indicating that contracting out was more successful as the size of the operation increased.

Q. Have A-76 comparisons resulted in reduced in-house costs even where activities were not contracted to the private sector?

A. Yes. If the activity remains in-house after the cost comparison study, substantial cost savings may result from the streamlining or "management review" process (especially within DOD). Where such management reviews are obligatory, there is evidence of savings. During the period 1979-1981, DOD streamlined activities which remained in-house after A-76 analyses at a savings of $14 million. Among civilian agencies, by contrast, data on streamlining savings are scarce due to the infrequency of A-76 studies for FY 1979-1981 and the inconsistent application of management reviews. Under the present circular, streamlining is encouraged but not required for civilian agencies.

Q. What did PPSS conclude about the 1979 change which rules out contracting unless contract costs are at least 10% below in-house costs?

A. This new requirement contradicts the announced policy of A-76 to rely on the private sector to supply commercial services and to keep Government out of business. The 10% cost differential requirement is incompatible with announced policy goals.

Even before this 10% differential is imposed, there are other major add-ons to the contract bid for comparison purposes. First, Federal contract administration costs are added, which range from 2% to 9%. Next, a <u>minimum</u> 2% is added to cover costs of severance, retraining, or relocating Federal employees who would be affected by contracting out. Such adjustments are logical for developing accurate costs of contracting for A-76 comparison purposes. But it makes no sense to impose an additional 10% penalty differential for contractors to overcome if the Government really means to rely on them for commercial services.

Q. Did PPSS uncover evidence of other impediments in the A-76 process against contracting?

A. Yes. Federal personnel costs -- specifically the element of retirement costs -- have been understated to reduce in-house costs. OMB prescribes in Circular A-76 the retirement benefit factor, stated as a percentage of gross salary, which agencies are required to use for A-76 cost comparisons.

The retirement benefit factor, as originally established for government-wide use in March 1966, was 7%. In March

1979, it was increased to 20.4%, the current factor. The original 7% figure was simply the charge levied against agency budgets and, as was known, did not represent the full costs to the Government of retirement benefits (see the "Retirement" section of this report).

For 1979, the Civil Service Commission (CSC), predecessor of the Office of Personnel Management (OPM), determined that the retirement factor should be 55%. OMB dismissed that and ordered CSC to submit another figure. CSC came up with a new figure of 34%. That too OMB rejected. OMB then promulgated the 20.4% factor without reference to any published cost data.

By way of comparison, OPM, as part of its annual financial report to Congress, calculated the Government contribution for Federal retirement in 1982 as 33.2%, and the long-term Government cost for Civil Service retirement as 29%. Despite being discredited, the 1979 figure of 20.4% still remains in effect for A-76 cost comparisons.

Q. What savings are possible if PPSS recommendations are implemented?

A. Based upon phased implementation, PPSS projects first year savings of $1.15 billion and cumulative first three year savings of $7.39 billion. When fully implemented (after four years), savings will exceed $5 billion annually, as shown below:

Government Savings
from Contracting Out
($ Billions)

	Year	(1) Annual	(2) Cumulative
(1)	1	$1.15	$ 1.15
(2)	2	2.42	3.57
(3)	3	3.82	7.39
(4)	4	5.36	12.75

Without the changes in Circular A-76 recommended by PPSS, savings only in the millions -- not billions -- are likely. With the recommended changes, savings of $5 billion annually become possible, after full implementation.

A four-year implementation period would require making A-76 determinations covering an average of 125,000 positions in each of those years, or more than 10 times the number now contemplated for completion during that period. PPSS estimated that about 80% of the positions analyzed will be eliminated. This will mean 100,000 Federal employee positions will be eliminated each year, or a total over the four years of about one-fifth of the Federal civilian work force, excluding the Postal Service.

In summary, A-76 cost comparison studies, and the contracting out that should result, have not been fully implemented by Federal agencies because of:

- Agency perceptions that A-76 is not a serious policy due to inconsistent support from successive Presidential administrations and opposition within Congress.
- Resistance from managers and staff conducting cost studies who perceive a loss of job security or possible demotion if their operation is contracted out.
- Complex, time consuming, cumbersome, costly, and inaccurate procedures for A-76 cost comparison studies.
- Concern over Congressional opposition leading to OMB delays and a concomitant reduction in savings.

For 28 years, there has been no real movement towards implementing A-76 policies. As a result, over that period the number of commercial activities performed by the Government has greatly expanded. PPSS recommended changes will provide large cost savings, but it must be recognized that they will significantly reduce the size of the Federal work force and that opposition from Congress and Federal employees will occur. If the long-standing, long-stalled policy of reliance upon the private sector is to be fully implemented, the President will have to direct the way.

