finding is that the external costs smokers impose on society (primarily because their larger lifetime medical expenditures are not reflected in the insurance premiums they pay or in contributions to programs such as Medicare) are substantially offset by the external savings they provide to society: their earlier death reduces their payout from the pension plans (including social security) to which they

[3] See Willard G. Manning, Emmett B. Keeler, Joseph P. Newhouse, Elizabeth M. Sloss, and Jeffrey Wasserman, *The Costs of Poor Health Habits*, A RAND Study, Cambridge, Mass.: Harvard University Press, 1991. The results for alcohol and tobacco appear also in "The Taxes of Sin: Do Smokers and Drinkers Pay Their Way?", *Journal of the American Medical Association* v. 261, March 17, 1989, pp. 1604-1609. The basic data for the study are from the Health Insurance Experiment conducted by the RAND corporation for individuals under age 60 (collected from years 1972-1982), supplemented with data from the 1983 National Health Interview Survey for older individuals. Data are expressed in 1986 dollars.

contribute.[4] (These pension plan savings are smaller than they would otherwise be because smokers retire earlier than non-smokers.)

In 1986 dollars, the Manning study found that the net external cost per pack of cigarettes is 15 cents for a new (young) smoker. This estimate includes 43 cents of external costs imposed on society: 26 cents of additional medical expenditures; one cent of sick leave costs; 5 cents of group life insurance costs; 2 cents of costs from fires; and 9 cents of lost tax revenue smokers would have paid to finance retirement and health programs had they not died early. Offset against these costs are external savings to society of 27 cents: 24 cents from reductions in retirement pensions; and 3 cents from reduced use of nursing homes. Rounding error accounts for the lost cent.

This 15 cents of net external costs equals 21 cents in 1995 dollars if the spillover effects are adjusted using the GNP deflator; and 33 cents if the medical expenditure and nursing home components of external costs are adjusted using the medical services price index.[5] (Unless otherwise stated, the 1995 estimate using this medical services price index will be used for all further per-pack calculations in this report.) The 50-cent current tax (Federal tax of 24 cents per pack and average State and local taxes of 26 cents per pack) is 1½ times as high as the 33-cent tax justified by the net external costs estimated in the Manning study.[6]

Notably, the Manning study suggests a much stronger case can be made for taxing alcoholic beverages at a higher rate. It estimates net external costs of at least 68 cents per ounce of alcohol.[7] A large fraction of this cost is associated with loss of life, medical expenditures, and property damage in automobile accidents. Current Federal taxes on alcohol are $13.50 per proof gallon, or

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[4] Note that counting these reduced costs of pension plan payouts as transfers to the nonsmoking population does not mean that there is a gain to society from premature death--such premature deaths are costly. That is, transfers have no effect on the total cost (to smokers and nonsmokers combined) of premature death. Because transfers are made, the cost of premature death to the smoker (internal costs) has increased—the retirement income the smoker is losing is higher. Costs to nonsmokers (external costs) are decreased by the same amount. This accounting for transfers must be made in order to analyze separately the two potential market failures identified in this report, spillover costs and imperfect information. Some have suggested that this treatment implies that society benefits from early death, and that, for example, early deaths from breast cancer would be treated as a savings when evaluating the desirability of breast cancer research. This analogy is not correct. In the case of breast cancer research, the reduction in premature death would obviously be treated as a benefit to society.

[5] These adjustments use the GNP deflator as projected by the Congressional Budget Office. The medical services price index is taken from actual data for 1986-1992; for additional years, the assumption is made that these costs rise in excess of the GNP deflator by the difference observed from 1986-1992.

[6] The average State and local tax of 26 cents per pack was reported in Tax Foundation, *Tax Features*, vol. 37, October 1993.

[7] There was not enough division of costs to separate out the medical expenditures component of traffic accidents, so the cost could be a few cents higher.

about 21 cents per ounce for distilled spirits; $18.00 per barrel of beer, or about ten cents per ounce; and $1.07 per gallon on table wine, or about eight cents per ounce. State taxes tend to be low (ranging from less than two cents to about ten cents per ounce for distilled spirits, generally less than one cent per ounce for beer, and from less than two cents to about 16 cents per ounce for wine).[8]

These data suggest that much larger taxes would have to be imposed on all of these products if alcohol taxes were to reflect net external costs.[9] In short, based on the criterion of matching tax revenue to net external costs, the data indicate that cigarettes are overtaxed and alcohol is undertaxed.[10]

Qualifications to the Manning Study

Because the Manning study is alone in its attempt to calculate all financial spillover effects (both costs and savings) as a basis for assessing the economically efficient level of tax, it is important to discuss thoroughly potential issues that may raise doubts about the results. This section considers a variety of such issues: the likelihood of estimation error from model specification; the sensitivity of the estimate to the choice of discount rate; the omission of passive smoking from the external cost estimate; the proper treatment of non-health-related external costs; some miscellaneous issues; and the consistency of the estimate with findings of related studies. Many of these issues and caveats are also discussed in the Manning study.

Much of this discussion is quite technical and is presented below. A brief summary of these issues is provided for those readers who may wish to skip the technical details and proceed directly to the information and addiction discussion in the next section.

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[8] These are rates as of September 1992, as reported in Tax Foundation, *Facts and Figures on Government Finance*, 1993, pp. 256-57. Some States do not allow private sale and typically impose taxes as a percentage of price; note also that the higher tax rates on wine are imposed only in a very few States; most States impose taxes well below the Federal level.

[9] Some argue that significant differences exist between alcohol and tobacco in that some alcohol is consumed in moderate amounts by individuals who do not drive while intoxicated. This nonabusive consumption does not generate external costs and should not be subject to an excise tax whose purpose is to correct for externalities. It is also true, however, that the magnitude of external effects from tobacco depends in part on the amount of exposure in packs per day and the number of years smoked. Those who smoke for a short period are more similar to nonsmokers than to smokers in their health and mortality characteristics. Obviously, use of an excise tax as an instrument to correct for external costs is imperfect for both alcohol and tobacco.

[10] Some might ask why this report does not evaluate the other major selective excise revenue raiser, the gasoline tax, as a substitute revenue source for cigarette taxation. A primary rationale for both alcohol and cigarette excise taxation is control of socially undesirable (costly) behavior. The primary rationale for the gasoline tax is to require highway users to provide tax revenue in exchange for the benefits they receive from highway construction.

- Estimation error—The Manning study's lower-bound and upper-bound estimates of spillover effects are designed to account for the possibility of estimation error. The lower-bound estimate produces net external savings of 14 cents per pack (recall that all estimates are adjusted to 1995 price levels). The upper-bound estimate produces a net external cost of 53 cents. Neither of these estimates justify a 75-cent increase in the cigarette tax which currently averages 50 cents per pack.

- Discount rate—Any study whose results involve a comparison of costs and savings with significantly different time patterns can alter the relative magnitudes by changing the discount rate. Raising the discount rate from five to ten percent would increase net external costs of smoking to 42 cents per pack. Lowering the discount rate to just under four percent would produce net external costs of zero; below that rate net external savings would be generated. In neither case is a 75-cent increase in the tax rate justified on spillover grounds.

- Passive smoking—Differences exist about whether passive smoking effects are largely internal or external costs. The link between passive smoking and disease is uncertain. The best available estimate of this link implies external costs of no more than a few cents per pack, not enough to justify a 75-cent increase in the cigarette tax.

- Non-health-related external costs—The Manning study does not incorporate effects such as general distaste and annoyance on the part of many for smoking. These effects cannot be quantified and may be best dealt with through regulation rather than taxation.

- Relationship of the Manning study to other studies—The Manning study is likely to be more accurate in its estimates of the economically efficient level of tax because it is the only study that uses the appropriate analytical framework and includes all financial spillover costs. Other studies, when considered in the appropriate framework, are generally consistent with the Manning study.

1. Estimation error from model specification

The Manning estimate uses a procedure that attributes variations in individuals' total lifetime health costs to smoking status, income, sex, and various other attributes. This is a standard estimation strategy—it attempts to control for the influence of nonsmoking factors on total health costs, thereby isolating the influence of smoking. This is referred to as the "base case" in the following discussion.

The Manning study estimates an upper limit for the external costs of smoking that arise from effects on smokers' health by attributing all the variation in total health costs among individuals to smoking status, in effect assuming that no other differences among individuals contribute to the observed

differences in health costs. This "upper-bound" analysis produces net external costs of 53 cents. This cost is likely to be an overestimate since some of the deleted nonsmoking factors are found to be statistically significant and therefore are likely to have some influence on total health costs. With this upper-bound case, the conceptually desirable tax (on efficiency grounds) would argue for only a three-cent increase in selective cigarette excise taxes.

It also is possible that the 33-cent net external cost estimate, based upon total health costs, is an overestimate. This would occur if omitted variables generate nonsmoking health costs that happen to be correlated with smoking. Consider risk. Smokers are found to be more likely to engage in risky activities and as a consequence are, for example, more likely to incur health costs from accidents.[11] These nonsmoking health costs to some extent would be attributed to smoking status by the base-case methodology, even though they are caused by differences in risk-taking rather than smoking status.

The Manning study's authors attempt to control for such bias by restricting health costs to those thought to be related to the smoking habit (e.g., certain cancers, respiratory illness, circulatory diseases, and ulcers). Using this approach, they construct a "lower-bound" estimate that also eliminates any effect of smoking on early retirement (which affects the level of pensions and foregone taxes). Attributing variations in these smoking-related or habit-related health costs to smoking status, income, sex, etc., and eliminating the retirement effect, produces net external *savings* (external savings exceed external costs) of 14 cents. Of course, if smoking produces net external savings rather than a net external cost, a cigarette tax justified as compensation for net external costs would not be appropriate.

If medical expenditures are adjusted only to reflect habit-related disease, but unlike the case just discussed the effect on early retirement from the base case is retained, the result is a net external cost of 12 cents. If instead early retirement costs in the base case are reduced in the same proportion as the reduction in the change in medical expenditures moving from the base case to the lower bound, the result is net external savings of four cents.

What is one to make of these three cases and their permutations? The upper-bound case seems unrealistic—it comes from a clearly misspecified model that attributes too many health costs to smoking, yet still produces estimates of net external costs that fall far short of justifying a 75-cent tax increase. The lower-bound estimate (and estimates adjusted to various treatments of early retirement) could be a better estimate of spillover effects than the base case. If the base-case model were perfectly specified (no omitted variables), it would provide the same results for medical expenditures as the lower-bound case (provided the latter correctly identified smoking-related health costs). Which model provides a better estimate of spillover effects depends upon one's belief about whether omitted variables in the base case are more of a problem than the

[11] See W. Kip Viscusi, *Smoking: Making the Risky Decision*. New York: Oxford University Press, 1992.

measurement error incurred when separating smoking-related health costs from total health costs.[12] Neither justifies the current 50-cent cigarette excise tax on the basis of spillover effects.

2. Choice of discount rate

Any study whose results involve a comparison of costs and savings with significantly different time patterns can alter the relative magnitudes by changing the discount rate. Discounting provides a way to compare, at a given point in time, amounts that will be received at different points in the future. Discounting accounts for the fact that a dollar received or spent in the future is less valuable than a dollar received at present, since a dollar received now can be invested at interest. The higher the interest (discount) rate, the smaller the value of amounts paid or received in the future.

Discounting is important in the Manning study because the external costs of smoking accrue more quickly across time than do the offsetting external savings from smoking. Thus, the relative importance (dollar value) of external costs and external savings is affected by the choice of discount rate. Also, much of the tax is paid in advance of either the savings or the costs.

Raising the discount rate from the five percent used in the base case to ten percent increases the difference between the external costs and the offsetting external savings from 33 cents to 42 cents. A further increase in the discount rate has little effect on net external costs, because at a ten percent discount rate, future external savings are already so heavily discounted that further discounting has a minor effect. Also, all values are reduced relative to tax receipts, which occur earlier in time. Lowering the discount rate has a more powerful effect: external costs equal external savings (net external costs become zero) at a discount rate of slightly under four percent (and at a zero discount rate, smoking produces external savings of $1.18 a pack).

A zero discount rate is not reasonable, but the ten percent rate is probably too high. A discount rate reflecting the pre-tax return on capital would probably be around seven percent, or about halfway between the five percent and ten percent levels.[13] Because of the way in which discounting affects net external savings, the seven percent discount rate produces results that are very close to

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[12] These measurement errors could arise from imperfect medical knowledge or from misdiagnosis of illness. The direction of such a measurement error is not clear. For example, some smoking-related illnesses could be diagnosed as a non-smoking-related disease because smoking is a contributing rather than primary cause. At the same time, physicians may be more inclined to diagnose as smoking related the illnesses of smokers than those of non-smokers. See Hans J. Eysenck, "Smoking and Health," in *Smoking and Society*, ed. Robert D. Tollison, Lexington: D.C. Heath, 1986 for a discussion of evidence on this latter effect.

[13] This seven percent rate of return is consistent with two methods of derivation: dividing estimated net capital income by the estimated capital stock, and grossing up an estimated after-tax return by the estimated effective tax rate.

the ten percent rate. None of these discount rates generate net external costs that justify current excise tax rates.

3. Passive smoking

Some suggest the Manning study underestimates net external costs from smoking because it does not include the external costs of passive smoking. The exclusion of these effects is not due to a failure to address the issue. These issues are addressed in a variety of ways in the Manning study. With respect to the data used to estimate costs for active smokers, the Manning study cuts its medical expenditure data eight ways in a search for evidence of passive smoking effects. It examines both total medical expenditures and the subset associated with illnesses related to smoking, for adults and children as outpatients and inpatients. The data analyzed indicate a statistically significant effect for habit-related (smoking-related) inpatient medical expenditures for adults; the data do not indicate an effect for the other categories.

Several reasons suggest it may be appropriate to omit passive smoking effects from the calculation of the corrective tax: first, there is much less certainty about the link between passive smoking and health than the link between direct smoking and health; second, to the extent that evidence does exist, it has been associated with effects within families and largely to spouses of smokers, thereby raising questions as to whether the effect should be considered an external or an internal cost; third, taxes may be a flawed instrument to correct for passive smoking effects; and finally, based on available evidence, these costs are quite small relative to current and proposed taxes. Each of these points is discussed.

First, the effects of passive smoking on health are far weaker and less certain than the effects of active smoking. There has been a debate about passive smoking's effect on health; much of the discussion about this issue is technical in nature and is discussed in Appendix A.

Second, if a passive smoking effect exists, the effect may be most likely to occur within families.[14] Reasons exist for considering a family, rather than an individual, to be the decision-making unit when designing externality-correcting taxes. One reason is that corrective governmental action often is not desirable for spillover effects that occur within groups that are small enough to negotiate with each other, since members of the group can come to a mutual agreement that maximizes welfare. Passive-smoking effects that occur within a family unit may fit this description. This is a gray area where public policy might well consider these effects either as internal or as external costs depending upon the

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[14] Although the Environmental Protection Agency issued a risk assessment that classifies environmental tobacco smoke as a cancer-causing agent, the epidemiological studies they use are based on studies of passive smoking within the home, not in the workplace or in public places. See United States Environmental Protection Agency, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*, December 1992.

relative bargaining strengths of those affected. The findings of the Manning data, which tend to show that costs are more likely to be associated with adults (who presumably have relatively comparable bargaining strengths) than with children (who presumably would operate from a relatively weak bargaining position) might argue for treatment as internal costs. In addition, since smoking tends to be initiated at an earlier age than marriage, individuals generally know whether or not their spouses will be smokers.

If the smoker or the parents together make the decisions and there are effects on children, there is still a reason to treat costs as internal. Many, one hopes most, parents consider the welfare of each other as well as children in making decisions. Thus, many family smokers should already be taking into account, at least in part, any negative consequences of smoking for other family members, regardless of how decisions are made.

Third, if passive smoking effects are considered external costs, equity considerations suggest a tax remedy may not be desirable. The justification for a tax to correct externalities is made on efficiency grounds because it is *possible* to make all individuals better off. This "all win" scenario is accomplished (assuming a net external cost) by: (1) imposing the tax on cigarette smokers, thereby reducing their after-tax income; (2) altering smokers' behavior, thereby making nonsmokers better off; and (3) making lump sum payments to compensate smokers for their tax payments. In practice, the third step is omitted, which causes distributional effects—smokers lose and nonsmokers gain. Many people, however, perceive this distributional effect as fair, since smokers impose costs on nonsmokers in the first place. Were a tax used to correct spillover effects within families, however, nonsmoking family members in families with smokers who continue to smoke will be made worse off—they receive little or no reduction in passive smoking costs and their after-tax income is reduced by the amount of the family's tax payments. Thus, while a tax to reflect such passive-smoking costs might be efficient, these equity considerations may make it less desirable.

Finally, even if all costs of passive smoking are considered to be external and existing data are used to measure a per pack amount, the costs probably are small relative to current and proposed taxes. The Manning study calculates a total cost of smoking (both external and internal costs in excess of the price of the product) that includes medical expenditures, lost productivity due to illness, lost productivity due to early death, and costs from fires. This total cost equals $2.53 per pack (recall that these numbers are adjusted to 1995 levels). While the literature does not provide good data on the relationship between these active-smoking costs and passive-smoking costs, and indeed does not really show for certain that a passive-smoking cost exists, these total active-smoking costs along with other data can be adjusted to make three rough estimates that are suggestive of the general magnitude of potential passive-smoking costs.

Estimate based upon EPA's estimate of deaths from lung cancer—Although the uncertainty of the epidemiological studies on passive smoking is discussed in Appendix A, these results can be used to generate possible passive-smoking

costs. Divide EPA's estimated 3000 deaths from lung cancer due to passive smoking by the lung cancer deaths attributed to active smoking, and multiply this 0.022 result by the per pack total cost.[15] This generates passive-smoking total costs of six cents per pack.

Estimate based upon EPA's estimate of child hospitalizations—A second epidemiological-based estimate can be made using EPA estimates that hospitalizations of young children due to respiratory disease from passive smoking range between 7,500 and 15,000. The average hospitalization is estimated to cost between $3,000 and $4,500.[16] If these amounts are converted into per-pack costs they would range from one-tenth to three-tenths of a cent per pack.[17]

Estimate based upon relative physical exposure to smoke—A third adjustment is to multiply the estimate of total active-smoking costs by the ratio of nonsmokers-to-smokers' physical exposure to smoke and by the ratio of nonsmokers to smokers.[18] This calculation generates a passive-smoking total cost of 2.5 to 5 cents per pack.

The first and third estimate might understate passive-smoking costs if the $2.53 per pack total active-smoking cost is understated. First, if individuals are willing to pay more than expected lost earnings for the expected change in life expectancy (internal costs for active smokers, but external costs for passive smokers), the $2.53 per-pack cost could rise by as much as $5 a pack, according to Manning. Stated in 1995 price levels, this increase could be as much as $6.84 per pack. Another difficult area to assess is the cost of low birth-weight babies due to maternal smoking. Some have argued that these passive-smoking costs

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[15] Premature lung cancer deaths attributable to smoking are estimated at 137,000 in 1989. See United States Environmental Protection Agency (1992); and U.S. Library of Congress. Congressional Research Service. *Mortality and Economic Costs Attributable to Smoking and Alcohol Abuse*, Report 93-426 SPR by C. Stephen Redhead, April 20, 1993. Note that this method assumes that the relationship between active and passive premature deaths for lung cancer holds for the overall ratio of health and mortality costs for all diseases.

[16] Testimony of Alfred Munzer, American Lung Association, Before the Subcommittee on Specialty Crops and Natural Resources of the House Committee on Agriculture, July 21, 1993, stated that 15,000 hospitalizations would cost between $45 million and $68 million.

[17] Current Federal taxes at 24 cents a pack account for $5.7 billion; thus each penny per pack is worth $238 million. The total cost of the hospitalizations would range from $23 million (7,500 at $3,000) to $68 million (15,100 at $4500). Thus, the amount per pack would be from less than one-tenth of a cent to less than three-tenths of a cent.

[18] Kyle Steenland, "Passive Smoking and the Risk of Heart Disease," *Journal of the American Medical Association*, January 1, 1992, Vol. 267, pp. 94-99 reports urinary cotinine (a marker for nicotine) in nonsmokers to be less than one percent of that of smokers, and in nonsmokers living with smokers, two percent or less. Since there are roughly an equal number of never-smokers and former/current smokers, the passive cost would be one to two percent of active smoking. These estimates may actually be somewhat high: see the discussion of biological markers in Chapter 3 of the Environmental Protection Agency (1992). Note that this method assumes a linear relationship between exposure and disease.

are very high, but measurement is difficult and only a small group of smokers (pregnant women) impose these costs.[19]

Adjusting for these higher total active-smoking costs gives passive-smoking costs of 21 cents per pack for the calculation based upon estimated lung cancer deaths and 9 to 18 cents for the calculations based upon physical exposure. These seem rather high for a few reasons. First, as stated above, the epidemiological evidence for passive-smoking-related disease is weak. Second, the estimates based upon physical exposure assume a linear relationship between exposure and disease. In fact, strongly nonlinear relationships in which health effects rise with the square of exposure, and more, have been found with respect to active smoking (see Surgeon General's Report, 1989, p. 44). For example, if health effects rise with the square of exposure, the effects would be one-tenth to one-fifth as large as with a linear relationship. Adjusting the nine to 18 cents per pack to allow for such a nonlinear relationship would reduce passive-smoking costs to a range of one to four cents per pack.

These calculations suggest that if a passive-smoking cost were to be considered appropriate for inclusion as an external cost, it would be quite small, and unlikely to raise the estimate of spillover effects above the level of the current tax. Thus, it would not justify the 75-cent tax increase.

4. Non-health-related external costs; intangible costs

Some also suggest the Manning results are understated because they do not incorporate non-quantifiable external costs such as irritation from smoke, smell, nuisance, or general distaste. This is a complicated issue whose resolution requires more than economic analysis. The distaste some individuals have for smoking is difficult to quantify. The stance society should take—whether it should protect the observer's right to be free from the sights, sounds, and smells of others, or whether it should protect the individual's right to indulge in the offending habit when there is no way to measure damage—is not subject to clear guidelines. Individuals undertake many activities that others find distasteful, and many, perhaps most, of them are not subject to government control.

In any case, a tax might not be the best approach to correct for such behavior, for choosing the efficient level of tax relies on quantification of dollar value and is imposed whether or not repelled observers are present. Rather, regulations which separate smokers, allow specific smoking areas, or restrict the

[19] See Joel W. Hay, "The Harm They Do Others: A Primer on the External Costs of Drug Abuse," in *Searching for Alternatives: Drug-Control Policy in the United States*, ed. Melvyn B. Krauss and Edward P. Lazear, Stanford: Hoover Institution Press, 1991.

activity in close environments, might be more appropriate. Such regulations have been shown to be effective in reducing the demand for cigarettes.[20]

Note, however, that an argument can be made that, to achieve efficiency, private businesses should be able to make their own decisions about allowing, disallowing, or separating smokers, since they must respond to the tastes of their customers and workers. For example, owners of restaurants and bars will modify their conditions to attract customers so that some will allow smoking, some will not allow smoking, and some might segregate smokers from nonsmokers.[21] This is a fairly straightforward argument that holds up as long as sufficient choice is available and customers have adequate information. Some decisions would still have to be made about public facilities that are subject to monopoly provision. In practice, of course, many such regulations already exist, some affecting private businesses as well as public facilities.

Some argue these estimates of net external costs are not relevant because they do not account for the intangible costs of premature death (e.g. the grief of family and friends). On the efficiency grounds being discussed here, the relevance of this issue depends upon whether the individual accurately values the effect of this risk on his family and friends (presumably relatively few individuals ignore these risks). There is no compelling reason to believe the individual undervalues this risk. In any case, a policy that assigned an arbitrary value for the underassessment of intangible cost of premature death would have far-reaching implications. It would imply imposition of the rights and preferences of groups relative to those of individuals, a policy that could be viewed as inconsistent with certain basic political and economic values of society. Pleasure driving, many recreational activities, some dietary practices, and some occupations, to name just a few activities, involve the same actuarially-validated risk of premature death and grief. In fact, we do not impose taxes on these activities. Taxing such activities involves value judgments that are beyond the scope of economic analysis.

5. *Miscellaneous issues*

Several other issues suggest viewing the estimates in the Manning study with some uncertainty.

(1) The estimates indicate the appropriate tax only for a new (young) smoker, not for the current mix of smokers. Ideally one might wish to tax each

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[20] Two recent studies include a "regulation index" as a determinant of the demand for cigarettes. See Theodore E. Keeler, Teh-Wei Hu, Paul G. Barnett, and Willard G. Manning "Taxation, Regulation, and Addiction: A Demand Function for Cigarettes Based on Time-series Evidence," *Journal of Health Economics*. Vol. 12, 1993, pp. 1-18; and Jeffrey Wasserman, Willard G. Manning, Joseph P. Newhouse, and John D. Winkler. "The Effects of Excise Taxes and Regulations on Cigarette Smoking," *Journal of Health Economics*. Vol. 10, 1991, pp. 43-64

[21] This argument is made by Robert D. Tollison and Richard E. Wagner, *The Economics of Smoking*, Boston: Kluwer Academic Publishers, 1991.

cigarette based on its marginal net external cost; such estimates do not exist and such an approach is impossible to translate into an excise tax, which cannot be varied by the age and characteristics of the purchaser. Moreover, the fact that existing smokers have already paid taxes and had their smoking decisions influenced by these taxes would need to be considered. The lifetime perspective offers the only feasible method of calculating a net external cost and the associated corrective tax. The implications of a lifetime perspective for calculating the tax receive more attention in Appendix B.

(2) Changes in the tar and nicotine content of cigarettes may result in a decrease in net external costs for current new smokers as compared to the cross section of existing smokers.

(3) The share of cost borne privately may differ in the future from the assumptions in the Manning study. In the Manning study, approximately 28 percent of the present value of lifetime medical costs and half of nursing-home costs was paid by the smoker. If there were no cost sharing, the per-pack amount would rise to 46 cents from 33 cents. The President's proposed health care plan will, however, also involve some cost sharing through deductibles and copayments. If cost sharing were 15 percent, the per-pack amount would be 37 cents; if cost sharing were ten percent, the per-pack amount would be 40 cents.

(4) The estimates include only the foregone tax revenue from early death that is used to finance transfer payments. Exclusion is clearly an appropriate decision for the remaining taxes that finance benefit-type goods, since the demand for these goods is also reduced. Exclusion may be less appropriate for those taxes that finance collectively-consumed goods (such as defense) where a reduction in the number of consumers provides no cost savings. At the same time, there are other collective non-market benefits (e.g. reduction in congestion) that are not accounted for. Their exclusion raises an interesting conceptual issue which would require subjective judgments to quantify.

(5) Interview surveys, on which some of the data are based, may be subject to considerable errors in recall. The Manning study also prepared an estimate based on the National Health Interview Survey for all ages. The 39-cent net external cost is higher due to higher sick leave costs.

(6) When comparing the spillover effects with the proposed tax at 1995 price levels, the likelihood that average State taxes would increase during that time period is ignored.

6. *Relationship of the Manning study to other studies*

There are other studies of the costs of smoking, particularly of the medical expenditures component of these costs, and there are other estimates of per-pack medical expenditures or total health costs. The Manning study is likely to be more accurate in its estimates of the appropriate level of tax because it is the

only study that uses the appropriate analytical framework and seeks to include all spillover costs.

Five other studies/calculations are discussed in Appendix B. Of these, two studies provide evidence on the magnitude of excess lifetime medical expenditures of smokers; the Manning study's estimate of excess lifetime medical expenditures falls between these two estimates. Others of these studies provide calculations of per-pack medical expenditures or total health costs that are inconsistent with the Manning results. The Appendix discussion illustrates the conceptual deficiencies of these estimates *as an indicator of net external costs and the corrective tax.*[22]

This section states and explains the general characteristics of the Manning study that make it conceptually correct. First, the Manning study attempts to identify all financial costs and savings of smoking that are *external* to the smoker. Thus, it includes medical expenditures and costs of lost productivity, but adjusts these costs to exclude amounts that are paid out of pocket by the smoker; that is, external costs are distinguished from internal costs. As a consequence of this procedure, it includes changes in the smoker's payments to society and society's payments to the smoker that result from the smoker's early death.

Second, the Manning study controls statistically for many other attributes that might affect observed differences in health care expenditures for smokers and nonsmokers, such as education, income, and other health habits. (This control does not necessarily, of course, capture all of these other factors.)

Third, the Manning study calculates the tax from a lifetime perspective, where costs and savings of smoking are discounted over a lifetime and used to generate a tax of equal present value. This lifetime perspective is important because of the time-dependent nature of the smoking/health phenomenon. Typically, individuals smoke for many years before smoking-related disease appears; taxes are collected well in advance of additional medical expenditures, and as a result taxes and medical expenditures have different present values. Also, when individuals die early as a result of smoking, health and other costs (e.g. pensions) are foregone (and thus reduced). These external savings (foregone medical expenditures and pension savings) occur even later in (expected) life and are even more heavily discounted than are smokers' additional medical expenditures.

[22] It is important to note that the discussion of these studies here and in Appendix B is not meant to imply that these five studies are done incorrectly. In general, the studies are not intended to generate information suitable to estimate the efficient tax, but are simply explorations of the available data to increase knowledge about the relationship between smoking and medical expenditures. The after-the-fact comparison in this report is necessary, however, because the results of these studies are used by others to draw inferences about the efficient tax, and these inferences cast doubt upon the validity of the Manning study estimates.

Although the five studies discussed in Appendix B are useful for a variety of policy issues, they all omit at least one of these three characteristics, which renders their results for calculating the optimal tax somewhat deficient.

7. Summary

The detailed discussion of the qualifications to the Manning study suggests reasons may exist to increase and to decrease its estimates of net external costs. If all the adjustments that might suggest an increase in net external costs—a higher discount rate, passive smoking effects, a smaller share of costs borne privately, and higher lifetime excess costs found in one of the studies reviewed in Appendix B—were assumed to be appropriate, the measured external cost could be large enough to justify the 75-cent proposed tax addition.

But such an upper-limit measure does not appear to be the most reasonable choice to make. Indeed, there are adjustments that also suggest the net external cost is very small, or perhaps even net external savings—restriction of the costs to habit-related diseases, a lower discount rate, lower lifetime excess costs found in another of the studies reviewed in Appendix B. The range of reduction is at least as large as the range of increase in the numbers. The 33 cent number represents a central position between the upper and lower bounds.

Given the current state of information, Manning's base-case estimate appears to be the one that best informs the policy decision regarding the spillover effects of smoking.

INFORMATION AND SMOKING CHOICE

Aside from spillover effects, standard economic theory holds that a tax is justified on efficiency grounds if individuals are unable to recognize the full costs of smoking to themselves (internal costs). Thus, a second argument for imposing a tax on cigarettes is that people are not informed of the hazards of smoking and do not recognize the full cost to themselves. Or, they are not able to make sensible choices because the consumption of the commodity is habit-forming and they do not fully understand the difficulties of altering future behavior.

Before discussing these two issues, it is important to understand an important observation from economic theory: the fact that individuals engage in hazardous or dangerous activities does not mean that they are making bad choices. Individuals are presumed to choose activities, in accordance with their subjective tastes and preferences, that make them the happiest. This choice does not necessarily mean that they will maximize their health or their lifespan. Individuals engage in all sorts of behaviors that impose some danger in exchange for benefit (driving small cars or riding motorcycles, working in risky jobs, eating unhealthy diets, engaging in risky sports). Thus, nothing in economic theory precludes the notion that individuals smoke because their enjoyment of

the activity outweighs the sum of the actual costs of purchasing cigarettes and the internal health costs.

Some studies have found that both teenage and adult smokers tend to be risk takers in a variety of ways (e.g., they are willing to work at riskier jobs and they are less likely to wear seat belts).[23] Thus the average smoker, in continuing a behavior that involves a health hazard, seems to be behaving in a way consistent with other decisions he makes.

From an economist's perspective, if there is a market failure, it is not in making a choice to engage in a dangerous or risky activity, but rather in making that choice with incorrect information. Two aspects of this information problem are considered in turn: whether the individual is knowledgeable about the health hazards; and whether the individual understands the cost of changing behavior in the future. The final subsection discusses the policy implications of these findings.

Information on Health Hazards

An argument is frequently made that smokers may not be correctly informed about the risks of smoking. The Congressional Budget Office, for example, cited statistics indicating some smokers are not aware of the linkage between cigarette smoking and various diseases.[24]

In a recent study, Viscusi uses two surveys of the general population—his own and one provided by the tobacco industry—to quantify smokers' and nonsmokers' perceptions of the health risks of smoking.[25] The two surveys yield similar results. Survey respondents were asked how many of 100 smokers are likely to die from smoking-related diseases.

According to Viscusi, mortality statistics on smoking-related deaths indicate the total lifetime mortality risk to smokers ranges from 0.18 to 0.36 (18 to 36 of each 100 smokers are likely to die from disease caused by smoking).[26]

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[23] Viscusi (1992).

[24] Congressional Budget Office. *Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels*. Washington, D.C.: U.S. Government Printing Office, August 1990.

[25] Viscusi (1992). Portions of his book also appear in "Do Smokers Underestimate Risks?" *Journal of Political Economy*, vol. 98, 1990, pp. 1253-1269, and "Age Variations in Risk Perceptions and Smoking Decisions," *Review of Economics and Statistics*, vol. 73, no. 4, 1991, pp. 577-588.

[26] These lifetime estimates must be derived from annual estimates of smoking-related disease. The technique for preparing this estimate is discussed in some detail by Viscusi. It begins, however, with the basic data on annual deaths attributed to smoking. See U.S. Library of Congress. Congressional Research Service. *Mortality and Economic Costs Attributable to Smoking and Alcohol Abuse*, Report 93-426 SPR by C. Stephen Redhead, April 20, 1993 for further information on attributable deaths.

Survey respondents perceive this risk to be 0.54.[27] This perceived risk differs somewhat depending on smoking habits—0.47 for current smokers, 0.50 for former smokers, and 0.59 for those who have never smoked. The perceived risk is higher for younger ages than for older ages, probably because the young have been more heavily exposed to information on smoking and health risks. Viscusi also finds a tendency among respondents to overstate the expected number of years of life lost because of smoking.

To summarize, Viscusi finds that while smokers perceive smaller risks than nonsmokers, smokers also perceive risks to be higher than indicated by scientific evidence. Thus, while some individuals may not be aware of or may reject the evidence on the health cost of smoking, this does not appear to be the case overall. These results should not be surprising, as it is common for individuals to overestimate the risk of a highly publicized discrete event that is reported without reference to the event's frequency of occurrence in the population to whom such an event may occur (common examples are the risks of being killed by tornadoes or struck by lightning).

If individuals overestimate the health hazards of smoking, a tax would not correct for imperfect information.[28]

Information on Habit-Formation and Addiction

In addition to inaccurate risk assessment, market failure also could result if individuals incorrectly assess the impact the addictive properties of tobacco will have on any future attempt to quit.

According to the economic theories applied to addictive behavior, simply because individuals engage in behavior that involves habit formation or addiction does not mean they are making a mistake, as long as the individual recognizes the difficulty of modifying behavior in the future and the possibility of a need for such modification.[29] Individuals make many decisions that are difficult to change (and that they are probably aware are difficult to change)—marriage, job, purchasing a home, locating in a given area—without those decisions being seen as bad choices and appropriate targets for government intervention.

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[27] Much of this overestimation of risk is due to overestimation of the risk of lung cancer

[28] Some argue that an individual's perception of risk differs when considering the risk for people as a group versus the risk for him or herself. Unfortunately, no quantitative measure exists to ascertain the extent, if any, of this difference. See U.S. Department of Health and Human Services. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General 1989*, DHHS Publication No. (CDC) 89-8411, p. 216, hereafter Surgeon General's Report, Chapter 4 for a discussion of this issue.

[29] For a model of rational addiction, see Frank Chaloupka, "Rational Addictive Behavior and Cigarette Smoking," *Journal of Political Economy*, Vol. 99, no. 4, August 1991, pp. 722-742.

From this perspective, when smokers make a mistake it is due to a failure of information—a failure to understand either the difficulty of altering future behavior or the likelihood that alteration will be desired. It is not easy to assess the extent to which this problem occurs. A variety of observations support both the view that incomplete information is a serious problem and the view that it is a less important problem.

Two types of evidence might shed some light on the severity of this information problem. The first is evidence of the strength of the addiction problem. The less pronounced the addiction problem, the less serious is any failure to understand the problem. Second, if the addiction problem is serious, is there evidence that individuals are aware of the problem?

1. *Evidence on habit formation and addiction*

The evidence supporting the problem of habit formation is straightforward. That smoking is habit forming is essentially beyond dispute. There is also a substance in tobacco, nicotine, that is physically addictive to some degree.[30] A very large number of smokers say they would like to quit or have tried to quit at least once,[31] and quitters experience a high rate of recidivism.[32] Individuals also continue to spend money on smoking cessation programs.

Other observations suggest, however, that addiction is not serious enough to make smoking decisions significantly different from many other decisions in which the government does not intervene. For example, although many smokers have tried to quit and failed, many also have tried and succeeded, the vast majority without help.[33] The number of former smokers is now as large as the number of current smokers.

Smoking decisions also respond to changes in prices in a way that is consistent with consumption decisions about many other products, and increased publicity about health risks did reduce smoking substantially. Thus, individuals appear to be able to cease smoking when the price (either in actual cost or in implicit, perceived health costs) increases substantially.

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[30] This issue is discussed in U.S. Department of Health and Human Services, *The Health Consequences of Smoking: Nicotine Addiction, 1988*, Surgeon General Report, DHHS Publication No. (CDC) 88-8406. Another discussion that takes the position that there is a serious problem with physical addiction and that is written for the general public is in the chapter on smoking in Jeffrey Harris, *Deadly Choices: Coping with Health Risks in Everyday Life*, Basic Books, New York: Harper-Collins Publishers, 1993, p. 167.

[31] Seventy percent of current smokers have made at least one serious attempt to quit. See Congressional Budget Office. *Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels*. Washington, D.C.: U.S. Government Printing Office, August 1990.

[32] For data on relapses after quitting attempts, see Harris (1993), p. 167.

[33] Surgeon General's Report (1989).

The fact that many individuals say they would like to quit is indicative of the difficulty of breaking pleasurable habits but does not necessarily prove a serious addiction problem. As an illustration of how one might interpret discrepancies between statements of preferences and action, Viscusi notes that half of the people who live in Los Angeles say they would like to leave. The fact that they do not leave does not mean that they have no control over the decision, but rather that they perceive the benefits of staying to be greater than the benefits of leaving. Similarly, individuals may say they would like to quit, but when dealing with the actual decision continue to smoke because they enjoy it and cessation is a deprivation of an accustomed pleasure.

Indeed, some of the arguments used to support the case that smoking, addiction, and the difficulty of changing behavior is a serious problem are applicable to many other activities. Individuals not only engage in risky activities, but they also fail to initiate or persist in many behaviors that would contribute to their health (e.g. diet and exercise). When they do initiate changes, they exhibit a high rate of failure to follow through even when considerable money is spent on programs to attain these ends. Many overweight individuals have made a serious attempt to lose weight and failed; many sedentary individuals have made an effort to initiate and maintain a regular exercise program and failed. Few suggest these behaviors justify government intervention.

2. *Evidence on information regarding addiction*

Even if addiction is a serious problem, there is no market failure if individuals are aware of it when they make the initial smoking decision.

The argument that incomplete information is a serious problem begins with the observation that most smokers begin early in life, typically in the teenage years, when a lack of information or understanding may be more severe. A survey of teenagers showed that half expect not to be smoking in five years,[34] whereas data show that smoking participation generally does not decrease until much later in life. This evidence suggests that teenagers may well have incorrect perceptions about their ability to stop smoking.

On the other hand, some data indicate that even the very young are aware that it is difficult to quit smoking. About 75 percent of those 14 and younger, when queried about the difficulty of stopping smoking, identified as true the statement "It is very hard to stop smoking."[35]

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[34] Surgeon General's Report, 1989.

[35] Viscusi (1992). It is possible that young teenagers who smoke may have different perceptions from the average, however.

Policy Responses

The fundamental tax policy issue is twofold. If smoking decisions are assumed to be reasonably informed, then the government should not intervene beyond correcting for spillover effects. If, however, the decision is assumed not to be informed, then intervention may be appropriate and a tax might make smokers better off in the long run if it led them to quit or fail to take up the habit.

The preceding discussion suggests uncertainty about the degree to which the smoking decision is a wrong decision when it is placed in the context of individual preferences. The evidence presented suggests that there is not much of a case for a market failure with respect to information on the health hazards of smoking. Indeed, it is possible that individuals overestimate these health costs, on average. Whether individuals are informed about the difficulties of changing future smoking behavior is much less certain.

As a correction to information problems regarding addiction, a tax has certain shortcomings. First, use of a tax that is set properly requires a quantification of the degree to which information is incorrect, a measure that cannot be made based on current information and that would presumably vary widely across individuals.

Second, the tax would be an effective deterrent to smoking primarily for those who have not yet begun and for those smokers who are *least* addicted. This is not an inconsequential step, but the tax would not be an effective remedy for correcting behavior for those who have already made an uninformed choice.

Finally, as in the case of spillover effects within the family, a tax aimed at "helping the smoker" produces distributional or equity effects that blur the desirability of the policy overall. Consider, for example, a tax of the magnitude proposed by the health care plan. Based on the elasticities used in section II, the short-run participation elasticity of tobacco consumption (percentage change in share of individuals smoking divided by the percentage change in price) is about -0.3 and the long run elasticity is about -1.2. Assuming a constant elastic function with a 75-cent tax, about ten percent of individual smokers will quit smoking in the short run. In the long run, the reduction will be about a third. This is troubling because the tax makes worse off the majority of those it is intended to help, and is particularly burdensome to lower-income individuals.

On the whole, therefore, a tax may not be the most appropriate policy instrument to deal with the information problem. It is true that some estimates of behavioral response suggest that taxes can elicit a large response from teenage smokers (a reduction for the 75-cent tax increase up to a third). But

adolescent smokers account for only six percent of all smokers.[36] Non-tax alternatives may be better targeted. If lack of information about addiction is the primary problem, perhaps a better response is to disseminate information to the young about the dangers of addiction through educational programs in the schools, general advertising, and perhaps through warning labels. If the age of initiating smoking and immaturity of decision-making by young smokers seems to be the primary problem, an approach might be to introduce stricter laws limiting the sale of cigarettes to minors and to enforce those laws.[37] To help current smokers who will constitute the great majority of smokers in the near and medium term, more assistance for quitting (including information and better nicotine replacement devices) may be a desirable public policy.[38] Indeed, one feature that may be desirable in a health care plan is to provide coverage for expenditures on smoking cessation. Finally, a policy option that might help all individuals would be the development of a less dangerous cigarette.[39]

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[36] Calculated from data in National Cancer Institute, *The Impact of Cigarette Excise Taxes on Smoking Among Children and Adults*, Summary Report of a National Cancer Institute Expert Panel, August 1993.

[37] It has been argued that laws barring sales of cigarettes to minors are enforced in only two of the 47 states with such laws. See "U.S. Urged to Escalate Tobacco War," *Washington Post*, January 12, p. A16. See also the discussion in the 1989 Surgeon General's Report, pp. 587-588 and 596-608 regarding smoking policies in public schools, State laws regarding sale and possession by minors, and enforcement issues.

[38] Jeffrey Harris, *Deadly Choices: Coping with Health Risks in Everyday Life*, New York: Harper-Collins Publishers, 1993, suggests that nicotine replacement devices might be improved.

[39] Viscusi (1992) indicates that public health officials have not encouraged such improvements, such as a "smokeless" cigarette that would continue to deliver nicotine and mimic actual smoking without many other adverse effects.

II. CIGARETTE TAXES AS A REVENUE RAISER

The proposed health care program is to be permanent, and the cigarette tax has been presented as a permanent feature of its financing. One standard for evaluating the tax might be whether it will generate revenue sufficient to finance a constant share of the program's costs over time. If it does not, policy discussions of the proposed health care program ought to consider what financing source will replace cigarette tax revenue beyond the budget window.[40]

This section demonstrates that long-run cigarette tax collections, although increasing over time, will be a diminishing share of long-term health care costs. First, the impact of failure to index the proposed per-unit cigarette tax is discussed. While real spending is likely either to grow (if the health care "price index" increases faster than the rate of inflation) or to remain constant (if the health care "price index" rises at the rate of inflation), the real value of every dollar of tax revenue will decline as the price level rises. Second, it is demonstrated that, even were the tax indexed and income growth zero, health care costs will grow at the rate of population growth while revenue will grow at less than the rate of population growth. This discrepancy occurs because the sensitivity of smoking participation rates to price changes will increase over time, which in turn will generate larger reductions in cigarette consumption and tax revenue. The net effect on the Government's budget from reduced cigarette consumption—the possibility that the Government's reduced medical expenses due to smoking will offset its reduced cigarette tax revenue—is discussed. Third, the effect of per capita income growth on health care spending and cigarette tax revenue is discussed. Finally, an estimate is made of the proposed tax's effect on State tax revenue.

INDEXING

To simplify exposition of the consequences of adopting an unindexed cigarette tax, assume that the price level rises at an annual rate of four percent and that health care costs also rise at this rate of inflation (an underestimate given the current rate of increase in medical care prices). The absence of indexing affects cigarette tax revenue in two ways.

Were the cigarette tax indexed such that the tax rate on a pack of cigarettes always generated 75 cents in real 1994 dollars, the tax revenue collected on each pack of cigarettes would purchase the same amount of health care at any point in time, 75 cents worth in 1994 dollars. Why? Because both health care costs

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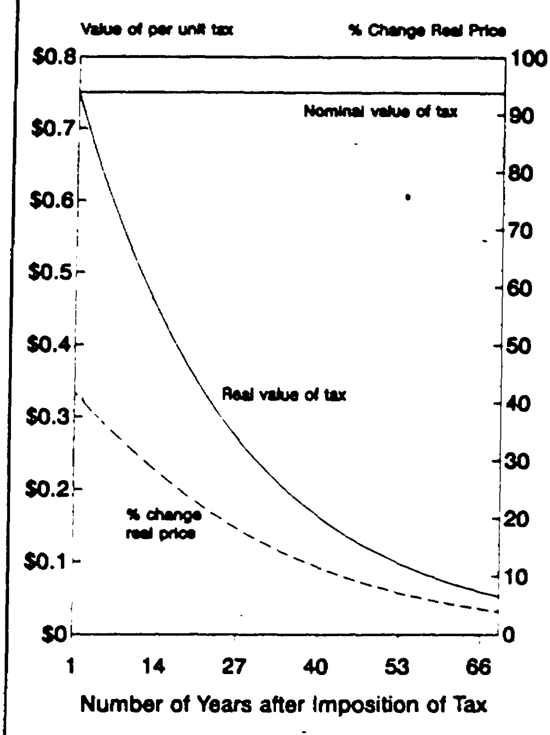
[40] Although some might argue that anticipated long-term administrative cost savings will compensate for the long-term decline in cigarette tax revenue identified in this report, two factors suggest this is far from certain. First, experience shows administrative cost savings to be easy to conceptualize but difficult to achieve. The Reagan budget projections of savings from elimination of "waste, fraud, and abuse" are instructive in this regard. Second, the estimates of long-term cigarette tax revenue decreases in this report do not account for continuance of the long-term downward trend in cigarette consumption, and the decrease therefore is understated.

and revenue would increase at a four percent rate. This is not true for an unindexed tax. After six years, the 75-cent tax on a pack of cigarettes will purchase only 62 cents of health care; after 14 years, 45 cents; after 40 years, 16 cents; and after 53 years, 10 cents. The growing discrepancy between nominal and real tax collections is illustrated by the solid lines in figure 1.

Figure 1. Effect of Four Percent Inflation on $0.75 per Unit Cigarette Tax: Nominal Value, Real Value, and Percentage Change in Real Price



These calculations apply to the tax collected on each pack of cigarettes. The number of packs will be responsive to the price change—the topic of the next section. Any reduction in the quantity smoked will eventually dissipate as the real price effect declines over time. The average pre-tax price of a pack of cigarettes is currently $1.30 ($1.80 minus 24 cents of Federal tax and 26 cents of State/local tax). Assume this pre-tax price of $1.30 is allowed to increase at the rate of inflation and add the 50 cents of existing cigarette taxes to this inflated price. The dashed line in figure 1 is the 75-cent tax divided by this adjusted nominal cigarette price. This percentage change in real price declines from 42 percent today to 28 percent in 14 years, 11.5 percent in 40 years, and 7 percent in 53 years.

SHORT-RUN VERSUS LONG-RUN PARTICIPATION RATE

Even if the tax were to be indexed or if there were zero inflation, cigarette tax revenue would reasonably be expected to finance a decreasing share of health care program cost over time due to behavioral responses of smokers. The response of cigarette consumption to price changes is summarized by estimates of the price elasticity of smoking participation rates and the price elasticity of the quantity of cigarettes smoked per smoker. The participation rate elasticity measures the percentage change in smokers divided by the percentage change

in the price of cigarettes. The quantity elasticity measures the percentage change in quantity of cigarettes purchased per smoker divided by the percentage change in the price of cigarettes.

Two facts are discernible from table 1: the smoking participation rate (column 2) is much more sensitive to price than is the average consumption of smoking participants (column 3); and the smoking participation rate of the young is much more sensitive to price (-1.2 elasticity for 12-17s) than is the participation rate of other age groups (-0.15 elasticity for 36-74s).

Table 1. Price Elasticity of Smoking Participation Rate and Quantity per Smoker, by Age

Age	Participation Rate	Quantity per smoker
12-17	-1.20	-0.25
20-25	-0.74	-0.20
26-35	-0.44	-0.04
36-74	-0.15	-0.15
All ages	-0.31	-0.11

Source: Department of Health and Human Services, *Reducing Health Consequences of Smoking: 25 Years of Smoking, 1989*. Surgeon General Report, Table 13, p.537. These estimates represent a synthesis of numerous econometric studies. See the Surgeon General's report for a summary.

The difference in participation rate elasticity among age groups is consistent with expectations about demand for an addictive or habit-related product. Since one's addiction or habit dependence presumably increases the longer one consumes a product, the ability to quit in response to a price increase is likely to decrease with age.

These elasticity differences have important consequences for long-term revenue collections. The 12-17s' elasticity of -1.2 suggests that a one percent price increase would reduce smoking participation by 1.2 percent. In contrast, the 36-74s' elasticity of -0.15 suggests a one percent price increase would reduce smoking participation by 0.15 percent. As a result, the reduction in smoking participants in response to the 75-cent tax would not be great in the short run—note the weighted price elasticity of participation rates for all ages is -0.31 (53 percent of current smokers in 1992 were 36 or older). Since the 75-cent cigarette tax represents a 42 percent increase in the average $1.80 price of a pack of cigarettes, the number of smokers will decline in the short run by 10.2

percent.[41] When the response of quantity per smoker is incorporated, a reduction in cigarette consumption of 15.1 percent becomes the base for the short-run revenue estimate.

As the years march on, the population of smokers comes to be dominated by new cohorts of 12-17s whose initial smoking participation decision will be made in response to a -1.2 elasticity rather than the -0.15 elasticity. This process will generate a substantial decrease in the long-run aggregate participation rate relative to the rate in effect in the first five or six years of the tax. The expected long-run reduction in consumption of cigarettes will be much greater than in the short run.

As is true with econometric estimation of any behavioral parameter, the precise magnitude of these price elasticities is the subject of considerable debate. The estimates in table 1 are from the "traditional" framework, in which quantity demanded is a function of current price. The long-run price elasticity is inferred from the differences in elasticities by age group, as described above. Recent research has investigated the possibility that an addictive good such as cigarettes is subject to a much more complex demand relationship. This "rational addiction" framework suggests that today's consumption is dependent upon both past and future consumption.[42] This framework estimates short-run and long-run elasticities directly, and finds the long-run elasticity to be higher than the short-run elasticity, a result consistent with this report's use of the elasticities in table 1. The rational addiction estimates, however, tend to find a somewhat smaller difference between the short-run and long-run elasticities than is implied by the estimates in table 1. These smaller differences may be less accurate than the differences from the traditional literature for two reasons: the estimates represent a time period considerably shorter than probably is necessary to capture the full response to price; and the specification of the rational addiction model creates serious econometric estimation problems.

The purpose of the long-run revenue projections presented in this section is to illustrate the existence of a growing revenue shortfall over time. This phenomenon would occur no matter which estimating framework's elasticities are used. Obviously, numerous other factors affecting revenue and not taken into account here would change over the lifetime span of these revenue estimates.

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[41] A simple linear calculation suggests a reduction of 13.2 percent, the product of 0.31 and the price change of 0.42, converted into a percentage. A constant elasticity demand function is used in this report, which produces a participation rate reduction equal to $[1 - \{(1.80 + .75)/1.80\}^{-0.31}]$, or 0.102.

[42] See Becker, Gary S., Michael Grossman, and Kevin M. Murphy. *An Empirical Analysis of Cigarette Addiction*. National Bureau of Economic Research Working Paper No. 3322. March 1993; Keeler, Hu, Barnett, and Manning (1993); and Chaloupka (1991).

Federal Revenues

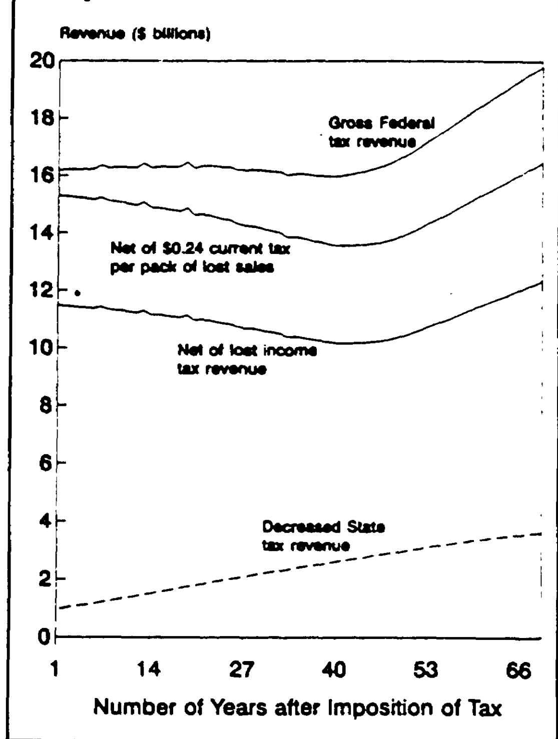


Figure 2. Federal and State Revenue from Indexed $0.75 Federal Cigarette Tax: Assumes Population Growth, Increasing Participation Rate Sensitivity, No Per Capita Income Growth

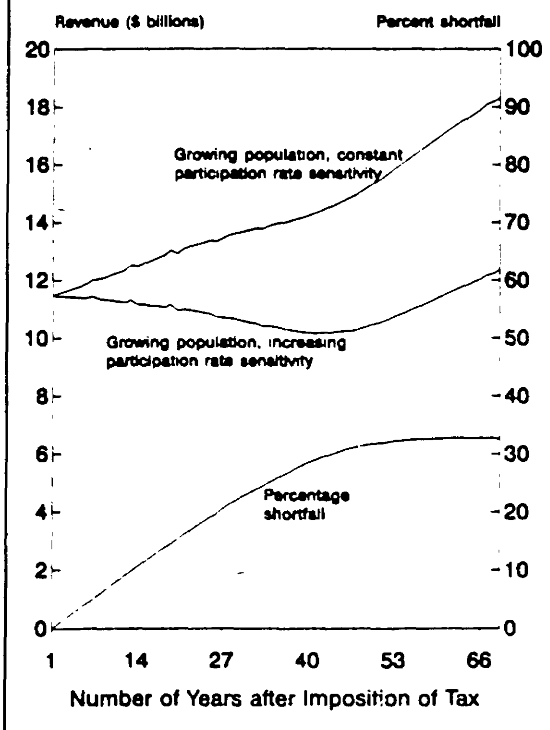
CRS's estimates of gross and net Federal revenue generated by the proposed cigarette tax for the next 69 years are presented in figure 2. These revenue estimates *assume the tax is indexed* and passed forward in a higher price. The estimates incorporate: zero per capita income growth; population growth; and a changing aggregate participation rate elasticity as today's population is aged for 69 years. This allows the entire population (age 12 to 80, an age range that includes almost all smokers) to have its initial smoking participation response to the proposed 75-cent tax be made as a member of the 12-17 age group. The details of these calculations are provided in Appendix C.

Gross Federal revenue in figure 2 is 75 cents times the number of packs of cigarettes sold. Net Federal revenue reflects two adjustments: a reduction of 24 cents per pack for the existing cigarette tax that is not collected on consumption discouraged by the 75-cent tax (the difference between before-tax and after-tax consumption); and a reduction of 25 cents per dollar of revenue (net of the 24-cent per pack adjustment) for the lost Federal income tax collections attributable to reduced factor incomes (capital and labor income from cigarette sales revenue decreases by the amount of the increased Federal cigarette tax revenue). Net revenue grows over the 69 years from $11.466 billion to $12.353 billion.

The time path of revenue in figure 2 reflects the combined influence of population growth, which increases consumption and revenue, and the population's increasing participation rate sensitivity to the tax-induced price change, which decreases consumption and revenue. The effect of increasing participation-rate sensitivity (fewer smokers) on long-term revenue collections

can be isolated in two ways. In figure 3, the upper revenue line is the first year's net cigarette tax revenue ($11.466 billion from figure 2) growing in response to increasing population.[43] No adjustment is made for the increasing participation rate sensitivity—the first year's participation rate sensitivity is assumed to prevail through time. The second revenue line in figure 3 is the same as the lowest solid line in figure 2 that incorporates both population growth and increasing participation rate sensitivity. The difference between the two series is attributable to the changing participation rate sensitivity. As illustrated by the bottom line in figure 3, net tax revenue falls short of the revenue that would be required to finance a constant share of real health care costs (which are assumed to grow at the population growth rate). The shortfall becomes a constant 33 percent of the upper revenue line after 56 years.

Figure 3. Shortfall of Revenue from Indexed Cigarette Tax Due to Increasing Participation Rate Sensitivity: Assumes Population Growth, No Per Capita Income Growth

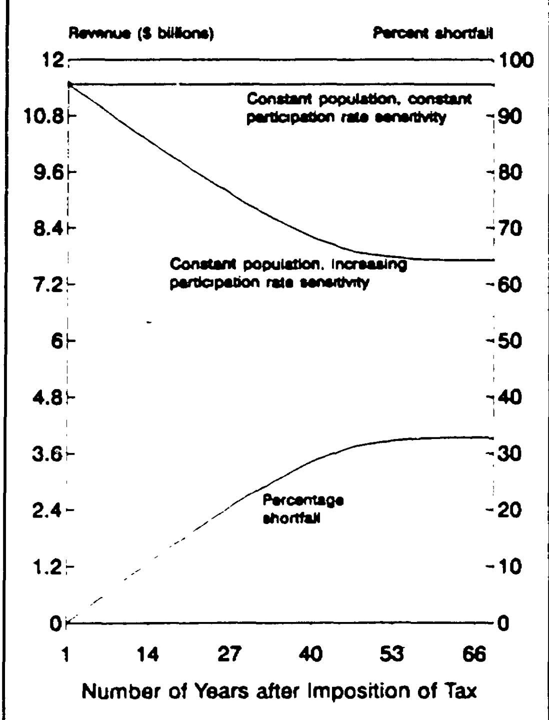


An alternative view of this shortfall is presented in figure 4. Assume that the five-year-budget-window revenue estimate of about $11.4 billion per year will prevail into the future. The resulting horizontal revenue line in figure 4 ignores the influence of both population growth and increasing participation rate sensitivity. The middle line in figure 4 is actual tax collections (lowest solid line in figure 2) "normalized" to remove the effect of population growth, but leaving the influence of increasing participation rate

[43] Figure 2 net revenue in year X is multiplied by the ratio of before-tax consumption in year X to before-tax consumption in year 1. The 505.107 billion cigarettes subject to Federal tax in year 1 grows to 806.670 billion cigarettes in year 69.

sensitivity.[44] In effect, this is the revenue from a tax had it been instituted many years ago; that is, a tax that had been instituted many years ago would provide long-term revenue of $7.7 billion, not $11.4 billion. The difference between the two revenue lines is attributable to increasing participation rate sensitivity. One might say that the shortfall is the amount by which one would overestimate long-run revenue collections if one assumed the budget-window revenue estimate would prevail into the future. Again, the percentage shortfall is 15 percent after 20 years, reaches 30 percent about year 43, and becomes a constant 33 percent of the upper revenue line after year 56.

Figure 4. Shortfall of Revenue from Indexed Cigarette Tax Due to Increasing Participation Rate Sensitivity: Assumes No Population Growth, No Per Capita Income Growth



Net Budgetary Effect

Some may argue that this estimate of a long-run revenue shortfall from an indexed cigarette tax is not an important policy issue because the reduction in smoking will lead to offsetting budgetary savings as the Government's medical expenditures decline.

Several factors suggest that reduced smoking will not improve the Government's budgetary position. First, the preceding section indicates that the net external cost of smoking is less than the tax per pack. For each pack that is not smoked there is a loss of 99 cents (the tax) and a gain of 33 cents (if all external costs are borne by the Government). Thus, the net budgetary effect could be an increase in the deficit of 66 cents.

Second, the 33-cent per pack gain may be received by private sources rather than the Government. In fact, it seems likely that the Federal budget currently

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[44] Actual revenue is normalized by multiplying figure 2 revenue in year X by the ratio of before-tax consumption in year 1 to before-tax consumption in year X.

benefits from smoking because of the Government's heavy involvement in Social Security and Medicare, whose costs appear to be reduced due to early death of smokers. In that case, reduced smoking would add to the deficit.[45]

Finally, for purposes of the narrow issue of Government budgetary costs, the appropriate discount rate should be the Government's real borrowing rate, which is typically quite low, perhaps currently in the two percent range.[46] As demonstrated in section I, a discount rate this low generates net external savings from smoking, which means reduced smoking probably would cause an increase in net budgetary costs.

This issue should be explored more carefully. This brief discussion suggests, however, that smoking reductions induced by the proposed tax will generate reductions in Government medical expenditures that are too small to offset the associated reductions in cigarette tax revenue.

INCOME GROWTH

An important determinant of demand for any good or service is income. A "normal good" is one for which consumption tends to increase as income increases. An "inferior good" is one for which consumption decreases as income increases. This relationship is summarized as the income elasticity of a good. A normal good will have an income elasticity greater than zero; an inferior good will have an income elasticity less than zero.

Research on the demand for consumer goods suggests that both health care and cigarette consumption are normal goods for which the income elasticity of demand is more than zero but considerably less than 1.0. At the moment, this literature does not provide strong grounds for suggesting that the demand for cigarettes will grow at a slower rate than will the demand for health care in response to income growth.[47]

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[45] The Government/private shares of medical costs for nonelderly workers might shift under the new system, depending on how binding the percentage caps are. Under the President's proposed health care plan, mandated payments will be limited to a cap as a percentage of earnings. If these caps were binding everywhere, reductions in medical expenditures would result in smaller Government subsidies. If the caps are binding nowhere, there will be no effect. Presumably, the effects will be binding in some cases and not in others.

[46] Based on the WEFA Group forecast for 1992 through 1996 (*U.S. Economic Outlook, January 1994*), the average real rate of interest is less than one percent for 3-month T-bills and slightly over three percent for ten-year bonds.

[47] See Viscusi (1992) for a summary of the cigarette literature. Wasserman, Manning, Newhouse, and Winkler (1991) estimate the income elasticity of cigarette demand at different points in time (1970 through 1985). They find a small negative income elasticity beginning in 1983, which if correct would generate a somewhat larger revenue shortfall than estimated above. For a summary of the medical care literature, see Feldstein, Paul J. *Health Care Economics*. Albany, New York: Delmar Publishers, 1993; and Folland, Sherman, Allen C. Goodman, and Miron Stano, *The Economics of Health & Health Care*, New York: Macmillan Publishing

STATE REVENUE LOSS

As noted earlier, the States levy an average 26-cent tax on a pack of cigarettes. The 75-cent proposed Federal tax will reduce consumption of cigarettes. As a result, States will lose 26 cents on every pack of reduced cigarette consumption.[48] These State revenue losses over time are presented in figure 2 as the dashed line at the bottom of the figure. The State revenue loss grows from $1.0 billion to about $3.6 billion over the 69 year period.

Company, 1993. Feldstein provides a discussion of the estimation issues that plague the income elasticity estimates for health care and leave its "true" value in a state of uncertainty.

[48] After-tax consumption is 85.4 percent of before-tax consumption of 505 billion cigarettes in year 1 of the tax and 65.5 percent of before-tax consumption of 806.7 billion cigarettes in year 69.

III. INDUSTRY EFFECTS OF TOBACCO TAXES

Questions have been raised about the effect on the tobacco industry in general, and its employment in particular, if a tax equal to 42 percent of price is imposed on cigarettes. The issue of job loss from any national policy needs to be discussed from the perspectives of the national economy and the local or regional economy.

JOB LOSS AS A NATIONAL ISSUE

The Tobacco Institute combines its own estimate of reduced demand with Price Waterhouse's estimate of jobs attributable to tobacco to produce an estimate of 273,000 jobs lost from a 75-cent tax.[49]

These job loss estimates are argued to be too high. Studies by the Coalition on Smoking OR Health and Arthur Andersen indicate that almost 90 percent of the jobs attributed to the tobacco industry by the Price Waterhouse study are either indirectly related to the industry (e.g., jobs in retail trade or suppliers to the industry) or are the result of multiplier or expenditure-induced jobs.[50] The expenditure-induced effect accounts for about two-thirds of the job loss, and is based upon an assumption that reduced compensation (factor incomes) in the tobacco industry will in turn reduce demand in other sectors. Other criticisms by these groups of the job loss estimate include: a possible overstatement of effects due to use of a linear demand curve for tobacco; a failure to adjust the estimate for already existing declines in employment and prices; and a failure to consider exports.[51]

In evaluating the jobs issue, first note that the effect of tobacco taxes on total jobs is short-run. In the long run, workers will shift to new jobs; such a tax would not affect the overall long-run unemployment rate.

Even the short-run aggregate job loss estimate is overstated because the assumption of a zero spending offset is not realistic. Money not spent on tobacco by those who quit purchasing it will be spent on other commodities.

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[49] Tobacco Institute, *Economic Impact of the Tobacco Industry and Economic Losses Due to a 75 Cents Per Pack Tax Increase*. 1993; Price Waterhouse, *The Economic Impact of the Tobacco Industry on the United States in 1990*. October 1992.

[50] Coalition on Smoking OR Health, *Tobacco, Health and Jobs: Myths and Realities* (undated); Arthur Andersen Economic Consulting, *Tobacco Industry Employment: A Review of the Price Waterhouse Economic Impact Report and Tobacco Institute Estimates of "Economic Losses from Increasing the Federal Excise Tax"*, October 6, 1993.

[51] Some of these criticisms are more valid than others. The elasticities applied by the Tobacco Institute are quite modest, and there is no reason that the tax-induced decline in employment in the tobacco industry will be influenced by any secular trend already occurring. Indeed, such an existing trend would make it less likely that such contractions could be absorbed by attrition. Similarly, the fact that prices have recently fallen has no obvious implication for a tax that is still two years from imposition.

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Taxes collected by the Government will be used for other purposes (lower health insurance premiums). While it is true that a tax that reduces the deficit can induce short-run nationwide unemployment, a tax that is offset by an increase in income and spending elsewhere is unlikely to have much effect.[62]

JOB LOSS AS A REGIONAL ISSUE

The jobs issue is a short-run, regional issue. In those areas of the country where tobacco growing and manufacturing are concentrated, job losses would occur. Moreover, a local multiplier effect probably exists, although whether it is as large as that suggested by Price Waterhouse is not clear. The fact that these losses largely will be offset by gains in other areas, however, does not lessen the economic significance of the issue for the affected areas.

On the other hand, if a policy is judged to be beneficial to the Nation as a whole, it ought not necessarily be abandoned simply because it produces subsets of winners and losers. It may be preferable to cushion the blow by simultaneously adopting policies to both compensate losers and smooth their transition. For example, adjustment assistance to affected workers might be offered in the form of payments and training. The remainder of this section estimates the regional job loss for the major tobacco-producing States, to provide some idea of the possible need for, and cost of, transition assistance.

Price Waterhouse estimated an overall nationwide employment of about 160,000 in tobacco growing and auctioning and about 50,000 in manufacturing. About 93 percent of these jobs are concentrated in six states (North Carolina, Kentucky, Virginia, Tennessee, Georgia, and South Carolina), with the lion's share located in the first three.

North Carolina has 40 percent of the growing/auctioning jobs (64,000) and 43 percent of the manufacturing jobs (22,000). Kentucky has 27 percent of growing/auctioning jobs (43,000) and about 14 percent of manufacturing jobs (7,000). Virginia accounts for 7 percent of growing/auctioning jobs (12,000) and a quarter of manufacturing jobs (12,000). The remaining three States are involved mostly in growing and auctioning; each of the three has about 12,000 tobacco-related jobs. Tobacco-related jobs account for slightly under three percent of total State employment in North Carolina and slightly over three percent in Kentucky, but less than one percent in the other States.

If the tax is fully passed on in price and <u>if all production is directed to the domestic market</u>, the expected short-run consumption decrease would generate about a 15 percent reduction in tobacco-related jobs. But all production is not

[62] Some small effect might result from the time needed for adjustment. These issues are discussed in U.S. Library of Congress. Congressional Research Service. *Is Job Creation A Meaningful Policy Justification?*, Report 92-697 E by Jane G. Gravelle, Donald W. Kiefer, and Dennis Zimmerman, September 8, 1992.

directed to the domestic market, and the job loss estimate must be reduced substantially to reflect the effect of exports, which are not subject to the tax.

Data for 1992 indicate that about 45 percent of flue-cured tobacco production and 32 percent of burley tobacco production are exported as leaf tobacco. In addition, 26 percent of cigarette production (which uses most of the remaining 55 percent of flue-cured leaf tobacco and 68 percent of burley leaf tobacco) is exported. These numbers suggest that exports account for 50 percent of burley tobacco production, 59 percent of flue-cured tobacco production, and 26 percent of cigarette production. Weighting by jobs in manufacturing and growing, and assuming that tobacco in Kentucky is burley and tobacco in the other States is flue-cured, these export effects reduce the estimated tobacco-related job loss by 51 percent in North Carolina, 47 percent in Kentucky, and 38 percent in Virginia. That is, demand for tobacco workers would be expected to fall, after adjusting for export demand, by 7 percent in North Carolina, 8 percent in Kentucky, and 9 percent in Virginia.

The importance of this job loss to each State's economy depends on both the percentage change in tobacco-related employment and tobacco-related employment's share of total employment. Multiplying these percentages indicates that total employment would fall by about three tenths of one percent in Kentucky, about two tenths of one percent in North Carolina, and less than one tenth of one percent in Virginia. Even a large regional multiplier would be unlikely to increase any effects beyond one percent. Of course, these effects are not evenly spread across each State, and would produce larger local effects.

Two factors might reduce the effect on jobs. The first is the possibility that the tax will not be immediately passed on in price. Tobacco manufacturers who are not able to alter instantaneously their capital stock may absorb some of the tax in the short run. Second, consumers may take some time to adjust to the higher prices.

Finally, one of the best forms of transition assistance for a major policy change such as the cigarette tax increase might be to phase it in over a few years. The proposed tax does just the opposite—because it is not indexed, it begins as a large tax that declines in value over time.

IV. THE EQUITY ISSUE

Selective excise taxes often are not considered desirable revenue raisers because they disproportionately burden those who use the taxed products, thereby imposing horizontal inequities (unequal taxation of those with equal income). Excise taxes also may be considered undesirable because they tend to impose a heavier share of the burden on lower-income individuals than does the traditional source of Federal revenue, the income tax.

These equity issues have always been important in evaluating excise taxes on tobacco, and have been discussed comprehensively in a recent Congressional Budget Office study.[53] These equity issues are summarized below.

Cigarette taxes are especially likely to violate horizontal equity and are among the most burdensome taxes on lower-income individuals.[54] Only about a quarter of adults smoke, and less than half of families have expenditures on tobacco. Tobacco is more heavily used by lower-income families than are other commodities, and is unusual in that actual dollars (in addition to the percent of income) spent on tobacco products decline in the highest income quintile. As a result, tobacco taxes impose a burden (as a percent of income) on the lowest fifth of families that is 3.6 times the average burden and 8.0 times the burden on the highest quintile.[55] In contrast, the income tax burden on the lowest quintile is less than one-tenth the average burden.[56] However, these concerns about distribution across incomes may be ameliorated by the benefits of the health care program, which would constitute larger proportion of the income of lower-income individuals.

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[53] Congressional Budget Office, *Federal Taxation of Tobacco, Beverages, and Motor Fuels*, August 1990, Washington, D.C., U.S. Government Printing Office, p. 34.

[54] It is probably appropriate to focus on the amount of the tax imposed in excess of spillover costs, however, in assessing horizontal equity.

[55] Congressional Budget Office (1990), p. 29.

[56] Congressional Budget Office, Effects of Adopting a Value Added Tax, February 1992, Washington, D.C., U.S. Government Printing Office, p. 35.

V. POLICY IMPLICATIONS: ALTERNATIVE FINANCING SOURCES AND OTHER POLICIES

An increased cigarette tax as a method of financing health care reform appears questionable on efficiency, budgetary, and equity grounds. The most straightforward justification for linking the two—that smokers impose financial costs on nonsmokers—probably has already been corrected by existing cigarette excise taxes. The revenue from the tax will be substantial but will decline over time relative to budget-window estimates and will finance an increasingly smaller share of health care costs. The cigarette tax will fall on a small share of the population and will disproportionately burden lower-income individuals compared to almost any other revenue source. On the other hand, the tax does have considerable popular support and would help to deter the young from becoming smokers, although stricter enforcement of restrictions against sales to minors and prohibition of smoking in areas frequented by minors might accomplish the same goal.

If the Congress is interested in exploring alternatives to cigarette tax financing, several are available. First, other taxes that possess more desirable economic effects might be considered to replace all or part of the revenues to be derived from the tobacco tax. Second, some of the spending programs in the health plan might be adjusted or eliminated, thereby making tax increases unnecessary. Third, should all or part of the tobacco tax be retained, design improvements might be considered. Finally, alternative policies to target concerns about teenage smoking are discussed.

OTHER TAX SOURCES

An alternative revenue source that comes to mind in this context is an increase in the excise tax for alcoholic beverages. As with tobacco consumption, a link exists between alcohol consumption and health (both as a result of damage due to drinking and from traffic injuries). Evidence from the Manning study suggests that, unlike tobacco, spillover effects for alcohol substantially exceed current taxes. Thus, substitution of an alcohol tax for the tobacco tax would improve economic efficiency. Alcohol taxes are also regressive, but they are less regressive than tobacco taxes. About $8.0 billion is estimated to be collected from alcohol taxes in FY 1994 (compared to $5.7 billion for tobacco), so that the current taxes would have to be increased by a smaller percentage to yield the same amount of revenue. Taxes are currently lighter on beer and wine, per ounce of alcohol, than they are on distilled spirits.

Another alternative is to increase the rates or broaden the base of the traditional main source of Federal revenue, the income tax. Either rate increases or base broadening would be progressive compared to the regressive tobacco tax, and would fall broadly on all individuals rather than on a narrow group. Thus, the income tax might be considered a more equitable source of revenue for a national health care system. In addition, some base broadening options would seem to be natural for health care reform because they could also

promote economic efficiency in the health care market. A prime example is employer-paid health care premiums, which under current law and under the proposed plan distort consumer choices because they are excluded from the individual's income and are deductible by the employer.

PROGRAM REDUCTIONS

The health care proposal is a very large, complicated plan, and opportunities may exist to reduce spending. In general, tax revenues collected under the plan are dispensed either in benefit increases to public health programs (such as increased drug benefits for Medicare) or in a network of subsidies woven into the plan. One subsidy would prevent mandated employer premiums from exceeding a percentage of salaries; another would help lower-income individuals pay for their share of program costs.

Within this network of subsidies, the set of subsidies for small businesses might deserve particular attention. Under the proposal, small businesses will receive special subsidies for their mandated premiums, with the subsidies based on a sliding scale that moves with business size and wage income. The argument for these subsidies is essentially a transitory one—concern that the imposition of these mandated payments on smaller firms that did not already have such plans will cause unemployment. As a permanent measure, such subsidies are likely to be inefficient—favoring workers of small firms may misallocate resources and generate less economic output. Due to the transitory nature of this problem, these subsidies could be phased out over a few years.[57]

MODIFICATIONS TO A CIGARETTE TAX

If a cigarette tax is to be used owing to its feasibility, short-run revenue generating potential, impact on smoking reduction (particularly among the young), and ease of administration, policy makers are faced with a revenue source that declines in real terms and relative to the program expenditures.

A straightforward revision would be to index the tax. While one can debate the merits of imposing a tax in the first place, if the tax is to be imposed, indexation would ensure that the tax maintains its real value. A tax that is not indexed creates short-term disruption in the industry for a revenue source that eventually will dissipate. In addition, because the erosion in real value due to failure to index occurs slowly, an unindexed tax looks better for budgetary purposes in the short run than in the long run. Of course, indexation could be achieved by periodic revisions on an ad hoc basis, but it is difficult to see the merits of such an ad hoc system as opposed to the certainty of an indexed tax if maintenance of a fixed share of financing through the tax is a policy goal.

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[57] Over a long period, the small business subsidies will eventually disappear because they are tied to average earnings of the firm's employees, which are not indexed.

Even with an indexed cigarette tax, revenues from it will still decline. Unless a similar decline in spending can be identified in the current program, or can be incorporated into the health plan, the shortfall in the tax will lead to an increase in the budget deficit.

POLICIES TO AFFECT SMOKING AMONG THE YOUNG

If the primary focus of the cigarette tax is to decrease youth participation rather than to generate revenue, an alternative and more carefully targeted approach might be increased regulation and information programs. A regulatory approach might target restrictions in areas frequented by teenagers (such as schools and libraries) or might include stricter laws prohibiting the sale of cigarettes to minors. Although research on the effects of regulations has only just begun, it suggests that regulatory policies may be effective in discouraging the initiation of smoking among the young.[68] Indeed, it is possible that price responses actually are smaller than those estimated, and that some of the measured response is reflecting the effect of regulatory policies. Such regulatory policies might be more effective than taxes, as well as more targeted. Such policies would avoid the adverse economic consequences that cigarette taxation imposes on the mature smoking population. Should taxation remain the preferred deterrent even without the revenue goal, greater reductions in smoking would be obtained if the tax was cut loose from the health care program and its revenue earmarked for increased antismoking regulatory and education efforts, perhaps including a system of grants to the States. Such earmarking was a feature of California's 25 cent per-pack tax that was enacted in 1989.[69]

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[68] Wasserman, et al. (1991), included.

[69] National Cancer Institute (1993).

APPENDIX A: EVIDENCE ON PASSIVE SMOKING EFFECTS

The Manning study data do not indicate much of an effect of increased health costs from passive smoking. These data are used to calculate the health care costs of active smoking, but not passive smoking.[60]

The claim that passive smoking results in damage to the health of nonsmokers is based upon both theory and empirical analysis. In this view, the theoretical case for the existence of passive-smoking effects is considered to be sound and leads investigators to expect to find empirical support for the proposition.

This theoretical case that passive smoking imposes external costs on nonsmokers can be summarized in three steps: (1) environmental tobacco smoke has the same components as smoke inhaled by smokers; (2) there is physical evidence of some absorption of these components; and (3) a positive relationship exists between active smoking and additional disease and health costs.

Questions have been raised about this entire chain of reasoning, but the focus here is the third link in the chain. This link is based upon evidence on active smokers who report different amounts of smoking. Even the lightest smokers among active smokers, however, experience far greater exposure to and absorption of disease-causing agents than do passive smokers. Such evidence on active smokers is necessary but not sufficient to conclude that a similar relationship exists for passive smokers. It is entirely plausible that the (unknown) health effects/physical damage function rises very little over the range of exposure levels for passive smokers and begins to rise rapidly as the physical damage levels experienced by active smokers are approached.

The existence of an exposure threshold for disease onset below which many passive smokers fall is not implausible. Most organisms have the capacity to cleanse themselves of some level of contaminants. It is for this reason that public policy usually does not insist that every unit of air or water pollution be removed from the environment; the damage of low levels of pollutants is sufficiently small (through the self-cleansing process) that removal is not cost effective. In fact, strongly nonlinear relationships in which health effects rise with the square of exposure, and more, have been found with respect to active smoking (see Surgeon General's Report, 1989, p. 44). Were these relationships projected backward to construct the lower (unknown) portion of the health effects/physical damage function, the observed relationship might lead researchers *a priori* to expect no empirical relationship. Thus, the issue raised by this potential break in the causative chain is whether researchers should expect to find a significant relationship between passive smoking and health effects.

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[60] The Manning study uses other data to make some calculations on the cost of cancer deaths from passive-smoking The details of these calculations are unclear and the results appear to be inconsistent with the remainder of the study.

A number of epidemiological studies have assessed the effects of environmental tobacco smoke on specific diseases, with the largest body of research focusing on lung cancer among nonsmoking wives of smokers. There have also been a number of studies on heart disease in spouses of smokers and general respiratory illnesses in children. Based upon these studies, several Government agencies have, in the last few years, taken the position that environmental tobacco smoke causes health hazards, including the Office of the Surgeon General and the Environmental Protection Agency (EPA).[61] These hazards include lung cancer risks in nonsmoking adults and respiratory effects in children. EPA issued a risk assessment in 1992 that classifies environmental tobacco smoke as a cancer-causing agent.

The positions taken on passive smoking's effects on health by Government agencies and by the EPA 1992 assessment in particular have been subject to criticism by the tobacco industry and by some researchers.[62] The following discussion of the lung cancer effect draws on the evidence presented on both sides of the passive smoking issue with regard to the statistical and scientific evidence.[63]

First, critics have questioned how a passive smoking effect can be discerned from a group of 30 studies of which six found a statistically significant (but

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[61] U.S. Department of Health and Human Services, *The Health Consequences of Involuntary Smoking, 1986*, Surgeon General Report, DHHS Publication Number (CDC) 87-8398; and United States Environmental Protection Agency (1992).

[62] A group of tobacco growers and manufacturers has filed a lawsuit challenging the EPA assessment as not being supported by the evidence. Among the issues raised is the use of empirical work based upon exposure in the home to draw inferences about health effects from exposure in the workplace.

[63] These sources include the U.S. Department of Health and Human Services, Surgeon General Reports for 1986 and 1989; United States Environmental Protection Agency (1992), which detail the rationales for their positions. These reports also summarize the epidemiological studies on environmental tobacco smoke, especially on lung cancer and childhood respiratory illness. The reader is also referred to a hearing at which researchers who both supported and criticized the EPA study appeared: U.S. Congress, House Committee on Agriculture Subcommittee on Specialty Crops and Natural Resources, *Review of the U.S. Environmental Protection Agency's Tobacco and Smoke Study*, 103rd Congress, 1st Session, July 1993. For a view that questions the passive-smoking hazard, focusing particularly on lung cancer, and that is written for the layman, see Gary L. Huber, Robert E. Brockie and Vijay Mahajan, "Passive Smoking: How Great a Hazard?" *Consumers' Research*, July 1991, 10-15, 33-34. Huber, et al. also wrote a companion paper on cardiovascular disease "Passive Smoking and Your Heart," *Consumers' Research*, April 1992, pp. 13-19, 33-34. Finally, see Kyle Steenland, "Passive Smoking and the Risk of Heart Disease," *Journal of the American Medical Association*, January 1, 1992, Vol. 267, pp. 94-99. These last two articles provide capsule summaries of epidemiological studies on passive smoking and heart disease. Finally, see The Tobacco Institute, *EPA Report Scientifically Deficient* for a summary of the industry's criticism of the EPA report. Some critics of the claim that passive smoking causes disease have also raised questions about institutional bias in the Government or in the professional journals; those issues are not addressed here

small) effect, 24 found no statistically significant effect, and six of the 24 found a passive smoking effect opposite to the expected relationship.[64]

EPA attempted to standardize this diverse group of studies to account for statistically important differences in their methodologies. One important difference in the studies is the chance they accepted the absence of a passive-smoking effect when in fact a passive-smoking effect existed. The smaller the size of the sample (number of observations, or people, for whom data was available), the greater the chance of making such a mistake. To correct for these differences, EPA adjusted (weighted) the estimate of passive-smoking effect in each study.[65] This has the effect of reducing the importance of studies with small sample size, studies that would tend to find less significant effects for passive smoking, and increasing the relative importance of studies with large sample size, studies that would tend to find more significant effects for passive smoking.

EPA adjusted the results of each study for misclassification bias (classifying smokers or former smokers as never-smokers). It also made subjective judgments about the extent to which the studies suffered from a variety of other statistical problems, such as confounding (failure to consider the influence of other factors that might increase risk). Those that fared poorly in this analysis were placed in a "Tier 4" category and excluded from the analysis of joint significance of the studies. This procedure allowed EPA to "emphasize those studies thought to provide better data...". (EPA, p. 5-61). After making all these adjustments, EPA combined the studies to conclude that, as a group, the remaining studies indicate existence of a passive-smoking effect.

Another test the EPA conducted was to examine the included studies for evidence of a positive relationship, within each study, between risk and degree of exposure (e.g. number of years smoked). They found such a relationship in 10 of the 14 studies for which such data were available. They also found that the highest-exposure-level group had higher risks than other groups combined, which was statistically significant in 9 of 16 comparisons.

One thing EPA did in its assessment is change the standard for statistical significance from the usual standard, and the one generally used in the original studies. Admittedly, it is unusual to return to a study after the fact, lower the required significance level, and declare its results to be supportive rather than unsupportive of the effect one's theory suggests should be present.

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[64] In this context, if 50 to 100 out of 1,000 active smokers will die of lung cancer, 1 to 2 out of 1,000 passive smokers will die of lung cancer. This is based upon EPA's estimates of lung cancer deaths from passive smoking divided by the total lung cancer deaths attributable to active smoking, plus Viscusi's reported estimates of the lifetime risk of lung cancer deaths from active smoking.

[65] The weight is the reciprocal of the study's passive-smoking effect variance divided by the sum of the weights for all studies, times 100

However, this characterization masks the critical issue raised by the change in the statistical significance standard. The test of statistical significance used in these studies answers the following question: How large a chance, statistically speaking, are we willing to take that we accept existence of a passive-smoking effect when in fact a passive-smoking effect does not exist? In effect, EPA changed the standard from accepting a chance of two-and-a-half percent to accepting a chance of five percent. The policy implication of this change is that there will be a greater chance of focusing resources on an inappropriate intervention (from an efficiency standpoint).