The preceding pages discussed some of the major areas where privatization and contracting out present viable options for services currently performed by the Government. Additional areas where services could be transferred from Government to the private sector include:

- Increased application of A-76 by defense agencies, the Coast Guard, and the General Services Administration.
- Reduced Federal housing and hospital construction. Greater reliance on the private housing market to meet the needs of military personnel, and contracting out for additional hospital bed capacity required by the Veterans Administration.

- Discontinuation of the agency status of both the Federal National Mortgage Association and the Farm Credit System.

- Transference of the freight forwarding activities of the USDA to the private sector.

The three-year total of all the recommendations in this section, after elimination of duplication and overlap among issues, is $37.078 billion -- equal to the three-year taxes of 5.6 million median income families.

C. SELECTED FEDERAL PROGRAMS: HOW TO MAKE THEM DELIVER WHILE REDUCING THE COST TO TAXPAYERS

III-C. Selected Federal Programs: How to Make Them Deliver While Reducing the Cost to Taxpayers

The efficiency or inefficiency with which Government conducts its business is most clearly evident in individual programs.

Repeatedly it is brought to the attention of the general public that subsidy programs have error rates far in excess of what might reasonably be expected. It has been estimated that ten cents of every dollar in the Food Stamp program is wasted. The Farmers Home Administration has a delinquency rate on its loans 10 times greater than private lenders -- and 70% of the FmHA borrowers and two-thirds of its programs are for non-farm purposes. Wage laws enacted by the Federal Government to ensure that workers under Federal contracts are adequately compensated, result in wages that are significantly higher than those prevailing in the local market -- $11.650 billion higher over three years. Federal insurance programs offer coverage totalling $2.1 trillion, yet premiums on these programs do not reflect the relative risks of those insured and reserves are insufficient to cover potential claims. Federal research and development efforts, costing over $44 billion in 1983, are uncoordinated and are often initiated at the lower levels of department and agency management. As a result, programs are started without adequate consideration of national goals and priorities and are often duplicative of research efforts being conducted elsewhere in the Federal maze. All are indicative of Government deficiencies in the design, execution and management of Federal programs.

PPSS recommendations in these areas are intended to focus Federal management policy not on the gross amount of benefits these programs provide to selected recipients, but rather on the net benefit provided to those truly in need above the financial cost to the general taxpayer.

In lending programs this would involve greater attention to loan repayment than the current emphasis on loan origination. In subsidy programs this would involve greater accounting for total benefits received through various programs.

For research and development it would involve the formulation of strategy to achieve coherent national goals and the integration of department and agency research efforts into this strategy. For insurance programs it would involve realistic assesment of risks and insurance premiums fully reflecting those risks.

Full acceptance of this philosophy would result in legislative initiatives to repeal the three major wage laws, the

Davis-Bacon Act, the Walsh-Healey Act and the Service Contract Act, since these laws provide few real benefits to the public at an unconscionable cost to the taxpayer.

Subsidized Programs

In 1982, the Federal Government spent $124 billion to reduce poverty. The reduction in poverty as a result of this expenditure was $37 billion -- about 30% of the amount expended. PPSS noted that benefits appear to be misdirected and are not being received by intended recipients. Adequate information does not exist to fully assess subsidy programs. PPSS recommended that the Federal Government centralize the administration of these programs and develop an accounting system which will provide information on all the benefits distributed to each recipient. A statement of both cash and non-cash benefits, similar to a W-2 form, should be prepared for all recipients and provide the basis for managing subsidy programs.

In addition, PPSS has made specific recommendations to (a) improve administration of Social Security; (b) reduce overlapping and duplicative Food Stamp benefits; and (c) control long-term Federal health care costs through system reform.

In FY 1983, the Government spent $222.3 billion in the specific areas covered by PPSS recommendations, with spending estimated to increase to $1,355.4 billion by the year 2000 if present policies are continued. Implementing PPSS recommendations would reduce spending to $1,099.5 billion in 2000, a saving of $255.9 billion or 18.9%.

Overview

A useful way of viewing Federal expenditures is to distinguish between outlays that are clearly made for the traditional functions of Government (such as those for national defense, interest on the public debt, and such general Government functions as the administration of justice, legislative and executive activities, and fiscal management), and those non-traditional outlays which are targeted to specific classes of individuals, businesses, or institutions. The following chart shows the growth in traditional and non-traditional outlays over the 1962-1982 period. The figures are in constant 1982 dollars in order to identify the "real" growth, rather than the growth associated with inflation.