A few other issues are worthy of mention. These studies do not have (and indeed cannot have) very precise estimates of exposure from environmental tobacco smoke. The data are based on interviews of the subjects or their relatives. If errors in measurement occur in a systematic way that is correlated with development of the disease, the effect would be to bias the results. An example would be if those individuals who developed lung cancer (or relatives of those individuals) remembered or perceived their exposure differently from those who did not develop the disease.

Another concern is the possibility that some nonsmokers are actually current or former smokers and that such current or former smokers are more likely to be married to husbands that smoke. While EPA made some adjustment for this effect, it is not possible to correct precisely for this problem. That is, it remains possible that a relationship observed might reflect the effects of active rather than passive smoking.

In addition, while EPA considered the presence of confounding factors in its evaluation of the studies, this issue is not laid to rest. If wives of smokers share in poor health habits or other factors that could contribute to illness and that are not or cannot be controlled for, statistical associations found between disease and passive smoking could be incidental or misleading. This effect could presumably be correlated with exposure levels.

These limitations of studies are often inevitable, but they impart some degree of uncertainty to the results, especially when relatively small risks are estimated.

Two epidemiology studies that each covered a large number of observations were published in 1992 after the cutoff date for inclusion in the EPA report. The one with the largest number of observations found no overall increased risk of lung cancer among nonsmoking spouses of smokers,[66] the other found an

[66] Ross C. Brownson, Michael C. R. Alavanja, Edward T. Hock, and Timothy S. Loy, "Passive Smoking and Lung Cancer in Women," *American Journal of Public Health*, November 1992, vol. 82, pp. 1525-1529.

increased, but statistically not significant, lung cancer risk.[67] Both studies looked at exposure levels within their samples and both found a statistically significant increased risk among the highest exposure group in some categories. In smaller exposure groups, the first study found an unexpected relationship (a negative relationship between passive smoking and disease) and the second found a positive, but not a statistically significant, relationship. It has been pointed out that in large studies where the data are broken into several subsets and each is analyzed separately, some associations may be statistically significant as a matter of chance.

Many of the statistical concerns raised above with regard to lung cancer are relevant to respiratory effects in children and heart disease in adults. Indeed, the conclusions by these Government agencies about passive smoking and disease are generally not extended to heart disease. The presence of other factors that may be related to these illnesses that are not controlled for are particularly important in the case of heart disease and general respiratory illness, where the link between active smoking and the disease is not as powerful as in the case of lung cancer. To restate this criticism, if wives or children of smokers share in poor health habits or other factors that could contribute to illness, statistical associations found between disease and passive smoking could be incidental or misleading.[68]

The public health community, at least as represented by these Government agencies, is of the opinion that the weight of the evidence shows that exposure to passive smoke constitutes a small, but real, risk of lung cancer. However, the tobacco industry, some researchers, and some others question that conclusion.

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[67] Heather. G. Stockwell, Allan L. Goldman, Gary H. Lyman, Charles I. Noss, Adam W Armstrong, Patricia A. Pinkham, Elizabeth C Candelora, and Marcia R. Brusa, "Environmental Tobacco Smoke and Lung Cancer Risk in Nonsmoking Women," *Journal of the National Cancer Institute*, September 16, 1992, vol. 84, pp. 1417-1422.

[68] Huber, et al., (1992) and Steenland (1992), present a tabular summary of the heart disease and passive smoking literature. The respiratory illness in children and passive smoking literature are surveyed in Environmental Protection Agency (1992).

APPENDIX B: COMPARISON OF ESTIMATING PROCEDURES OF MANNING AND OTHER STUDIES

This appendix explains why the Manning study provides the best estimate of the net external cost of smoking and the size of cigarette tax that is appropriate to compensate for these external costs. Note that the five studies discussed in this appendix control for the influence of age and sex. References to the failure of these studies to control for the influence of nonsmoking factors on external costs refer to factors other than age and sex.

RICE, ET AL.

Several studies attempt to measure the medical expenditures and other health related costs that are caused by smoking. One of the most comprehensive is by Rice, Hodgson, Sinsheimer, Browner, and Kopstein.[69] This study identifies smokers' and nonsmokers' medical expenditures for what are thought to be smoking-related diseases. Smokers' medical expenditures in excess of nonsmokers' medical expenditures are estimated to be six percent of total medical expenditures in 1980.[70] The estimates are not translated into a per-pack cost. Note that this study does not estimate lifetime medical expenditures, includes all excess medical expenditures of smokers (not just the portion paid by society, the external cost share), and does not control for nonsmoking factors known to influence medical expenditures. This study also estimates total lost output due to disability and early death (costs that are largely internal).

OFFICE OF TECHNOLOGY ASSESSMENT (OTA)

The OTA uses the same methodology as Rice et al. to calculate total health costs (external and internal). It finds smokers' excess medical expenditures (for 1990) to be only three percent of total medical expenditures.[71]

The OTA translates these costs (both medical expenditures and lost productivity) into a $2.59 per-pack total cost of smoking in 1990 income levels. This cost greatly exceeds the Manning estimates of spillover effects for several reasons.

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[69] Dorothy P. Rice, Thomas A. Hodgson, Peter Sinsheimer, Warren Browner, and Andrea N. Kopstein, "The Economic Costs of the Health Effects of Smoking, 1984," *Milbank Quarterly*, v. 64, no. 1, 1986, pp. 489-548; they also compare their results to several other studies and find the Rice, et al. results to be slightly higher.

[70] Medical expenditures are taken from House Ways and Means Committee, *1993 Green Book (Overview of Entitlement Programs)*, July 7, 1993, p. 266.

[71] Statement of Roger Herdman, Maria Hewitt, and Mary Laschober, Office of Technology Assessment (OTA), *On Smoking Related Deaths and Financial Costs*, before the Senate Special Committee on Aging, May 6, 1993.

Most importantly, the OTA costs are not limited to and were not intended to measure external effects. There is no offset for the lower pension and Social Security costs of smokers, which would be appropriate to measuring external costs. Almost two thirds of the $2.59 cost results from productivity losses from disability and early death; the majority of these productivity costs are costs to the individual and not spillover costs. The remainder, which amounts to 79 cents, is an estimate of smokers' total excess medical expenditure.

There are other reasons that OTA's costs are larger than the Manning estimates. These appear upon examination of the 79-cent medical expenditures portion of the estimate, which is more readily compared to the Manning estimate. The Manning study's estimate of external medical expenditures amounts to 34 cents in 1990 dollars (adjusted for the medical services price index) for the base case and 20 cents for the estimate that restricts expenditures to those related to smoking-related diseases (cancer, circulatory, respiratory, etc.). Since the OTA study focused on habit-related diseases, it is appropriate to compare OTA's 79-cent figure with Manning's 20-cent figure.

Two adjustments can be made to the OTA 79-cent estimate to make it comparable to the Manning estimate. First, the Manning estimate accounts only for external costs, while the OTA estimate includes both internal and external medical costs. Manning estimated the smoker's out-of-pocket costs (excess internal medical expenditures) to be 28 percent of excess smoker medical expenditures. Using this 28 percent share as a guide to eliminate the internal cost share, the OTA 79-cent estimate is reduced to 57 cents of external costs.

Second, the Manning estimate includes only the portion of these excess costs that remain after adjusting to control for attributes other than smoking that might influence differential health costs. This adjustment reduces costs by about 15 percent. If that same 15 percent reduction were to be applied to the OTA 57-cent estimate, the estimate would fall to 49 cents.

After making these adjustments, the OTA's 49-cent estimate is still 2.5 times the size of Manning's 20-cent estimate. Two additional reasons for these differences are discussed in more detail in the mathematical discussions below, and arise from making lifetime medical expenditure estimates based upon observation of current differences in medical expenditures of smokers and nonsmokers. First, this approach ignores the offsetting medical expenditure savings from smokers' average earlier deaths. Second, it ignores the impact of the time-dependent nature of the relationship between smoking and health care. The health consequences of smoking typically occur many years after smoking has commenced and may appear after smoking has ceased. To calculate the efficient tax, one takes into account the timing of taxes and payments—taxes come earlier. Applying current costs to current cigarette consumption does not

adjust for this effect, as described in the mathematical discussion, and overstates the tax appropriate to cover excess medical expenditures.[72]

Because the OTA estimates do not meet any of the three criteria for estimating external costs—identifying a complete set of *external* savings, controlling for other attributes of smokers besides smoking that might cause medical costs, and using a lifetime perspective—they cannot be used as evidence for the appropriate tax level to account for spillovers.

LIPPIATT

Other studies have examined the costs of lifetime medical expenditures. Some find that lifetime *medical* expenditures are smaller for smokers than for nonsmokers due to earlier death and lower future medical expenditures. One such study is Lippiatt's[73], which relies in turn on Oster, Colditz, and Kelly's estimates of the costs of lung cancer, emphysema and coronary heart disease.[74] The Lippiatt study has been criticized by Hodgson (see next study), who suggests the finding of smaller lifetime medical expenditures for smokers is attributable to using too narrow a definition of smoking-related illness, as well as other limitations.

The Lippiatt study, whether its estimates are right or wrong, uses the same methodology as the Manning study in looking at lifetime external expenditures, but is confined to estimating only the medical expenditure component of external costs. It does not control statistically for other attributes (other than age and sex). Its purpose is to provide a comparison to Manning's estimates of excess lifetime medical expenditures, not to calculate a fully developed spillover effect. This study's finding that smokers have lower lifetime medical expenditures than nonsmokers suggests Manning's net external cost estimate (at least, the estimate when the focus is on smoking-related diseases) may be too high.

The Lippiatt study is an incomplete analysis that cannot be used to measure the total spillover effect, but if its estimates were correct there would likely be significant external *savings* to smoking. Even setting the medical expenditures at zero (no difference between smokers and nonsmokers) would lead to net external savings of 17 cents if there were no adjustment to the effect of smoking on retirement age, and savings of 43 cents if the full adjustment

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[72] Of course, cigarettes smoked over a lifetime may vary individually in their effects on health. Ideally, a tax would reflect the marginal cost of each cigarette, but such an estimate would be difficult to make and such a tax impossible to design.

[73] See Barbara C. Lippiatt, "Measuring Medical Cost and Life Expectancy Impacts of Changes in Cigarette Sales." In *Preventive Medicine*, vol. 19, no. 5, September 1990, pp 515-532. This study focused on the habit-related diseases.

[74] Gerry Oster, Graham A. Colditz, and Nancy L. Kelly. *The Economic Costs of Smoking and Benefits of Quitting*, Lexington, Mass.: D.C. Heath and Company, 1984.

were made. Moving from a net external cost of 33 cents to a net external savings of 17 cents to 43 cents is a shift of 50 to 76 cents per pack.

HODGSON

A recent study by Hodgson finds, like Manning, that lifetime medical expenditures are larger for smokers.[75] The Hodgson study uses the same methodology in measuring lifetime medical expenditures as Manning and Lippiatt. The Hodgson study finds a larger increase in lifetime medical expenditures for smokers than the Manning base case—37 percent for males and 31 percent for females.[76] The Manning study's calculations of per-pack spillover effects reflect an estimated excess of 18 percent.

The Hodgson study does not control for the effect of nonsmoking characteristics. In the Manning study, smoking accounts for about 85 percent of excess medical expenditures. After adjusting for this factor, the Hodgson estimate remains about 60 percent higher than the Manning estimate. Hodgson did not investigate the consequences of restricting the analysis to diseases actually thought to be related to smoking.

As in the case of the Lippiatt study, the Hodgson study does not provide a complete set of estimates that can be used to calculate the external costs per-pack. If all calculations in the Manning study were increased by 60 percent to reflect the higher Hodgson estimate, the total per-pack net external cost would be 53 cents. If only the medical expenditures component were adjusted, the net external cost would be 62 cents. The absolute increases are 20 to 29 cents. These amounts are somewhat higher than the current tax of 50 cents, but would justify only a small increase in tax.

HARRIS

In recent testimony before Congress, Harris estimates that smokers' excess medical expenditures alone add up to $3.71 per pack of cigarettes at 1995 income levels.[77] Comparable estimates from the Manning study are 49 cents

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[75] Thomas A. Hodgson, "Cigarette Smoking and Lifetime Medical Expenditures," *Milbank Quarterly*, Vol. 76, No. 1, 1992, pp. 81-125. This study also reviews other studies. The techniques used by the Hodgson study differ from those in the Manning study in a variety of ways; one which may be a partial source of difference is the use of ten-year age intervals in the Hodgson study.

[76] The Hodgson study uses a base case with a 3 percent discount rate, but reports results at a 5 percent rate as well. For a 3 percent rate, the costs are 32 percent and 24 percent higher respectively.

[77] Testimony of Jeffrey E. Harris. Regarding Financing Provisions of the Administration's Health Security Act, before the Ways and Means Committee, November 18, 1993 Harris also reports $2.32 of costs imposed on nonsmokers by smokers when he adjusts for the fact that smokers share in the higher insurance premiums paid by everyone. This adjustment is not made

for the base case and 28 cents for the lower-bcund case based upon habit-related illnesses.

This $3.71 figure relies on an estimate that smokers' lifetime medical expenditures exceed nonsmokers' costs by 20 percent, a difference only slightly greater than the 18 percent difference Manning uses in the base case estimate. So what accounts for the gap between Harris' per-pack excess medical expenditure estimate of $3.71 and the comparable Manning estimate of 49 cents?

Harris' figure is not adjusted for the share of these excess medical expenditures paid for by the smoker (internal costs). If the $3.71 is reduced by the 28 percent internal cost share of the Manning study, it declines to $2.67, or 5.5 times as large. (This adjustment may be too large, but the objective of this exercise is to try to reconcile the two numbers). If the $2.67 figure is adjusted for the slight difference in the two estimates of smokers' excess lifetime medical expenditures (20 percent for Harris and 18 percent for Manning), it declines further to $2.36.

The remaining difference between these estimates is attributable to the upward bias that arises when the 20 percent estimate of excess lifetime medical expenditures is converted into dollar terms by using current medical expenditures and current cigarette consumption rather than using discounted lifetime values. The mathematical exposition below explains that this procedure incorrectly incorporates lifetime medical expenditures into the analysis and causes a substantial overestimate of external excess medical expenditures. This overstatement is particularly likely when smoking has been declining and is probably magnified by the projection forward to 1995.

CONCLUSION

Although some of the other research discussed appears to produce different results from the Manning study, none of these studies correctly estimates the net external costs or savings translated into a per pack equivalent tax. Indeed, the lifetime medical care studies provide some reassurance that the Manning results are reasonable. The Manning study's estimate falls between the two estimates reported here.

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in the Manning study; nor would it be appropriate to do so for measuring the efficient tax. The Manning study attempts to estimate the tax that will correctly price cigarettes to smokers—that is, the costs imposed by the individual smoker on others that are not taken into account by the smoker. If smoking raises insurance costs for everyone, the individual smoker would pay only a tiny fraction of the cost he is imposing since that additional cost is spread over all the individuals in the pool.

MATHEMATICAL COMPARISON OF MANNING, OTA, AND HARRIS ESTIMATES OF PER-PACK COSTS

This section places the Manning estimating procedure in mathematical terms and uses it as a framework for illustrating why the net external costs (and optimal tax) estimated by the OTA and Harris studies are too large.

To illustrate how the Manning per pack calculations are made and how they relate to other calculations, assume a simple model where individuals live for three periods, incurring medical costs in each period. All smoking (designated as one unit of tobacco in period one) occurs in periods one and two, with half as much smoked in the second period (to represent those who quit after the first period). The smoker (whether or not he quits) lives only two periods. Note that the model is not designed to represent smoking behavior, but rather to explain the fundamental differences in the types of calculations.

The present value of health costs for non-smokers is:

(1) $PVHC_n = C_0 + C_1/(1+R) + C_2/(1+R)^2$

C represents health costs in each of the three periods, subscripted by 0, 1, and 2. R is the discount rate. Suppose the smoker incurs an additional cost of C_x in the second period. The present value of health costs for the smoker is:

(2) $PVHC_s = C_0 + (C_1+C_x)/(1+R)$

The present value of excess lifetime costs of health care for smokers relative to nonsmokers is the difference between (2) and (1), or:

(3) $PVHC_d = C_x/(1+R) - C_2/(1+R)^2$

The correct tax will be a tax that sums in present value to these excess costs. If the tax is T per unit, the present value of the tax collected will be (remember, there is one unit of smoking in the first period and .5 units in the second period):

(4) $PVT = T + .5T/(1+R)$

To determine the tax, set (3) equal to (4) and solve for T:

(5) $T = \{C_x/(1+R) - C_2/(1+R)^2\}/\{1 + .5/(1+R)\}$

Equations (1) through (5) illustrate the Manning study's calculation of excess smoker medical costs. The optimal tax per pack is then calculated by deleting those excess medical costs paid directly by the smoker (internal costs) and adding the smoker's non-medical external costs.

Neither the OTA nor the Harris estimates used this approach.

OTA Estimates

The OTA estimate of tax per pack attributed to medical care is based not on observing the present value of cost differentials, but rather on the amount of smoking-related health costs observed in the economy at any given time. These total health costs that one observes in the economy at a given time can be expressed as the sum of the costs of all the smokers and nonsmokers of different ages in the economy:

$$(6)\quad TC = F\{C_0 + (C_1+C_x)/(1+G_s)\} + (1-F)\{C_0 + C_1/(1+G_n) + C_2/(1+G_n)^2)\}$$

G refers to the growth rate (of smokers and non-smokers respectively), and F is the share of the youngest group that smokes. The growth rates are necessary to add up the population (and associated costs) of smokers and non-smokers of different ages. Thus, if smokers are growing at growth rate G_s, there will be $1/(1+G_s)$ smokers one period older than the youngest cohort.

The OTA estimates of health costs result from an observation of the additional medical costs of smokers in period 2. The base of the tax will be the actual units consumed (not the present value). The calculated tax will be:

$$(7)\quad T = \{C_x/(1+G_s\}/\{1 + .5/(1+G_s)\}$$

Comparing (7) to (5), one can see that this method overstates the tax for two reasons. First, there is no accounting for the offsetting savings from early death (the second term in the numerator of equation (5)). Second, the second-period costs are discounted at the smoker growth rate rather than the discount rate. Two conditions have to occur for this use of the growth rate rather than the discount rate to overstate the tax. The discount rate must be greater than the growth rate. And the consumption of tobacco must occur earlier than the occurrence of the medical costs. Note that since smoking has been declining, the growth rate will actually be negative. It appears that both conditions for overstatement are satisfied.

Harris Estimates

Now consider the effects of the method used by Harris. Harris begins with an estimate taken from other studies of the percentage increase in lifetime health costs due to smoking, using a ratio slightly higher than Manning's base case estimate. In this example, this excess health cost is:

$$(8)\quad \{C_x/(1+R) - C_2/(1+R)^2\}/\{C_0 + C_1/(1+R) + C_2/(1+R)^2\}$$

Harris converts this number into a per-pack tax, by using observations of shares of the population that are smokers (current and former) and nonsmokers, observations of current consumption, and observations of current medical costs. As is shown below, this procedure can result in significant errors in measurement of the tax.

As a first step, Harris converts the ratio in (8) into a total share of medical costs by the formula $F'r/(1+F'r)$, where r is the ratio in (8) and F' is the observed share of smokers (and former smokers). This share is multiplied by total observed medical costs and applied to observed consumption. After some rearrangement, one finds this tax is equal to the correct tax (in equation (5)), multiplied by three factors.

The first factor is the ratio of F' (the observed share of smokers) to F (the share of the youngest group that smokes). This number will tend to be larger than one (F' greater than F) if the growth of smoking cohorts is smaller than the growth of non-smoking cohorts. In that case, the share of the population that is composed of current and former smokers is greater than the share of the youngest generation that smokes. Since smoking has been declining for many years, this value is likely to be greater than one. (There is some offset for smokers who die earlier than nonsmokers, which reduces the observed population share, but this effect is likely to be quite small, as it affects only a few cohorts.)

The second factor is the ratio of the observed to the present value of medical costs, but with the present value of the smoker's and non-smoker's costs weighted by F' rather than F:

(9)

$$\frac{\{C_0 + C_1/(1+G) + FC_2/(1+G_s)) + (1-F)(C_2/(1+G_n)^2)\}}{\{C_0 + C_1/(1+R) + F'(C_2/(1+R)) + (1-F')(C_2/(1+R)^2)\}}$$

where G represents the overall growth rate of the population (a weighted value of G_s and G_n from the previous period. This ratio will also be greater than one because growth rates are lower than discount rates.

Finally, it will be multiplied by the ratio of the present value of the units of tobacco consumed to the observed value:

(10) $\{1 + .5/(1+R)\}/\{1 + .5/(1+G_s)\}$

This ratio will be less than one because the growth rate, G_s, is smaller than the discount rate.

Theoretically, the product of these three ratios is ambiguous, but when tobacco usage precedes the appearance of most illness by a large stretch of time, the second factor will greatly outweigh the third in importance and a large overstatement of the tax will result. Since tobacco use typically begins in the teenage years and many individuals subsequently quit, but tobacco-related illnesses tend to occur in middle and old age, much more discounting is involved in (9) than in (10). As a result, the discounting that takes place in the ratio of observed to present value medical costs is greater than in the ratio of observed to present value of units of tobacco consumed.

With a significant difference in discount rates and growth rates and a large difference in discounting periods, the calculated tax could be several times the actual tax. Suppose that we ignore the effect of F'/F and any differences between growth rates of smokers and non-smokers. Assume the growth rate is one percent and the discount rate is 5 percent. If medical costs are discounted on average for 40 years, but consumption for ten years, the tax calculated in this fashion will be three times too big. If medical costs are discounted over 50 years, the tax will be five times too big.

APPENDIX C: ESTIMATING PROCEDURE FOR REVENUE PROJECTIONS

Every age between 12 and 80 is assigned the participation rate, average consumption, participation-rate elasticity, and average-consumption elasticity appropriate to its age group.[78] The participation rate and average consumption are combined with population-by-age data to provide an estimate of total cigarette consumption for 1992. This total consumption proved to be about 90 percent of the 504.314 billion U.S. cigarette consumption reported for 1992. Each age group's average consumption is then adjusted upward to ensure that beginning consumption is approximately equal to 1992 cigarette consumption.

Per capita U.S. cigarette consumption has declined steadily from 2,821 in 1979 to 2,009 in 1992. The model estimated here does not attempt to adjust the average cigarette consumption of smokers for this downward trend (although the downward trend in per-smoker consumption would be less significant than the downward trend in per capita consumption due to the downward trend in participation). The output of the model is pre-tax and after-tax consumption for a period of 69 years, a period of time sufficient to allow the entire population to have responded to the tax as teenagers.

Understanding this model requires explanation of two calculations: the size of the population at any point for a given age; and the after-tax participation rate and average consumption for a given age group as it moves in time toward 80 years of age.

SIZE OF POPULATION BY AGE

Data on mortality rates for 1991 indicate that deaths per 100,000 population increase steadily as age increases, from 25.8 for ages 10-14 to 4,806.8 for ages 75-79.[79] This pattern is assumed to remain invariant for the next 69 years. The population in place today at any given age is assumed to die at these mortality rates. Thus, next year's 46s are equal to today's 45s minus the number who die during the year they are 45. The resulting population of 46s in year two (45 year old survivors) in turn dies at the mortality rate of 46s.

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[78] Participation rate and average consumption data are from several publications of the U S Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics: *Advance Data*. No. 221, December 2, 1992, Table 2; *Health United States 1992 and Healthy People 2000 Review* DHHS Pub. No (PHS) 93-1232, Tables 64 and 66; and *Vital and Health Statistics, Smoking and Other Tobacco Use: United States, 1987*. DHHS Pub. No. (PHS) 89-1597, Table 1. The elasticity estimates come from the Surgeon General's report cited in table 1 of the text.

[79] U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics *Monthly Vital Statistics Report* Vol. 42, No. 2, Supplement, August 31, 1993

thereby generating the number of 47s in year three (46 year old survivors who were 45 when the tax was imposed). This process continues until the original 45s are 80, at which time it is assumed (in order to reduce the computational burden) that all age 80s die (nobody survives to 81). This process allows for no immigration or emigration.

The total population grows at the Census Bureau's 60-year annual growth rate projection (1990 to 2050, middle-series projection) of 0.72 percent. The number of new 12s in year two is equal to the projected new population minus all the survivors for the original 12s through 79s.[80] The number of new 12s in year three is equal to the projected population minus all the survivors for the 12s through 79s in year two. Continuing this process through the years, the number of new 12s in year 69 is equal to the projected population minus all the survivors for the 12s through 79s in year 68.

PARTICIPATION RATES AND AVERAGE CONSUMPTION

The population in each age group is assumed to respond to the implicit price increase imposed by the $0.75 tax at the participation-rate and average-consumption elasticities presented in table 1 on page 23. All pre-tax smokers are assumed to respond to the tax only at the time it is imposed. But participation-rate data indicate that an age cohort's participation rate (prior to the 75-cent tax) increases through age 44 and then begins to decrease. Thus, some nonsmokers below age 45 at the time the tax is imposed will begin smoking at a later date, and some smokers older than 45 at the time the tax is imposed will stop smoking at a later date.

How do these nonsmokers at the time the tax is imposed respond to the 75 cent tax when they begin smoking at a later date (an older age)? As long as the participation-rate elasticity for the age group the new smokers were in at the time the tax was imposed is identical to the participation-rate elasticity for their new (older) age group, the new smokers are subject to the same response to the tax price increase as the original smokers in the cohort. But when the participation-rate elasticity has decreased (see table 1), potential new smoking participants (the difference between a higher participation rate and the previous lower participation rate) are assumed to respond to the lower elasticity. At that point, the after-tax participation rate for the age cohort is a weighted average of original participants responding at the original, higher participation-rate elasticity and new participants responding at the new, lower participation-rate elasticity.

Another strategy is called for when a cohort's participation rate decreases. The weighted after-tax participation rate calculated for the cohort at a younger age is reduced by the percentage reduction in the participation rate, thus

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[80] In year two, total population is equal to the original population times $(1+.0072)^1$, in year three, the multiplication factor is $(1+.0072)^2$, and in year 69, the factor is $(1+.0072)^{68}$

assuming smoking dropouts are spread proportionately over original and new smokers.

Average consumption of a cohort's smokers also changes over time. It is assumed that all smokers in an aging cohort, whether they be original or new smokers, consume cigarettes at the historical record of average consumption for their current (post-tax) age, adjusted for the price elasticity of average consumption for their current (post-tax) age. That is, if at the time the tax is adopted after-tax consumption for a 45-year-old is X and for a 60-year-old is Y, today's 45s will consume Y at age 60 (whether new or old smokers) and today's 12s will consume X at age 45.

PREPARED STATEMENT OF KENNETH E. WARNER

Mr. Chairman, Members of the Committee, good morning. I am Kenneth Warner, an economist and Professor and Chair of the Department of Public Health Policy and Administration of the University of Michigan School of Public Health. I have studied economic and public health aspects of tobacco use for 18 years, with special attention to the health and economic effects of tobacco taxes and the impact of reduced tobacco consumption. I also served as the Senior Scientific Editor of the 25th anniversary Surgeon General's Report on Smoking and Health, published in 1989.

In 1992 I chaired an expert panel of 26 economists and health policy experts convened by the National Cancer Institute to assess the state of knowledge of the impact of tobacco taxes on tobacco use. The report of that expert panel, "The Impact of Cigarette Excise Taxes on Smoking Among Children and Adults," was issued by the National Cancer Institute in August 1993.

I am pleased to be here today on behalf of the American Cancer Society, American Heart Association, and American Lung Association, united as the Coalition on Smoking OR Health. The Coalition and more than 100 health and civic organizations support a major cigarette tax increase of $2 per pack. A list of these organizations is attached. The case for such an increase is compelling because it will simultaneously avoid a substantial number of premature deaths and raise a substantial amount of new revenue at predictable levels for the remainder of the decade.

I will make five main points that, in my judgment, represent the consensus of independent health policy experts who have studied tobacco taxes over the years:

1. *A. major increase in tobacco taxes is good health policy.* Any significant tobacco tax increase will avoid premature deaths by reducing tobacco use. A $2-per-pack increase will reduce cigarette consumption by nearly a quarter and encourage more than seven million Americans not to smoke, thereby preventing nearly 2 million premature deaths over time. It is the single most effective way to rapidly and significantly reduce tobacco use among children and adults.

2. *A major increase in tobacco taxes is good health care policy.* A reduction in smoking would result in a less expensive health care system. The most recent and thorough analysis of the medical costs associated with smoking concludes that smoking imposes an estimated $501 billion in excess lifetime health care costs for current and former smokers (in 1990 dollars). That number grows by approximately $9–10 billion annually due to the additional excess lifetime health care costs of the one million teenagers who take up smoking each year.[1] This study takes into account the fact that nonsmokers live additional years in which they incur health care costs, but finds that the higher annual costs of smokers more than outweigh these costs.

3. *Tobacco taxes are a highly reliable source of significant revenue and will continue to be for many years to come.* Although tobacco tax increases will reduce tobacco use, the tax will generate substantial new revenue because the percentage drop in consumption is far less than the percentage increase in price.

4. *It is fair to single out tobacco as a source of revenue for health care reform.* Tobacco is unique. Unlike any other consumer product, tobacco kills hundreds of thousands of people; indeed, it kills more people than all other consumer products com-

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[1] T. Hodgson, "Cigarette Smoking and Lifetime Medical Expenditures," *Milbank Q.*, vol 70, pages 81–125, 1992.

bined. Furthermore it is harmful to users at all doses and is highly addictive. Virtually all new tobacco users are children and the adverse effects of tobacco use fall disproportionately on the poor. We would expect a major tax increase to reduce smoking most dramatically among young people and in low-income communities, while simultaneously providing revenue to help extend health care to those least likely to be served today.

5. *Tobacco taxes are a popular financing mechanism for health care reform.* A national poll shows that about two-thirds of American voters support a $2-per-pack tobacco tax increase, including 66 percent of Democrats, 63 percent of Republicans, 65 percent of voters in tobacco-growing states, 71 percent of Latino voters, 63 percent of African Americans, and even 33 percent of smokers!

Two major arguments have been made by opponents of a tobacco tax increase. They argue that a tobacco tax increase will cause major job losses and that tobacco users are already paying their fair share. I examine each of these premises below.

A MAJOR TOBACCO TAX INCREASE IS GOOD HEALTH POLICY

Tobacco products will kill about 1,100 Americans today and every day this year—one every 75 seconds. In all, tobacco kills more than 1 in 3 long-term users and is responsible for about one in five of all deaths each year. It is a major cause of heart disease, lung cancer, mouth and throat cancer, emphysema, chronic bronchitis, chronic obstructive pulmonary disease, low birth weight babies, strokes and many other diseases. Tobacco is, beyond question, the single greatest cause of preventable death in the U.S.

Despite all of the educational efforts over the past thirty years and the major reduction in the percentage of the adult population using tobacco, 46 million Americans continue to smoke. Even more significantly, virtually all new users are teenagers or younger and the average age of initial use has been getting younger and younger. If today is a typical day, 3,000 children too young to purchase cigarettes legally will light up for the first time and many of them will become addicted long before their 18th birthday.

Tobacco taxes have been shown to significantly reduce tobacco use by discouraging young people from beginning to smoke and encouraging current smokers to quit. It is possible to estimate with a fair degree of confidence the likely health benefits of a $2-per-pack cigarette tax increase (or of any other tax increase). This is because analysts who have studied tobacco taxation agree on a number of key points, as reflected in the consensus statement from the 1992 National Cancer Institute's meeting on the subject. The points include the following:

1. The price elasticity of demand for cigarettes is between −.3 and −.5, with −.4 being a reasonable mid-range estimate. A −.4 price elasticity means that, for example, when the price of cigarettes is raised by 10 percent, consumption of cigarettes will fall by about 4 percent.

2. A major increase in tobacco taxes will have an effect on teenagers that is at least as great, if not greater than its effect on adults. One of the more compelling studies on this point found that teenagers are as much as 3 times more price sensitive than adults.[2]

3. The main impact of higher tobacco prices is on the prevalence of smoking. This is important because it means that tax increases do not just encourage people to cut back, which would provide only marginal health benefits, but to quit smoking entirely, or not to start smoking in the first place.

By applying what we know about smoking and tobacco taxes to the current population, we estimate that the President's proposal to increase the tax by 75-cents per pack would reduce consumption by about 12 percent and would discourage about 3.7 million Americans from smoking. A $2 cigarette tax increase, as the Coalition on Smoking OR Health proposes, would reduce consumption by about 23 percent, and would discourage about 7.6 million Americans from smoking. Based on the best available epidemiological data, we conservatively estimate that about 1 in 4 of these people ultimately would have died of diseases caused by smoking. Thus, a 75-cent tax increase would prevent about 900,000 premature deaths over time. A $2 tax increase would prevent about 1.9 million premature deaths over time.

These estimates demonstrate that the matter before you today is not simply one of revenue raising. It is, quite literally, a life and death issue for up to two million Americans.

[2] E. Lewit, D. Coate and M. Grossman, "The Effects of Government Regulation on Teenage Smoking," *Journal of Law and Economics*, vol. 24, pp. 545–569, December, 1981.

To insure that the full benefit of the projected tobacco tax increase is realized, Congress should take two related actions.

First, Congress should index any tobacco tax increase to inflation, to maintain the value of the tax in real terms. The U.S. has failed to do this in the past with the ironic result that tobacco taxes are much lower today in real terms than they were before we knew about the death and disease caused by smoking. In the absence of indexing, federal and state tobacco taxes fell from 51 percent of the retail price of cigarettes in 1966 to 26 percent in 92. Another result of the failure to adjust tobacco taxes to correct for inflation is that U.S. tobacco tax rates have fallen below those of every other major industrialized nation.

Second, Congress should tax all tobacco products at approximately equal rates, as President Clinton has proposed. Any significant discrepancy in tax rates will encourage the substitution of smokeless and other tobacco products for cigarettes. This would perpetuate tobacco's public health disaster because each of these tobacco products causes cancer and other diseases.

A MAJOR TOBACCO TAX INCREASE IS A RELIABLE SOURCE OF SIGNIFICANT NEW REVENUE

The amount of new revenue raised by tobacco taxes is substantial and highly predictable. The Joint Committee on Taxation, the Congressional Budget Office, and the Department of the Treasury all agree that President Clinton's proposed 75-cent-per-pack tax increase (with equivalent taxes on other tobacco products) will generate $10 to $11 billion per year in new revenue over each of the next five years and beyond: Revenue estimates for a $2-per-pack tobacco tax increase (with equivalent taxes on other tobacco products) consistently have fallen in the range of $100 billion in new revenue over the next five years. I believe that the Joint Committee and others have been conservative in their calculations and that the amount of new revenue will in fact be higher.

It is important to note that all of these estimates, including my own, are conservative estimates that fully account for the expected drop in smoking and other revenue effects of raising tobacco taxes. While theoretically there is a figure at which tax increases so dramatically increase the price and discourage consumption that actual revenue will begin to drop, none of the proposals currently being debated comes close to that point.

A MAJOR TOBACCO TAX INCREASE IS THE SINGLE MOST APPROPRIATE SOURCE OF REVENUE FOR HEALTH CARE REFORM

The tobacco industry argues that tobacco should not be singled out for a tax increase, yet the facts suggest exactly the opposite. Tobacco is a uniquely appropriate source of revenue for health care reform.

Tobacco is unique because it kills more Americans than alcohol, car accidents, AIDS, violent crime, cocaine and heroin—**combined.**

Unlike products that are harmful to some people under some circumstances, tobacco is unique because it is harmful to all users at all doses. In the form of environmental tobacco smoke, it is harmful to non-users, ranging from babies in the womb to elderly victims of heart disease.

Tobacco is unique because it contains nicotine, a highly addictive and toxic substance that is heavily regulated **except** when sold for human consumption in tobacco products.

As I already have noted, tobacco is unique because virtually all new users of tobacco are children. Most smokers start before the age of 16, and at least 90 percent start before they are out of their teenage years. The vast majority of adult smokers say that they want to quit smoking, and most have tried, although only a small fraction succeeded in any given year. Thus the decision to start smoking is made by children, not adults, and the decision to continue smoking is a result of the addictive power of tobacco, and not the result of a "free choice."

THE TOBACCO INDUSTRY'S ARGUMENTS AGAINST A TAX INCREASE FAIL AS A MATTER OF HEALTH AND ECONOMICS

a. The Tobacco Industry Has Grossly Exaggerated the Number of Jobs that Will Be Affected

The tobacco industry claims that a major tobacco tax increase will have a devastating effect on jobs. This is an issue I have researched over a period of many years. I can say with authority that the tobacco industry's claims are grossly exaggerated and misleading.

The tobacco industry exaggerates its economic importance in its estimates by assuming that money not spent on tobacco products will simply disappear from the economy. Of course that money will not disappear, but will be redistributed by consumers to other goods and services, providing comparable employment and business opportunities in other industries.

With a colleague, I have published a study demonstrating that total employment in my home state of Michigan will **increase** as tobacco use declines. A similar increase in employment would be expected in the vast majority of states as consumer dollars are redirected toward other goods and services.

The actual number of jobs that would be affected in tobacco-producing states is much smaller than the tobacco industry suggests. The industry's estimates, for example, do not account for the fact that more than 50 percent of all tobacco grown in the U.S., and more than 30 percent of all cigarettes, are exported and will be unaffected by the tax.

Economists who have reviewed the tobacco industry's job loss estimates, including Arthur Andersen Economic Consulting, have concluded that the industry's unrealistic assumptions build on one-another in a cumulative fashion, and that actual net job losses, if any, would be a small fraction of the number predicted. Ironically, tobacco companies themselves are afar greater threat to farmers and manufacturing workers than any tobacco tax. The companies reduced manufacturing jobs by 29 percent between 1982 and 1992 through increased automation, and boosted imports of foreign tobacco from 13 percent to 35 percent over the same time period.

The tobacco sector has been in decline since the 1970s. That trend will only accelerate in the future. Tobacco farmers, tobacco manufacturing workers and their elected representatives need to prepare for this continued decline. In this sense, a high tobacco tax, with a generous portion earmarked to help tobacco farmers and their communities make the transition to other sources of income, may represent much more of an opportunity than a threat. The tax increase presents an historic opportunity simultaneously to provide meaningful assistance to communities reliant on tobacco, reduce tobacco use and help fund health care reform. It is not an opportunity that will be repeated and I urge this Committee to take advantage of it. The Coalition on Smoking OR Health strongly supports an earmark from a $2-per-pack tax increase to assist communities reliant on tobacco.

b. The Argument that Smoking "Pays Its Own Way" Is Fundamentally Flawed

The health policy debate about whether to increase the tax on tobacco products has too often been sidetracked into a debate over economic theory about how to measure the social costs of tobacco use. On one side of the debate are those who point to the billions of dollars a year that are spent treating tobacco-related diseases and the billions of dollars of lost productivity caused by tobacco-related disease. On the other side are those who consider only the social costs of smoking that are "external" to smokers and their families. In essence, this view says that tobacco-induced asthana in the children of smokers is considered and implicitly accepted by smokers as a cost of their smoking, and that this cost presumably is more than offset by some "benefit" they perceive themselves to be deriving from smoking. Interestingly, this view attributes a major economic benefit to the death of these same smokers as the result of savings realized from reduced expenditures on social security and pensions. The argument goes that these smokers die before they collect their social security and pension, thereby saving society billions of dollars.

In my opinion it is wrong to base the decision of whether to increase the tax on tobacco products on either of these narrow economic analyses for at least three fundamental reasons. First, the conventional model of rational economic behavior applies when adult consumers are in a position to make free, fully informed consumption decisions. The model does not apply to an addictive product, especially when the addiction is initiated during childhood. Cigarettes are not widgets, and the economic assumptions that apply to the purchase of widgets do not apply to cigarettes. Anyone who has even a modest appreciation of the discipline of psychology, the addictive nature of tobacco, and the data which demonstrate that virtually all new smokers are children, understands that addicted smokers are not "rational consumers " in the traditional sense.

Second, analyses of the external costs of smoking significantly underestimate these costs. Even according to their own ground rules, the estimates made to date significantly underestimate true external costs by employing very low estimates of the health effects of environmental tobacco smoke (ETS). Impressive recent research suggests that the death toll associated with ETS may be 10 times greater than the estimates used in the economic analyses referenced by opponents of a cigarette excise tax increase.

Finally, an economic model that assigns no value at all to the 419,000 lives lost to tobacco every year fails to take into account the true public health cost of tobacco. We consider human life to have value and we do not consider preventable, premature death to be an economic benefit in making other public policy decisions. If we did, Congress would cease much of the funding for research to combat heart disease and cancer, diseases that, after all, afflict much of their damage on the retired population. This cold view of economics ostensibly views senior citizens as a pure liability. This is inhumane and even ridiculous. Frankly, it embarrasses me to see fellow economists demeaning our profession with such absurdities.

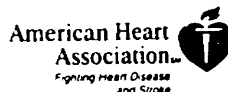
CONCLUSION

Congress has before it a unique and indeed uniquely desirable opportunity: a chance to do good while doing well. The chance to do good is the impact a tax will have on smoking and health: it will help millions of smokers and potential smokers avoid the prison of addiction and premature death. The opportunity to do well reflects the cigarette tax's certain contribution of billions of dollars to federal revenues.

This Committee is contemplating methods of funding health care reform. Clearly there is an appealing conceptual tie between taxing the leading cause of preventable illness and restructuring health care delivery and finance. But it is important to recognize that a substantial increase in the cigarette excise tax would constitute significant "health care reform" all by itself, regardless of the fate of proposed changes in the health care delivery and financing system. A large cigarette tax increase would produce a public health achievement with few precedents. In the process, it would decrease the nation's health care bill.

ATTACHMENTS

1. Supporters of a $2-per-pack Increase in the Cigarette Excise Tax
2. Tobacco Taxes in Major Industrialized Nations



Coalition on Smoking OR Health

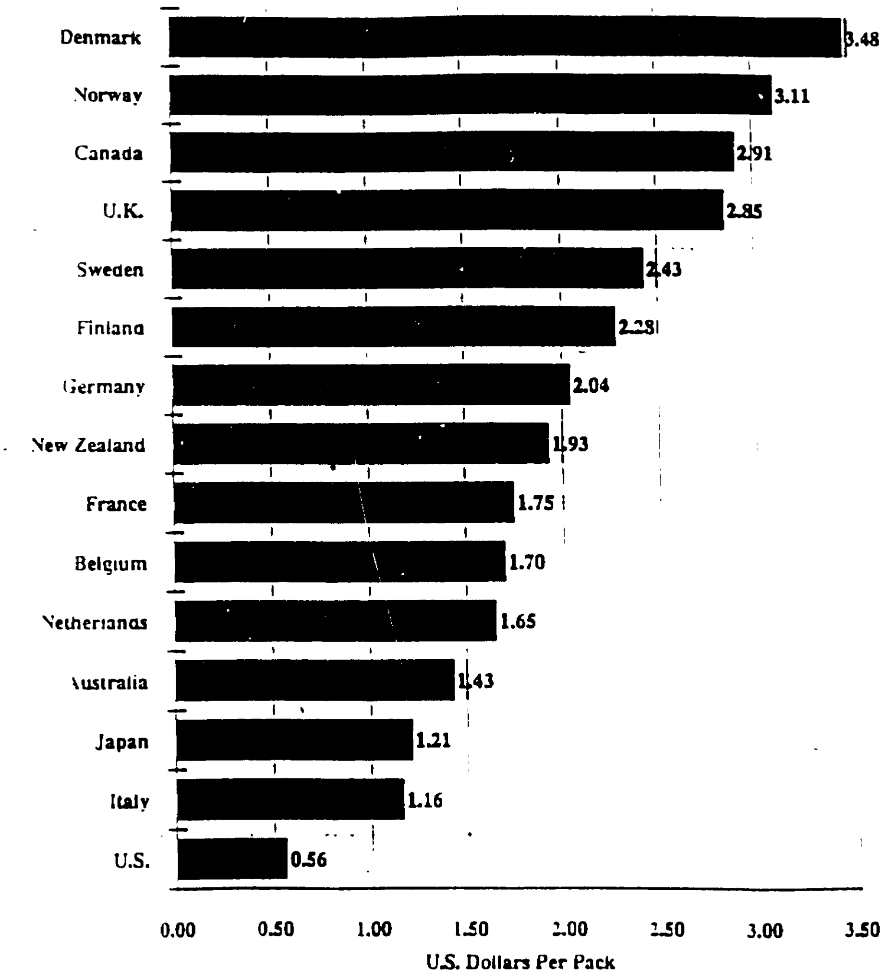
Supporters of $2.00 Per Pack Increase in the Cigarette Excise Tax

Action on Smoking and Health
American Academy of Family Physicians
American Academy of Otolaryngology
Head and Neck Surgery
American Association of Dental Schools
American Association of Occupational
Health Nurses
American Association for Respiratory Care
American Cancer Society
American College of Cardiology
American College of Chest Physicians
American College of Nurse-Midwives
American College of Physicians
American College of Preventive Medicine
American College of Sports Medicine
American Council on Science and Health
American Dental Association
American Diabetes Association
American Heart Association
American Licensed Practical Nurses
Association
American Lung Association
American Lung Association of Metro Chicago
American Medical Association
American Medical Student Association
American Medical Womens' Association
American Nurses Association
Coalition for a Healthy New Jersey
Coalition for a Healthy New York
Coalition for a Smokefree Maryland
Commission for a Healthy New York
Committee for Children
Congress of National Black Churches
Doctors and Lawyers for a Drug Free Youth
Evangelicals for Social Action
Friends Committee on National Legislation
GASP of Colorado
GASP of Massachusetts
General Board of Church and Society
United Methodist Church
General Board of Global Ministries
Special Program on Substance Abuse
and Related Violence
Houston GASP
Howell Community Allian[illegible] for the
Prevention of Al[illegible] Drug Abuse
Interfaith Center on Corpor[illegible]sponsibility
Tobacco Issue Group
Interhealth/American Protestant Hospital
Association
Interreligious Coalition
Joint Council of Allergy and Immunology
Massachusetts GASP
Memorial Sloan-Kettering Cancer Center

The American Muslim Council
American Psychological Association
American Public Health Association
American Society of Addiction Medicine
American Society of Clinical Oncology
American Society of Internal Medicine
American Speech-Language-Hearing Association
American Veterans Committee
Americans for Nonsmokers' Rights
Association for Nonsmokers - Minnesota
Association of Schools of Public Health
Association of State and Territorial Health Officers (ASTHO)
Association of Women's Health, Obstetric and Neonatal Nurses
Asthma and Allergy Foundation of America
Boston Women's Health Book Collective
Cancer Care, Inc.
Catholic Charities USA
Center for Science in the Public Interest
Christic Institute
Church of the Brethren
New York Public Interest Research Group
North Dakota State Department of Health and Consolidated Laboratories
Oncology Nursing Society
Operation SCAT (Student Coalition Against Tobacco)
Operation Taking Charge
Physicians Committee for Responsible Medicine
Presbyterian Church (U.S.A)
Prospect Associates
Public Citizen Health Research Group
Roswell Park Cancer Institute
Scenic America
Sierra Club
Seventh-Day Adventist Church
SmokeFree Pennsylvania
Society of Cardiovascular & Interventional Radiology
Society for Public Health Education
STAT (Stop Teenage Addiction to Tobacco)
Tobacco Divestment Project
Tobacco Free Clarke County
Tobacco-Free Education and Action Coalition for Health (TEACH)
Minnesota Coalition for a Smoke-Free Society 2000
Muscular Dystrophy Association
National Association of Community Action Agencies
National Association of Elementary School Principals
National Association of Evangelicals
National Association of Medical Directors of Respiratory Care
National Association of Nonsmokers
National Coalition for Cancer Research
National Coalition for Cancer Survivorship
National Coalition of Hispanic Health and Human Services Organization
National Council for International Health
National Nonsmokers Foundation
National PTA
National Ready to Learn Council
National Women's Law Center
NETWORK: A National Catholic Social Justice Lobby
New Jersey GASP
Tobacco Free Michigan Action Coalition
Tobacco Free North Dakota
Tobacco Free Washington Coalition
Union of American Hebrew Congregation, Religious Action Center of Reform Judaism
United Church of Christ
United Methodist Church
U.S. Public Interest Research Group
Virginia GASP
Washington DOC
The Washington Institute
West Virginia Tobacco Control Coalition
Wisconsin Initiative on Smoking and Health
Women and Girls Against Tobacco
YMCA
YWCA U.S.A.

Joseph A. Califano, Jr., former Secretary, Department of Health, Education and Welfare
President Jimmy Carter
C. Everett Koop, M.D., former Surgeon General

CIGARETTE TAXES IN MAJOR INDUSTRIALIZED NATIONS



Notes:

1. Foreign taxes expressed in U.S. dollars are approximate due to currency fluctuations after December 1, 1993.
2. Data provided by the Non-Smokers' Rights Association of Canada; chart produced by the Coalition on Smoking OR Health.

COMMUNICATIONS

STATEMENT OF A. PHILIP RANDOLPH INSTITUTE

My name is Norman Hill and I am the president of the A. Philip Randolph Institute (APRI), an organization of African-American trade unionists established in 1965 by the late civil rights and labor leaders, A. Philip Randolph and Bayard Rustin. APRI has over 150 chapters nationwide, and I am proud that our voter participation campaigns have brought millions of African Americans to the polls.

On behalf of our two million members, I want to express our support for President Clinton's efforts to reform the nation's ailing health care system. All Americans are anxious to see health care costs brought under control and universal access to health care assured—two major goals of the Clinton program.

African American workers comprise a large proportion of the uninsured. Even those who have health insurance live in fear of losing their jobs and the health insurance benefits that often are provided with employment. For this reason, we are particularly pleased with the President's commitment to providing universal access to health insurance benefits for all Americans. The Health Security Act includes a provision requiring employers to pay 80 percent of an employee's insurance premium. Although this provision is controversial, we view it as one of the most important elements of the President's plan. For those employers who cannot afford to bear the full burden of this cost, the plan provides significant subsidies to ease that burden.

APRI also applauds President Clinton's recognition that skyrocketing health care costs must be controlled for health care reform to be successful. We believe that limiting the annual increase in health insurance premiums will be a significant step forward in reducing these costs. In addition, as fewer health plans compete for larger shares of the consumer market, cost increases among insurance companies may also be reduced.

APRI is concerned, however, that the health care access and security that we so desperately need may come at the expense of low- and middle-income African Americans. Last year, we released a study titled *Fair Taxes: Still a Dream for African Americans*. The study shows that low- and middle-income African Americans pay a far higher share of their income in federal payroll and excise taxes as well as state and local taxes than wealthy Americans. In fact, an African American family of four with a combined income of $25,000 can pay proportionately almost six times more of its income in federal excise taxes on products like gasoline or tobacco than a family making $250,000 a year.

Whether you are African-American, Hispanic or Caucasian, if you are poor or middle-class, you will pay a higher percentage of your income in all of these taxes than if you are very rich. Our concern with the Health Security Act is that it relies heavily on flat premiums and tobacco excise taxes for financing. Based on the evidence provided in our own study, in addition to a number of studies and analyses by groups like Citizens for Tax Justice, this legislation places an unnecessary burden on the backs of all low- and middle-income Americans, including African Americans.

Health care reform is desperately needed, but a new health care system should not exacerbate existing inequities in this country. Over-reliance on regressive taxes will do just that.

As the President's health care reform plan moves through Congress, we call upon lawmakers to work with President Clinton to finance health care reform in a fair and equitable manner—in a way that asks all Americans to contribute based on their ability to pay, rather than taking more from those who can least afford it.

STATEMENT OF THE AMERICAN AGRICULTURE MOVEMENT

Mr. Chairman and Members of the Committee:

My name is Tom Asbridge. I am National Director of the American Agriculture Movement (AAM) an organization composed of and dedicated to the survival of America's family farmers. We have members in 35 states who represent farmers producing a wide variety of commodities across North America, and it is on their behalf that the AAM submits this testimony.

Rural Americans are well aware of the problems this country is facing in the health care debate, and we wholeheartedly support President Clinton's efforts to reform the nation's ailing health care system. We applaud his efforts to ensure health coverage for all Americans, and at lower costs. Unfortunately, we feel the administration's plan fails to consider the pocketbooks of all citizens in all regions of the country. Yes, the nation's health care system needs an overhaul—but not at the expense of the families who farm this country's land.

The AAM has a long history of opposition to excise taxes such as those levied on gasoline, alcohol and tobacco. These excise taxes are regressive and just plain unfair. It is not fair that rural men and women must pay a significantly higher proportion of their income of these taxes. For this reason, the AAM supports fair taxation for all Americans, regardless of how they earn their living.

Rural families rely heavily on the income generated from one of its most profitable crops—tobacco. Tobacco is one of only two crops allowed by federal policy to return adequate profit to growers. The other is peanuts. The tobacco and peanut programs are model agriculture programs that other commodity programs should copy.

Because tobacco is one crop that sustains so many rural families and communities in this country, the AAM strongly opposes the President's proposed quadrupling of the tobacco tax—the only new tax being proposed—to finance a national health care program. This tax will only serve to wipe out thousands of farms and farming communities that have already been devastated by flood, drought and past tax increases.

Farmers are under siege and are being hit coming and going. Earlier this year, we were hit with an increase in the gas tax which significantly raised the cost of driving our products to market. Now, on top of everything else, the President's plan seeks to add yet another tax to an already overburdened segment of the population.

It is ironic that currently, rural Americans pay a considerably larger portion of their income on excise taxes—33% more than urban families—and yet it is these very people who are being singled out to finance a health care program for the entire nation. Have not rural families and communities been targeted enough? Is it not time to find a more equitable way to solve the health care crisis? The AAM thinks so.

Mr. Chairman, the AAM believes that the President's plan will set the wheels in motion for the long road ahead in the quest for a national health care program. Rural families and communities would like nothing more than to see the light at the end of the tunnel in this journey. However, it cannot come at the expense of their livelihoods, their farms and their local economies. The Senate should adopt a more equitable plan that considers all citizens in all regions of the United States—not a plan that asks one segment of the population to shoulder the burden for a national program.

Thank you.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

INTRODUCTION

This country is at an historic juncture in the development of social policy. A consensus is emerging around the goal of universal health coverage for all Americans. AHA and its members have a longstanding commitment to meeting the health care needs of this country, and welcome the focus on the health status of the American people and the health care delivery system. As the reform debate has focused on the twin goals of access and cost containment, AHA and its members have advanced a vision of reform to accomplish those goals. It calls for universal access, restructuring of the delivery system, and adequate financing. The members of the AHA are ready to assume their share of responsibility for making the necessary changes to meet those goals. At the same time, it is important that other policies be examined against the health policy goals and be aligned to support their achievement.

Tax exemption of both plans and individual providers may be the appropriate means to encourage a community service mission. It may also be the means to move

community health-improvement efforts into a new era of collaboration with other community organizations and agencies, particularly local public health officials, schools, and social service agencies.

Tax-exempt health organizations should be held accountable for evaluating whether initiatives undertaken to improve health status are effective in improving it. We support a continuous quality improvement (CQI) approach to community health status. This approach identifies problems, designs and implements interventions, monitors and evaluates the effects of those interventions, and then starts all over again.

IMPLICATIONS FOR HOSPITAL TAX EXEMPTION

With the promise of universal health insurance coverage, some are questioning the continued need for hospital tax exemption. President Clinton's health reform proposal rightly preserves community benefit as the standard for awarding tax-exempt status to hospitals. The Administration's commitment to guarantee health insurance coverage to all, and the American people's support for access to health care, place health status and the delivery of health care among the top priorities of this country. Continuation of tax exemption for hospitals and other charitable health organizations under the community benefit standard is a means for this society to reinforce its commitment to universal access and health status. The award of tax exemption recognizes the charitable hospital's dedication of its resources to improving the health status of its community. It helps support the hospital to place the needs of its community at the forefront of its decision making.

As reform progresses it will become clear what the new health care environment requires. The charitable concept must evolve to reflect the times. The basic expectations of charitable hospitals will remain the same: to dedicate their resources to meeting the health care needs of their community. But what specifically they must do to fulfill those expectations will be identified community by community. Throughout the transition, however, whether as participants in or organizers of the new delivery system, the work of tax-exempt hospitals and the partnerships they forge can be expected to meet a commitment to the larger goal of improved health status.

Universal coverage does not undercut the legal basis for tax exemption. The underpinning for charitable tax exemption is public support for activities that serve the larger good—a concept that encompasses the broadest range of public purposes.

The governing body of a charitable organization has a fiduciary duty to see that the organization is organized and operated to fulfill its charitable mission; its resources must be dedicated to that purpose. Any benefit that flows to private parties must be incidental to carrying out its public purpose. When it undertakes business commitments, those decisions must be consistent with accomplishment of its mission. When it pays for goods and services, the commitment of resources should reflect the value of their contribution toward fulfillment of its purpose.

Since 1969, the promotion of health has explicitly been recognized as a purpose meriting tax exemption. Health care organizations may be awarded tax-exempt status by demonstrating that they promote health in a manner that benefits the community as a whole. The premise underlying the community benefit standard is that a public purpose is served by promoting health in a manner that benefits the larger community. The promotion of health alone is not sufficient, however; how it is done, when, and for whom are important factors. All health care providers have a professional responsibility to provide high quality services. Tax exemption requires more. The focus is not on what the hospital does, but whether those actions respond to community need. Providing charity care has been only one way to demonstrate benefit.

Universal coverage does not eliminate the purpose for exemption. Providing access to coverage does not address all of the needs related to health status. Access to insurance coverage alone will' not assure access to health services. Access to health services does not necessarily mean improved health. Focusing only on medical intervention does not address the needs related to health. Universal coverage creates the capability to pay for service, but of itself does not guarantee that services will be available when and where needed, or that all who need services will be reached. Access does not assure that service is received at the most effective point.

Meeting the community benefit standard means making the needs of the community the focal point. Benefit to the community becomes the screen against which decisions are made and the measure of success. The hospital must know the community to identify its needs, and work with the community to address those needs.

For example, is information available to encourage a healthy life style and personal responsibility for health? Is there outreach and early intervention to prevent and minimize the effects of illness? Is there support for individuals and families to prevent institutionalization, and allow independent living?

Responding only to medical needs falls short of addressing the larger issues of health status. The tax-exempt provider has the responsibility to exert leadership and take the initiative on matters of importance to health. Are efforts coordinated to address the interdependence of the needs for food, shelter, and family planning, with health status; to address violence in the neighborhoods, in the schools, and in the home? Not all that is needed can or should be done by the hospital alone.

The community benefit test is still a sound and viable basis for awarding tax-exempt status to hospitals. It places the focus at the local level and examines the merits of individual situations against the community environment in which they serve. The issue has been and should continue to be whether they are providing public benefit. Has the hospital conducted itself—made decisions, used its resources, leveraged its influence—in ways that benefit the entire community. Exemption is given in return for the commitment to meet the community's needs.

THE PRESIDENT'S PROPOSED NEW REQUIREMENT FOR CHARITABLE HEALTH ORGANIZATIONS

The Administration's proposal also includes a new statutory requirement that a charitable health care organization, with the participation of community representatives, assess the health care needs of its community and develop a plan to meet those needs. This change is consistent with AHA's vision of a reformed health care system. AHA has proposed restructuring health care delivery by establishing networks of hospitals, physicians and others that would provide a seamless continuum of care at the community level. As envisioned by AHA, these health networks would be responsible for maintaining and improving the health status of their enrollees.

Tax exemption of both plans and individual providers may be the appropriate means to encourage a community service mission. It may also be the means to move community health-improvement efforts into a new era of collaboration with other community organizations and agencies, particularly local public health officials, schools, and social service agencies.

Tax-exempt health organizations should be held accountable for evaluating whether initiatives undertaken to improve health status have any effect in improving it. We support a continuous quality improvement (CQI) approach to community health status. This approach identifies problems, designs and implements interventions, monitors and evaluates the effects of those interventions, and then starts all over again.

We believe the evaluative phase of this process is essential to making the best use of local resources and, by reporting results to the public, holds the health care system accountable to its community.

CONCLUSION

Continuing tax-exempt status for community benefit hospitals will make an important contribution toward achieving the goals of universal access and improved health status. Continuing tax-exempt status for certain health plans will also help ensure that the community health systems of tomorrow maintain a similar focus on community benefit.

STATEMENT OF THE AMERICAN WHOLESALE MARKETERS ASSOCIATION [1]

I. BACKGROUND

The American Wholesale Marketers Association represents 1,300 independent distributors in all 50 states. These companies supply convenience stores and small grocery stores with tobacco products, confectionery and candy, groceries, juices and bottled water, paper goods, health and beauty products and other sundry merchandise. The average AWMA members supplies 1,250 retail outlets and combined industry annual sales approximate $42 billion.

These full-line distributors constitute a vital link in the marketing chain between manufacturers and convenience and small retail grocer stores. Few, if any, manufacturers find it economically feasible to direct-ship the small quantity of product these retail outlets can hold in inventory. Thus, as the convenience industry grew, wholesale distributors have diversified their product mix to fill the needs of small retail merchants. However, according to industry studies, these distributors are heavily

[1] All charts referenced in this statement were prepared by Walpert, Smullan & Blumenthal, a certified public accounting firm. The composite "XYZ Company" with sales of $25 million is based on interviews with 20 wholesale distribution companies of tobacco products.

dependent on tobacco sales to keep their businesses operating, with tobacco generating 62 percent of sales and 46 percent of gross profits.

Distributors of cigarettes and other tobacco products operate at razor-thin margins because of the competitive structure of the tobacco market. According to industry data, distributors generally have gross profits in the range of 4–5 percent on cigarettes and a ratio of net income to net sales of merely 0.5 percent. Manufacturers enjoy strong market leverage with respect to popular brand names and have placed the distributors on a strict supply allocation basis. Thus, the independent distributor has a single source of supply for a popular brand name. By contrast, because of the number of distributors operating in any one market area, there is great competition to obtain retail customers.

II. AN EXCISE TAX INCREASE IS AN UNEQUITABLE DEVICE FOR RAISING REVENUE

AWMA opposes any further increase in the already-heavy excise tax on tobacco products. Such an excise tax increase unfairly singles out one limited segment of industry to bear an especially heavy burden in addressing the nationwide problem that is the escalating cost of health care.

Consumers of tobacco products already pay their fair share of taxes. The combined taxes—federal, state, local and sales—raise $14 billion annually. Moreover, excise taxes are extremely regressive. This fact has been well-documented by the Congressional Budget Office.

In addition, AWMA opposes the imposition of any floor stocks tax on those persons below the manufacturer in the chain of distribution. Properly viewed, the excise tax is imposed on the manufacturer and paid for by the consumer in the final product price. It is unfair to separately impose a tax on product in the hands of intermediaries in the distribution chain between the manufacturer and the consumer.

III. THE FINANCIAL IMPACT OF AN EXCISE TAX ON DISTRIBUTORS

A. Increased Operational Expenses

The proposed $7.50 increase in the FET will increase not only the inventory costs, but also the dollars in accounts receivable, the average of which is 15 days. This is due to the time lag between paying the manufacturers for the cigarettes and receiving payment from retailers. Therefore, an additional increase in financing will be needed to offset the increase in accounts receivable and provide working capital. This increase in working capital is needed to replenish the cigarette inventory at the increased cost. **XYZ Company will require $976,000 additional financing to fund the increased cost of inventory.** (Exhibit A)

Tobacco distributors also have a variety of additional costs associated with purchasing and holding cigarette inventory. These costs include interest expense, insurance, bad debt write-offs and security. All of these costs will increase in proportion to an increase in the Federal cigarette excise tax. (Exhibit B)

In order to fund the increased operational costs and the floor stocks tax, distributors will need to obtain additional financing. However, as demonstrated in Exhibits C & D, the imposition of the floor stocks tax and excise tax will decrease the working capital by 14 percent and increase the debt/equity by 65 percent. Financial institutions may not be willing to lend additional capital.

B. Effect on Gross Profit

As stated earlier, tobacco distributors operate on extremely thin margins. While one may argue that applying this margin, approximately four percent, to the increased price of a carton of cigarettes (current cost of $10.97 + $7.50 excise tax = $18.32) will increase the profit by 30 cents per carton. However, this "gain" will be negated by the increased operational costs. As exemplified in Exhibit E, gross profit dollars will actually decrease forcing the distributor to cut payroll and fringe benefits in order to regain the lost profit.

IV. THE DISTRIBUTOR FACES A SEVERE PROBLEM UNDER A TOBACCO FLOOR STOCKS TAX: INABILITY TO FUND PAYMENT OF THE TAX AND THE COST OF HIGHER-TAXED REPLACEMENT INVENTORY

In light of thin margins, the distributor faces two problems when the federal excise tax is increased and is coupled with a floor stocks tax on inventory held by sellers below the manufacturer in the chain of distribution.

First, the distributor must generate the income necessary to pay the substantial one-time floor stocks tax itself with respect to the inventory on hand. Merely zeroing out inventory holdings as of the effective date is not a viable option for the distribu-

tor. Continuity of purchases must be maintained to ensure continuity of supply to retail customers to retain credibility as a reliable supplier.

Second, since revenue from one inventory must be plowed immediately back to fund the purchase of the next inventory, the distributor finds that at today's margins he is unable to generate sufficient income to "step up" to the first purchase of the new higher-priced replacement inventory that includes the increased federal excise tax. (Exhibit F)

V. PROPOSAL TO INSTITUTE FAIRNESS IN IMPOSITION OF FLOOR STOCKS TAX

In order to fund both the increased inventory and the floor stocks tax, the distributor must be afforded the opportunity to apply the basic economic principle of replacement cost pricing by selling off a sufficient amount of additional inventory acquired at the old lower-taxed price. The distributor needs 36 days from the date of the floor stocks tax to generate the cash needed to pay the tax. (Exhibit G)

AWMA urges the committee to consider limiting the floor stocks tax to a taxpayer's average daily inventory over a specified period or a percentage of the inventory on hand, thus allowing the distributor the ability to realize the gain needed to pay the floor stocks tax.

Lest Congress be concerned that distributors will receive a windfall profit, several business constraints will effectively prevent this from occurring. First, cigarette manufacturers place distributors on a strict allocation basis, thus preventing distributors from increasing their inventory prior to the imposition of a federal excise tax. Secondly, even if distributors could increase their purchases, the substantial capital that would be required to support such an inventory increase would be prohibitive. Further, cigarettes have a limited shelf life of approximately 90 days. Hence, there would be no incentive for the distributor to acquire a supply that would become stale.

Finally, should a distributor realize some financial gain from this proposal, fully one-third of it would be returned to the U.S. Treasury in the form of a corporate tax.

VI. CONCLUSION

Wholesale distributors of tobacco and other convenience products represent the entrepreneurial spirit of this country. Many of these companies are owned by the grandchildren of their founders. These children and grandchildren have taken the business from the family garage to football field-sized warehouse operations, constantly adding and changing their product mix to meet the needs of today's consumer.

At the same time the business has been growing, competition among companies and from warehouse clubs has squeezed profits forcing many distributors to take on greater and greater amounts of debt. The proposed increase in the federal excise tax on cigarettes and other tobacco products and the floor stocks tax will force many of the small to mid-sized distributors to sell their business or close their doors.

XYZ COMPANY

SALES VOLUME $25,000,000

FUNDING OF INVENTORY

	CURRENT	INCREASED TAX
CARTONS ON HAND	145,000	145,000
CURRENT COST PER CARTON	$13.87	$21.22
COST OF INVENTORY	$2,011,000	$3,077,000
FINANCING NEEDED TO FUND INVENTORY LEVEL	$1,843,000	$2,819,000

ADDITIONAL FINANCING NEEDED TO FUND INCREASED COST

$976,000

EXHIBIT A

XYZ COMPANY

INCREASE IN INVENTORY CARRYING COSTS

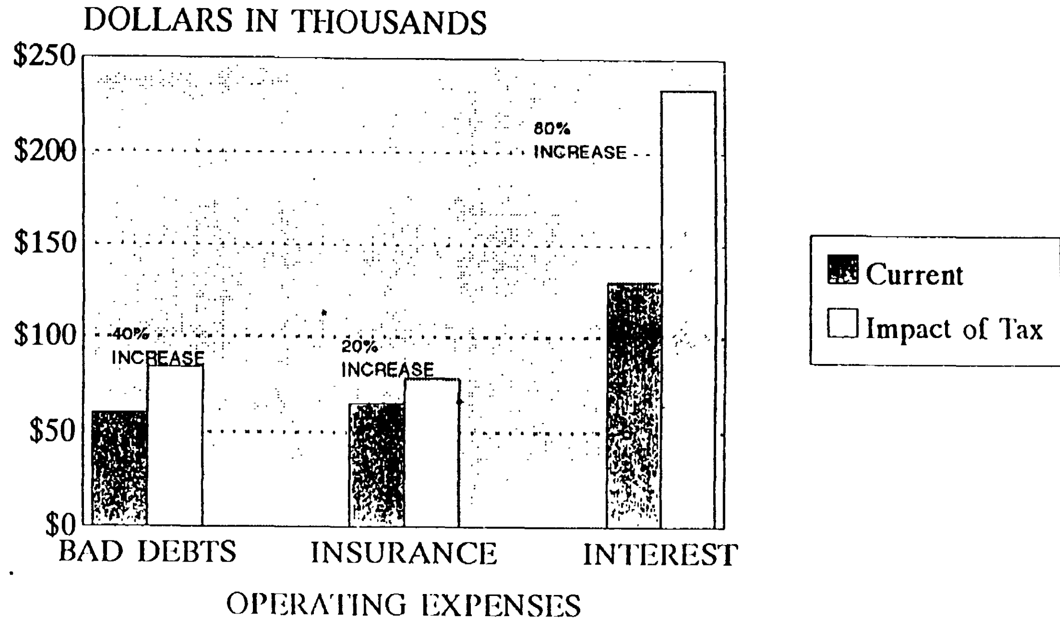
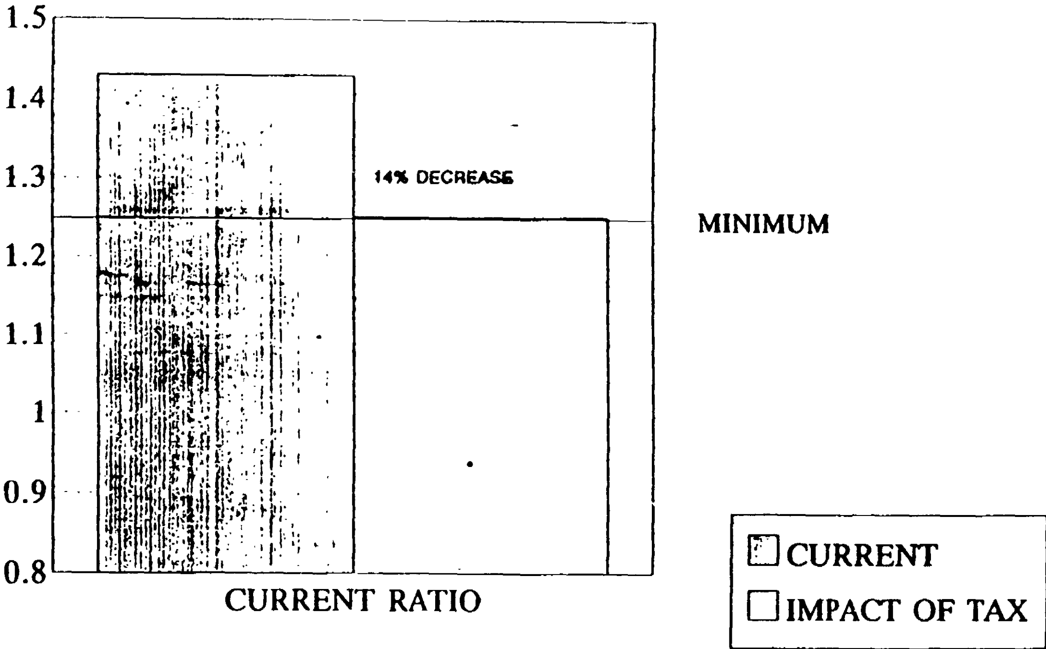


EXHIBIT B

XYZ COMPANY

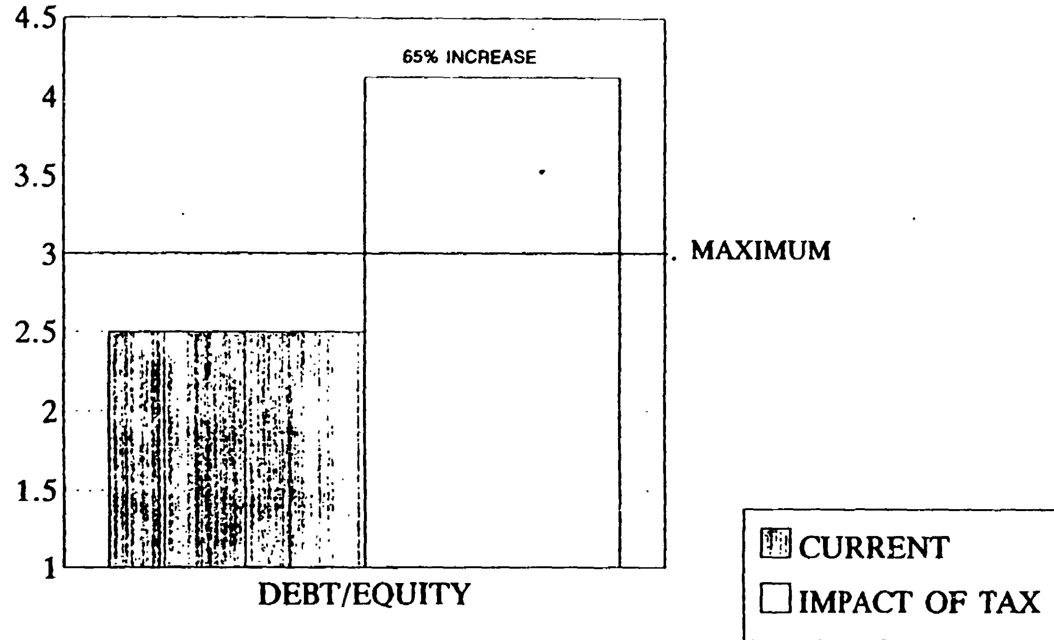
FLOOR STOCK AND EXCISE TAX



IMPACT ON WORKING CAPITAL
EXHIBIT C

XYZ COMPANY

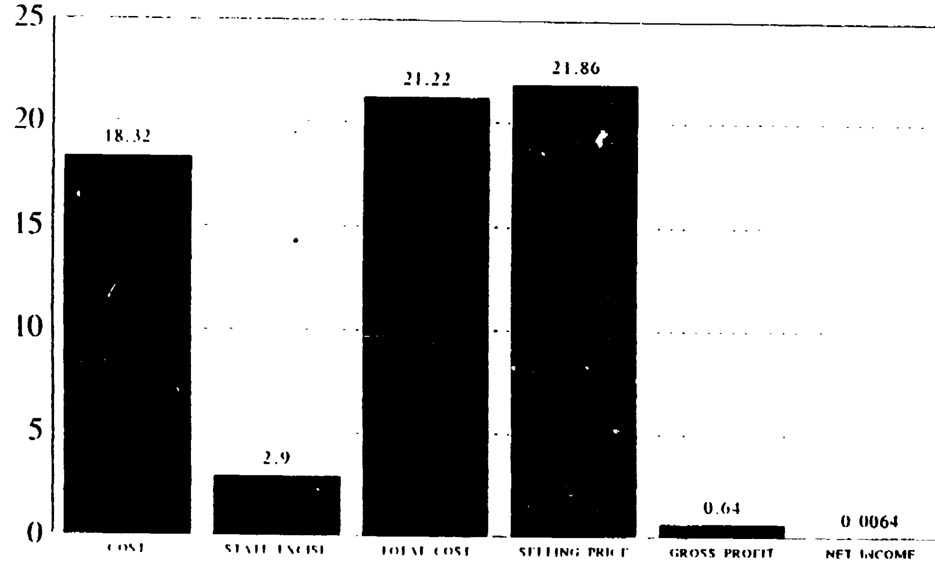
FLOOR STOCK AND EXCISE TAX



IMPACT ON LEVERAGE
EXHIBIT D

XYZ COMPANY

INCREASE IN EXCISE TAX
EFFECT ON GROSS PROFIT

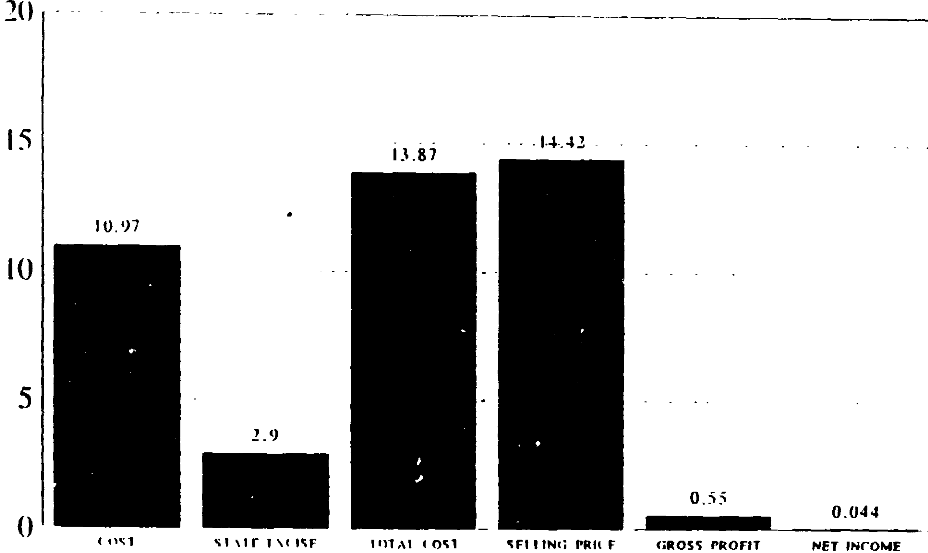


STATE EXCISE TAX IS BASED ON AVERAGE

EXHIBIT E

XYZ COMPANY

COST PER CARTON
CURRENT EXCISE TAX



STATE EXCISE TAX IS BASED ON AVERAGE

EXHIBIT E

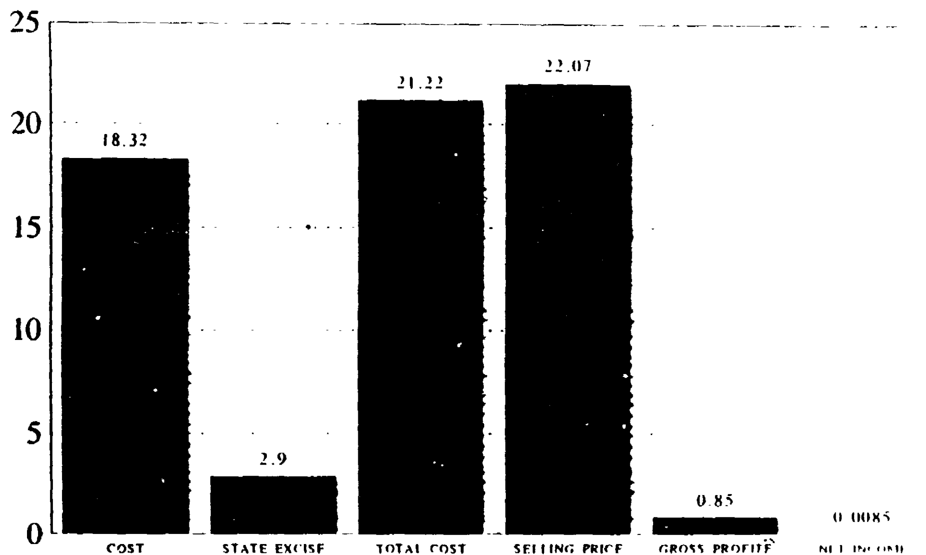
XYZ COMPANY
ALLOCATION OF GROSS PROFIT DOLLARS

EXHIBIT E

CURRENT	IMPACT OF TAX	CUTS IN EXPENSES TO REGAIN PROFIT
PAYROLL & FRINGE BENEFITS 55%	PAYROLL & FRINGE BENEFITS 55%	PAYROLL & FRINGE BENEFITS 48%
BAD DEBTS 3%	BAD DEBTS 4%	BAD DEBTS 4%
INSURANCE 3.5%	INSURANCE 4.5%	INSURANCE 4.5%
INTEREST 7%	INTEREST 12%	INTEREST 12%
OTHER EXPENSES 23.5%	OTHER EXPENSES 23.5%	OTHER EXPENSES 23.5%
PROFIT 8%	PROFIT 1%	PROFIT 8%

XYZ COMPANY

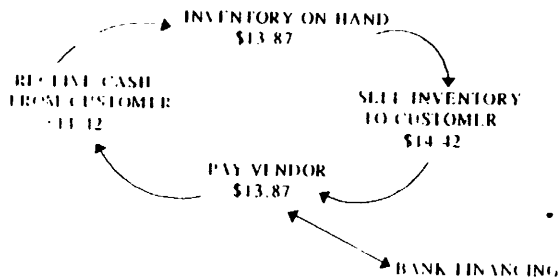
COST PER CARTON
INCREASE IN EXCISE TAX



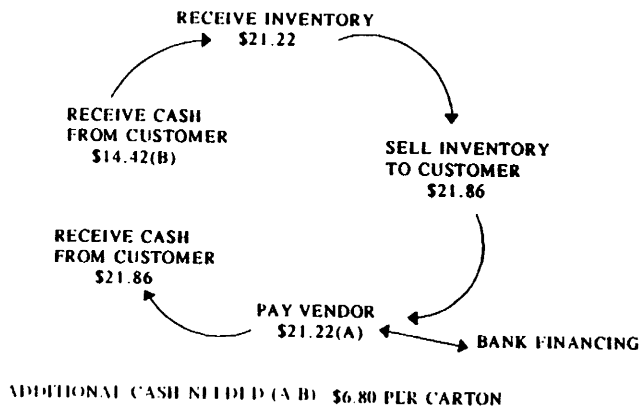
STATE EXCISE TAX IS BASED ON AVERAGE

EXHIBIT F

CASH CYCLE



INCREASE IN EXCISE TAX EFFECT ON CASH FLOW



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EXIBIT F

XYZ COMPANY

PHASE–IN OF FLOOR STOCK TAX

CASH–TO–CASH CYCLE

ACCOUNTS RECEIVABLE – DAYS OUTSTANDING	16 DAYS
INVENTORY – DAYS ON HAND	25 DAYS
TOTAL	41 DAYS
LESS: ACCOUNTS PAYABLE – DAYS OUTSTANDING	5 DAYS
TOTAL CASH–TO–CASH CYCLE	36 DAYS

THE DISTRIBUTOR NEEDS 36 DAYS FROM THE DATE OF THE FLOOR STOCK TAX TO GENERATE THE CASH TO PAY THE TAX. THE CASH WILL BE GENERATED BY SELLING THE INVENTORY ON HAND AT THE INCREASED PRICE.

EXHIBIT G

Statement of the Bakery, Confectionery & Tobacco Workers International Union

My name is Robert Curtis and I am International Vice President and head of the tobacco sector of the Bakery, Confectionery and Tobacco Workers International Union (BC&T), which represents 125,000 hard-working men and women; I also serve as President of the Kentucky AFL–CIO. We offer this testimony because United States tobacco workers are deeply concerned about many aspects of the current health care system and the potential impact of health care reform on themselves, their families and their communities.

As a result of hard-fought collective bargaining agreements, BC&T has secured excellent health care benefits for our members. Generally, these agreements provide fully-paid physician and hospital coverage as well as coverage for dental, mental health care and other important services.

BC&T AND HEALTH CARE REFORM

We are proud of the health care protection provided to members of BC&T, particularly during a time of rising health care costs and efforts by employers to cut back on health care benefits. However, we also recognize that these benefits are not free and that the growing cost of health care has resulted in lower wage increases at the bargaining table.

For this reason, BC&T strongly supports President Clinton's plan to limit the rising cost of health care through statutory limitations on the annual increase in insurance premiums. This provision alone is likely to save our members and all consumers billions of dollars every year.

In addition, our union strongly endorses President Clinton's effort to provide universal health care protection for the 37 million Americans who do not now have health insurance. Far too many employers fail to offer health insurance to their employees. It is about time they are required to do so. For those employers who cannot afford to pay the entire cost of health insurance, the plan will make available subsidies to employers and employees.

Finally, we applaud the President for proposing a comprehensive health care benefit package that mirrors those offered by many of America's Fortune 500 corporations. President Clinton's program offers the promise of universal access to a comprehensive health care program in an environment that effectively controls the unrestrained growth in health care costs.

The promise of such protection cannot be guaranteed without a stable and secure source of funding. In our view, the plan's heavy reliance on tobacco taxes to pay for part of the program gravely jeopardizes that promise. Experience at both the state and national level confirms the fact that as tobacco excise taxes increase, the amount of revenue derived from them invariably decreases. This means that the proposed 75 cent tax on tobacco would create a widening gap between the cost of the health care program and the revenues necessary to pay for it.

ECONOMIC IMPACT OF TOBACCO TAXES

Tobacco Taxes Unfairly Target the South. President Clinton has said that health care reform will expand the American job base and make our nation more competitive. We disagree. According to a recent analysis of a Price-Waterhouse study on employment and compensation in the U.S. tobacco industry, a 75-cent-increase in the federal tobacco tax would cost more than 80,000 Americans their jobs. In general, these are high wage jobs in production, manufacturing and distribution of tobacco products.

Moreover, these jobs are primarily located in one region of the country—the South. Our figures show that the South will lose close to 40,000 jobs or 3.5 times as many jobs as the rest of the country if a 75-cent federal tax increase on cigarettes is imposed. My state of Kentucky alone would suffer a projected job loss of more than 7,000, making Kentucky the second hardest-hit state in the nation, only behind North Carolina. Health care reform is a national program. One group of workers, one industry and one region of the country should not be forced to shoulder the burden.

Given the very high wage and benefit levels earned by tobacco industry workers, losing these jobs has a far greater impact on local and regional economies than the raw numbers might suggest. Because tobacco workers earn three and even four times the wages of workers in the retail and service sectors, losing 650 jobs in Durham, as an example, is really the equivalent of losing 1900—2400 lower paying jobs in retail or service.

With these job losses come a significant decrease in aggregate purchasing power and an undermining of community tax bases. The result is a decline in the standard of living within the region similar in nature to what has occurred in communities around the country which have been devastated by massive layoffs in industries such as steel, auto, machine tool, timber and aerospace. The irony, in the case of tobacco, is that it would be government policy and not legitimate market forces causing the destruction.

For the past 20 years, the South has put a premium on improving its manufacturing base. But the crippling of the domestic cigarette manufacturing industry, which is what would result from tripling the excise tax, would be a serious body blow to this effort.