[Table on following page]

Traditional vs. Non-Traditional Outlays
(millions of constant 1982 dollars)

	(1)	(2)	(3)
	Outlays		
	Targeted (Non-Traditional)	Non-Targeted (Traditional)	Total
(1) 1962	$147,471	$164,975	$312,446
(2) 1972	289,193	192,559	481,752
(3) 1977	407,385	186,844	594,229
(4) 1982	461,801	266,574	728,375
Avg. Ann. % Increase			
(5) 1962-1982	5.9%	2.4%	4.3%
(6) 1962-1972	7.0	1.6	4.4
(7) 1972-1982	4.8	3.3	4.2
	As a % of Total Outlays		
(8) 1962	47.2%	52.8%	100.0%
(9) 1972	60.0	40.0	100.0
(10) 1977	68.6	31.4	100.0
(11) 1982	63.4	36.6	100.0

As shown, targeted or non-traditional outlays grew at an average annual rate of 5.9% over the 1962-1982 period, or 2.5 times as fast as the 2.4% growth rate for traditional expenditures. As a result, targeted outlays went from 47.2% of all outlays in 1962 to 63.4% in 1982. The fastest growth rate in targeted outlays was in the decade from 1962-1972 (7.0% per year versus 4.8% in the next decade). However, in terms of dollars, the constant dollar increase was actually greater in the decade 1972-1982 at $173 billion versus $142 billion in the decade 1962-1972.

The following shows how these non-traditional targeted outlays were distributed on a functional basis:

[Table on following page]

Non-Traditional Targeted Outlays
Top Five Functions in 1962, 1972 & 1982
(millions of constant 1982 dollars)

		(1) Amount	(2) % of Targeted Outlays
	1962		
(1)	Income Security	$ 68,918	46.7%
(2)	Veterans Benefits	16,454	11.2
(3)	International Affairs	16,384	11.1
(4)	Transportation	12,508	8.5
(5)	Agriculture	10,393	7.0
(6)	Subtotal	124,657	84.5
(7)	All Other	22,814	15.5
(8)	Total	$147,471	100.0%
	1972		
(9)	Income Security	$141,589	49.0%
(10)	Health	33,680	11.7
(11)	Education, Training	26,145	9.0
(12)	Veterans Benefits	22,409	7.7
(13)	Transportation	17,517	6.1
(14)	Subtotal	241,340	83.5
(15)	All Other	47,853	16.5
(16)	Total	$289,193	100.0%
	1982		
(17)	Income Security	$263,281	57.0%
(18)	Health	74,017	16.0
(19)	Education, Training	26,300	5.7
(20)	Veterans Benefits	23,955	5.2
(21)	Transportation	20,560	4.5
(22)	Subtotal	408,113	88.4
(23)	All Other	53,688	11.6
(24)	Total	$461,801	100.0%

As shown in the preceding chart, five functional areas continue to absorb about 83%-88% of targeted outlays. By far the largest category is Income Security, which increased from 46.7% of total targeted outlays in 1962 to 57.0% in 1982. Over the same period Veterans benefits declined from 11.2% to 5.2%. The biggest functional change was in Health, which increased from $3 billion or 2.4% of targeted outlays in 1962 (when it did not rank in the top five) to $74 billion or 16.0% by 1982 (when it ranked second). Of note, Income Security and Health outlays represented only 4.5% of GNP in 1962 versus 11.0% in 1982.

All these breakdowns do not, however, reflect the value of the subsidies which are inherent in most of these targeted outlays. In certain cases, the subsidies comprise all of the payments -- as in means-tested programs geared primarily to the poor or near-poor, and in crop support payments to farmers. In other cases, such as Social Security and Medicare, the benefits in part reflect the return of money that beneficiaries and their employers put into funds, but primarily reflect non-contributory outlays. In still other cases, the payments reflect either mainly the return of contributed funds (such as with unemployment insurance) or form part of total compensation, such as the benefits paid to retired military and civilian employees.

As noted previously, 63.4% of 1982 total Federal Government outlays represented funds targeted primarily to eradicate poverty, provide retirement benefits to the elderly, and assist farmers and selected other businesses and individuals through direct aid, credit, preferential tax treatment, or some combination of the three.

Q. Given that the Federal Government is spending such a large proportion of its outlays for these social purposes, why is it that the poverty rate, for example, has been increasing?