Consumer Excise Taxes Are Regressive. As countless studies over the past decade have concluded, tobacco taxes are among the most regressive taxes raised by federal and state governments. According to studies by the Congressional Budget Office (CBO) and Citizens for Tax Justice (CTJ), the burden of tobacco taxes is more than five times greater on families earning $30,000 per year than it is to families earning more than $100,000 per year. For this reason, CTJ, the AFL–CIO and countless other progressive organizations in the United States have long opposed increases in consumer excise taxes as a means of financing government services and programs. It is simply an unfair tax on low- and middle-income Americans.

Retraining. Some say that retraining is the answer to the massive dislocation of tobacco workers anticipated as a result of such an extraordinary excise tax increase. We support retraining programs; they are a requisite element of any serious attempt to put displaced workers back into the economy.

But when we discuss retraining workers in the tobacco sector in the South, we must first acknowledge the inherent paradox—retraining programs alone cannot ensure that tobacco workers secure comparable employment at a comparable skill level for comparable wages and benefits. Men and women working in tobacco manufacturing facilities in my own state of Kentucky and other tobacco-manufacturing states are the highest-paid manufacturing workers in the country.

We cannot delude ourselves into thinking that any program that retrains these people for jobs in the service-sector economy can be judged as adequate. Most displaced tobacco workers would find themselves lost in the want-ads, where they would find only minimum-wage or part-time employment opportunities.

Limited unemployment benefits would not be nearly enough to carry these workers and their families through the duration of an extended retraining program which can take up to two years. Yet, extended retraining is encouraged by the U.S. Labor Department because longer training programs have lead to higher-skill, higher-wage jobs.

These concerns lead us to the conclusion that retraining is not a panacea, and that the best recourse for tobacco workers and the communities who depend on tobacco income is to preserve employment, preserve their industry and oppose exorbitant increases in the cigarette excise tax.

CONCLUSION

BC&T views health care reform as a critical priority for our members, for millions of uninsured Americans and for the nation. We support the President in this effort and recognize the challenges he faces in Congress. Ultimately, these challenges can be overcome as long as a majority of Americans believe the new health care system includes universal coverage, genuine cost-containment and equitable financing.

We believe that the President's plan addresses the first two goals. However, we remain extremely concerned that the program's reliance on tobacco taxes jeopardizes the critical principle of equitable financing. Therefore, we encourage the Senate Finance Committee to identify other funding sources that are more broad-based in scope, more progressive in design and which treat each region of the country in a fair and equitable manner.

STATEMENT OF THE COALITION OF LABOR UNION WOMEN

My name is Gloria Johnson. I am President of the Coalition of Labor Union Women (CLUW), the nation's only organization of trade union women. CLUW is an organization of 20,000 members from 75 affiliated chapters, representing 7.5 million women in unions from diverse geographic, industrial and occupational backgrounds. Since its inception in 1974, CLUW has been a strong voice on issues ranging from reproductive rights and affirmative action, to family leave and national health care reform.

The Coalition of Labor Union Women applauds the courage and commitment of President Clinton and First Lady Hillary Rodham Clinton to take on the issue of health care reform. Thanks in large part to their leadership, we now have an historic opportunity to enact a national health care plan that will guarantee everyone in this country access to high quality, affordable and comprehensive health care benefits.

The Coalition of Labor Union Women is on record in support of a single-payer approach to health care reform. We have endorsed and strongly support the American Health Security Act (H.R. 1200 and S. 491) introduced by Congressman Jim McDermott (D–WA) and Senator Paul Wellstone (D–MN). CLUW believes that ultimately the United States will have to move to a single-payer system in order to solve the many fundamental problems we face in our health delivery system. That being said, CLUW is committed to passage of health care reform that meets the principles of a single-payer system and serves the needs of working women and their families. On close examination, the Administration's Health Security Act, meets several of CLUW's basic principles for reform.

One of these key principles is universal access and we commend President Clinton's commitment to providing universal coverage by 1998. No other health reform proposal under consideration—other than single-payer—comes close to achieving this important goal.

Currently 15 million American women have no health insurance and nine million children are uninsured. Together, women and children comprise over two-thirds of the 37 million Americans without coverage. All too often jobs that are typically "women's work" like food service, clerical or retail jobs have little or no health coverage. Women also make up two-thirds of the part-time workforce and most part-time jobs provide no health benefits. Women, particularly working women, will benefit disproportionately from the inclusion of universal coverage in the Clinton bill.

Strong cost containment is a second principle by which CLUW evaluates any health reform legislation. The Administration's bill effectively puts the breaks on spiraling health care costs through statutory limits on the annual increase in insurance premiums. This single feature of the Clinton bill would likely save working women and men and all consumers billions of dollars every year.

Comprehensive benefits, including the full range of women's health care needs, is a crucial provision of the health reform package. We applaud the Clinton plan for guaranteeing a uniform, national benefit package that mirrors some of the best private health plans currently available. Better still, the Administration's plan emphasizes preventive care services designed to keep Americans healthy rather than treat them only after they become ill.

Delivery of routine mammograms, pap smears, pre- and post-natal health care top the list of preventative measures that, if available to all women, could dramatically improve women's health and save lives. This year, 44,000 women will die of breast cancer; 13,200 of these deaths could have been prevented by early detection through mammograms and early treatment. Nine out of 10 deaths from cervical cancer could be prevented by early detection through regular pap smears. Similarly, 25% of all pregnant women do not receive adequate prenatal care, a major cause of low birth weight in infants.

The Administration's Health Security Act goes a long way to address women's health care needs. The standard benefit package combined with routine physical examinations, preventative screenings and laboratory tests would provide millions of American women with basic care that is currently out of reach. In the area of family planning, the plan would offer the full range of reproductive health services, including abortions.

Under the Clinton plan, health security would become a reality for the nation's 65 million children. The standard benefit package covers children for well-baby and well-child check-ups, routine immunizations, and dental and vision care up to age 18. Fully funding the Special Supplemental Food Program for Women and Children (WIC) will help meet the nutritional needs of low-income women and children. Together, these benefits would enhance not only the health of millions of children, but also the peace of mind of their parents.

The Clinton Administration has displayed foresight and leadership by introducing a bill that acknowledges that chronic care needs are as important as acute care. The creation of a long-term home and community-based care program for Americans of all ages takes the crucial first step of meeting the chronic care needs that particularly burden our elderly. A new prescription drug benefit for the elderly and a commitment to mental health coverage are additional elements of the expansion of coverage many Americans would achieve under the President's plan.

The financing of health care reform may be the most difficult aspect of developing a plan. Yet, when it comes to fairness and equity, it is also the single most impor-

tant component of any reform package. CLUW believes that health care reform must be financed in a progressive manner based on ability to pay. To that end, we have consistently supported income taxes as the preferable funding mechanism for the nation's health care program. The Administration plan's reliance on flat premiums and excise taxes is a matter of much concern to the working women of CLUW. Consumer excise taxes—whether broad-based value added taxes or narrow tobacco taxes such as those in the Administration's proposal—are regressive, costing those with the least the greatest share of their income. Unfortunately, working women would bear a disproportionate burden. We would like to see the new health care program improve rather than exacerbate this workplace inequity and hope that this is achieved as health reform moves through Congress.

America's health care system is in critical condition and is in urgent need of reform. President Clinton has taken an admirable first step by introducing legislation that will address many of the most serious problems which exist in our current system. CLUW applauds the Administration's efforts on three of our most important principles for health care reform: universal coverage, comprehensive benefits and cost control.

Thank you.

STATEMENT OF THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE

The Council for Affordable Health Insurance commends the Honorable Chairman and Members of the Senate Finance Committee for your commitment to resolving the inequities in the American health care system. We are extremely supportive of the Committee's attempt to address the inequitable tax treatment of health benefits and would like to submit this written testimony for consideration by the Committee.

The Council for Affordable Health Insurance is an organization of companies and individuals who are vitally involved with our health care financing system and its ability to serve all segments of our population. We have researched the issue of employer-provided health benefits extensively.

Through our research, we discovered that the United States currently has two classes of citizens—those who are fortunate enough to work for generous employers and receive tax-free health benefits on the job, and those who are self-employed or purchase their own and must pay for coverage with after-tax dollars. This preferential tax treatment of employer-based health insurance can be attributed to the evolution of our nation's tax policy, beginning in the 1940's. Over the years, the tax laws have been changed to tilt more in favor of large corporations and further from those who need help the most. (*Please see Exhibit 1.*) More specifically, the tax laws have been changing in the wrong direction. Starting in 1982, the U.S. Congress has made it increasingly difficult for individuals to deduct their medical expenses and health insurance premiums. This has contributed to the alarming rise in the numbers of Americans with no health insurance coverage. (*Please see Exhibit 2–A.*) Providing an unlimited tax exclusion for employer-provided health benefits has also caused an explosion in the amount of money spent on health care in the United States. (*Please see Exhibit 2–B.*) This same tax policy has encouraged excessive coverage for some, which in turn has resulted in over-utilization of health care services and an increase in medical costs. At the same time, it has discouraged individuals from sharing in their own health care expenses.

The Council for Affordable Health Insurance believes that Federal tax policy should be modified to treat coverage that is paid directly by individuals in the same way that employer-purchased health insurance is currently treated. This change in tax policy would directly address the problem of the uninsured. Lower-income families could be provided with vouchers to buy health insurance, while middle income taxpayers would be permitted to deduct the full out-of-pocket costs of health care, both for health insurance as well as for medical expenses. Some studies estimate that this change alone could increase the number of insured by ten million, reducing the numbers of uninsured by over one-fourth, at little cost to the government or the public. If the Federal tax policy remains unchanged, medical costs will keep rising and the number of uninsured will increase.

TAX POLICY, HEALTH CARE, AND THE UNINSURED TODAY

Federal tax treatment of health care expenses has been a major contributor to the problems in the health care system. It has encouraged excessive coverage for people employed by large corporations. These employees have been exempt from the economic consequences of their health care decisions, and have driven the alarming increases in the price and utilization of health care services.

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At the same time, the erosion of tax benefits for individually-paid premiums have raised the number of people who can no longer afford to pay for their own coverage. These include workers whose employers have cut back on or eliminated payment for dependent coverage. In the 1970's, workers whose employers did not cover them or their dependents could purchase individual health insurance policies and deduct a large amount of those premiums from their gross income.[1]

Today, most of the uninsured are full-time, year-round workers or their dependents. Of the 38.5 million uninsured in 1992, 84% lived in families headed by a worker. Nearly 50% of these workers were self-employed or worked in firms with fewer than 25 employees. (*Please see Exhibit 3.*) The rate of non-insurance is particularly high in certain industries such as agriculture (46%), construction (32%), and retail trade (26%).[2] The uninsured are low-income, with 52% of the uninsured (20.2 million) having family incomes below $20,000. (*Please see Exhibit 3.*) The uninsured are young. Nearly 60% or 21.8 million of the total 38.5 million are under age 30.[3] The uninsured are not chronically without coverage. Half of the uninsured regain coverage within four months and 70% are covered within a year. Only 15% remain without coverage for two or more years.[4]

Currently tax policy permits business to deduct the full cost of health care for their employees, but provides only limited deductibility for individuals who pay for their own care. This policy has resulted in a health care system that provides generous subsidies to those individuals who work for large employers, but very limited help for the self-employed, the unemployed, people paying COBRA premiums, and people who work for companies that do not provide coverage on the job. (*Please see Exhibit 4–C.*) Ironically, this latter group are the very people who are most in need of the kind of assistance currently available and unlimited for those who are fortunate enough to work for the nations largest and wealthiest employers.

Over the years, federal tax policy has cruelly tilted ever more in favor of the large corporations and away from the people who must pay for their own health care expenses. Under current tax law, individuals may deduct health insurance premiums and health-related expenses only if they exceed 7.5% of adjusted gross income. Most taxpayers who purchase individuals health insurance receive no benefit from the medical expense deduction either because they do not itemize, or if they do itemize, they are unable to reach the floor of 7.5% of adjusted gross income except in years of unusually large medical expenses.[5] For example in 1989 only five million federal income tax returns claimed the medical expense deduction. This represented 15.9% of all itemized returns and 4.5% of all tax returns filed. This reflects a substantial decrease from tax year 1986, when the floor was at 5% of adjusted gross income. In 1986, 10.5 million returns claimed the medical expense deduction, representing 25.9% of all itemized returns and 10.2% of all tax returns filed.[6]

Corporations may treat health care as a business expense, thereby avoiding not only personal income taxes on the benefit, but Social Security (FICA), Medicare Part A (SECA), and state income taxes as well. Estimates of the cost to the federal government of this tax-free treatment of corporate health care benefits in fiscal year 1992 have been set at $33.5 billion by the Treasury Department and $37.7 billion by the Joint Committee on Taxation.[7] Meanwhile, the self-employed individual must pay both the Social Security (FICA) and Medicare Part A (SECA) tax and may only deduct up to 25% of the cost of providing health insurance from personal income. (That is, when the temporary, partial deduction is active. It currently expired on December 31, 1993, and the self-employed have no deduction for health insurance benefits available to them unless Congress enacts a measure that will enable them to do so.) Part-time workers, students, the unemployed, and everyone not receiving employer-provided health insurance receive no tax deduction at all. These Americans must pay for all their health insurance with after-tax dollars, doubling the effective cost of the coverage.[8]

Finally, the tax subsidy of employer-based insurance is not equally distributed across all workers. Those with higher incomes and more job security are more likely

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[1] Craig, Victoria. *Federal Tax Policy: Its Effect on Health Care Costs, Coverage and the Uninsured*, The Council for Affordable Health Insurance, October 1992.

[2] Employee Benefits Research Institute (EBRI). *Special Reports #123, #133 and #145, February 1992, January 1993 and January 1994, respectively.*

[3] Ibid.

[4] Swartz, Katherine and McBride, Timothy D. "Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry*, Fall 1990.

[5] Noto, Nonna. "Tax Issues Related to Health Insurance Reform," *Congressional Research Service Report for Congress*, January 2, 1992.

[6] Ibid.

[7] Ibid.

[8] Health Solutions for America. *Federal Tax Policy and the Uninsured*, January 1992.

to receive employer-provided health insurance than those in lower-paid and less permanent jobs. Also, the exclusion is more valuable to higher-income workers because taxes increase as income rises. For every 100 dollars in health insurance paid by an employer, the employee in the 15% bracket saves 15 dollars in taxes, whereas the employee in the 28% bracket saves 28 dollars. When state and local taxes are added, the health care tax savings can reach as high as 35% of the total cost of coverage.[9]

OPTIONS FOR HEALTH CARE REFORM IN ADDRESSING AMERICA'S TAX POLICIES

Tax policy does not exist in a vacuum. It is driven by economic and political conditions. And, in turn, it drives economic decisions. The health care system we have today is in large measure the result of tax policies that have been in effect since 1939. The favorable tax treatment of employer-financed health care has resulted in an employer-based system. The increasing restrictions on individually-paid health care since 1982 has contributed to the decline in individually-paid health insurance coverage.

Looking to the future of health care reform, there are four options that are possible in federal tax treatment of health insurance for Americans

1. **Business as usual—same tax policy that exists today.** Providing an unlimited tax exclusion for employer-provided health benefits has encouraged excessive coverage for some, which in turn has caused over-utilization of health care services and an increase in medical care costs. At the same time, it has discouraged individuals from paying for their own health care expenses. If this situation is allowed to continue, medical costs will keep rising and the number of uninsured will increase. There will come a point in time when even those who have basic insurance will not be able to afford certain health services. This will then increase the number of uninsured even higher than 38.5 million.

2. **Allow equal tax treatment for all health care costs—by allowing individually-paid premiums to be treated the same as employer-paid premiums.** Most of the health care reform proposals before Congress recognize the tax treatment inequities individuals and the self-employed who do not receive employer-provided health benefits are subject to. Congress should enact health care reform that equalizes the tax treatment for coverage that is paid directly by individuals with the deduction that is available to employer-purchased health insurance. This change is tax policy would directly address many of the problems in the current American health care system. Lower-income families could be provided with vouchers to buy health insurance, while middle-income taxpayers would be permitted to deduct the full out-of-pocket costs of health care. This change in tax structure would avoid the burden on small businesses that would result from many of the current health care reform proposals before Congress (such as the Health Security Act, the American Health Security Act, and the Managed Competition Act, to name a few) and allow individuals and employers to choose whether employer-based coverage, individual coverage or some other group arrangement is the best approach to securing the individual's health care needs.

3. **Move away from employer-provided health benefits and shift the responsibility to the individual.** Some of the health care reform bills before Congress (such as the Health Equity and Access Reform Today Act) would end the link between health care tax breaks and the place of work. This would require people to obtain health insurance if it isn't provided by their employer. It could give government subsidies to low-income people and allow a tax deduction for middle-income people.

4. **Allow the creation of Medical Savings Accounts (MSA's) under any of the preceding options.** In his address before Congress last September, President Clinton implored "personal responsibility" to serve as a guiding principle in reforming the American health care system. Yet, his reform package and several other major reform proposals (such as the Health Security Act, the American Health Security Act, and the Managed Competition Act, to name a few) confine personal responsibility only to one's choice of health insurance coverage. In these above proposals, each individual is personally accountable for selecting a health plan, but little else. Faced with a menu of different policies, those persons who chose to join more expensive plans pay the extra premium out-of-pocket. Other proposals only focus on changing the tax treatment of health premiums, for example, placing a tax cap on an employer's contribution toward health insurance. While these are both mecha-

[9] Fuchs, Beth, et al. "Taxation of Employer-provided Health Benefits," *Congressional Research Service Report for Congress*, October 2, 1992.

nisms that can and will promote more responsibility in insurance choices, they do little to encourage people to use medical services more prudently at the point-of-purchase. Medical Savings Accounts are a promising type of insurance instrument which embody the principle of personal responsibility in a broader and more meaningful way. MSAs are an insurance arrangement that give consumers a financial incentive to control their own health care costs by combining a high-deductible health insurance policy with an individual savings account. The health insurance policy provides insurance protection for large medical bills, while the savings account portion of the plan, called a Medisave account, provides a source of funds to pay small medical expenses out-of-pocket.[10]

There are at least fourteen Medical Savings Accounts bills before Congress. The Medical Savings Account would be fully portable and would assist the individual during times of unemployment. (Medical Savings Accounts are really Section 125 or "Flexible Spending" Accounts, except that an individual would be able to roll-over the remaining balance at the end of the year instead of spending it or losing it back to the employer.) These MSAs would also have beneficial system-wide effects such as: restoring the direct relationship between patients and physicians; empowering patients to take a more active role in their own care; reducing administrative costs by taking insurers out of the small claims business; and bring market forces back into the American health care system. This approach would result in the reduction of total health care costs as individuals begin to have an economic incentive to consider the cost of treatment.

CONCLUSION

One of the most urgent problems of our time is the American health care system and its inability to address health care costs and access. The system we have today is in large part a consequence of federal tax policy. The United States has an employer-based health care financing system because the tax laws have encouraged corporations to provide virtually unlimited, first-dollar coverage to employees. At the same time, the erosion of tax benefits for individuals has contributed to the growing problems of the uninsured.

Providing an unlimited tax exclusion for employer-provided health benefits has encouraged excessive coverage. Between 1950 and 1987, employer-contributions to group health insurance plans rose from 0.8% to 5.1% of total compensation through the work place. The total value of those benefits has been estimated to be as much as $145 billion.[11] The unlimited tax exclusion also has resulted in extremely rich benefit plans which have insulated employees from the consequences of their own health care decisions. This has encouraged excessive utilization and an indifference to cost, making the United States the health care wastrel of the world.

The Council for Affordable Health Insurance believes that an essential part of the solution to the dual problems of the uninsured and health care inflation lies in making federal tax policy equitable between employer-based groups and individually-paid health expenses. This will result in more people having coverage and in a greater awareness of the cost of health care services by consumers.

Enclosures.

[10] Jensen, Gail A. and Morlock, Robert J. "Why Medical Savings Accounts Deserve A Closer Look in Health Reform." *The Journal of American Health Policy*, Vol. 4, No. 3, May/June 1994.

[11] Fuchs, Beth, et al. "Taxation of Employer-provided Health Benefits," *Congressional Research Service Report for Congress*, October 2, 1992.

Exhibit 1

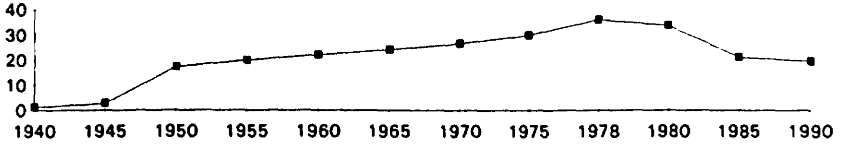
Historical Overview of Tax Policy and Health Care						
YEAR	Health Care Spending in Billions	% GNP	Millions Covered			Change in Tax Code
			Blue Cross and Blue Shield	Commercial Group	Commercial Non-group	
1940	3.8	4.9	6.0	2.5	1.2	1939 – First compiled into single code in 1939. Section 23 established medical expense deduction (M.E.D.)
1950	12.7	4.4	38.8	22.3	17.3	N/A
1955	17.7	4.4	50.7	38.6	19.9	1954 – I.R.C. reorganized in 1954 Section 23 now Section 213. M.E.D. for expenses that exceed 3% AGI if under age 65.
1960	27.1	5.3	58.1	54.4	22.2	N/A
1965	38.9	5.9	63.3	65.4	24.4	1965 – MEDICARE and MEDICAID enacted Added $150 deduction for 1/2 of insurance premiums M E D for expenses that exceeded 3% AGI.
1970	67.2	8.6	80.5	75.1	26.7	N/A
1975	132.9	8.3	86.4	87.2	30.1	N/A
1980	250.1	9.1	86.7	97.4	33.8	1982 – Eliminated the $150 deduction for insurance premiums Raised M E D floor from 3% to 5%.
1985	422.6	10.5	78.7	99.5	21.2	1986 – M.E.D. floor raised from 5% to 7.5% Added a 25% deduction for self-employed to purchase health insurance

Please note Since Congress enacted the self-employed 25% tax deduction in 1986, Congress has made the extension an annual ritual, often retroactively – 1988, 1989, 1990, 1991, and 1992 It expired on December 31, 1993, and has not been extended Since that time, the number of individuals with individual health insurance policies has dropped to 18.2 million.

Sources HIAA, 1994, and Cummulative Changes in the Internal Revenue Code of 1939, 1954, and 1986

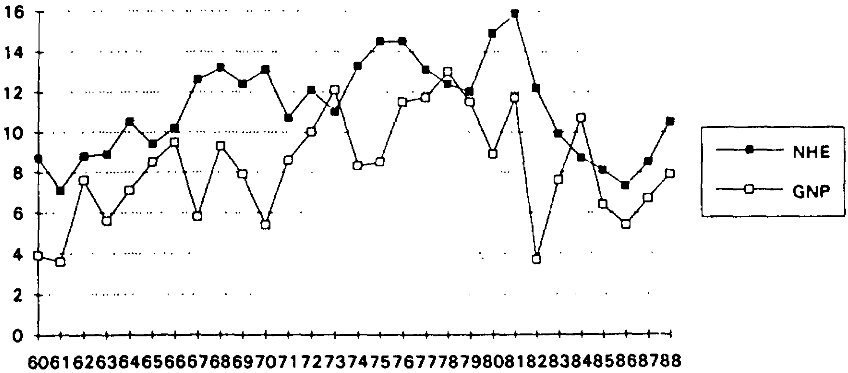
Exhibit 2-A

Millions With Individual Health Insurance Policies



Please note: the number of individuals dropped from 19.7 million in 1990 to 18.8 million in the reporting year of 1993.
(Sources: HIAA Source Book of Health Insurance Data, 1994 and the Employee Benefits Research Institute, January 1994.)

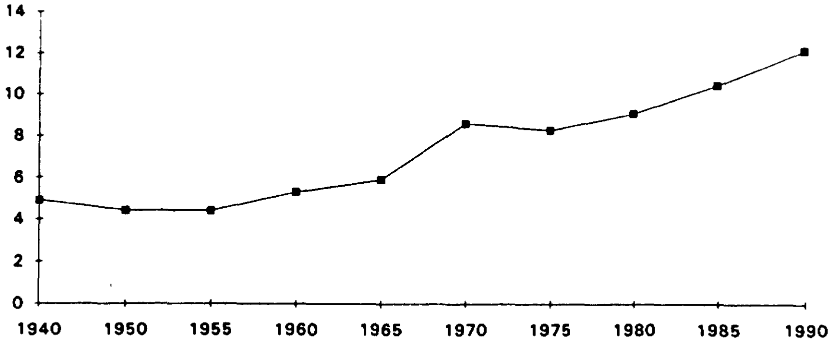
Annual Rate of Growth, National Expenditures vs Gross National Product



(Source: HIAA Sourcebook of Health Insurance Data, 1994)

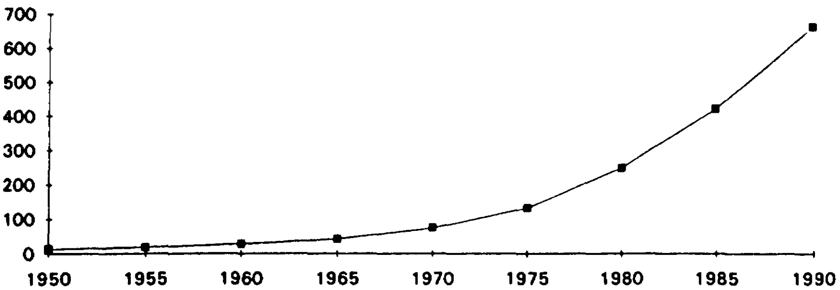
Exhibit 2-B

Health Care Spending as % of GNP



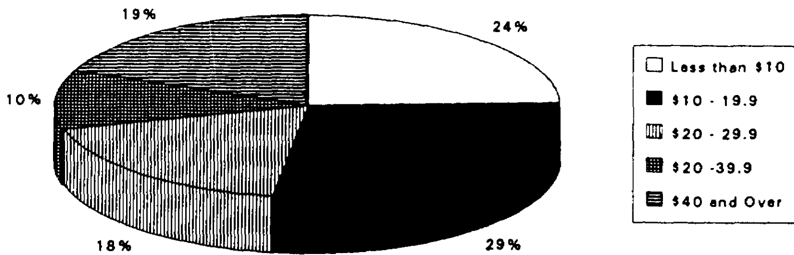
Please note: for reporting year 1993, it is estimated to be 13.8%. (Source: HIAA Sourcebook of Health Insurance Data, 1994.)

National Health Expenditures (in billions)

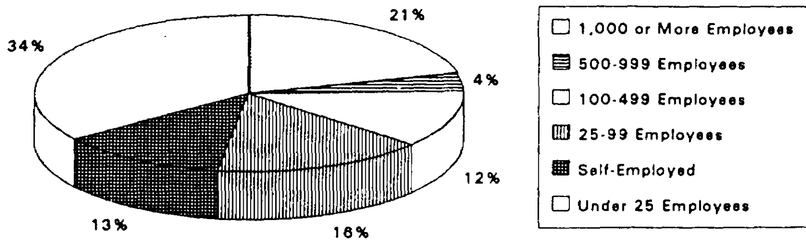


Please note: for reporting year 1993, it is estimated to be $819.9 billion. (Source: HiAA Source Book of Health Insurance Data, 1994.)

Exhibit 3



(Source: EBRI Special Report #145, January 1994)



(Source: EBRI Special Report #145, January 1994.)

DUCKS
UNLIMITED
INC.

NATIONAL HEADQUARTERS

One Waterfowl Way
Memphis, Tennessee 38120-2351
(901) 758-3825

WASHINGTON OFFICE

1155 Connecticut Avenue NW
Suite 500
Washington, DC 20036
(202) 452-8824

May 11, 1994

The Honorable Daniel Patrick Moynihan
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Ducks Unlimited is the largest international wetlands conservation organization. Founded in 1937, we have over 530,000 members across the United States and have funded and performed wetland improvement projects in all fifty states. Since inception, DU's members have raised over two-thirds of a billion dollars in private funds to restore, protect, and enhance the wetland habitats of North America. This has resulted in nearly seven million acres in Canada, Mexico, and the United States being protected for wildlife.

We are aware of the Finance Committee's consideration of proposals that would have the effect of decreasing the annual revenues generated for wildlife habitat protection by the firearms excise tax. The fact that funds are available to state governments for habitat restoration work and research from this tax, has helped lead our organization to pledge a portion of the contributions received within each state to wildlife habitat work there. We dedicate a share of our funds as matches to monies received by states under the Pittman-Robertson program.

If Congressional action results in reducing the revenues states receive under the Pittman-Robertson program it will not only affect their federal share, but could compound the loss by damaging matching environmental partnership programs that groups like ours have with the states. We would oppose the idea of weakening wetland restoration efforts occurring in the states under this program by decreasing the revenues available to the Pittman-Robertson fund.

Thank you for your consideration of these concerns. We ask that you include this letter in the record of the Committee's recent hearing on this issue and share it with the other members of the Finance Committee and their staffs.

Sincerely,

Scott Sutherland
Director of Federal Relations

EMBASSY OF JAMAICA
1520 NEW HAMPSHIRE AVE. N W
WASHINGTON, D C 20036

TELEPHONE (202) 452-0660
FACSIMILE (202) 452-0081

REF NO

May 9, 1994

The Hon. Daniel Patrick Moynihan
Chairman
Finance Committee
U.S. Senate
205 Dirksen Bldg.
Washington, D.C. 20510

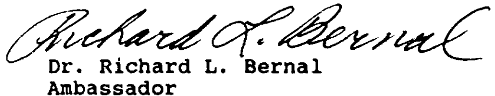
Dear Senator Moynihan:

Attached is a letter that the Embassies of three Caribbean Basin counties, including Jamaica, recently sent to the Hon. Dan Rostenkowski, Chairman of the House Ways and Means Committee concerning the effects that tax increases on cigars may have on Caribbean economic development.

I am bringing this letter to your attention as well because of your long-standing interest in and support for strong U.S./Caribbean trade relations. As you continue the health care debate, I thought you would want to be aware of the importance of the Caribbean cigar industry to Caribbean Basin economic growth, and to the U.S./Caribbean commercial partnership.

Please accept my continued best wishes and the assurances of my highest regards,

Sincerely,



Dr. Richard L. Bernal
Ambassador

Attachment

The Honorable
Dan Rostenkowski
Chairman
House Committee on Ways and Means
United States House of Representatives
Washington, D. C. 20515

Washington, April 8, 1994

Dear Mr. Chairman:

We, the Ambassadors of major cigar exporting countries in the Caribbean Basin, appreciate the strong support you have demonstrated over the years for promoting the economic stability and security of the people of the region through trade enhancement initiatives such as the Caribbean Basin Economic Recovery Act. In this regard, we are writing to bring to your attention our concern about the pending proposal for a very large increase in the Federal excise tax on cigars. The proposed increase (over 300% for large cigars; over 3,000% for little cigars) would be detrimental to our countries' economies.

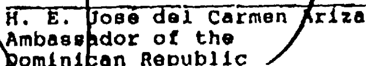
Collectively, the Dominican Republic, Honduras, and Jamaica account for nearly 60% of the total value of U.S. imports of cigars and cigar tobaccos. These products are an important source of foreign exchange earnings for our countries. For example, in 1993, Dominican exports of cigar tobacco products to the United States reached $38 million. This represents about 10% of traditional Dominican exports to the United States and 7% of traditional exports to all destinations.

There are about 18 cigar manufacturers in our three countries employing some 7,600 workers in addition to those engaged in growing cigar tobaccos. We expect cigar production in some countries, such as Jamaica, to double in the coming year. Such growth will generate hundreds of additional jobs as well as increased foreign exchange earnings.

Due to the extreme price sensitivity of cigars, the proposed increases would substantially reduce cigar sales in the United States. That is, the U.S. market for cigars and cigar tobaccos would most certainly shrink, causing economic adverse effects in our countries. As you know, alternative uses for our productive resources are limited. Like many sectors in our trade-based economies, the Caribbean cigar industry is highly dependent upon U.S. market access and consumption for its continued viability. In Jamaica, nearly 100 percent of annual cigar production is exported to the United States; in the Dominican Republic and Honduras nine out of ten cigars are destined for the U.S. Market.

In light of these considerations, we hope you will convey to the other distinguished members of your Committee the concerns of your neighbors from the Caribbean Basin about the potential for unintended harm inherent in a large increase in cigar taxes and that under your leadership an alternate or much more moderate approach could be devised.

Sincerely,



H. E. José del Carmen Ariza
Ambassador of the
Dominican Republic

H. E. René A. Bendaña
Ambassador of Honduras

H. E. Richard Bernal
Ambassador of Jamaica

STATEMENT OF THE DISTILLED SPIRITS COUNCIL OF THE UNITED STATES, INC.

My name is Fred Meister and I am President/CEO of the Distilled Spirits Council of the United States (DISCUS). DISCUS represents producers and marketers of distilled spirits. DISCUS and its member companies commend President Clinton for his commitment to improving America's health-care system and his sound policy decision of not proposing another tax increase on distilled spirits to help pay for this most important endeavor.

The nation's distillers oppose any new taxes on any form of beverage alcohol. Unfortunately, however, recent discussions have suggested that there should be a broadening of the financing package included in the President's plan, to include increases in the Federal excise tax on alcohol in general or, in some instances, on distilled spirits in particular.

There is absolutely no justifiable basis to single out distilled spirits for another tax hit. There are particularly strong facts and public policy arguments that support exempting distilled spirits from an FET increase. Why is a further increase in distilled spirits taxes particularly unfair?

1. IT IS A FACT THAT DISTILLED SPIRITS TAXES WOULD NOT RAISE ANYWHERE NEAR THE REVENUE ESTIMATED

- For the first time ever, after the 1991 8% distilled spirits tax increase, Federal government statistics report that the government actually collected less in total revenue—$89 million—than the year before. As a result of the 1985 distilled spirits-only tax increase of 19%, over the next three fiscal years the government actually collected $2.7 billion less than anticipated due to rapidly declining distilled spirits sales.
- The FET on distilled spirits is 29% higher today than it was in 1985. One distilled spirits tax increase took place in 1985 and another in 1991. Additionally, there have been 200 state tax increases affecting distilled spirits since 1980.
- Despite these two tax increases at the Federal level, the government's own figures show that 1993 collections were $72 million less than in 1980.
- Distilled spirits are the most highly taxed consumer product in the United States. Taxes on a typical purchase of distilled spirits total 44% of the retail price. The federal tax burden on distilled spirits is much higher than that on either beer or cigarettes.
- 1993 FET collections from distilled spirits were 2.4% less than in 1992.

2. A DISTILLED SPIRITS TAX INCREASE WILL NOT DEAL WITH THE SERIOUS PROBLEMS OF ALCOHOL ABUSE, ESPECIALLY AMONG GROUPS SUCH AS UNDERAGE DRINKERS

- By increasing the tax on distilled spirits, the government is sending a wrong message that one form of alcohol is qualitatively different from other forms of alcohol. This undermines effective public education. Alcohol is alcohol is alcohol.
- There is no drink of moderation, only responsible practice by each and every citizen.
- Every Federal agency understands that alcohol is alcohol is alcohol. Unlike some products, the Federal government has recognized that an increasing number of scientific, medical studies may point to potential health benefits from moderate consumption of beverage alcohol. The extent that there are any such benefits is unknown, but if such benefits exist, they are equally accrued from distilled spirits as well as beer and wine.
- The Federal government also recognized alcohol as alcohol as alcohol when, in 1988, identical health warning labels were placed on beer, wine and distilled spirits.
- A distilled spirits-only tax will not be politically viable. Voters are responsible citizens, parents and people of logic with a strong understanding of what is good public policy. They will support a tax policy that treats all beverage alcohol products fairly and will oppose one that does not.

3. A DISTILLED SPIRITS TAX WOULD DRAMATICALLY AND UNFAIRLY REVERSE CURRENT FEDERAL TAX POLICY THAT RECOGNIZES THAT DISTILLED SPIRITS ARE UNFAIRLY TAXED

- In 1991, excise taxes were raised on distilled spirits, beer and wine. The House and Senate Conference Report supporting that increase states, "there are substantial differences among the different alcohol beverages in present-law effective tax rates on alcohol content. The increased rates are designed to ameliorate such differences in part."
- Despite the 1991 tax increases on beer, wine and distilled spirits, the alcohol in distilled spirits is burdened with an FET that is twice that imposed on beer

and almost three times the tax rate for table wine. The present FET on distilled spirits is $13.50 per proof gallon (defined as a standard U.S. gallon containing 50 percent by volume of ethyl alcohol). The comparable FET per proof gallon for beer is $6.45 and for table wine, $4.86.

- On a per-drink basis, the Federal tax on a typical distilled spirits cocktail is 10.5 cents, compared to 5.4 cents for 12 ounces of beer and 4.2 cents for 5 ounces of standard table wine.
- Only 31 percent of the alcohol consumed is distilled spirits, but distilled spirits still account for 49 percent of the Federal excise tax revenue received from the beverage alcohol industry.

4. A HIGHER DISTILLED SPIRITS TAX WILL HURT LOW AND MIDDLE INCOME AMERICANS AT LEAST AS MUCH AS ANY OTHER TYPE OF TAX

- An excise tax on distilled spirits is just as regressive and damaging as is a tax on beer. Beer is not the "drink of the working man or Joe Six-Pack" any more or less than distilled spirits.
- The demographics of drinkers are virtually identical by income levels. There are virtually as many drinkers of distilled spirits as of beer in the $30,000 and less income range and in the $30-$60,000 income range.

5. A HIGHER DISTILLED SPIRITS TAX COULD PUT TENS OF THOUSANDS OF AMERICANS OUT OF WORK AND JEOPARDIZE BILLIONS OF DOLLARS IN ECONOMIC ACTIVITY

- As a result of the 1985 and 1991 distilled spirits tax increases, 87,000 American workers lost their jobs. That is more than the population of any one of 17 state capitals. These lost jobs are represented substantially by small "Mom and Pop" operations, because almost two-thirds of U.S. alcohol retail establishments have fewer than five employees.

In summary, a distilled spirits tax increase will not raise anywhere near the revenue estimated. A distilled spirits tax increase will not deal with the serious problem of alcohol abuse. A distilled spirits tax increase will not meet any standard of fairness. A distilled spirits tax increase will not avoid hurting low and middle income working Americans and would put thousands of people out of work as well as jeopardize billions of dollars in economic activity.

Again, the nation's distillers commend the President for his decision to exclude distilled spirits from the health care financing package. We urge the Congress to stand by the President's decision. Thank you.

STATEMENT OF GROUP HEALTH INC. (GHI)

Group Health Incorporated (GHI) is a New York not-for-profit health service corporation which provides health benefit coverage for over 2 million people. GHI is pleased to provide this written statement for the hearing of the Committee on Finance on the tax treatment for health care organizations under the Administration's Health Security Act (the Act).

GHI supports the President's goal of reforming the country's health care system to expand the availability of affordable, quality insurance coverage. Not-for-profit organizations like GHI have historically played a very important role in providing affordable, quality coverage for many Americans who would not otherwise be covered by for-profit companies providing health insurance. These GHI subscribers are generally older and lower paid than average New York State residents. In large measure GHI is already part of the solution to our nation's health care problem. To help ensure accessible and affordable health care as well as universal coverage for all Americans, favorable tax treatment of not-for-profits must be continued.

GHI is part of an important New York State tradition, that has encouraged the providing of both the delivery and the insuring of health care, through not-for-profit organizations, be they the not-for-profit voluntary hospitals or the not-for-profit health insurers and HMO's. GHI is organized in New York under Article 43 of the Insurance Law, a special section of law solely devoted to not-for-profit health service corporations. As an Article 43 corporation, GHI is subject to significantly greater scrutiny, regulation and legal restrictions than its for-profit health insurance competitors. Further, health insurance and related activities are the only lines of business GHI is permitted to underwrite. Moreover, these rules mandate the establishment of state statutory reserve as a liability for not-for-profit insurers.

GHI was established in the late 1930's by a group of socially conscious organizers as a means to provide access to medical care and coverage primarily to the poor, the working class and the middle class. From its inception, GHI has maintained a

true not-for-profit philosophy and a commitment to the community of New York State. As a result, GHI throughout its history has been an innovator in providing cost effective accessible coverage to its subscribers and in developing programs that the for-profit commercial insurers initially avoided due to the unknown risks involved. GHI was in fact at the forefront of developing programs in New York State that today are taken for granted such as:

- First dollar coverage through networks of PPO styled providers. In fact with over two million covered people and over 30,000 providers in its various networks, GHI is the largest PPO operating solely in one state.
- GHI was the first carrier to provide dental coverage. In fact, GHI wrote the early accepted treatise on dental coverage.
- GHI was the first carrier to provide out-of-hospital psychiatric coverage.
- GHI was the first carrier to make available second surgical opinions.
- GHI was the first carrier to pay for in-hospital medical care.

GHI continues to innovate and take similar risks, whether it be the development of service specific PPO's, participation in government sponsored pilot projects like the Child Health Plus Program[1] or the development of a PPO/POS styled Managed Medicaid program.[2] Additionally, as a community oriented not-for-profit company, GHI has also developed programs to aid the broader community it serves. Traditional commercial health insurance carriers have shown little interest in doing similar community service initiatives due to the risk involved. Without the continued support of the special benefits provided under current tax law, these programs risk being adversely affected.

Examples of such programs include:

- Providing through its wholly owned certified Home Care agency health service and health evaluations to the homeless in the Port Authority area of New York City. This project was originally funded in 1987 in cooperation with the New York State Department of Health. Since 1989, GHI has maintained the program at its own cost and provided nursing, referral, support service and health evaluations to the homeless. GHI is the sole insurer in New York involved in projects to extend medical care to the homeless.
- Providing dental care and service through its Albany Dental Health Facility to poor AIDS patients and special preventive dental care to poor and underserved children in the Albany area.
- Providing on-site training and guaranteed jobs to select students of Martin Luther King Jr. High School in New York City through a program GHI developed and brought to this public high school.

The special contribution of not-for-profit insurers is recognized under current law which provides a deduction under Section 833 of the Internal Revenue Code (the Code) for the difference between 25 percent of the not-for-profit organization's claims and expenses over its adjusted surplus. The current encouragement of not-for-profit carriers also allows favorable tax treatment for premium reserve growth in calculating the tax liability for these health insurance organizations. For a number of reasons, retaining these special tax incentives or replacing them with corresponding incentives for not-for-profits, like GHI, is essential in aiding the goal of expanding affordable health care coverage. This is so because:

1. Not-for-profits provide a competitive benchmark to for-profits in prices, coverage and competitive market innovation.
2. Not-for-profits provide a competitive benchmark to for-profits in measuring efficiency and administrative costs.

---

[1] GHI is part of a demonstration project for affordable health insurance for children in low-income families ("Child Health Plus") that provides health insurance for at least 56,000 children in New York State. Despite repeated efforts by the state of New York to encourage all licensed health insurers to join this program, only GHI and the state's other not-for-profit health insurers have developed health insurance products for these low-income children. GHI established its demonstration project in the medically underserved area of the South Bronx. GHI's work in this regard was recently recognized by the International Foundation, which awarded GHI its Creative Excellence in Benefits award for this program.

[2] Another example of community service that will be at risk without special tax incentives is GHI's voluntary program to assist Medicaid recipients. GHI has applied to the New York Department of Health to establish an HMO which targets Medicaid recipients. The program will provide affordable health coverage which might not otherwise exist. To our knowledge, there is no commercial health insurer involved in a similar undertaking—establishing an HMO whose target market will be Medicaid beneficiaries. Without continued favorable tax treatment for GHI and similar organizations, high risk populations in geographically undesirable areas will have a considerably greater difficulty being integrated into "mainstream" health plans.

3. Not-for-profits are laboratories for innovative health insurance practices and coverage programs.
4. Not-for-profits serve citizens who would otherwise be underserved.
5. Not-for-profits can bridge the transition to universal coverage (and fill the gap in universal coverage if a less than 100% coverage plan is adopted).
6. Not-for-profits voluntarily serve a high percentage of small businesses and individuals.
7. Not-for-profits save Federal, state and local governments money (75% of GHI's clients are government employees) in several ways:

a. by lower premiums
b. by providing portable coverage that reduces "out and back" administrative costs
c. by minimizing administrative costs
d. by maximizing benefits per dollar of premium

Attached to this statement is a report submitted by the independent economic consulting firm of J.W. Wilson & Associates that more fully addresses many of these issues and the compelling argument of why not-for-profit health insurers continue to deserve and need tax preferential treatment especially in an era of health care reform. In fact, the Clinton Administration has testified previously before Congress in favor of continued tax-exemption for hospitals and other nonprofit health care providers, explaining that:

> "The achievement of universal coverage, and resulting elimination of the need for charity care, does not mean that the activities of nonprofit health care providers will be indistinguishable from those for-profit providers.
>
> [n]profit providers generally provide services to the community in addition to the treatment of fee-paying patients. *Treating patients who are unable to pay the cost of the care is only one type of additional service* that nonprofit providers offer today. Others include medical research, educational programs, health screening, immunization, preventative care, and outreach programs. As noted above, these preventative, community-based services are important to meet community needs and achieve control over health care costs."[3]

This same rationale applies to the special benefits afforded not-for-profit health insurance corporations under current law. While it is. true that the Administration's proposal will require health insurance plans to provide open enrollment and community-rating, *this is only one feature of the not-for-profit plans that make them unique and essential* to universal coverage.

As noted, GHI historically has viewed its mission as serving the health and social needs of the community of New York State. Throughout its 55 year existence, GHI has voluntarily initiated programs and aggressively pursued actions which clearly address community needs and benefits. As such, GHI has traditionally offered coverage to individuals and small groups on a community-rated basis and on an open enrollment basis without medical underwriting or evidence of insurability. As part of the move to health care reform on both the Federal and state level, it is likely that all companies providing health care coverage whether they be not-for-profit or for-profit organizations, will have to follow similar underwriting requirements. As a result, proposals have been suggested to remove the tax preferential treatment of the not-for-profits. GHI strongly believes that such a move would be a mistake, the result of which would be the diminished participation or the elimination of not-for-profit insurers in a market best served by the not-for-profits.

GHI, like most not-for-profit health service corporations, is restricted and limited both as to its lines of business (health-related only), the use of its funds for investment purposes, its ability to raise or maintain capital, and by the State liabilities imposed upon it. In particular, as a New York State Article 43 corporation, GHI is required by law to establish a Statutory Reserve over and above its claims reserve. This reserve, which is required for the protection of our subscribers and which is funded from income, serves as GHI's only source of capital and is set at an amount equal to 12½% of GHI's earned premiums. Contributions to this Statutory Reserve are required to be made at the rate of an amount equal to a minimum of 1% of earned premium per annum until such Statutory Reserve is fully funded. This Stat-

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[3] Selected Tax Provisions in the Administration's Health Security Act: Hearing Before the Subcommittee on Select Revenue Measures of the House Committee on Ways and Means, 103rd Cong. 1st Sess. (December 14, 1993) (statement of Maurice B. Foley, Deputy Tax Legislative Counsel (Tax Legislation), Department of the Treasury).

utory Reserve is not a "free reserve" which a company can invade at will. If a company falls short of its Statutory Reserve requirement in New York, it must submit a detailed plan to the Superintendent of Insurance for restoring such required reserves. Yet under current law, GHI's as well as other not-for-profits, do not receive any Federal tax preference for this required liability for Federal Income Tax purposes.

Therefore, GHI suggests, if Section 833 and its related provisions are to be eliminated (as proposed in the Health Security Act), continued tax preferential treatment should be given to not-for-profits in a more direct and meaningful form. A tax preference could be designed for organizations that meet certain criteria. These organizations should be permitted to take their contribution to State Statutory Reserves as a deduction for Federal Income Tax purposes or, in the alternative, that earned income which is required for the establishment of State Statutory Reserves be taxed at a maximum tax rate which would be equivalent to the Alternative Minimum Tax. Under such a proposal all income earned in excess of the State Statutory Reserve in a given year would be taxed at the full corporate tax rate. A not-for-profit should not be subject to the full corporate tax rate for funds required to meet a state liability.

In order to qualify for tax preferential treatment GHI proposes that a not-for-profit organization meet the following standards:

(1) Be organized as a not-for-profit and operate pursuant to state law defining and regulating not-for-profit health service corporations.

(2) Be subject to state limitations on the kinds and types of investments the not-for-profit can make.

(3) Have substantially all activities of such organization involve the providing of health insurance or other health related activities.

(4) Prohibit any of its net earnings inuring to the benefit of any private shareholder or individual.

(5) Continuously operate in all markets (individual, small group and large group) throughout its service area and provide coverage on an open enrollment basis without medical examination or evidence of insurability. Additionally, individual and small group coverage must be underwritten on a community rated basis.

(6) Incur expenses (administrative charges) of less than 15% of premium.

(7) Have no more than 10% of the earnings of such organization result from the earnings of for-profit subsidiaries.

Such tax preferential treatment for such qualified not-for-profit health service corporations, GHI believes, is appropriate and necessary for the continued viable participation of not-for-profits in this tumultuous health care market. If what remains of the not-for-profit health service coverage system is effectively decimated as the result of the tax policy under health care reform, it may be lost forever and difficult or impossible to resurrect in the future.

GHI supports fair tax treatment of health insurance plans recognizing differences among them in servicing community needs. As recognized by the Administration, not-for-profit health providers are distinguishable from for-profit providers because of the additional services that not-for-profits offer. GHI is similarly distinguishable from other health insurers. Clearly, insurance companies facing "bottom line" pressures will have difficulty in voluntarily providing the creative additional services which must exist for the more equal treatment of the disadvantaged population envisioned in the Administration's proposal. The removal of special tax treatment for not-for-profit health insurance providers would threaten the ability to maintain this community service philosophy. Given the limitations imposed on the not-for-profits as well as the tradition and commitment of the not-for-profits, we believe this would be a disservice to the cause of health reform and those not-for-profit health service corporations, like GHI, who already are part of the solution of the nation's health care problems.

GHI thanks you for this opportunity to present this testimony and requests that you carefully consider the results of the elimination of tax preferential treatment for not-for-profits, as well as our alternative suggestions related to State Statutory Reserves and the arguments set forth in the attached paper from the economic consulting firm of J.W. Wilson & Associates.

Attachment.

STATEMENT OF DR. ROBERT JOHNSTON, ON THE ECONOMIC IMPACT OF THE HEALTH SECURITY ACT'S INSURANCE COMPANY TAX PROVISIONS, ON BEHALF OF GROUP HEALTH INC. (GHI)

Group Health Incorporated (GHI) is a New York not-for-profit health service corporation which provides health benefit coverage for over 2 million people. GHI has requested that I submit this analysis of the tax treatment of non-profit health insurance companies under the Administration's Health Security Act and other proposed health care reform legislation.

Current tax law contains special tax benefits for Not-For-Profit (NFP) health insurers in recognition of the valuable role they have played and continue to play in providing affordable and high quality health insurance to the public. For a number of reasons, retaining these special tax incentives for NFPs or replacing them with corresponding incentives is essential in aiding the goal of expanding affordable health care coverage. This is so because:

1. NFPs provide a competitive benchmark to For-Profits (FPs) in prices, coverage and competitive market innovation.
2. NFPs provide a competitive benchmark to FPs in measuring efficiency and administrative costs.
3. NFPs are laboratories for innovative health insurance practices and coverage programs.
4. NFPs serve citizens who would otherwise be underserved.
5. NFPs can bridge the transition to universal coverage (and fill the gap if a less than universal coverage plan is adopted).
6. NFPs voluntarily serve a high percentage of small businesses.
7. NFPs save national, state and local governments money (75% of GHI's clients are government employees) in several ways:
    a. by lower premiums
    b. by providing portable coverage that reduces "out and back" administrative costs
    c. by minimizing administrative costs
    d. by maximizing benefits per dollar of premium

CURRENT TAX TREATMENT

The Tax Reform Act of 1986 (TRA 86) eliminated the full tax exemption of NFP health insurers. Under TRA 86, NFPs pay tax under the rules relating to non-life insurance companies (Section 831 of the Internal Revenue Code).

However, in subjecting NFPs to income taxation, Congress recognized the special importance of NFP health insurance providers, and crafted special rules in Section 833 of the Code, applicable to GHI and similar Blue Cross/Blue Shield-type NFP organizations. These rules reflect the recognized role of NFPs in providing affordable, community-wide insurance for health care expenses and recognition that these NFP corporations provide an essential service to the community beyond that provided by traditional FP insurers. The Section 833 benefits include exemption from taxation of increases in unearned premium reserves and, most importantly, a deduction from taxable income equal to the excess of (1) 25 percent of the sum of health claims and expenses over (2) adjusted surplus. Although the Section 833(b) deduction offsets regular taxable income, it is not allowed as a deduction against Alternative Minimum Taxable (AMT) income. The result of the TRA 86 was that NFP insurers began paying an effective income tax rate approximating the statutory AMT rate of 20 percent.

ADVERSE IMPACT OF LEGISLATIVE PROPOSALS

By deleting these special allowances of the TRA 86, the tax provisions of the Administration's proposed Health Security Act would drain the scarce capital of NFP insurers and impose an income tax increase of as much as 70 percent. The Committee should understand the full significance that such a large tax increase would have for NFP insurers. Unlike stockholder-owned firms, NFP insurers are totally dependent on funds generated internally to provide capital reserves required by law. Increased taxes will make it much more difficult to raise capital, starving the expansion of health insurance services. Paying the proposed tax increase can only be accomplished by (1) reducing insurance coverage so that capital ratios do not fall below levels required by New York state law and prudence, (2) by slowing innovation and expansion of coverage, or (3) by raising rates. All of these results defeat the Administration's objectives of expanding access to insurance coverage and containing health care costs.

RAISING TAXES ON NFP INSURERS WOULD BE INEQUITABLE

The equity of tax legislation cannot be realistically assessed without analyzing its impact on the *effective tax rate* incurred by the various firms to which it applies. The tendency of effective tax rates—i.e., actual tax expense as a percentage of pretax income of firms—to depart from statutory tax rates by varying amounts for different types of firms is a well-known and often highly controversial feature of the real-world application of tax laws. The Health Security Act (and similar tax proposals) would sharply boost NFP insurers' taxes even though they already pay tax rates comparable to those paid by large mutual companies (Prudential, Metropolitan, and Principal Financial) and higher than the tax expense incurred (including deferred tax benefits) by the largest stockholder-owned diversified health insurers, such as Aetna, Travelers, and CIGNA. Comparative tax rates are shown on Exhibit 1.

Although the Tax Reform Act of 1986 ended NFP health insurers' statutory tax exemption, it attempted to shield NFPs from the full brunt of the 34 percent statutory tax rate. Viewed from the perspective of real world effective tax rates, this apparent "special treatment" actually produced a more equal impact of taxation than would otherwise have been the case. As shown on the attached Exhibit 1, the tax rate paid by GHI since 1987 (20.66%), including the impact of the TRA 86 special allowances, has averaged over four (4) percentage points higher than the effective tax rate experienced by stockholder-owned health insurers (15.91%). As also shown on Exhibit 1, GHI's tax rate is within approximately three (3) percentage points of the 23.88% tax rate paid by the largest mutual firms—even though they are not eligible for the NFPs' "special" tax benefits.

Forprofit insurers have opportunities to avoid taxation that are not equally available to NFP insurers. Stockholder-owned and mutual health insurers are typically diversified across several lines of insurance, enabling the pooling of the relatively small investment funds generated by health insurance with the larger pools of investment funds accumulated in property-casualty and life operations. This pooling of funds, as well as the funds raised by stock companies through securities sales, enable FP insurers to invest in more risky, less liquid, and more tax-advantaged investments than would be possible or prudent for NFP insurers. Unlike stock-financed firms, NFP insurers cannot issue stock to make up losses on tax-advantaged but risky investments such as real estate or common stocks. Because of the requirements of New York's NFP health insurer law, its need to maintain liquid resources to meet its rapidly maturing claims, and because of its lack of access to equity financing (mandated by state law), GHI, for example, invests almost exclusively in high-quality Treasury and corporate debt instruments of short or intermediate maturity. If the NFP insurers are hit with higher tax rates, they will probably consider modifying their investment portfolios to shift more funds into municipal bonds and other tax-advantaged instruments. However, because NFP health insurers do not have life or property-casualty insurance businesses to generate investment funds and tax shelters, tax-exempt income is not, and realistically cannot be, as important a source of income for NFP health insurers as for FP firms.

Experience has shown that the NFP health insurer provisions of TRA 86 have achieved their objective of narrowing the wide and inequitable variations in effective tax rates that would otherwise exist. The result is that current tax law imposes an effective tax rate on GHI that is similar to or higher than the rate incurred by forprofit mutual and stockholder owned health insurers. The most likely practical result of the NFP health insurer related income tax provisions of the Health Security Act will be to impose a higher effective tax rate on NFP insurers than on stock-financed and mutual health insurers. Reasonable arguments can be made for subjecting NFP health insurers to a *lower* tax rate than FP firms. Reasonable arguments can even be made for subjecting NFP firms to the *same* tax rate as FP firms. But surely it would be perverse public policy to impose a higher effective tax rate on NFP health insurers than on FP insurers.

EFFICIENCY, EXPENSES AND EXECUTIVE COMPENSATION

A *significantly* higher percentage of GHI's premiums are paid out in benefits (and conversely a lower percentage goes to expenses and commissions) than is true in the FP sector of the industry. GHI pays health care benefits equal to more than 85 percent of the premiums collected; the FP insurance industry total is less than 70 per-

cent.[1] GHI's expenses are about 10 percent of premiums; the FP insurance industry total is more than 30 percent.[2] (See table)

Another way to view relative efficiency is to examine administrative costs relative to benefits paid. The comparison is startling. While GHI's administrative costs are 12 percent of benefits, the industry average is 48 percent, or about than 4 times as great. Important reasons for this difference are the sales commissions and executive compensation paid by FP insurers. For example, in 1993 the average compensation for the top five executives of large stock insurance companies was about $1,000,000 each; for GHI it was $213,600.

BENEFIT AND EXPENSE COMPARISONS

	GHI	For-profit insurers		
		All Policies	Group Policies	Individual Policies
Benefits As a Percentage of Premiums	86.1%	68.1%	73 8%	53.2%
Expenses As a Percentage of Premiums	10.25%	32.8%	27.7%	45.3%
Expenses As a Percentage of Benefits	11.9%	48.2%	37.5%	86.4%

Source Best's Aggregates & Averages—Accident/Health Insurers, and GHI Annual Report, 1993.

Other important differences that warrant special tax consideration for NFPs include the following:

NFPS ARE LABORATORIES FOR INNOVATIVE HEALTH CARE FINANCING

A. PPO's (Preferred Provider Organizations) and HMO's (Health Maintenance Organization) were experiments brought to fruition by NFPs.

B. NFPs (particularly GHI) lobbied for the use of schedules of allowances in Medicare rather than using higher usual, customary and reasonable fee provisions.

C. NFPs broke new ground in providing coverage for mental health and dental services—and keeping costs reasonable for those services.

NFPs HAVE UNIQUE CLIENT PROFILES

A. GHI's clients are lower income and more elderly than the average New York state citizen.

B. A large percentage of GHI coverage is for children.

C. A much higher percentage (75%) of GHI insurance is for government employees.

CONTRIBUTIONS TO UNIVERSAL COVERAGE (PAST AND FUTURE)

Many of those covered by NFPs would not otherwise have health insurance, and others would be paying a higher portion of their disposable income for the same coverage. Even the Health Security Act as proposed will not reach universal coverage for years. Alternative proposals would not achieve universal coverage until 2004 . . . and some not at all.

NFP Health Insurance can continue to increase the percentage of citizens with health insurance and bridge or narrow the transition gap if any of these plans fall short.

[1] Sources: GHI 1993 Annual Statement to the New York Insurance Department and *Best's Aggregates and Averages* for Accident and Health Insurers, 1993 Edition. GHI's paid benefits were $906 million out of $1,052 million of premiums while the national totals for all stock and mutual companies were $47.3 billion of benefits out of 69.5 billion of premiums.

[2] Sources: GHI Annual Statement and Best's Aggregates and Averages. GHI's expenses were $107.8 million (10.25% of premiums) while the stock/mutual company total was $22.8 billion (32.8% of premiums).

SMALL BUSINESS AND NFPs

One of the most hotly contested issues in the current debate is "employee mandates," particularly for small businesses. In that NFPs like GHI offer community-wide enrollment to small businesses, they are already assisting on that front. By offering community-wide open enrollment at reasonable rates to small businesses, which voluntarily purchase health insurance, GHI is helping to reduce the need for compulsory small business mandates. NFPs can only continue to provide this vital small business service with adequate tax incentives.

CONCLUSION

NFP insurers have played and continue to play a vital role in providing quality health care insurance to America. The continuation of tax preferences for NFP health insurance organizations is an important element in furthering the goal of enhancing affordable health care coverage for every American by preserving and encouraging a vibrant, innovative, competitive not-for-profit health insurance sector.

DR. ROBERT JOHNSTON & J.W. WILSON & ASSOCIATES

Robert Johhston, Ph.D., has twenty five years of public policy analysis experience: As a professor at the U.S. Military Academy (West Point, N.Y.) and the University of Arkansas at Little Rock, as a state legislator, as Chairman of the Arkansas Public Service Commission (appointed by then-Governor Bill Clinton), and as an economic consultant. He has a B.S. M.E. from Rice University, an M.A. from Oxford University and a Ph.D. from Columbia University.

J.W. Wilson & Associates is a full-service economic counsel firm with more than twenty years experience in insurance and other public policy issues.

EFFECTIVE TAX RATES
GHI VS. THREE LARGEST STOCKHOLDER OWNED AND MUTUAL HEALTH INSURERS

1987-1992

GHI	1987	1988	1989	1990	1991	1992	Average for All Years
Income Tax	$938,146	$915,409	$1,065,283	$688,943	$3,174,991	$4,184,132	$10,966,904
Income Before Tax	$5,477,148	$6,169,051	$5,305,000	$3,912,000	$15,098,000	$17,109,377	$53,070,576
Effective Tax Rate	17.13%	14.84%	20.08%	17.61%	21.03%	24.46%	20.66%
AGGREGATE OF THREE LARGEST STOCK HEALTH CARRIERS 1987-1992							
Income Tax	$458,100,000	$311,500,000	$398,600,000	$44,100,000	$59,000,000	$24,000,000	$1,295,300,000
Income Before Tax	$2,286,900,000	$1,457,000,000	$1,920,000,000	$976,200,000	$1,324,000,000	$179,000,000	$8,143,100,000
Effective Tax Rate	20.03%	21.38%	20.76%	4.52%	4.46%	13.41%	15.91%
AGGREGATE OF THREE LARGEST MUTUAL HEALTH CARRIERS 1988-1992							
Income Tax		$132,116,000	$267,635,000	$186,298,000	$581,827,000	$752,873,000	$1,920,749,000
Income Before Tax		$1,234,389,000	$1,148,663,000	$1,635,590,000	$1,888,398,000	$2,136,563,000	$8,043,603,000
Effective Tax Rate		10.70%	23.30%	11.39%	30.81%	35.24%	23.88%

Data Sources: Stock Company Data from Annual Reports to Stockholders
GHI data from GHI's Statutory Annual Statements, adjusted for actual tax return liabilities. Mutual data from A. M. Best.

Exhibit 1
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EFFECTIVE TAX RATES
THREE LARGEST STOCKHOLDER OWNED HEALTH INSURERS

1987-1992

	1987	1988	1989	1990	1991	1992	1987-1992 TOTAL
AETNA							
Income Tax	$161,100,000	$104,500,000	$180,600,000	$10,100,000	($88,000,000)	NMF 1/	$368,300,000
Income Before Tax	$1,027,900,000	$804,000,000	$820,000,000	$624,200,000	$417,000,000	NMF	$3,693,100,000
Effective Tax Rate	15.67%	13.00%	22.02%	1.62%	-21.10%	0.00%	9.97%
TRAVELERS							
Income Tax	$123,000,000	$102,000,000	$84,000,000	NMF 1/	$16,000,000	NMF 1/	$325,000,000
Income Before Tax	$444,000,000	$157,000,000	$508,000,000	NMF	$323,000,000	NMF	$1,432,000,000
Effective Tax Rate	27.70%	64.97%	16.54%	0.00%	4.95%	0.00%	22.70%
CIGNA							
Income Tax	$174,000,000	$105,000,000	$134,000,000	$34,000,000	$131,000,000	$24,000,000 2/	$602,000,000
Income Before Tax	$815,000,000	$496,000,000	$592,000,000	$352,000,000	$584,000,000	$179,000,000	$3,018,000,000
Effective Tax Rate	21.35%	21.17%	22.64%	9.66%	22.43%	13.41%	19.95%

1/ Not meaningful because pretax income was negative.

2/ Figure reflects add-back of $182,000,000 tax benefit related to prior year. Reported tax was a negative expense of ($158,000,000).

Data Sources: Annual Reports to Stockholders

Exhibit 1
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EFFECTIVE TAX RATES
THREE LARGEST MUTUAL HEALTH INSURERS

1988-1992

	1988	1989	1990	1991	1992	1988-1992 TOTAL
PRUDENTIAL						
Income Tax	$204,197,000	$161,158,000	$137,992,000	$339,396,000	$370,301,000	$1,213,044,000
Income Before Tax	$761,948,000	$624,328,000	$1,060,504,000	$1,273,513,000	$1,345,239,000	$5,065,532,000
Effective Tax Rate	26.80%	25.81%	13.01%	26.65%	27.53%	23.95%
METROPOLITAN						
Income Tax	($140,770,000)	$2,154,000	($67,496,000)	$127,456,000	$261,687,000	$183,031,000
Income Before Tax	$317,781,000	$256,296,000	$197,584,000	$209,598,000	$460,955,000	$1,442,214,000
Effective Tax Rate	-44.30%	0.84%	-34.16%	60.81%	56.77%	12.69%
PRINCIPAL FINANCIAL GROUP						
Income Tax	$68,689,000	$104,323,000	$115,802,000	$114,975,000	$120,885,000	$524,674,000
Income Before Tax	$154,660,000	$268,039,000	$377,502,000	$405,287,000	$330,369,000	$1,535,857,000
Effective Tax Rate	44.41%	38.92%	30.68%	28.37%	36.59%	34.16%

Data Source: A. M. Best

NOTES TO EXHIBIT 1

Description of Effective Tax Rate Calculations

GHI Tax Rate. The calculations of effective tax rates in Exhibit 1 attached to this report are derived from publicly reported financial information For GHI, the income before tax amounts were taken directly from GHI's statutory financial statements as filed with the New York Department of Insurance. The amounts shown for GHI's income taxes are taken directly from tax returns filed with the Internal Revenue Service. Tax return amounts were slightly less than taxes paid per GHI's statutory statements because the statutory statements reflected tax liability estimates that were subsequently revised for tax filing purposes. If the unrevised statutory tax expense figures had been used, the computed tax rate for GHI would have been 21.79 percent.

Accounting Basis Figures for stockholder-owned firms are derived from Annual Reports to Stockholders, which are prepared using Generally Accepted Accounting Principles (GAAP). Figures for GHI and mutual health insurers are derived from statutory Annual Statements filed with state insurance regulators, and were obtained by J. W. Wilson & Associates from GHI or through A M. Best's electronic data service. Figures for 1987 were not available electronically from A M Best. GAAP financial statements for GHI and the mutual health insurers are not available

Statutory accounting is a systematic basis of accounting which is significantly different from GAAP accounting. The most important income tax-related difference is that statutory accounting generally reflects taxes paid in the current year and does not reflect deferred income tax liabilities or benefits which are recognized under GAAP accounting. The stockholder-owned firms used in this comparison paid substantially more income taxes during 1987-1992 than their reported GAAP income tax expense for those years because they incurred large deferred tax benefits that will reduce taxes paid in subsequent years. GAAP accounting , which reflects tax benefits incurred in the current year but which will reduce tax payments in subsequent years, more accurately presents the economic substance of the tax expense for these large diversified firms. GHI and other similar health-only insurers do not have deferred tax liabilities or benefits of a magnitude comparable to large diversified insurers. Thus, although GHI's tax expense would probably be different from that reported on its statutory Annual Statements if GAAP accounting were used. J. W. Wilson & Associates does not believe that the difference between the effective tax rate computed under GAAP accounting for GHI or similar health-only insurers would be substantially different from the effective rate computed under statutory accounting for such firms.

STATEMENT OF THE HEALTHCARE FINANCING STUDY GROUP

The Healthcare Financing Study Group ("HFSG") is pleased to submit this testimony to the Senate Finance Committee regarding the federal tax treatment of health providers. The HFSG is a national trade association of investment bankers, bond counsel, bond insurers and other firms that serve the needs of non-profit health care institutions for capital to finance the efficient delivery of health care services throughout the United States. This testimony focuses on (1) the importance of allowing non-profit health providers to retain their tax-exempt status under Internal Revenue Code[1] Section 501(c)(3), and (2) the need to eliminate or expand the $150 million volume limitation on Section 501(c)(3) non-hospital bonds issued by these providers.

TAX-EXEMPT HEALTH PROVIDERS

The health reform debate has triggered renewed consideration of the appropriate standards for granting tax-exempt status to health care providers in the United States. Currently, the "community benefit" standard permits hospitals and other charitable health care providers to qualify for tax-exempt status under Section 501(c)(3). This standard has been defined and applied by the Internal Revenue Service ("IRS") differently depending upon the type of organization and the nature of health services rendered. In the case of hospitals, for example, the IRS focuses on whether the hospital operates an emergency room open to the entire community regardless of ability to pay, accepts Medicare and Medicaid patients on a non-discriminatory basis, has a governing board representative of the community served, has an open medical staff, and/or conducts medical research and educational programs.[2] The IRS' community benefit standard does not incorporate an explicit charity care requirement, although provision of an open emergency room and compliance with Medicare/Medicaid regulations generally entail a substantial amount of uncompensated care. For integrated health care delivery systems, which integrate the provision of hospital and physician services, the IRS applies more rigorous criteria in determining whether to grant tax-exempt status. Under President Clinton's Health Security Act (the "Act"), hospitals and other health care providers exempt under Section 501(c)(3) would be required to conduct annual community health needs assessments and develop a plan to meet community health care needs. The proposal attempts to codify the IRS' community benefit standard.

Critics of non-profit health care providers have attempted to raise doubts as to whether the community benefit standard is appropriate in light of the Administration's goal to provide universal health care coverage for all Americans. These critics argue that universal coverage will do away with the need for charity care and that some providers do not provide their communities with other benefits commensurate with the value of the tax exemption. Others point to abuses by some non-profit entities as a reason for tightening standards for tax-exemption.

The critics have failed to consider certain fundamental benefits provided by non-profit health care institutions. Unlike for-profit entities, non-profit health care providers must elevate their patients' interests over profit-making objectives. The motive to maximize profits may cause for-profit providers to avoid locating in a particular geographic area or avoid providing certain benefits, because to do so would be unprofitable. By contrast, non-profits generally are obligated to serve all persons in the community regardless of ability to pay. Non-profits typically bear the responsibility of providing services in economically underprivileged areas. (A good example is the Cook County Hospital in Chicago, which is called upon to serve an unusually high volume of gunshot victims, who often require expensive, complex care.)

Non-profits conduct the majority of medical research and education in the United States—compared with the minimal research and education offered by for-profits. It is non-profits that typically offer specialized care units such as burn and trauma centers, which are costly to operate and rarely provide commensurate return on the investment. Similarly, the children's hospitals in the United States are non-profit, and these facilities, again, provide relatively high-cost, low-return services for the nation and their communities such as pediatric intensive care units, infant intensive care units, neonatal units, and tertiary care such as treatment for congenital defects, pediatric nephrology, and pediatric hematology/oncology. Increasingly, these non-profit children's hospitals are expanding their services to the community through outreach services and outpatient clinics. A good example is the Children's Hospital and Medical Center of Seattle. Among the numerous community outreach

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[1] All section references herein are to the Internal Revenue Code of 1986 (the "Code"), as amended, unless otherwise noted.

[2] *See* IRS Hospital Audit Guidelines, IRS Manual Transmittal 7(10) 69–35 (March 22, 1992).

programs operated by this non-profit hospital are: a Children's Resource Center, which provides child and teen health information through community education programs and a newsletter; a Parent Resource Center, which offers information and education about children's health; and the Odessa Brown Children's Clinic, which provides medical, dental and counseling services to children in inner-city Seattle with programs that include a sickle-cell disease clinic, foster care medical case management, a dental clinic, health education, and nutrition counseling.

Such varied community benefits are typical of non-profit health care institutions and should be evaluated carefully by Congress before consideration is given to possible new standards for tax-exempt status.

The HFSG understands the importance of reconciling the Administration's goal of providing universal health care coverage with appropriate standards for tax exemption for non-profit health care providers. At the same time, it should be noted that forces beyond the control of Congress and non-profit health care providers have led to significant consolidation and downsizing of the United States' non-profit health care sector. Changes in health care delivery under any reform plan will only contribute to this trend. Reform is intended to, and therefore likely will, shift resources away from tax-exempt acute care and extended care facilities into the primary and preventive care arena. Additionally, the cost containment that is a major goal of health reform will increase imperatives for efficiency in operations and facilities. Existing institutions will need to be merged or otherwise converted into facilities that are more responsive to the dictates of health reform, old facilities may have to be sold or torn down, and new facilities may have to be constructed, all of which will require new sources of funding. The ultimate results will be increases in the efficiency of health care service delivery, but achieving these desirable goals will require new and significant investment along the way.

As this trend continues, the prospect of loss of tax-exempt status under potential new standards is daunting for non-profit health care providers. While it generally will be difficult to measure the effects of subjecting tax-exempt health care organizations to the federal income tax, it is not difficult to show the chilling effect that loss of tax exemption will have on the tax-exempt bond market and the ability of such organizations to continue financing projects and operations after health reform. As a result of the $150 million limitation on non-hospital bonds (discussed below), one New York City provider represented by an HFSG member was recently forced to obtain needed funds in the taxable bond market at an interest rate nearly 250 basis points (2.5%) higher than the provider could have obtained in the tax-exempt market. Assuming a principal amount of $50 million, the provider will be forced to pay annual, increased interest payments of $1 million to bondholders, an increase the organization can barely afford.

In addition, the prospect of increased IRS enforcement efforts in the tax-exempt bond area has already led to stricter requirements imposed on non-profit bond issuers, resulting in higher financing costs and risk to issuers and bondholders. The perceived increased investment risk by bond investors and the market due to loss or potential loss of tax-exempt status has further raised the cost of financing for non-profit facilities that are dependent on the tax-exempt bond market for access to capital. [3] Marginal cash flow and incidental profit margins previously earned by certain non-profits have already been eliminated by such increased financing costs. The likely result of changing the standards for tax exemption will be that many of these facilities will be forced out of business.

It is not just health care institutions that would suffer profound damage if standards for tax-exemption were significantly changed, causing some facilities to lose their tax-exempt status. In that event, perhaps the greatest damage would occur to the bondholders themselves—approximately 60% of whom are individuals who purchase the bonds directly or through mutual funds. In some cases, loss of tax-exempt status by an institution can cause outstanding bonds to become accelerated and due because of the violation of a covenant based on the tax-exempt status of the provider. In that event, individual bondholders would suffer the consequences immediately and directly. Many of the investors in tax-exempt bonds are residents of the community served by the institution. When a facility loses its tax-exempt status, there is a double blow to the community because of the impact on the institution and the impact on bondholders who are community residents. The federal govern-

[3] Unlike for-profit health providers, non-profit health care institutions are unable to rely on the equity markets to raise funds for capital projects and working capital. Generally, sources of equity capital afford for-profit providers broader access to capital than non-profits, placing the non-profits at a competitive economic disadvantage. The tax-exempt bond market tends to counteract this disadvantage. However, if tax exemption is at risk, the ability to issue tax-exempt bonds disappears.

ment even may be required to rescue investors in institutions from loss of tax-exempt status, at an enormous cost to taxpayers. Clearly, the prospect of another savings and loan crisis should convince the Congress and this Committee to proceed cautiously before implementing changes in standards for non-profit status.

Congress should carefully examine the possible consequences of altering standards for tax exemption for non-profit health providers before enacting any changes. Failure to fully understand and weigh the consequences may lead to the unintended, disastrous results described above. Moreover, changes to standards for tax-exempt status should not be made in a vacuum. The Committee and Congress should postpone the task of redefining the standards for tax-exempt status until the precise extent of "universal coverage" under health reform, and the practical workings of the new "universal coverage" system, become clearer.

To facilitate the enactment of health reform without jeopardizing the financial stability of tax-exempt bond issuers and bondholders, Congress could adopt expanded reporting requirements for Section 501(c)(3) organizations that are not unduly burdensome and that would allow the IRS to gather accurate information regarding the activities of, and benefits provided by, non-profit health care providers. Such information could provide a basis for the careful exploration that Congress should undertake before considering significant changes in standards for tax-exempt status. In the meantime, any changes in the law enacted as part of the current health reform effort should address only those abuses involving non-profit health care providers that are documented in the legislative record.

$150 MILLION TAX-EXEMPT BOND LIMITATION

In addition to the already emerging trend in the health care industry toward consolidation and down-sizing in the acute care sector, health care reform will necessarily lead to mergers and combinations of diverse types of health care providers. Current laws governing tax-exempt bond financing need to be revised to keep pace with these changes. Specifically, the HFSG urges Congress to implement the following changes to guarantee non-profit health care providers access to the private capital markets at the lowest possible cost to the government and the lowest risk to bondholders.

The Tax Reform Act of 1986 imposed a limit of $150 million on the aggregate amount of outstanding qualified Section 501(c)(3) bonds, **other than hospital bonds,** from which any 501(c)(3) organization may benefit. In determining whether the $150 million limitation has been exceeded, advance refundings are taken into account. Historically, hospitals were viewed as the appropriate beneficiaries of tax-exempt financing, and this view justified an exception to the $150 million limitation for qualified Section 501(c)(3) hospital bonds. Because health reform, under almost any plan, will propel a shift from acute care to primary and preventive care, and because the population is aging, there will be increased demand across the country for non-hospital long-term care and managed care entities. At the same time, the existence of excess capacity in the acute care sector may require restructurings of acute care facilities, or renovations of such facilities to become providers of primary, preventive, or other non-acute care services. Such renovations will necessarily increase overall efficiency and reduce costs in the health care system. Yet because the resulting entities will not be "hospitals" under the current, narrow statutory exception, such beneficial restructurings will subject non-profit providers to the $150 million cap.

The various pending health reform bills encourage the development of non-traditional, non-hospital health delivery systems, but the $150 million cap creates a powerful disincentive for the creation of these new systems. While traditional non-profit hospitals may need to shift resources into areas such as neighborhood diagnostic and treatment facilities, long-term residential care facilities, medical equipment acquisition entities and the like, the $150 million cap restricts their ability to modify their services in the interests of efficiency and cost-effective care. The cap also restricts the ability of non-profit hospitals to merge with other hospitals. Finally, the cap prevents many non-profit health providers that are now paying relatively high interest rates from lowering their costs of capital through advance refundings of their bonds, because the original bonds are still considered to be outstanding for purposes of the cap. Because of the cap, the dramatic drop in interest rates that occurred in the early 1990s has passed many of these institutions by. (The federal government shares in such unnecessarily high financing costs whenever a non-profit institution is the recipient of research funding from the National Institutes of Health, because the increased financing cost requires a larger grant than would otherwise be the case.)

Examples of the problems caused by the cap abound. As noted above, one New York institution represented by an HFSG member had to turn to the higher-cost taxable bond market for a necessary project because the institution had already reached the $150 million limitation. Many other facilities have chosen to forego expansion or reconstruction of outdated facilities in lieu of pursuing taxable bond financing. One of the largest tax-exempt providers of long-term care in the United States is being forced to seek taxable bond funding at exorbitant costs because its facilities are not considered "hospitals" under current law. Other health care educational and research systems are facing similar prospects. A major Washington state clinic that wishes to refund existing bonds and to merge with another local facility—steps intended to increase operating efficiency and reduce costs—can do neither as a result of the cap. A large cancer research center in the same state is prevented from refunding to obtain lower interest rates because, for cap purposes, it is considered a non-hospital institution.

The new emphasis on non-hospital care and the high likelihood that new institutions will provide varied types of care makes an exception limited to "hospitals" obsolete. A logical solution to these problems would be to expand the exception to the $150 million limitation to include not only hospitals but also non-hospital health care facilities. Alternatively, the $150 million cap should be lifted in its entirety.

STATEMENT OF THE INTERNATIONAL ASSOCIATION OF FISH AND WILDLIFE AGENCIES

The Association appreciates the opportunity to submit a statement for the record on the proposed increases to the firearms excise tax and subsequent use for various health care proposals. The Association certainly shares the concerns of the nation over the impacts of violent crime, but is compelled to conclude (1) that virtually all of those who would pay this increased excise tax are not criminals but law abiding hunters and those who shoot in competition or for sport; and (2) increasing the tax would have little or no effect on lowering the commission of crime. However, these proposals would seriously impact the Pittman-Robertson fund to which the firearms and ammunition excise taxes have been dedicated since 1937, for use by the 50 state fish and wildlife agencies for wildlife conservation purposes. Therefore, the Association must continue to oppose any measure that would divert the firearms and ammunition excise tax from any purpose other than for its dedicated uses through the Pittman-Robertson fund.

The International Association of Fish and Wildlife Agencies, founded in 1902, is a quasi-governmental organization of public agencies charged with the protection and management of North America's fish and wildlife resources. The Association's governmental members include fish and wildlife agencies of the states, provinces, and federal governments of the U.S., Canada, and Mexico. All 50 states are members. The Association has been a key organization in promoting sound resource management and strengthening federal, state, and private cooperation in protecting and managing fish and wildlife and their habitats in the public interest.

The Pittman-Roberts fund was established by Congress in 1937 as the original user pay-user benefit program. It remains today a primary source of funds to supplement state funds, mostly from hunting and fishing licenses, for state wildlife programs. For example, in 1994 the Pittman-Robertson Wildlife Restoration Fund provided approximately $182.1 million to the states and territories for their wildlife and hunter education programs. This Act, originally conceived and promoted by a coalition of sportsmen, sporting arms manufacturers, and fish and wildlife agencies, has become the basis for successful wildlife programs in each of the 50 states. The wildlife resources, and therefore present and future generations of our citizens, benefit tremendously from this very successful program.

Enclosed for your information is the fiscal year 1994 Apportionment of Federal Aid in Wildlife Restoration Funds broken down on a state by state basis. As you can readily see, these funds are significant to each of the states for vital wildlife conservation and hunter education programs.

While some legislative proposals increasing the firearms or ammunition excise tax apparently seek to legislatively protect the existing Pittman-Robertson fund, increases to the firearms and ammunition excise tax (as in S. 1616 and S. 1798) and dedication to health care programs would still have serious detrimental impacts to the fund. First, by the impact of significantly raising the excise tax on firearms and/or ammunition, sales to the licensed hunters and shooting sports enthusiasts will decline significantly, and thus the money accruing to the Pittman-Robertson Fund will decline. Secondly, these bills would place a *de facto* cap on the Pittman-Robertson Fund since they would capture all revenue above the existing percentage going

to the Pittman-Robertson Fund. This would preclude any future increase to the fund to be used for wildlife conservation purposes.

I enclose, for your information, some examples of letters from State fish and wildlife agency Directors across the nation, reflecting serious and sincere concerns about the impact of these bills. These are reflective of the concerns expressed in the conservation community over the effects of bills such as S. 1798 and S. 1616.

Needless to say, the diversion created by these legislative proposals would have a devastating effect on the future of the wildlife resources of this Nation. We also feel that it is inappropriate to levy the burden of paying for the result of society's ills on the legitimate firearm owners of this Nation. The Association urges you to retain the integrity of the current dedication of the firearms and ammunition excise tax to wildlife conservation purposes only.

FINAL APPORTIONMENT OF FEDERAL AID IN WILDLIFE RESTORATION FUNDS FOR FISCAL YEAR 1994

STATE	WILDLIFE RESTORATION	HUNTER EDUCATION	TOTAL
ALABAMA	2,369,236	878,412	3,247,648
ALASKA	7,234,635	373,884	7,608,519
ARIZONA	3,299,201	796,810	4,096,011
ARKANSAS	2,568,256	373,884	2,942,140
CALIFORNIA	5,215,645	1,121,652	6,337,297
COLORADO	3,674,619	716,192	4,390,811
CONNECTICUT	723,464	714,609	1,438,073
DELAWARE	723,464	373,884	1,097,348
FLORIDA	2,192,805	1,121,652	3,314,457
GEORGIA	2,924,474	1,121,652	4,046,126
HAWAII	723,464	373,884	1,097,348
IDAHO	2,967,476	373,884	3,341,360
ILLINOIS	2,699,352	1,121,652	3,821,004
INDIANA	2,299,150	1,121,652	3,420,802
IOWA	2,476,525	603,658	3,080,183
KANSAS	2,670,496	373,884	3,044,380
KENTUCKY	2,279,475	801,173	3,080,648
LOUISIANA	2,280,138	917,410	3,197,548
MAINE	1,671,829	373,884	2,045,713
MARYLAND	929,661	1,039,477	1,969,138
MASSACHUSETTS	723,464	1,121,652	1,845,116
MICHIGAN	6,438,900	1,121,652	7,560,552
MINNESOTA	4,289,890	951,134	5,241,024
MISSISSIPPI	2,392,731	559,410	2,952,141
MISSOURI	3,977,361	1,112,437	5,089,798
MONTANA	4,488,983	373,884	4,862,867
NEBRASKA	2,493,136	373,884	2,867,020
NEVADA	2,728,707	373,884	3,102,591
NEW HAMPSHIRE	723,464	373,884	1,097,348
NEW JERSEY	723,464	1,121,652	1,845,116
NEW MEXICO	3,156,314	373,884	3,530,198
NEW YORK	4,477,924	1,121,652	5,599,576
NORTH CAROLINA	2,761,133	1,121,652	3,882,785
NORTH DAKOTA	2,028,361	373,884	2,402,245
OHIO	3,262,876	1,121,652	4,384,528
OKLAHOMA	2,784,269	683,841	3,468,110
OREGON	3,589,751	617,912	4,207,663
PENNSYLVANIA	6,135,117	1,121,652	7,256,769
RHODE ISLAND	723,464	373,884	1,097,348
SOUTH CAROLINA	1,603,607	757,999	2,361,606
SOUTH DAKOTA	2,465,629	373,884	2,839,513
TENNESSEE	3,583,757	1,060,286	4,644,043
TEXAS	7,234,636	1,121,652	8,356,288
UTAH	2,941,126	373,884	3,315,010
VERMONT	723,464	373,884	1,097,348
VIRGINIA	2,580,099	1,121,652	3,701,751
WASHINGTON	2,701,971	1,058,005	3,759,976
WEST VIRGINIA	1,777,300	373,884	2,151,184
WISCONSIN	4,648,340	1,063,456	5,711,796
WYOMING	2,922,025	373,884	3,295,909
PUERTO RICO	723,464	0	723,464
GUAM	241,155	62,314	303,469
VIRGIN ISLANDS	241,155	62,314	303,469
AMERICAN SAMOA	241,155	62,314	303,469
N. MARIANA ISLANDS	241,155	62,314	303,469
TOTAL	144,692,712	37,388,401	182,081,113

State of Louisiana

Joe L. Herring
Secretary

Department of Wildlife and Fisheries
Post Office Box 98000
Baton Rouge, LA 70898-9000
(504) 765-2800

Edwin W. Edwards
Governor

April 19, 1994

Honorable John B. Breaux
United States Senator
516 Hart Senate Office Building
Washington, D. C. 20510

Dear Senator Breaux:

I am writing to express my concern and strong opposition to legislative proposal to be considered by the House and Senate that would divert or otherwise impact funds from the Federal Aid in Wildlife Restoration Act (Pittman-Robertson). Specifically, S. 1798 would segregate the firearms excise tax on handguns, semi-automatic "assault weapons" and their ammunition and dedicate the tax revenue to a gun violence trauma care trust fund. Funds would be generated by increasing the existing excise tax from eleven percent to thirty percent. Taxes collected above the existing eleven percent would be dedicated for this health care initiative. Legislation of this type, if passed, would have a devastating effect nationally and on the Louisiana Department of Wildlife and Fisheries and programs funded with the Pittman-Robertson fund.