A. The Federal Government first began measuring poverty in the early 1960's, when the U.S. was considered a relatively affluent society. Yet, an estimated 22% of the population in 1959 -- 39.5 million Americans -- were deemed poor. During the next 14 years, the combination of Great Society programs and sustained economic growth (per capita real GNP increased by an average of 2.7% per year over the entire period) resulted in the poverty rate falling to a low of 11.1% in 1973. During the balance of the 1970's, the poverty rate remained in the 11%-12.5% range, and then gradually increased during the recessions that followed to reach 15% in 1982. The obvious question is why the poverty rate is still this high in spite of transfer payments having quintupled in real dollars over the 1959-1982 period and means-tested programs specifically geared to the poor having increased more than six-fold.

Part of the answer is statistical: poverty is defined by and limited to cash income -- earnings, social security, retirement benefits, and cash assistance to the poor. However, a large percentage of all transfer payments and the majority of means-tested programs are now in non-cash forms, including in-kind medical benefits, housing assistance, food stamps, and school lunches. The following table, based on OMB statistics, shows the rise in non-cash transfer payments in constant 1982 dollars, in total and for the major means-tested programs:

[Table on following page]

(billions of constant 1982 $)	(1) All Transfer Payments Cash	(2) All Transfer Payments Non-Cash	(3) All Transfer Payments Total	(4) Memo: Non-Cash as a % of Total
(1) 1959	$ 71.9	$ 1.3	$ 73.2	1.8%
(2) 1966	106.2	6.8	113.0	6.0
(3) 1973	180.8	50.0	230.8	21.7
(4) 1983	255.4	106.9	362.3	29.5
(5) 1983 as a multiple of 1959	3.6x	82.2x	4.9x	N.A.
	Major Means-Tested Programs (a)			
(6) 1959	$ 11.3	$ 1.3	$ 12.6	10.3%
(7) 1966	13.4	6.8	20.2	33.7
(8) 1973	23.0	29.3	52.3	56.0
(9) 1983	22.4	56.4	78.8	71.6
(10) 1983 as a multiple of 1959	2.0x	43.4x	6.3x	N.A.

(a) Major means-tested cash includes Aid to Families With Dependent Children and Supplemental Security Income, while non-cash includes Medicaid, Food Stamps, Child Nutrition, and Housing Assistance.

As shown in the preceding chart, in real terms, i.e., excluding inflation, non-cash payments increased 82.2 times overall and 43.4 times for major means-tested programs. By 1983, non-cash transfers accounted for 29.5% of all transfer payments and 71.6% of benefits under major means-tested programs.

However, the non-cash items are not included in the poverty statistics by the Bureau of the Census, which determines how poverty will be measured. OMB estimates that adding the cash value of these non-cash benefits to other sources of income would have caused the reported poverty rate in 1982 to drop from 15.0% to 9.6%. It should also be noted that the household surveys that the Census Bureau conducts every year to measure the poverty level are based on voluntary responses by those surveyed. OMB's comparisons between survey responses and program data indicate that there is significant underreporting of benefits -- at rates of about 19% of all benefits and 33% for means-tested benefits -- which could result in $62 billion in total

benefits and $24 billion in means-tested benefits not being reported. That's enough to make a significant dent in the poverty rate.

The issues addressed by PPSS are how well program objectives are being met and what operational improvements can be instituted to increase the effectiveness and efficiency of the programs.

Q. What conclusions did PPSS draw from its analyses?

A. A central conclusion is that, despite the magnitude of the dollars expended in these targeted areas, adequate information does not exist to determine the degree to which the intended recipients of these subsidy programs are receiving sufficient benefits or, conversely, the degree to which benefits are being bestowed upon undeserving recipients to the detriment of all taxpayers. Indeed, there is no way to identify all the subsidies a particular person receives. Major public policy decisions regarding the poor are therefore made on the basis of sample data obtained through annual census surveys -- which show significant underreporting of both income and benefits. Moreover, there are numerous programs which aren't even included in these reports. The Census surveys cover only the major means-tested programs (such as Foods Stamps and Medicaid) and exclude over 60 other programs, with over $40 billion in expenditures, that have income eligibility tests.

The situation is similar in farm and other business credit programs and subsidies, where no records are kept regarding all the benefits received from the variety of programs of which businesses or individuals can take advantage. For example, most agency accounting systems are unable to determine the total amount owed government-wide by a debtor when the debtor has many loans or other amounts due. There is limited ability to share credit information on Government debtors among Federal agencies, among various programs within an agency, or with the private sector. Consequently, when a loan application is being reviewed for credit worthiness, agencies cannot determine if the applicant has other outstanding Government credit, is current in his repayments, or is delinquent or in default on other Government credit. Further examples of how inadequate information contributes to mismanagement of Federal programs can be found in the Information Gap section of this report.