A previous attempt was made to fund a similar health care initiative by utilizing Pittman-Robertson funds. This legislation was overwhelmingly rebuffed by state directors of fish and wildlife agencies and the sporting public. They rightfully pointed out that the law abiding sportsmen of this country should not be required to underwrite a gun violence trauma trust fund that is completely unrelated to their lawful pursuits of hunting and shooting recreation. S. 1798 is just another attempt to tap into the P-R fund and is, in my opinion, an insidious attempt to defang sportsmen's opposition by asserting that no additional money will be diverted from the original intent of the Wildlife Restoration Act.

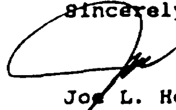
Currently, excise taxes on firearms and ammunition collected under Section 4181 of the Internal Revenue Code of 1986, are dedicated to the Pittman-Robertson fund. These funds are administered by the U. S. Fish and Wildlife Service (USFWS) and provided to state fish and wildlife agencies for wildlife conservation and hunter education programs. This Act, originally conceived and promoted by sportsmen, sporting arms manufacturers and state agencies, is the basis for the successful wildlife programs in all fifty states, Puerto Rico, Guam, the Virgin Islands, Samoa and North Mariana Islands. Wildlife resources, both present and future, benefit from this successful and highly effective user pay-user benefit program.

I firmly believe that S. 1798 and the additive tax that it imposes will have an immediate, direct effect by reducing sales of arms and ammunition thus reducing P-R income and the resulting funding to the states. Many wildlife agencies, including Louisiana's, are operating on very austere budget. Any decline in P-R revenue to the state will have a significant impact on the resource and the public that enjoys this resource. I am also concerned that an additive tax will ensure a **permanent legislative cap** that will reduce the dollars available for wildlife conservation. This, too, will limit the state's abilities to plan and manage resources today and into the future.

The Louisiana Department of Wildlife and Fisheries is opposed to, and believes it is inappropriate, to amend or otherwise change the basic premise of the Wildlife Restoration Act. We share the concerns of the country with regards to gun violence but feel it is inappropriate to unduly tax individuals who are not responsible for the problem. Instead, legislation should be directed at the criminal misuse of firearms and instituting tougher penalties and seeing that these penalties are strictly enforced. This is a concept that all sportsmen would embrace.

I urge you to retain the integrity of the current law for the dedication of the firearms and ammunition excise tax for wildlife conservation and education and continue the concept of user pay-user benefit.

Sincerely,



Joe L. Herring

MISSOURI DEPARTMENT OF CONSERVATION

MAILING ADDRESS
P.O. Box 180
Jefferson City, Missouri 65102-0180

STREET LOCATION
2901 West Truman Boulevard
Jefferson City, Missouri

Telephone: 314/751-4115
Missouri Relay Center 1-800-735-2966 (TDD)
JERRY J. PRESLEY, Director

April 11, 1994

The Honorable John C. Danforth
U.S. Senator
249 Russell Senate Office Building
Washington, D.C. 20510

Re: S.1798 "Gun Violence Health Care Costs Prevention Act"

Dear Senator Danforth:

I am writing to you in your capacity as a member of the Committee on Finance to share with you my concern and opposition to S.1798 which seriously alters the relationship between the manufacturer's tax on arms and ammunition and lawful hunting and shooting enthusiasts.

Historically, that tax has been dedicated for the use of state fish and wildlife agencies for environmentally important land acquisition for public use and wildlife conservation as well as safety and ethics education for hunters and shooting enthusiasts.

S.1798 would irrevocably alter a relationship originally conceived and promoted by a coalition of sportsmen, arms manufacturers, fish and wildlife agencies and passed by Congress in 1937. That act (Federal Aid in Wildlife Restoration Act) has become the basis for a successful wildlife program in each of the fifty states and has often been cited as a model of a highly successful user pay/user benefit program. S.1798 ruptures the user pay/user benefit basis for the tax and burdens lawful citizens, hunters and shooting enthusiasts with the costs of a social program unrelated to the original intent and groundswell of support for the act.

The logic behind S.1798 is seriously flawed as it seeks to recover the costs of criminal activity, carelessness and just plain inappropriate behavior. All of this flies in the face of the intent, results and accomplishments of over fifty years operation of the Federal Aid in Wildlife Restoration Act. S.1798 effectively caps and will eventually erode this trust fund in a time of increasing environmental degradation and concern without even attempting to deal with the activities that eventually result in death and injury.

It makes no more sense to tax legitimate purchasers of firearms and ammunition for victims of firearms misuse than to tax purchasers of automobiles to pay the medical expense resulting from criminal, careless or inappropriate use of automobiles.

The Federal Aid in Wildlife Restoration Act and the resulting dedicated fund has stood the test of time. I implore you to protect the integrity of that act and the measurable and immeasurable benefits that have accrued, are accruing and will continue to accrue to the nation and its citizens through the dedicated expenditures of these funds for environmentally sound purposes.

I believe that S.1798 is an ill-advised and mis-directed effort to solve a real social ill. It is also an inappropriate attempt to divert the firearms excise tax from its highly successful dedicated purposes and uses. I hope you agree.

Sincerely,

JERRY J. PRESLEY
DIRECTOR

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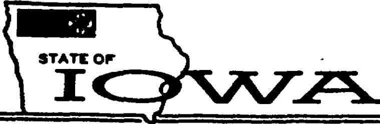


TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF NATURAL RESOURCES
LARRY J. WILSON, DIRECTOR

April 19, 1994

The Honorable Charles E. Grassley
Congress of the United States
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Grassley:

As a member of the Senate Finance Committee I wanted to bring to your attention S. 1798 by Senator Bradley. This bill would segregate the firearms excise tax on handguns, semi-automatic assault weapons, and their ammunition, increase the tax on those items to 30%, and dedicate the tax revenues to a gun violence trauma care trust fund.

While we have sympathy for funding for the care of gun trauma victims it is the position of the Iowa Department of Natural Resources that it is inappropriate to look to the firearms excise tax for any purpose other than for its dedicated uses through the Pittman-Robertson fund. S. 1798 would de facto cap the Pittman-Robertson fund.

I know that you understand the importance of the funds that come through the Pittman-Robertson program to the hunters of Iowa, the wildlife management programs they depend upon, and the hunter safety program that safely educates young hunters. It is my hope that you will continue to support the Pittman-Robertson program and oppose efforts to use firearms excise tax for other purposes.

Sincerely yours,

Larry J. Wilson

Larry J. Wilson, Director

WALLACE STATE OFFICE BUILDING / DES MOINES, IOWA 50319 / 515-281-5145 / TDD 515-242-5967 / FAX 515-281-8895

NORTH DAKOTA GAME & FISH DEPARTMENT

"Variety in Hunting and Fishing"

GOVERNOR, Edward T. Schafer
DIRECTOR, K. L. Cool
100 North Bismarck Expressway
Bismarck, North Dakota 58501-5095
Phone: (701) 221-6300
FAX: (701) 221-6352

April 20, 1994

Senator Kent Conrad
United States Senate
724 Hart Senate Office Building
Washington, DC 20510

Dear Senator Conrad:

I am writing to request that you oppose S. 1798, the "Gun Violence Health Care Cost Prevention Act," introduced by Senator Bill Bradley (D-NY) on January 25, 1994.

This bill would increase excise taxes collected under the auspices of the Federal Aid in Wildlife Restoration Act on all handguns, and certain semi-automatic firearms and ammunition. Currently, 10-11 percent excise taxes on these items help to support wildlife-conservation projects across the country. Senator Bradley's bill would attach an "additive tax" of 30 percent for the funding of treatment for gunshot victims.

I believe the added tax will increase considerably the cost to law-abiding citizens of their legitimate, legal, and time-honored traditions of outdoor recreation, and result in a proportionate reduction in participation in these activities. Additionally, I believe it is an unfair tax because instead of punishing criminals it penalizes law-abiding hunters and target shooters. The Federal Aid in Wildlife Restoration Act, also known as the Pittman-Robertson Act, has been one of the most successful federal government programs. Since its inception in the 1930's, it has funded recovery of many wildlife species, from game animals such as white-tailed deer and elk to non-game wildlife such as eagles and alligators. Sportsmen asked for this tax as a means of funding conservation and point with pride to the many good works it has accomplished.

While inner cities may suffer high violent crime rates, here in North Dakota things are vastly different. Per capita, North Dakota ranks high when it comes to the number of federal firearms license holders and ownership of firearms. Yet, North Dakota also ranks among the lowest in violent crime. Senator Bradley's proposal would punish law-abiding North Dakotans for the egregious crimes committed in urban areas.

Automobiles injure and kill many thousands more Americans than do guns. Using the logic in Senator Bradley's bill, automobiles should see a commensurate 30 percent excise tax to pay for the actions of drunk drivers. Nonetheless, we do not hear a call for this, because society punishes drunk drivers rather than all those who drive in a lawful manner.

Senator Bradley's bill also poses another problem in my view. It continues the stigmatization of those who own handguns, such as the Smith and Wesson .44 magnum, and semi-automatic rifles, such as the Colt AR-15. This stigmatization portrays those who own them as disreputable sociopaths because both the gun and the owner have been labeled by the anti-gun forces and the media as "bad." Many of our state's hunters use these guns for hunting fox, coyotes, and deer. Additionally, many use these types of firearms for target and match shooting on department-funded shooting ranges, which, incidentally, they pay for with their excise taxes. Ammunition used in the Colt AR-15 and .44 magnum handgun are frequently used in various makes of other deer and varmint rifles. While Senator Bradley's bill would in my estimation disrupt present wildlife management programs, it also would make it impossible to justify future increases for conservation purposes. In the main, however, I believe an equally important issue is one of protecting the rights of law-abiding citizens. I believe that the Second Amendment was added to the Constitution for a purpose, and I cannot state strongly enough that law-abiding citizens should not be penalized for the actions of criminals.

As the work continues in Congress on crime prevention measures I hope we in North Dakota can count on you and the rest of our delegation to help urban state senators and representatives maintain a realistic perspective. As you well know, North Dakota and much of the country is not like New York City or Washington, DC. People here use their firearms for hunting and target shooting, often with their families. Outstanding family traditions often center around the lawful use of firearms and associated outdoor experiences. Senator Bradley's bill penalizes lawful firearms owners for the actions of criminals and would have the net effect of beginning to dismantle decades of strong conservation work funded with firearms excise tax dollars. I'm confident you won't allow that to happen.

If you need additional information, of if I can be of help in anyway, please do not hesitate to contact me.

Sincerely,

K.L. Cool
Director, North Dakota Game and Fish Department

Joe D. Tanner, Commissioner
David Waller, Director

Georgia Department of Natural Resources
Wildlife Resources Division

2070 U.S. Highway 278, S.E., Social Circle, Georgia 30279
(404) 918-6400

April 21, 1994

The Honorable Paul Coverdell
United States Senate
Washington, D.C. 20510

Dear Senator Coverdell:

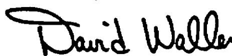
On November 4th of last year, I wrote to share with you my concerns regarding diversion of funds from wildlife conservation to pay for medical care for gunshot victims. Since then additional proposals for excise taxes on firearms and ammunition have surfaced. None of the new proposals, that I am aware of, adequately protect existing funding of state wildlife conservation programs through the Pittman-Robertson Act (P-R).

One, S. 1798, is of particular concern. S. 1798 takes the approach of an additive tax to existing P-R excise taxes, supposedly insuring continuation of funding to federal aid to wildlife restoration. However, this new tax will have the effect of a permanent legislative cap on the P-R excise tax.

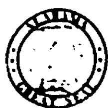
Additionally, and perhaps most importantly, increasing the price of equipment will drive down participation in legitimate shooting sports. Hunting and shooting enthusiasts in middle and lower income brackets will over time participate less. Many occasional participants will drop out altogether. The results will be a reduction in critical P-R funding for wildlife conservation programs and a loss of recreational opportunity for millions of Americans. These impacts are highly undesirable. I urge you to oppose any use of the firearms excise tax other than for its dedicated purpose of supporting wildlife programs through the Pittman-Robertson fund.

As I mentioned to you before, I am available to discuss this issue and others affecting wildlife with you and appropriate staff members at any time that fits your schedule.

Sincerely,



David Waller



STATE OF ALABAMA
DEPARTMENT OF CONSERVATION AND NATURAL RESOURCES
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April 12, 1994

THE FOLLOWING LETTER WAS MAILED TO ALL MEMBERS OF THE ALABAMA CONGRESSIONAL DELEGATION

Dear :

Once again a member of the U.S. Senate has introduced legislation that, if passed, would greatly harm the conservation efforts in this country. Senate Bill 1798, "Gun Violence Health Care Cost Prevention Act," introduced by Senator Bill Bradley is a thinly disguised attempt to damage the Pittman-Robertson Wildlife Restoration Program. While changed from previous bills that directly diverted the excise tax on sporting arms and ammunition from wildlife restoration to health care, the Bradley Bill increases the excise tax and directs the increase towards health care. This would effectively "cap" the Pittman-Robertson Program forever and would force millions of honest, law-abiding sportsmen to pay for gun violence problems created by an extremely small minority of gun owners, many of which are not legal gun owners and would in no way be affected by increased taxes, as our law-abiding citizens will be.

Since its passage in 1937, the P-R Act has been the backbone of wildlife conservation in this country. It has continued to work extremely well during its entire 57 year existence. The excise tax is popular with the users that pay it and all society receives the benefits from this program. The program is still on track as Congress intended it to be in 1937. That cannot be said of many federal programs. I have personally been associated with the P-R Program since 1954, which covers most of its existence, and I am proud to regularly brag that this program is the finest example of a federal-state cooperative program.

I continue to be both concerned and alarmed that some of our national leaders could be so misdirected that they would risk damaging this highly successful program to accomplish their own objective, whether that be health care reform or something else such as another wedge towards implementing stronger gun control. I am convinced we must unite now to very forcefully stop these efforts before further damage is done. I know you are aware of much of this, and I urge you to increase your effort to resist those that would take those destructive paths.

I would appreciate the opportunity to make you more aware of the benefits we receive in Alabama from the Pittman-Robertson Program. They are impressive.

Sincerely,

Charles D. Kelley

STATEMENT OF THE LABOR COUNCIL FOR LATIN AMERICAN ADVANCEMENT

My name is Ralph Jimenez and I am president of the Labor Council for Latin American Advancement (LCLAA). On behalf of the 1.4 million LCLAA members, I want to express our support for President Clinton's proposed health care reform plan. The President is to be commended for taking action to resolve a serious crisis for millions of Americans.

As the Hispanic arm of the AFL-CIO, LCLAA joins with countless working men and women who are anxious to see health care costs brought under control and universal access to health care assured. Hispanic workers comprise a large segment of the 37 million Americans without health insurance. Even those who have health insurance live in fear of losing their jobs and the health insurance benefits that often are provided with employment.

We are proud of the union health care protection provided to members of LCLAA, particularly in this time of escalating health care costs and efforts by employers to cut back on health care benefits. However, we also recognize that these benefits have an adverse affect on the cost of health care which has depressed wages and benefits. For this reason, LCLAA strongly supports the President's plan to contain health care costs by limiting annual increases in insurance premiums.

In addition, LCLAA strongly endorses the Administration's effort to provide universal health care protection for the uninsured. Far too many employers fail to offer health insurance to their employees. When Hispanics and other minority Americans are fortunate enough to find work, they rarely enjoy the benefits of health care coverage. Not only does the President's plan require employers to offer coverage, it also offers subsidies to employers who are unable to bear the full cost of insuring their employees.

We applaud President Clinton's vision on the health care issue. But essential to any health care plan is a source of funding that is fair and equitable to all Americans. The President's reliance on flat premiums and excise taxes as sources of funding for health care will not only put serious reform in jeopardy, but also unfairly discriminate against low- and middle-income Americans.

Last year, LCLAA released a study entitled *Hispanics and Taxes: A Study in Inequality*, which shows that Hispanics in the United States pay a far higher share of income in payroll and consumer excise taxes than do the very wealthy. Financing the new health care program should improve, rather than exacerbate this inequity. We are concerned that, to the extent the plan relies on excise taxes as a major source of new financing, this goal will not be met.

As our study shows, federal taxes in the United States are becoming more and more regressive. In particular, consumer excise taxes take a greater share of income from Americans of low and moderate incomes than from the wealthiest Americans. This policy of regressive taxation is extremely detrimental to the growing Hispanic population in the United States, which still predominantly falls into the low- and moderate-income categories.

The LCLAA study provides telling statistics of just how biased the current United States tax system has become on Hispanic Americans. Following are three key findings of the study:

1. A Hispanic family of four with an income of around $18,000 will pay in federal consumer excise taxes a share of their income between 10 to 15 times greater than a family in the richest two percent of the nation.
2. A female Hispanic head of household with one child and an income of $17,200 will pay in federal payroll taxes proportionately three times as much as a family whose income falls in the top two percent of the nation.
3. The third major federal tax, an income tax, is much fairer for Hispanics. Still, the income tax has undergone dramatic changes due to Reagan-Bush tax policies of the past decade, many of which have worked to the advantage of the wealthy and at the expense of minorities such as Hispanics.

These findings point toward one obvious conclusion: President Clinton's health care plan relies too heavily upon regressive taxes and insurance premiums and not heavily enough on fairer, more progressive income taxes. In essence, President Clinton, like many Presidents in the past, is counting on low- and middle-income Americans to bear the brunt of financing a plan that will benefit all Americans.

As the health care issue is debated over the coming months, please keep in mind that it was Presidential candidate Bill Clinton who said that he would not raise taxes to finance health care reform. We now have President Bill Clinton who seeks to have lower- and middle-income Americans bear the financial brunt of his health care plan.

We all want the President to succeed in his health care reform efforts, and controlling health care costs and providing universal coverage is essential to any health care plan. But relying on flat premiums and a tobacco excise tax as major sources of funding is an accident waiting to happen.

Thank you.

STATEMENT OF MATTIE MACK

Mr. Chairman and Members of the Committee, I am a tobacco farmer from Brandenburg, Kentucky, and I want to share with you my concerns about the proposed tobacco tax to pay for health care reform.

I want to start by telling you what tobacco means to me and my family.

I began farming tobacco back in 1963, when my husband brought me to Kentucky to start our own farm. Over the years, we have built up a 100 acre farm on which we raise cattle, corn, hay and 10,000 pounds of tobacco each year.

Our tobacco crop has been the foundation on which we built our farm and our family. My husband and I raised four children on tobacco. The money from our tobacco crop has paid for their medical care, for their food and for their education.

We have also raised 38 foster children on our farm. The welfare office always sent the "problem children" to us. I discovered that the real problem was that these children did not have anything to do but to get into trouble. So I put them to work on our farm—they cleaned out the barns, they helped put in the tobacco crop, they hoed the tobacco and they helped top the tobacco. After a long days work, those kids ate a good supper, took a shower and went straight to bed. There was no energy left in them to cause trouble.

My own children and our foster children saved money from tobacco so that they could go to movies or to ball games. I always told those kids: When you spend that money, tell people you earned it from tobacco.

Tobacco is our livelihood.

Today our livelihood is being threatened. I cannot express enough how deeply concerned I am about the President's proposal to increase tobacco taxes to pay for health care reform. Farm families like mine stand to suffer a great deal if this proposal becomes a reality.

I want to tell you that I support the idea of health care reform. When I was young, I studied to be a nurse and worked for a while in the Louisville Children's Hospital. I know first hand that our health care system is in serious need of reform and I congratulate the President for recognizing this fact.

But the President has proposed a 75 cent per pack cigarette tax as the sole tax to pay for health care reform. This proposal asks farmers, like me, to foot the bill for a system that benefits the entire nation. This is unfair.

It is unfair to tobacco farmers whose hard work already generates $62,000 per acre in state and federal taxes. It is unfair to black farmers, many of whom grow tobacco, and who historically have lost their farms at a faster rate than white farmers. It is unfair to my home state of Kentucky, which stands to lose over 300 million dollars, and it is unfair to the South as a whole, which stands to lose the very foundation of its economy.

The Bible says that you earn your living by the sweat of your brow and I can tell you that farming tobacco makes you sweat. But farmers are accustomed to hard work. We are also accustomed to dealing with the hardships of nature—we always have to worry about too much rain in our crop, or not enough. But no amount of hard work or resiliency will prepare us for dealing with the man-made hardships that come from Washington. American tobacco farmers cannot survive this threat to our livelihoods.

I want to invite President and Mrs. Clinton and all of the members of this committee down to Kentucky to see the people who are working so hard to make ends meet—they are doing it with tobacco. I want them to meet tobacco farmers and their families—face to face—and to learn just how much our crop means to us, and to the South. If they understood that, I am certain they would not insist on this unfair tobacco tax. All we ask is the tax be spread around so that everybody pays their fair share.

STATEMENT OF THE NATIONAL RIFLE ASSOCIATION OF AMERICA

Mr. Chairman and members of the Subcommittee, I am Tanya K. Metaksa, Executive Director for the Institute for Legislative Action of the National Rifle Associa-

tion of America. I appreciate the opportunity to present the views of our more than 3.3 million members.

Jean Baptiste Colbert wrote several hundred years ago that, "The art of taxation is in so plucking the goose as to obtain the largest possible amount of feathers with the smallest amount of hissing." The proposals before this Committee prove that the centuries have wrought little change in government or goose plucking—it's still a matter of trying to find the right bird.

The NRA believes that the premise of the various proposed excise tax increases on firearms and ammunition is flawed. For the record, we are unequivocally opposed to increasing taxes on firearms, ammunition, or any other lawfully manufactured product, as a penalty to recover the costs of the consequences of criminal activities. We believe that such taxes are inappropriate in light of the impact they will have in expanding the illicit firearms market; the impact they will have on the ability of honest citizens—particularly those on the lower end of the economic scale—to afford firearms they may need for self-protection; and the impact they will have on established state wildlife management and education programs which are served by existing excise taxes on firearms and other related products.

Mr. Chairman, sportsmen and women pay their own way. Like most Americans, they don't mind paying taxes when the goals are worthy, the levies fair, and the funds used for the purpose for which they are collected. I believe the historical record provides ample proof of this.

Fifty-seven years ago, at the urging of sportsmen, Congress passed the Wildlife Restoration Act of 1937. Commonly called Pittman-Robertson (or "PR"), the Act levied a 10% excise tax on rifles, shotguns, and ammunition. In 1971, a 10% tax was levied on handguns. In 1975, again with the support of sportsmen and the industry, the law was amended to include archery equipment and raised to 11%, and a portion of the revenues were channeled to support hunter safety training and range development.

Since its passage in 1937, the PR fund has provided funding to the Federal Aid to Wildlife Restoration Fund managed by the Treasury. 16 U.S.C. §§669 *et seq.* Amounts in the Fund are allocated to state fish and game departments to support wildlife restoration and "comprehensive fish and wildlife resources management plan[s] which shall insure the perpetuation of these resources for the economic, scientific, and recreational enrichment of the people." §669e. "The term 'wildlife-restoration project' shall be construed to mean and include the selection, restoration, rehabilitation, and improvement of areas of land or water adaptable as feeding, resting, or breeding places for wildlife . . ." §669a.

Most importantly, all revenues from taxation of firearms and ammunition are allocated to wildlife—restoration. §669b(a) of the Act provides:

> An amount equal to *all revenues* accruing each fiscal year (beginning with the fiscal year 1975) *from any tax imposed on specified articles by sections 4161(b) [bows and arrows] and 4181 [firearms and ammunition] of Title 26,* shall, subject to the exemptions in section 4182 of such Title, be covered into the Federal aid to wildlife restoration fund in the Treasury (hereinafter referred to as the "fund") and is authorized to be appropriated and made available until expended to carry out the purposes of this chapter. (Emphasis added.)

The success of this levy is such that since 1937, hunters have generated approximately $2.5 billion to support wildlife conservation and hunter safety through habitat purchase and management, range development, and research on game and non-game species. If license and user fees are included, the total is over $3 billion.

The support for these programs has come from the knowledge that the money was placed in trust and used to help pay for the acquisition and management of wildlife areas and related programs for the benefit of present and future generations of Americans. There are those who disparage the idea of the hunter as conservationist, but the simple truth is that the money from PR and from other hunting- and fishing-related activities provides, according to the Wildlife Management Institute, 75% of the average budget for state wildlife agencies. Needless to say, the benefits which accrue to our nation are hardly monopolized by hunters and fishermen, but are enjoyed by Americans from every walk of life.

Now it has been suggested by proponents of various revenue raising proposals—individuals who are demonstrably opposed to the idea of Americans owning firearms—that it is appropriate to raise taxes on firearms, particularly handguns and ammunition, to recover the "health-care costs" of violence to society. The essential premise on which the proponents base these proposals is that taxes on gun buyers are justified because firearms are inherently bad, and that these taxes are in reality

a form of "user fee." Several bills have been introduced in Congress which provide for this in one form or another. We categorically reject this idea.

For instance, Senator Bradley has proposed S. 1798, the "Gun Violence Health Care Costs Prevention Act." The Senator states that this bill is designed to "reduce the public's share of the health care costs associated with gunshot injuries by significantly increasing the taxes and licensing fees associated with the sale and purchase of handguns, assault weapons, and the ammunition for these firearms."

S. 1798 increases the fees for most 3-year Federal firearms dealer licenses to $3,000. It also increases the manufacturer's excise tax on handguns, so-called "assault weapons," and the ammunition for these firearms to 30 percent. In addition, it establishes a new 30-percent Federal sales and transfer tax both on retail sales of these goods by gun dealers, and on subsequent private sales. Finally, this bill puts the revenue from these tax and licensing fee increases into a trust fund for the support of trauma centers and hospitals that have supposedly incurred large (and mostly uncompensated) costs while treating gunshot victims.

As this Committee is well aware, the Chairman has also introduced S. 1616, "The Real Cost of Handgun. Ammunition Act," which would increase the excise tax on the sale of handgun ammunition—apart from .22 caliber—from 11 to 50 percent. Handgun ammunition is defined as any centerfire ammunition that has a cartridge case of less than 1.3 inches in length.

The act would increase the excise tax rate to 10,000% on two handgun rounds: "Black Talon', type ammunition and .50 caliber handgun ammunition for handguns like the "Desert Eagle." The manufacturer of Black Talon has removed the ammunition from the civilian market, but the bill would still apply to some brands remaining on the market. The act also would impose a new occupational tax of $10,000 annually on each manufacturer and importer of handgun ammunition, similar to the occupational tax that applies to manufacturers of fully automatic firearms. The tax would not apply to manufacturers who conduct business exclusively with police departments, the military, and other government entities.

Whether it is Senator Moynihan's bill that simply puts the additional revenue into the general treasury, or Senator Bradley's bill that diverts the revenue for other purposes, all such proposals imposing prohibitive taxes on firearms and ammunition are an abuse of fair taxation principles and the trust fund concept. Under that concept, funds are put aside to be spent on projects to benefit the payers of the tax.

Moreover, both S. 1661 and S. 1798, and all similar proposals are designed to increase the excise tax exorbitantly, and punitively. We predict the effect of such increases will be to greatly reduce the demand for such products. Hence, funds which are currently directed into PR conservation efforts will fall significantly. Furthermore, these bills would effectively cap the PR trust fund from future additional revenue. Such legislation would thus wreck the system of wildlife restoration funding which has been in place for over fifty years.

It is also instructive to note that in S. 1798 the procedural mechanisms for administering the anticipated funds are either vague or non-existent. The bill would also construct a new source of discretionary congressional spending, with little certainty that the money collected would be spent for its intended purpose.

Mr. Chairman, these bills would not only abuse the trust fund concept and impair wildlife restoration efforts, they are grounded on faulty assumptions. Current U.S. health care costs add up to more than $800-billion per year. The most widely accepted estimate for the cost of treating gunshot wounds is $1.4 billion, including all injuries from any type of firearm, regardless of the source of the gun, the criminal behavior of the person injured or the intentions of the person pulling the trigger. This estimate includes accidents, attempted suicides, and injuries caused by criminals, as well as injuries inflicted in lawful self-defense or justifiably by police or private citizens.

By comparison, I would note that the cost of treating blood infections contracted *in hospitals*—not carried into the hospital by the patient—is estimated to be $5-billion per year and to result in 30,000 deaths annually—nearly as many as the total number of gun-related deaths annually (38,000). And there are about 40,000 motor vehicle deaths annually, plus about *two million* serious injuries, with estimated medical costs in excess of *$20 billion*.

To show why this tax is especially unfair, let's examine the results of a recent article that appeared in the March 9, 1994, issue of the *Journal of the American Medical Association* entitled, "A Longitudinal Study of Injury Morbidity in an African-American Population." The study is of interest since inner city trauma centers and young black males have been especially hard hit by violence.

This four-year study of approximately 68,000 people in west Philadelphia found that half the population made an emergency room visit for one or more injuries during the study period. But, based on that study's findings, firearms-related violence

accounted for only 10% of the hospital admissions, while knives accounted for 8.2% of the visits.

The point here. Mr. Chairman, is not to dispute that violence is a serious and terrible problem, and that we should take firm measures to reduce it. The point is that firearms are associated with only a fraction of the uncompensated care being provided for *injuries* treated in hospitals, and are associated with an even smaller percentage of uncompensated hospital visits as a whole. In other words, we need strategies to reduce injuries in general and violence in particular—but we do not need to punish law abiding gun owners through confiscatory taxes in order to solve those problems.

Additionally, taxes or other restrictions intended to keep law-abiding citizens from buying and using firearms would likely increase the injury and death of the law-abiding at the hands of criminals by reducing firearm use for protection. Since low-income Americans are the most likely to need firearms to preserve their lives in crime-ridden neighborhoods, prohibitive taxes on firearms would amount to a regressive tax that puts them at a severe disadvantage compared to the rest of the general population.

This is not a minor issue, either. Professor Gary Kleck, of Florida State University, has estimated, based on surveys conducted both by him and by others, that there are approximately 2.1 million defensive uses of firearms in the U.S. each year. 1.6 million of those incidents involve handguns. Prof. Kleck has noted the possibility that more lives are saved by the protective use of firearms than are taken in suicidal, homicidal, and accidental misuse. Certainly many injuries are prevented which would otherwise require medical care.

It should not be necessary to point out that the vast majority of criminals who injure people with firearms would not be paying the "user fee" supposedly created by excise tax proposals; those who do not abuse firearms would. We know from Justice Department-sponsored surveys of felons that only about 7% of serious armed criminals buy firearms directly or indirectly from retail outlets. We also know from the Justice Department's victimization surveys that handguns are used in fewer than 10% of the crimes that result in serious injuries.

On the whole, then, less than 1% of injuries inflicted by criminals would be inflicted by criminals who would pay the tax. On the other hand, only about one-tenth of one percent of U.S. handguns are used each year to injure someone seriously. What this boils down to is that overwhelmingly, the people who cause the injuries would almost never pay an excise tax, while the people paying the tax would almost never injure anyone.

Additionally, Prof. Kleck estimates that as many as 16,000 criminals are injured in self-defense and justifiable shootings by civilians each year; such injuries could account for 7–25% of gunshot injuries.

Should the law-abiding gun owner alone pay for the medical treatment of a drug dealer shot by another drug dealer, or a criminal shot in self-defense or justifiably? It's akin to billing a car's owner for injuries a car thief suffers when crashing the stolen car. In a sense it is worse, since injuring the criminal provides a public service by at least temporarily preventing the criminal from committing more crimes, and by giving the state a chance to prosecute him. What has happened to the concept that criminals should pay for their crimes? These tax bills stand that tenet on its head.

With other efforts, current or potential, to tax "users" of products which may be misused, creating medical costs, the person taxed is the person who suffers or causes the suffering requiring medical care. For example, most automobile injuries are caused by and/or inflicted upon someone who paid for a car and its fuel, yet there is no suggestion that motor vehicles or gasoline be taxed exorbitantly to pay the costs of medical care required by motor vehicles—a figure nearly fifteen times as high as the costs of treating gunshot wounds.

In addition, cannot imagine a policy more likely than these excise tax proposals to expand the criminal black market in firearms. The criminals who are most likely to misuse firearms, and most likely to acquire firearms by illegal means, will be the least likely to notice or care about an increase in price. More to the point, not one dollar from the sale of an illegal firearm will be put to any worthy use.

Both for honest citizens and for criminals, the market for firearms is governed by the commonly accepted rules of supply and demand. While increased cost would decrease lawful self-defense uses of firearms by honest citizens, it would also bring more illegal gun dealers into the market. Since excise taxes mean nothing to criminals, and since their demand for the tools of their trade is relatively inelastic, the profit margins of those illegal dealers would only increase. Higher profit margins will bring increased competition; and if we have learned anything from the illegal

drug market of the 1980s and 1990s, or from the alcohol market of the 1920s, more competition will only bring more violence.

To increase the tax above the existing 11% rate, even without the transfer taxes, will likely do what proponents hope: dampen lawful retail purchases. But for whom? The exercise of Second Amendment rights will depend, more than ever, on a person's income. If enacted, these proposals will certainly drive away those who can now barely afford to participate in lawful activities such as hunting or target shooting. Yet it is those on the lower end of the socio-economic scale for whom owning a firearm for self-protection or to put meat in the freezer is not a luxury. Furthermore, such taxes would spill over economically, with devastating effects on every facet of the sporting equipment industry.

And, to what end? Since the vast majority of guns and ammunition that are lawfully purchased are not used in crimes, any new taxes will only force the lawful to pay for the deeds of the lawless. This kind of a tax whether it is used to raise general revenues or used to pay for a specific program, is being commonly called a "sin tax." If paying for the sin is the question, can tell you the law abiding citizen is not the sinner. Rather, it would be more relevant, in searching for funds, to look at the crime victims restitution fund which makes the criminal pay the consequences of his crimes.

I would also like to draw your attention to another way these proposals affect only the law-abiding citizen. Specifically, S. 1798 creates an unprecedented new federal retail sales tax extending its reach to every firearm in existence at the time the tax is implemented. Each private transfer after the first retail sale would be taxed at the same rate.

It is not likely that the transfer taxes paid will recover the cost of implementing this program. Manufacturers and importers are knowledgeable about the present excise tax requirements because they are already paying those taxes. But, I seriously question whether the average consumer has the same knowledge, particularly since the tax is normally "hidden" from them in the price of the firearm or ammunition.

Thus, imposing a requirement that ordinary members of the public should file a tax form and pay a tax on a simple transfer, particularly a transfer of a firearm they have owned for some time, would most likely be unproductive, since law enforcement has little ability to police private transfers, the rate of non-compliance will likely be very high. Furthermore, even those who do comply might not add any net revenues to the U.S. Treasury. For instance, a $100 dollar sale with a $30 dollar tax fee filed with Treasury is going to require a one-time paperwork burden which will likely cost more than $30.

Experience bears this out. In California, which recently required private transfers of firearms to comply with a 15-day waiting period and background check—but not with an outlandish sales tax—only about 1% of private transfers are run through the Department of Justice, as required by law. Even if some sales are disguised as dealer transfers, it is clear that only a few percent comply with the law. If the same held true nationally, the proposed private-transfer tax would cause at least two million persons each year to break the law--partly because it would raise legitimate concerns about the registration of firearms. Any attempt at enforcement would inevitably be both arbitrary and inequitable.

Mr. Chairman, many in our society are increasingly unable to determine right from wrong. America's morgues are filled with object lessons not about the outcome of lawful firearms ownership, but about the failure to inculcate a large segment of society with the proper moral foundations, or failing that, to instill respect for the law through the swift and certain punishment of law breakers.

A 1993 Luntz-Weber survey indicates that 88% of the American people believe what the empirical evidence proves—that the criminal justice system is broken and needs major reform. As one proof, I would point to the declining amount of time criminals expect to spend behind bars, as documented by Morgan Reynolds of the National Center for Policy Analysis. When the expected penalty for a murder is only 1.8 years in prison, violent crimes are not being treated seriously. Furthermore, to suggest that there are no limits on guns is to ignore the twenty thousand or more existing laws governing the use and abuse of firearms.

This Congress would do a greater service to the nation, and dramatically increase the economic security of the community, if it would address the real issue—the breakdown of the criminal justice system—rather than seeking additional funding to pay for the consequences of that breakdown. These excise tax proposals on the one hand, would punish law-abiding citizens for crimes they have not committed, and on the other hand, would rob the states of important wildlife and recreation benefits. Hunters, fishermen and gun owners are not going to stand by and watch a 57-year investment in wildlife conservation wither away. Probably no issue could

better unite sportsmen and women, and all firearms owners, than these outrageous excise tax proposals.

STATEMENT OF THE OFFICE OF TECHNOLOGY ASSESSMENT

SMOKING-RELATED DEATHS AND FINANCIAL COSTS: OFFICE OF TECHNOLOGY ASSESSMENT ESTIMATES FOR 1990

INTRODUCTION

Cigarette smoking causes cancer, respiratory disease, and circulatory system disease, all conditions that contribute greatly to disability and death in the United States. In 1991, an estimated 46 million adults in the United States (26 percent) were current smokers and for the first time in nearly two decades smoking prevalence had not declined (MMWR, April 2, 1993;USDHHS, CDC, CCDPHP, 1989). Until many more U.S. residents stop or curb their smoking, smoking will continue to be the largest source of preventable death and disability and will burden the health care system with avoidable health care costs.

At the request of the Senate Special Committee on Aging in early 1993, OTA assessed the extent of smoking-related deaths and overall financial costs and developed estimates of the smoking-related health care costs borne by the Federal government through the Medicare, Medicaid, and other government-financed programs. These estimates, using 1990 data, update earlier ones published by OTA in 1985 (OTA, 1985).

OTA relied on a computer program called SAMMEC (Smoking Attributable Mortality, Morbidity, and Economic Costs), designed and distributed by the Centers for Disease Control and Prevention's Office on Smoking and Health, to estimate smoking-related mortality and economic impacts (USDHHS, PHS, CDC, OSH; Shultz, J.M., et al., 1991).

OTA Smoking-Attributable Mortality Estimates

OTA estimates that smoking-related illness accounted for nearly one in five deaths in 1990, killing as many as 417,000 U.S. residents (table 1).[1,2] These smoking-related deaths far exceed the combined number of deaths from

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1 OTA's mortality estimate excludes those dying as a consequence of smokeless tobacco and passive smoking. In 1988, an estimated 3,825 U.S. residents died from passive smoking (MMWR, February 1, 1991) and subsequent estimates of deaths attributable to passive smoking have been higher (Steenland, K., 1992). OTA's mortality estimates relied on preliminary data from NCHS. CDC has subsequently estimated 1990 smoking-attributable mortality to total 419,000 (MMWR, August 27, 1993).
2 The number of smoking-attributable deaths has declined since 1988 (i.e., from an estimated 434,000 in 1988) primarily because of a general decline in

AIDS, automobile and other accidents, homicide, and suicide (173,000 deaths). In 1990, more than one-fourth of cancer deaths, nearly one-fifth of cardiovascular disease deaths, and one-half of respiratory disease deaths were attributable to smoking (table 1). The smoking-related mortality burden falls disproportionately on young-to-middle aged adults. More than one-quarter of all deaths among those age 35 to 64 are smoking-related (table 2). Because many deaths occur at relatively young ages, there are many years of potential life lost due to smoking. Each smoker who died as a consequence of his or her smoking would have, on average, lived at least 15 additional years had they not smoked. For the population at large, this premature mortality translates into more than 6 million years of potential life lost.

OTA Smoking-Attributable Financial Cost Estimates

The greatest "costs" of smoking are immeasurable insofar as they are related to dying prematurely and living with debilitating smoking-related chronic illness with attendant poor quality of life. Measuring the financial costs associated with smoking is an inexact science, but generally three cost components are included:-

- the direct cost of providing personal health care services to those with smoking-related diseases;
- the indirect morbidity costs associated with lost earnings from work or housekeeping because of smoking-related illness; and
- the indirect mortality costs related to the loss of future earnings from premature death.

OTA estimates the total financial cost of smoking in 1990 to be $68.0 billion or $2.59 per pack of cigarettes sold in the United States. The total cost of $68.0 billion includes $20.8 billion in direct health care costs, $6.9 billion in indirect morbidity costs, and $40.3 billion in lost future earnings (figure 1) (table 3).[3] The total 1990 cost of smoking per smoker is $1,078, and per capita is $272 (table 4).

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cardiovascular deaths. Smoking-attributable cancer deaths have increased since 1988 (MMWR, February 1, 1991).

3 The indirect mortality estimate of $40.3 billion is based on a 4 percent rate to discount future lifetime earnings and excludes deaths of persons under age 35. Comparable indirect mortality costs using a 2 and 6 percent discount rate are estimated at $46.2 and $35.7 billion, respectively. If smoking-related deaths of persons under age 35 are included, 1990 indirect mortality costs are estimated to be $41.9 billion (at a 4 percent discount rate). Comparable figures for 2 and 6 percent discount rates are $49.4 and $36.6 billion, respectively.

Direct costs-Direct costs are measured as the expenditures for preventing, detecting, diagnosing, and treating smoking-related diseases and medical conditions (Rice, D.P., et al., 1986). In 1990, the United States spent an estimated $20.8 billion on health care for smoking-related diseases, representing 3.5 percent of total U.S. 1990 personal health care expenditures. This amounts to about $329 per smoker, $83 per capita, and 79 cents for each pack of cigarettes sold in the United States in 1990 (table 4).

OTA estimates that in 1990, Federal, state, and local governments together funded approximately 43 percent, or $8.9 billion, of smoking-attributable direct costs. The 1990 Federal government share was an estimated $6.3 billion or about 24 cents for each pack of cigarettes sold (table 5). Estimated Medicare costs were $3.5 billion, Medicaid costs were $2.7 billion, and spending for other government-funded health programs was $2.7 billion in 1990 (table 5).[4] Total government smoking-related direct costs were fairly evenly split between the population under age 65 ($4.5 billion) and the population age 65 and over ($4.3 billion) (table 5).

Indirect morbidity costs-Smoking-related disease results in productivity losses to the economy through lost time at work (e.g., sick leave) and lost housekeeping services by homemakers. OTA estimates indirect morbidity costs at $6.9 billion or $109 per smoker, $28 per capita, and 26 cents per pack of cigarettes sold in 1990 (table 4).[5]

Indirect mortality costs-The foregone earnings of those dying prematurely in 1990 from smoking-related causes amount to $40.3 billion or $639 per smoker, $162 per capita, and $1.54 per pack of cigarettes sold in 1990 (table 4).[6] The value of future earnings were discounted by 4 percent to 1990 present-valued dollars.[7]

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4 Other Federal government smoking-attributable direct medical expenditures include those of the following programs and agencies: Workers' Compensation; Department of Defense; Maternal and Child Health; Vocational Rehabilitation; Alcohol, Drug Abuse, and Mental Health Administration; Indian Health Service; and miscellaneous general hospital and medical programs. Other State and local expenditures include those of the Temporary Disability Program, Workers' Compensation, General Assistance, Maternal and Child Health, Vocational Rehabilitation, hospital subsidies, and school health (Levit, K.R., et al, 1991; USDHHS, HCFA, ORD, 1990; Waldo, D.R., et al., 1989).

5 Methods used to calculate population daily earnings in the SAMMEC program likely overestimate indirect morbidity costs.

6 The indirect mortality estimate excludes those dying before age 35.

7 Indirect mortality costs discounted by 2 and 6 percent rates are estimated at $46.2 and $35.7 billion, respectively.

<u>Improving Estimates of Smoking-Related Financial Costs</u>

OTA relied on techniques developed by the Centers for Disease Control and Prevention's Office on Smoking and Health to produce these 1990 estimates. The CDC's Office on Smoking and Health are further refining methods used to estimate smoking-related costs (Arday, D., personal communication, November 1993). The improved direct cost estimation will rely on analyses, by smoking status, of the 1987 National Medical Expenditure Survey (Rice, D.P., personal communication, April 1993) and will adjust for differences in sociodemographic characteristics that exist between smokers and nonsmokers (Novotny, T.E., personal communication, April 28, 1993).

<u>Factors Excluded From OTA's Estimate of Smoking-Related Financial Costs</u>

The 1990 OTA estimate of smoking-related financial costs does not include all of the effects that smoking has on the economy or on all government programs. Only the mortality toll of smoking and the effects of smoking on direct medical care spending and the indirect costs of lost productivity and lost earnings were estimated. Smoking currently leads to a substantial loss of life and significant health care spending. Reduction or elimination of smoking would improve health and extend longevity, but may not lead to savings in health care costs. In fact, significant reductions in smoking prevalence and the attendant increase in life expectancy could lead to future increases in total medical spending, in Medicare program outlays, and in the budgets of the Social Security and other government programs (Warner, K.E., 1987). OTA has not estimated what these hypothetical effects might be. Others have assessed these "off-setting" costs in their estimates of smoking-related costs (Manning, W.G., et al., 1991).

<u>CONCLUSIONS</u>

OTA estimates that as many as 417,000 United States residents died in 1990 as a consequence of smoking and that the total financial cost of smoking was $68.0 billion or $2.59 per pack of cigarettes sold in the United States in 1990. Reductions in smoking prevalence would lead to marked improvements in health and gains in years of life for thousands currently dying of smoking-related disease (USDHHS, Report of the Surgeon General, 1990). Health education and smoking cessation programs, especially those targeted to children, adolescents, and young adults might lead to large improvements in longevity and thus represent significant ways to improve health and prevent premature death. Other policies that might discourage smoking include raising taxes on tobacco products, enforcing minor-access laws, restricting smoking in public places, and restricting tobacco advertising and promotion (MMWR, April 2, 1993).

**SMOKING-RELATED DEATHS AND FINANCIAL COSTS:
OFFICE OF TECHNOLOGY ASSESSMENT ESTIMATES FOR 1990**

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Figure 1--Components of 1990 Smoking-Related Cost Estimates

Direct Costs + Indirect Costs = Total Costs

$ 21 Billion + $ 47 Billion = $ 68 Billion

(Costs of providing health care to persons with smoking-related illnesses)

Indirect Morbidity Costs
$ 7 Billion
(Costs of lost productivity for persons disabled by smoking-attributable diseases)

Indirect Mortality Costs
$ 40 Billion
(Estimates of forfeited earnings of those dying premature deaths from smoking-attributable diseases)

Source: Office of Technology Assessmentas calculated using the SAMMEC 2.1 program, 1993.

Table 1--Total Deaths and Deaths Attributable to Smoking by Cause of Death, United States, 1990[a]

Cause of death	Total deaths[b]	Smoking-attributable deaths	
		Number	Percent
All causes	2,148,463	416,829	19.4%
Neoplasms	505,322	148,224	29.3
Cardiovascular disease	916,007	179,436	19.6
Respiratory disease	168,203	84,872	50.5
Perinatal disease	15,237	2,215	14.5
Burns[c]	4,175	2,082	49.9

[a]These numbers are slightly lower than those published by CDC in August 1993. OTA used preliminary mortality data from NCHS in making these estimates. CDC estimates that 418,690 U.S. deaths were attributable to smoking in 1990.
[b]Total neoplasm deaths include ICD-9 codes 140-208, total cardiovascular diseases include ICD-9 codes 390-448, total respiratory diseases include ICD-9 codes 10-12, 466, 480-87, 490-96, total perinatal conditions include ICD-9 codes 765, 769, 770, 798.0, and total burn deaths include ICD-9 codes E-890-.899.
[c]One-half of all burn deaths are assumed to be cigarette-related (DHHS, CDC, Office on Smoking and Health, 1990).

SOURCES: Office of Technology Assessment, as calculated using the SAMMEC 2.1 program, 1993; USDHHS, PHS, CDC, NCHS, Advance Report of Final Mortality Statistics, 1990 41(7) Supplement, January 7, 1993.

Table 2--Total Deaths and Deaths Attributable to Smoking by Age and Sex, United States, 1990[a]

	Total deaths	Smoking-attributable deaths	
		Number	Percent
Total			
< 1-34	150,542	3,083	2.0%
35-64	454,866	121,275	26.7
≥ 65	1,542,493	292,471	19.0
All ages[b]	2,148,463	416,829	19.4
Male			
< 1-34	102,882	1,855	1.8
35-64	286,762	84,804	29.6
≥ 65	723,370	188,937	26.1
All ages[b]	1,113,417	275,597	24.8
Female			
< 1-34	47,660	1,227	2.6
35-64	168,104	36,470	21.7
≥ 65	819,123	103,534	12.6
All ages[b]	1,035,046	141,232	13.6

[a]These numbers are slightly lower than those published by CDC in August 1993. OTA used preliminary mortality data from NCHS in making these estimates. CDC estimates that 418,690 U.S. deaths were attributable to smoking in 1990.
[b]Age-specific numbers of deaths do not add to the total because of a small number of deaths with unknown age of death.

SOURCES: Office of Technology Assessment as calculated using the SAMMEC 2.1 program, 1993; USDHHS, PHS, CDC, NCHS, Advance Report of Final Mortality Statistics, 1990 41(7) Supplement, January 7, 1993.

Table 3--Smoking-Attributable Direct and Indirect Financial Costs by Age and Sex, United States, 1990

	Direct costs (millions of $) age			Indirect morbidity costs (millions of $) age			Indirect mortality costs[a] (millions of $) age		
	35-64	65 +	Total	35-64	65 +	Total	35-64	65 +	Total
Male	$11,315	$3,395	$14,710	$3,507	$1,171	$4,678	$25,088	$4,411	$29,499
Female	3,077	2,988	6,065	2,019	187	2,207	8,250	2,548	10,798
Total	14,392	6,383	20,775	5,527	1,358	6,885	33,339	6,959	40,298

[a]The indirect mortality cost estimates are based on a 4 percent rate to discount future lifetime earnings and exclude deaths of persons under age 35.

SOURCE: Office of Technology Assessment, as calculated using the SAMMEC 2.1 program, 1993.

Table 4--Cost of Smoking by Type of Cost and Sex, United States, 1990 (Page 1 of 2)

Type of cost by sex	Cost (millions of $)	Percent distribution	Per capita[b]	Per smoker[c]	Per pack[d]
Total	$67,958	100.0%	$272	$1,078	$2.59
Direct cost	20,775	30.6	83	329	.79
Hospital	14,419	69.4	58	229	.55
Physician	2,689	12.9	11	43	.10
Nursing home	2,332	11.2	9	37	.09
Medication	1,208	5.8	5	19	.05
Other professional	127	0.6	1	2	.01
Indirect cost	47,183	69.4	189	748	1.80
Morbidity	6,885	14.6	28	109	.26
Mortality[a]	40,298	85.4	162	639	1.54
Men, total	$48,887	100.0%	$196	$1,354	$1.86
Direct cost	14,710	30.1	59	407	.56
Hospital	11,533	78.4	46	319	.44
Physician	1,365	9.3	5	38	.05
Nursing home	1,137	7.7	5	31	.04
Medication	597	4.1	2	17	.02
Other professional	78	0.5	0	2	.00
Indirect cost	34,177	69.9	137	947	1.30
Morbidity	4,678	13.7	19	130	.18
Mortality[a]	29,499	86.3	118	817	1.12
Women, total	$19,071	100.0%	$76	$707	$.73
Direct cost	6,065	31.8	24	225	.23
Hospital	2,887	47.6	12	107	.11
Physician	1,324	21.8	5	49	.05
Nursing home	1,195	19.7	5	44	.05
Medication	611	10.1	2	23	.02
Other professional	49	0.8	0	2	.00
Indirect cost	13,005	68.2	52	482	.50
Morbidity	2,207	17.0	9	82	.08
Mortality[a]	10,798	83.0	43	401	.41

Table 4--Cost of Smoking by Type of Cost and Sex, United States, 1990 (Page 2 of 2)

Note: Numbers may not add to total due to rounding. Figures apply to the population age 35 and over.

[a]Discounted at 4 percent.
[b]Total United States resident population as of July 1, 1990 (U.S. Bureau of the Census, Current Population Reports, U.S. Population Estimates, by Age, Sex, Race, and Hispanic Origin: 1980 to 1991, Table 1, pg. 4).
[c]Smokers include both current and former smokers as of 1990 (smoking prevalence rates: 1990 National Health Interview Survey). Per smoker estimates for males include only male smokers; estimates for females include only female smokers.
[d]Total United States consumption of cigarettes, 1990 (U.S. Department of Agriculture, Tobacco Situation and Outlook Report, September 1992, Table 1, pg. 4).

SOURCE: Office of Technology Assessment, as calculated using the SAMMEC 2.1 program, 1993.

Table 5--Smoking-Related Government Spending for Providing Personal Health Care, 1990

Breakdown of expenditures	Amount (millions of $)	Share of total
<u>Total government spending</u>	$8,878	
<u>Level of government</u>		
Federal	6,257	70%
State/Local	2,621	30
<u>Government program</u>		
Medicare	3,478	39
Medicaid	2,678	30
Other*	2,722	30
<u>Age group</u>		
0-64	4,544	51
65 and over	4,334	49

Note: Numbers may not add to total due to rounding.

*Other Federal Government smoking-attributable direct medical expenditures include those of the following programs and agencies: Workers' Compensation; Department of Defense; Maternal and Child Health; Vocational Rehabilitation; Alcohol, Drug Abuse, and Mental Health Administration; Indian Health Service; and miscellaneous general hospital and medical programs. Other State and local expenditures include those of the Temporary Disability Program, Workers' Compensation, General Assistance, Maternal and Child Health, Vocational Rehabilitation, hospital subsidies, and school health.

Sources: Levit, K.R., Lazenby, H.C., Cowan, C.A., et al., "National Health Expenditures, 1990," <u>Health Care Financing Review</u>, 13(1):29-54, Fall 1991, Table 12; USDHHS, HCFA, ORD, <u>Program Statistics: Medicare and Medicaid Data Book, 1990</u>, HCFA Pub. No. 03314 (Baltimore, MD:1990), Table 4.23; Waldo, D.R., Sonnefeld, S.T., McKusick, D.R., et al., "Health Expenditures by Age Group, 1977 and 1987," <u>Health Care Financing Review</u>, 10(4):111-120, Summer 1989, Table 3.

Statement of the Public Securities Association

PSA is the international trade organization of securities firms and banks that underwrite and trade municipal securities, U.S. Government and agency securities, mortgage-backed securities and money-market instruments. PSA's membership includes nearly all firms that underwrite securities issued by public and non-profit health care organizations. As such, we take a strong interest in improving the nation's health care delivery system. We commend President Clinton for his commitment to health care reform and we commend Chairman Moynihan for holding this hearing.

Our comments will focus on tax-exempt bond related issues contained in the Administration's health care reform proposal, the $150 million limit on outstanding tax-exempt bonds of non-profit 501(c)(3) organizations and the $10 million annual limitation on so-called "bank qualified bonds."

ROLE OF TAX-EXEMPT HOSPITALS

Our country benefits from the extensive network of non-profit hospitals and other non-profit health care facilities. According to the American Hospital Association, in 1992, non-profits made up 60 percent of the nation's hospitals and provided 75 per-

cent of all inpatient and outpatient hospital care. Clearly, non-profits play a vital role in our health-care system.

Under current law, non-profit health care providers are required to maintain strict standards of community benefit to earn or keep their tax-exempt status. While we generally support in principle the Administration's proposal to require non-profit health care institutions to assess their communities' health needs annually and to develop plans to address those needs, PSA believes that current community benefit standards for non-profit health care facilities have served the federal government and the general public well. Charity care is but one of the many community benefits of non-profit institutions. Teaching institutions, specialized care and community outreach programs are examples of other services provided substantially by 501(c)(3) facilities. Imposing stricter standards of community benefit for 501 (c)(3) health care facilities, as some participants in the health care debate have suggested, could create financial hardships which would negatively affect their debt ratings and cost of capital and could make it more difficult to meet the changing needs of the populations they serve. In fact, it is necessary to review the existing restrictions on tax-exempt bonds issued by 501(c)(3) health care facilities as those restrictions may serve as obstacles to meeting some of the efficiencies proscribed under health care reform.

Historically, hospital revenue bonds have carried a higher rating-adjusted risk premium in the market compared to other major categories of revenue bond issuers. Imposing economically enervating standards of community benefit as a condition of ongoing tax-exemption for 501(c)(3) providers would raise the risk premiums required by investors in outstanding and future tax-exempt debt securities for non-profit hospitals. If, as a result of complying with stricter community benefit standards, a number of non-profit providers were downgraded below investment grade, it is possible that all health-related bonds could be perceived as inherently more risky. Such a perception would, in turn, raise the cost of capital for all new health care facilities' financings. For outstanding bonds, those hurt most would be bondholders, whose investments would suffer a significant decline in value as a result.

Uncertainty regarding the tax status of non-profit health care facilities could also raise concerns regarding the tax-exempt status of outstanding bonds issued under current community benefit standards. Overall, perceived risks to bondholders—credit risk and the risk that certain outstanding bonds could be declared taxable—would increase. Higher risks to investors, even perceived risks, translate into higher financing costs for non-profit providers that depend on access to the tax-exempt bond market to raise capital.

We recognize that conferring tax-exemption on a health care organization represents a valuable form of assistance for which the federal government foregoes significant tax revenues, a form of assistance that should not be granted frivolously. We support continued application of standards for tax-exemption but stress the importance of preserving the flexibility that allows facilities to tailor their services to the unique needs of each community. We urge the Committee and the Congress to weigh carefully the effects of any new, tighter standards against the market disruption and higher cost of capital that could result. At the very least, if Congress ultimately debates stricter community benefit standards, we urge you to consider the interests of bond holders and future non-profit issuers by protecting the tax-exempt status of bonds issued by 501(c)(3) organizations under current law.

LIMITATIONS ON BORROWING BY NON-HOSPITAL HEALTH CARE FACILITIES

The Tax Code contains a $150 million limit on most outstanding tax-exempt bonds of non-profit 501(c)(3) organizations. An exception to the limit is provided for debt used to finance hospital facilities. However, the legal definition of "hospital" is sufficiently narrow that many health care facilities, such as outpatient emergency care clinics, community health centers and long-term care facilities, do not qualify for the exemption. Because the Administration's health care reform proposal encourages institutions to broaden their non-inpatient focus as a means of containing costs and providing a continuum of services in a variety of settings, non-profit health care organizations will become increasingly constrained by the cap when financing non-hospital facilities. These facilities often provide certain kinds of care more efficiently—and at a lower per-patient cost—than hospitals but could ironically face a higher financing costs due to a definition of "hospital" which has become somewhat outmoded by health reform.

If is consistent with the spirit of the Administration's health reform plan that care be provided as efficiently as possible. We are beginning to see consolidations and mergers of health care organizations as a result of health care reform. Such consolidations can be potentially more complicated and costly as a result of the inconsist-

ency in definition between hospital and non-hospital facilities. Moreover, in today's health care market, non-profit health care providers are increasingly offering services at facilities such as outpatient clinics which at one time would never have been offered outside the hospital setting. The $150 million non-hospital cap is a disincentive to providing care as efficiently as possible.

Short of elimination of the 501(c)(3) volume cap, which has successfully passed previous Congresses, a broader limit, for example, exempting from the cap not just hospital bonds but bonds issued for all health care facilities, would allow greater financial flexibility for 501(c)(3) health care organizations and would be consistent with the spirit of the original 1986 cap. H.R. 11, passed by the 102nd Congress in 1992, contained a provision that would have eliminated the $150 million cap altogether for all 501(c)(3) organizations. Chairman Moynihan, we commend you for your long standing support of total elimination of the volume cap and your leadership in having that provision included in H.R. 11. PSA strongly supports this effort.

DEMAND FOR TAX-EXEMPT HEALTH CARE BONDS

Under current law, commercial banks are encouraged by a provision in the Tax Code to buy tax-exempt securities issued by small issuers that sell $10 million or less of bonds annually, known as "bank-qualified" bonds. Banks generally limit their purchases of tax-exempt bonds to bank-qualified bonds only. The increased market demand associated with bank purchases of qualified municipal bonds lowers the cost of financing for small issuers by as much as 25 basis points below what they would otherwise face and makes it easier for them to market their debt.

Many health care organizations do not issue bonds directly, but borrow through financing authorities that issue bonds on behalf of many organizations in their jurisdictions. Even though a small hospital might otherwise qualify for the small-issuer provision and sell its bonds to commercial banks—because they issue $10 million or less annually—that opportunity is lost because the hospital borrows through an authority that issues bonds for many organizations and the annual issuance for which exceeds the $10 million limit. To permit all qualified small health care facilities to sell bonds to commercial banks and thus benefit from lower financing costs, PSA urges that the $10 million limit be applied at the level of the borrower, rather than the issuer.

We believe that tax-exempt bond financing continues to play an important role in assisting state and local governments to leverage limited resources in order to finance health care facilities. However, we recognize that there are areas of the country where non-profit hospitals experience difficulty in assessing the capital markets. In an effort to address those difficulties, Senator Tom Daschle (D–SD) and Congressman Pete Stark (D–CA) introduced a proposal to provide for Essential Health Facilities. We noted that provisions from both bills that would provide for federal guarantees on municipal debt, interest payment subsidies for municipal bonds, direct matching loans, and capital grants to qualified health facilities were included in the bill passed by the Health Subcommittee of the Committee on Ways & Means. PSA strongly supports such measures. It may also be necessary to consider other restrictions in current law to ensure they don't frustrate other goals within the health care reform agenda.

PSA believes that responsibly crafted health care reform would benefit public and non-profit health care providers and would strengthen the nation's health care system overall. We look forward to working with this committee as the debate over health care reform proceeds. Thank you for the opportunity to submit comments. We would be pleased to respond to any written questions by Members of the Committee.

STATEMENT OF THE SMOKELESS TOBACCO COUNCIL, INC.

Mr. Chairman, my name is Jeffrey L. Schlagenhauf and I am the President of the Smokeless Tobacco Council, Inc., an association of domestic smokeless tobacco product manufacturers. I appreciate the opportunity to submit this statement, which expresses the views of the smokeless tobacco manufacturers on the revenue portions of the proposed Health Security Act, recently announced by the Administration. In a startling exercise in "new speak," the Administration, in material accompanying the introduction of the Health Security Act, makes the incredible assertion that smokeless tobacco tax increases of 10,417% and 3,472% are "fair" and "workable." This tax is neither "fair" nor "workable." Bluntly put, that assertion is false on its face; the tax increases proposed on this one industry are grossly unfair and completely unworkable. They are unjustifiable, outrageously excessive, regressive, burdensome to one region of the country, and punitive.

For those of you who may not be familiar with smokeless tobacco, it is tobacco which is intended to be used in the mouth and is available in two main varieties—snuff (moist and dry), and chewing tobacco (loose leaf, plug, and twist)—and is sold in a wide variety of package sizes and weights. Smokeless tobacco has been enjoyed in this country since it was first settled over 300 years ago. Indeed, one brand of smokeless tobacco, still a popular brand today, is one of the oldest consumer products in this country, having been granted one of the first trademarks issued by the U.S. Patent Office. Today, smokeless tobacco products are used by a wide variety of working Americans including factory workers, construction workers, others who work with their hands, and outdoorsmen.

Mr. Chairman, as this Committee is well aware, smokeless tobacco products have been subject to federal excise taxes for much of our nation's history. After the repeal of the smokeless tobacco excise tax in 1965 along with excise taxes on scores of other products, the federal excise tax on smokeless tobacco was reimposed in 1985. The smokeless tobacco tax was further raised along with the cigarette excise tax in 1991, and once again in January of this year. In the 1990 legislation that imposed those increases, Congress approved a formula by which smokeless tobacco tax rates were increased the same percentage amount as cigarette rates. This action reaffirmed and reinforced the long held recognition of the competitive niche of smokeless tobacco based on historical, cultural, and economic factors.

In the recently announced proposal for health care reform, the Administration has advocated only one new source of tax revenue—tobacco taxes—including punitive taxes directed at smokeless tobacco. Mr. Chairman, the amount of the proposed tax increase on smokeless tobacco is so outrageously high—10,417 percent in the case of chewing tobacco, and 3,472 percent in the case of snuff—as to be confiscatory. Incredibly, the Administration described the taxes as "fair" and "workable." This outrageous tax is nothing less than an unvarnished attack on our employees, distributors, wholesalers and those who retail our products, which will result in the loss of jobs. It is an attack on the growers of our tobacco, that will result in the loss of farms and do irreparable harm to farm communities. It is an attack on our consumers, who will be asked to shoulder an unfair burden of taxation.

This unworkable proposal also destroys market stability. Current law differentials between cigarettes and smokeless tobacco products have been reaffirmed by the Congress previously, are justified and should be maintained. If tax increases are absolutely unavoidable, (other health care reform proposals do not have new taxes), they should be broad based, not directed at one industry.

Mr. Chairman, the Administration has not only proposed an outrageously high tax, it has also proposed to destroy the balance in taxation between the two major categories of smokeless tobacco, moist snuff and chewing tobacco. In recognition of the important differences between the products (traditional package sizes and particularly value added) the Congress imposed differing rates of tax on snuff and chewing tobacco. This existing law differential must be maintained.

SMOKELESS TOBACCO—AN ADULT PRODUCT

Some anti-tobacco activists argue that higher excise taxes are necessary to discourage persons under the age of eighteen from using tobacco products. They claim that high and increasing rates of usage justify these outrageous proposals to use the tax code to manipulate individual adult choice to suit their own views of what is appropriate individual behavior.

The fact of the matter is that, according to a recent HHS report, use of smokeless tobacco by males under 18 years of age is low, decreasing and very close to HHS's "target" or goal for the year 2000. The 1992 Healthy People 2000 Review1 reflects that the reported use of smokeless tobacco products (defined as use on at least one occasion in the last 30 days) by 12–17 year old males decreased from 6.6% of that group in 1988 to 5.3% in 1991.

Moreover, a National Institute on Drug Abuse survey published in October 1993 reported that use of smokeless tobacco by 12–17 year old males had further declined in 1992 to 4.8%, which is very close to the 4.0% "target" for the year 2000 set in Healthy People 2000 Review. Furthermore, the reported usage of smokeless tobacco by the total 12–17 year old population (males and females) was 2.6% in 1992 according to the NIDA survey.

The Smokeless Tobacco Council agrees that tobacco products should not be sold or distributed to persons under the age of eighteen. Indeed, the Council has worked hard for many years to inform the public that smokeless tobacco products are for adults only. The trends revealed in the government's own surveys noted above suggest that our efforts are working. A description of the Council's adults-only program,

which has been conducted for a decade with the goal of keeping smokeless tobacco an adults-only product, is included with this testimony as Attachment A.

Legislatively, the Council has also supported the passage of state laws which prohibit the sale or distribution of tobacco products to persons under the age of 18. The Council also supported a provision in the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act which requires states to prohibit the sale or distribution of tobacco products to persons under the age of 18, or risk losing federal funds for other programs. We believe these laws are the effective way to keep tobacco products out of the hands of persons under the age of eighteen. In sharp contrast to these laws, however, excessive excise taxes unfairly punish the working adult Americans who are our consumers.

SMOKELESS TOBACCO TAXES ARE HIGHLY REGRESSIVE

The proposed new taxes on smokeless tobacco violate fundamental principles of equitable and efficient tax policy. The most important of these principles is vertical equity.

Excise taxes are inherently regressive, because they impose the same tax on a product regardless of the consumer's income level. The smokeless tobacco tax is the most regressive excise tax due to the demographics of smokeless tobacco consumers. Smokeless tobacco users are concentrated in the lowest income categories. Several data sources confirm this.

For instance, in 1988 about 29 percent of the U.S. population had family income of less than $20,000. On the other hand, market research has established that about 36 percent of snuff consumers and 37 percent of chewing tobacco consumers had family income of less than $20,000. This concentration is greater for smokeless tobacco products than for any other tobacco product.

Recent market research by Simmons Market Research Bureau revealed that 51 percent of chewing tobacco users and 42 percent of moist snuff users had family incomes below $30,000. Mediamarket Research Inc. established through survey analysis that 57 percent of all smokeless tobacco users had family incomes below $30,000.

The announced excise tax proposals demonstrate a complete lack of any sense of fairness by imposing the largest percentage increase on the most regressive taxes. As noted above, chewing tobacco has the highest percentage of low income consumers—yet chewing tobacco is subject to the largest percentage increase in taxes (10,417 percent). Snuff taxes, also highly regressive, are increased 3,472 percent.

The Administration has stated that it does not want to tax middle and lower income working men and women of America, as Members of this Committee will recall vividly from the rhetoric of the Budget Reconciliation debate. However, this proposal is aimed directly at those very same taxpayers. As this Committee will also recall from the luxury tax fiasco, substantial economic harm results from product specific taxes; harm that usually is inflicted on the American working person. This proposal will produce widespread economic harm to middle and lower income working men and women.

In selecting a financing system for the Health Security Act, the Administration has chosen to ignore the lessons of the past, as well as the principle of vertical equity by selecting only tobacco taxes as a tax revenue source. And of that category, the most regressive individual product taxes—those on chewing tobacco and snuff—incredibly are increased the most. Certainly, Members of this Committee will reject these regressive and punitive tax increases and pursue sound tax policy in funding such an important program as health care reform.

THE PROPOSED EXCISE TAX DISPROPORTIONATELY BURDENS ONE REGION OF THE COUNTRY

Sound tax policy also dictates that the burden of any new excise tax for a national health care reform plan should be equally distributed on geographic regions across the United States. Contrary to this fundamentally fair and sound policy, the impact of the proposed tax increase on smokeless tobacco products will be unfair because it will be unduly burdensome on only one region, the Southern region, of our country. Although twelve Southern states comprise about 25% of the nation's population, they account for less than 25% of the nation's disposable income. In sharp contrast to those shares, these twelve States will pay over half of the proposed smokeless tobacco tax.

States bearing the brunt of the new tax are Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia. For example, Mississippi would pay a portion of the new tax that is 6 times their share of disposable income and more than 4 times their share of the total population. Likewise, Tennessee consumers would pay a por-

tion of the new taxes that is over three times their share of disposable income. Yet another state unfairly burdened by the proposed tax would be North Carolina. North Carolina accounts for 2.4 percent of the nation's total disposable personal income, yet North Carolina would pay 7.9 percent of the new tax on smokeless tobacco products. As a final example of the extreme regional nature of the proposed tax increase, Georgians would pay a share of the new tax that is over two and a half times their national economic representation, based on disposable personal income.

These statistics clearly demonstrate that the punitive smokeless tobacco tax increase proposed by the Clinton Administration would substantially violate the fundamental principle that tax burdens should be equitably distributed.

This tax is a prescription for regional devastation caused not by natural events, but by deliberate, unthinking, governmental action. We cannot believe the Committee or the Congress will sanction such a single minded attack on one region of the country. The Smokeless Tobacco Council believes it is patently unfair to ask the people of a dozen Southern states to shoulder over half of an excessive tax burden that might at best provide only a small fraction of the massive funding for federal health programs benefiting the United States at large.

HEALTH CARE SHOULD NOT BE FUNDED BY A SINGLE INDUSTRY

Another important principle of tax policy is that revenue sources should be broad based and neutral. Broad-based and neutral taxes are administratively efficient—they raise revenue through a stable, standard mechanism. Broad-based taxes do not distort consumer choices and, thus, provide the most comprehensive and stable revenue.

Broad-based and neutral taxes are also equitable. They avoid policy choices and discrimination based on one group's notion of appropriate individual behavior and instead focus only on revenue needs.

The Health Security Act singles out one, and only one, industry for disparate treatment. It attempts to pay for health care for all Americans on the backs of a small minority of the population who choose to consume smokeless tobacco products.

EXCESSIVE TAXATION WILL CAUSE JOB LOSS

This tax will affect the thousands of people who are employed in the production, manufacturing and distribution of smokeless tobacco. The industry includes small farmers in states like Tennessee, Kentucky, Wisconsin, Pennsylvania and Virginia. In many cases, tobacco provides the cash margin that sustains a diversified family farm operation. Smokeless tobacco companies employ workers in states like Connecticut, Wisconsin, New Jersey, West Virginia, Virginia, Tennessee, Kentucky and Illinois. Many tobacco product distributors, convenience and "mom and pop" store operators will be affected in large states like Texas and Georgia.

Tax increases at any level, especially the likes of those proposed, will cause the loss of livelihoods both within the tobacco industry as well as among those who are suppliers and providers to the industry. There will be an inevitable cascading of the loss of those jobs and their economic harm throughout the larger farm and rural communities associated with tobacco. That is an inescapable conclusion.

Mr. Chairman, this proposal is so arbitrary and excessive that it cannot be viewed as the fair and reasonable exercise of a legitimate power. It is surely something more: a cynical and zealous attempt, based on one group's judgmental views about others' lifestyles, to punish and confiscate the business and livelihoods of the working people in the smokeless tobacco industry and to deny working adult Americans a simple pleasure.

THE PROPOSED TAX IS ILLUSORY AS A REVENUE RAISER

By placing a huge tax on top of the excise taxes currently in place at the state level, the proposed federal tax is largely illusory as a revenue raiser because its imposition would create a declining revenue base. This decline would come not only from shrinking revenues from the excise tax itself, but from declines in corporate and individual revenue associated with the tobacco industry. If taxes on smokeless tobacco products were increased to the suggested levels, large numbers of consumers could not afford, or would choose not, to purchase such products. The net result would be that tax revenues would plummet despite an increase in actual tax rates.

The Administration's own FY '94 budget submission is clear evidence of the effect of higher product-specific taxes on revenue and contradicts the assertions before the Committee that higher taxes on these products means higher revenue. Despite a 25% increase in the smokeless tobacco tax rate imposed in January 1993 [illegible] Administrations own FY '94 budget estimates that tax revenue from smokeles[illegible]co will decrease in the coming fiscal year.

This point illustrates a conflict inherent in the proposed tax. Some proponents say that the goal of the tax should be to influence individual adult choice (a choice contrary to their own) and decrease consumption of a lawful product. Others look to the tax as a source of revenue to fund the health care reform package. These goals conflict with one another because as consumption is driven down by higher taxes, revenue will inevitably decline. It is time for the proponents of this punitive tax increase to be honest with the Committee about their motives underlying this tax proposal. Funding health care on an unstable revenue source is tax policy folly; any tax, if mandated, must be neutral and broad based if it is to be fair and successful as a revenue source.

"EQUIVALENCY" IS MEANINGLESS BETWEEN CIGARETTES AND SMOKELESS TOBACCO PRODUCTS

Some have maintained that the confiscatory rates of increase on smokeless tobacco taxes are justified out of some notion of "equivalency" with cigarettes on a per pound of tobacco basis. This is merely a disingenuous smokescreen to impose massive tax increases on smokeless tobacco products. There is no meaningful definition of "equivalency" between cigarettes and smokeless tobacco products.

Unlike cigarettes, which are uniformly packaged, there are many different smokeless tobacco products which are packaged in a multitude of styles, sizes, and weights. Chewing tobacco and snuff are sold in five major product categories under more than 150 brand names in over 35 separate packages which in turn are available in a wide variety of sizes and weights. For example, chewing tobacco comes in loose leaf, plug, and twist forms and snuff comes in both moist and dry forms. Typical packages include bottles, pouches, plugs, packs, tumblers, bags, twists, gullets, ten varieties of cans and so on.

Substantial differentials in rates of tax between cigarettes and smokeless tobacco products are also warranted because the value inherent in the production of cigarettes far exceeds the value created by the production of smokeless tobacco products.

Both products use essentially the same raw input—tobacco. Yet there is about 8-to-10 times more value-added (the difference between the price a manufacturer gets for a pound of a product and the price of a raw pound of tobacco input) in cigarettes than there is value-added in chewing tobacco. Rational economic policy requires that tax rates based on weight reflect differing values. Historically, excise tax rates reflected value in some way. Prior to 1965, for instance, there were different manufacturers' excise taxes on radios, televisions, and other electrical appliances. It would not make sense to tax a pound of televisions the same as a pound of electric toasters.

Because of the relative level of regressivity between the different product categories, and the differences in product packaging and value added, there is simply no justification for notions of per pound "equivalency." If Congress insists on including tobacco excise taxes in health care reform legislation, despite the poor tax policy implications of such taxes, the rates of all tobacco products should be increased by the same percentage.

A FEDERAL EXCISE TAX ENCROACHES UPON STATE TAX BASES

A large federal excise tax on smokeless tobacco products will substantially encroach upon state tax bases and erode the ability of individual states to generate revenue.

This view was confirmed by the Federation of Tax Administrators (FTA) in December of 1993 when the FTA estimated the state revenue impact of the Administration's proposal on state revenues. The FTA estimated that the Administration's proposed $0.75 per pack Federal cigarette tax increase would cost the states $878 million in FY 1995 excise tax revenues, a 14 percent decrease. The loss over a five year period totals $4.2 billion. The State Revenue Tax Offset adds another $619 million in revenue losses, and $2.8 billion over a five year period.

The many states that derive revenue from taxes on tobacco products are able to do so solely because of the absence of an excessive federal levy. The excessive and punitive federal tax being discussed today would clearly endanger the effectiveness of existing state excise taxes by infringing upon the same tax bases tapped by states.

CONCLUSION

The smokeless tobacco industry is uniquely American. Use of smokeless tobacco by American working people has been a custom for over 300 years. From the very beginning, smokeless tobacco has been an all-American product; from the farmer to the manufacturing process in the United States, to the thousands of distributors,

stores and "mom and pop" shops that sell the product, and finally to the American working people who enjoy these products. The many men and women of the American smokeless tobacco industry—the growers, the factory workers, the consumers—should not bear this unfair tax because some want to restrict adult choice. Use of the taxing power in this punitive manner is unfair, unreasonable, and unprecedented. We urge the Committee to restore fairness and sensibility to the Administration's proposal and reject this tax.

STATEMENT OF THE U.S. VETERANS RIGHTS COALITION

I am writing to express the U.S. Veterans Rights Coalition's grave concern over the prospect of higher excise taxes, especially the current 75-cent per pack cigarette tax proposed by President Clinton. If approved by the U.S. Congress, this *wholly regressive tax* will have devastating consequences on our millions of American veterans who enjoy their right to smoke tobacco products each day.

I have seen some in Congress and the Administration loosely suggest on National Television that such an extreme rise in the cigarette tax will cause many to quit smoking. As a Veterans' Leader who knows his fellow Comrades quite well, I can categorically state that Veterans will **NOT** quit smoking because of **THIS** or **ANY OTHER** tax. To the contrary, they will spend their rent money, meal money, prescription drug money or, worse, go broke. *I know Veterans very well in this regard!*

Allow me to set forth an example of how a 75-cent cigarette tax, as an example, would adversely impact a hypothetical Veteran. If my friend were to smoke two packs of cigarettes daily, as is common with Veterans, a 75-cent tax would represent a $45 hit on his/her limited monthly income OR $547 annually (many elderly Veterans today live on fixed incomes, such as Social Security). This, is on top of ALL the other taxes that Veterans, like all Americans, must pay. As you can see, this Tax will be quite a pinch on our Veterans' household incomes.

It is ironic, in a way, that the same Government who once encouraged our GI's to smoke through War-time rations, now wants to make it a **financial punishment** to exercise what still remains our Veteran's **LEGAL** right to smoke. Why, we wonder, should Veterans have to suffer because a few in Washington now deem it "politically incorrect" to smoke?

It is simply NOT fair!

For your information, the U.S. Veterans Rights Coalition is made up of state and national leaders of the Veterans of Foreign Wars, the American Legion, the Disabled American Veterans and the Retired Enlisted Association in ALL 50 states and the District of Columbia. Our mandate is to Fight for and Protect the Rights of our Veterans, including their Right to Smoke.

I am attaching, for the record, copies of resolutions passed unanimously last year by the **VFW's Southern Conference,** which represents Veterans in 13 states, and the **West Virginia Department of the American Legion.** These resolutions call on the Congress "to explore options other than increase excise taxes" due to the adverse financial impact they will have on our Veterans and their household budgets. More resolutions, I am told, will be considered by VFW and American Legion groups in the coming months and I will make those a part of the record as soon as they become available.

I can't stress enough how much Veterans nationwide, and in our home State of West Virginia, are concerned about such an extreme hike in the cigarette tax, since millions of our Comrades, including myself, enjoy our right to smoke. We absolutely cannot afford to pay any more!

I want to state that my Membership is also concerned about Health Care Reform. But when our Government, with ALL its trillions of dollars in taxes, can't even properly fund our VA System now, how are we to honestly believe that taxing the heck out of cigarettes will guarantee health care coverage for the rest of our American citizens? I even saw the other day where Rep. Dan Rostenkowski said on television that MORE taxes will be needed to fully fund Health Care Reform.

To further illustrate my point, our V.F.W. Office in Washington advises us that President Clinton's FY '95 Budget for the Department of Veterans Affairs only provides for a meager $500 million increase over the current year's spending. This hardly accounts for inflation and the growing strains already being felt by the VA. As you know, our Veteran population is rapidly aging, meaning more and more Veterans are calling on their Government each day to live up to the promise given them long ago when they went off to war. Much greater funding is needed.

I am further advised that the President's VA Budget request would slash up to 3,680 VA employees from the payroll. This would be a disaster given the reasons I pointed out above.

I hope you see my point. We, in the American Veterans Community DO NOT want to see a costly cigarette tax that won't do what it is intended and only break the household budgets of our fellow Veterans. It is easy, I guess, to target cigarettes as the "tax of least resistance," but let me tell you that we Veterans intend to Fight this Tax aggressively, lest our elderly and lower income Veterans lose their dignity by going broke.

In closing, let me offer some other, much more appropriate suggestions for financing Health Care Reform. If the concept is to "tax" products that are deemed to be health care related, why not tax McDonald's cheeseburgers, steroids, toxic chemical plants, automobile exhaust systems, cocaine and other illegal drugs, silicone breast implants, police radar guns, semi-automatic weapons, cop-killer bullets, asbestos and other items that have proven to cause billions of dollars in annual health-related costs. These and many other products are the real culprits!

Please don't make cigarettes the scapegoat—it will NOT solve the problem and only cause our elderly and low-income Veterans to go broke. Our Veterans certainly deserve better treatment than that. Thank you! [1]

Attachments.

SOUTHERN CONFERENCE

VETERANS OF FOREIGN WARS OF THE UNITED STATES

[Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, WV.]

Whereas, America's veterans have fought, sacrificed and, in many instances, died so their countrymen, and themselves, could live free of excessive taxation and infringements on their personal liberties;

Whereas, Congress will soon be asked to consider increased excise taxes that will adversely impact the financial standing of many of America's veterans, especially those on fixed incomes, while their veterans' benefits continue to be decreased;

Whereas, the intent of legislation many American veterans' groups and over 100 Members of Congress worked tirelessly to pass last November, mandating indoor designated smoking areas within Veterans' Administration hospitals nationwide, is tragically being ignored by the U.S. Department of Veterans Affairs;

Whereas, non-compliance of the legislation known as H.R. 5192 still causes VA patients, including the terminally ill, elderly and wheelchair-bound to go outdoors in the blistering summer heat or frigid winter cold in order to exercise their freedom of choice to use legal tobacco products;

And, **Whereas,** veterans should be treated with the dignity and respect they so deserve;

Now, **Therefore,** Be it Resolved that the Southern Conference of the Veterans' of Foreign Wars, meeting in Louisville, Kentucky, July 9–11, urges the U.S. Congress to explore options other than increased excise taxes, while also urging the U.S. Secretary of Veterans' Affairs to completely comply with the provisions set forth in the law H.R. 5192, calling for the establishment of at least one indoor designated smoking area in each VA hospital.

This is to certify that the above Resolution was passed with no opposing vote in Louisville, KY, July 10, 1993, by the Southern Conference of the Veterans of Foreign Wars of the United States.

AL FEHER, *Secretary-Treasurer.*

DEPARTMENT OF WEST VIRGINIA

THE AMERICAN LEGION

CHARLESTON, WEST VIRGINIA 25332

Whereas, America's veterans have fought, sacrificed and, in many instances, died so their countrymen, and themselves, could live free of excessive taxation and infringements on their personal liberties;

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[1] John Payne is a World War II Marine Corp medic with over 40 years service to the American Legion and Veterans of Foreign Wars of the U.S. He is a Past VFW State Commander and current Commander of VFW Post #3466 in Charleston, W. Va. He is also a leader of the West Virginia Department of the American Legion.

Whereas, Congress will soon be asked to consider increased excise taxes that will adversely impact the financial standing of many of America's veterans, especially those on fixed incomes, while their veterans' benefits continue to be decreased;

Whereas, the intent of legislation many American veterans' groups and over 100 Members of Congress worked tirelessly to pass last November, mandating indoor designated smoking areas within Veterans' Administration hospitals nationwide, is tragically being ignored by the U.S. Department of Veterans Affairs;

Whereas, non-compliance of the legislation known as H.R. 5192 still causes VA patients, including the terminally ill, elderly and wheelchair-bound to go outdoors in the blistering summer heat or frigid winter cold in order to exercise their freedom of choice to use legal tobacco products;

And, **Whereas,** veterans should be treated with the dignity and respect they so deserve;

Now, **Therefore,** Be it Resolved that the West Virginia Department of the American Legion, meeting in Beckley, West Virginia, July 8–11, urges the U.S. Congress to explore options other than increased excise taxes, while also urging the U.S. Secretary of Veterans' Affairs to completely comply with the provisions set forth in the law H.R. 5192, calling for the establishment of at least one indoor designated smoking area in each VA hospital.

UNANIMOUSLY PASSED

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