In addition to major gaps in bottom-up information gathering, there are also major shortfalls in subsidy management. The sheer number of programs, the decentralization of responsibilities, the lack of coordination among administrative and legislative functions, and the complex, inconsistent, and sometimes conflicting program eligibility criteria all contribute to

a lack of control. The administrative management of programs for the poor, for example, is based on different pieces of legislation passed over the last 30 years. In fact, many Federal agencies are unable to determine total administrative costs associated with providing these subsidies. In contrast, few private sector companies would operate without knowing their total overhead costs of providing a product. The fact that the whole effort could be better managed and administrative costs reduced by combining certain programs never seems to be considered as a serious option, even though it could improve the targeting effectiveness and result in greater success in meeting overall goals.

PPSS was able to aggregate sufficient data to conclude that this lack of control has resulted in significant mistargeting of benefits, as exemplified by the following:

- Despite expenditures of $123.9 billion in 1982 on means-tested programs for the poor, such as Aid to Families with Dependent Children (AFDC), Food Stamps, and Medicaid, the poverty gap was reduced by only $37.4 billion -- from $50.1 billion before means-tested transfer payments to $12.7 billion after all these transfer payments had been made. In theory, the $123.9 billion should have not only brought all households out of poverty, but should have been sufficient to bring all households to 125% of the poverty level with $47.5 billion left over for other purposes such as reducing the Federal deficit. This failure to target effectively is also reflected in an OMB analysis which showed that 42.4% of those receiving benefits from major means-tested programs in 1981 actually had total incomes (including cash benefits such as AFDC and in-kind benefits such as Food Stamps and Medicaid) in excess of 150% of the poverty line.

- Despite massive unfunded liabilities and the prospect of confiscatory payroll taxes on future workers, $76.1 billion in social insurance payments were made to elderly persons who were above the poverty line -- above and beyond what these retirees and their employers contributed to these programs plus all accumulated interest. Indeed, 75% of social insurance payments (primarily Social Security) are in excess of what these retirees and their employers paid in, including interest, and thus constitute a major Federal subsidy.

- There appears to be no ongoing data gathering effort on the total benefits received by each family or corporate farmer from the many forms of farm subsidy. It has been estimated that as much as 50% of the

Farmers Home Administration loan portfolio could be replaced by private sector lenders.

- Another area of subsidy examined was the adequacy of user charges for Federal goods and services. Due in part to unclear administrative policies and insufficient data regarding the full costs incurred by the Government to provide goods and services, the users of Government goods and services often pay only a small fraction of the Government's full cost, with taxpayers not benefitting from these services having to absorb the majority of the expense.

Problems will not be solved by minor changes in, or fine-tuning of, subsidy programs. Controlling the growth of these programs will require an analysis of the entire field of subsidy programs. However, as noted previously, timely, complete, and accurate information does not even exist to determine the degree to which these subsidies are reaching those truly in need or, conversely, providing benefits to those who are not in need, to the detriment of all taxpayers.

Q. What recommendations did PPSS make based on these conclusions?

A. For the purpose of improving targeting and administration of means-tested programs, PPSS recommended (1) the increased use of computer matching of information between programs to verify income of program recipients and (2) consolidating Federal administrative funding and requirements for the Aid to Families With Dependent Children (AFDC), Medicaid, and Food Stamp Programs. PPSS believed these concepts can be expanded further in the area of targeted outlays and recommended that a form, similar to a W-2 form issued to wage-earners, be issued by each Federal department or agency providing a subsidy to a specific beneficiary, with a copy going to the IRS. All Federal payments shown on this form would be added to the beneficiary's earnings to arrive at total income.

Additionally, the concept of consolidating benefit programs should be pursued, particularly in areas such as feeding and housing, where many uncoordinated programs are attempting to serve the same objective. This could substantially reduce administrative costs and improve targeting of benefits.

PPSS also recommended that Federal agency accounting systems be improved in order to provide accurate data on total administrative cost for subsidy programs. Additionally, poverty statistics should be redefined to include in-kind Federal transfer payments such as Food Stamps and Medicaid.

Q. What savings will be achieved as a result of these recommendations?

A. PPSS identified savings of $58.9 billion over three years which could be achieved through improved targeting of means-tested benefits.

As noted earlier, $123.9 billion in means-tested program money has not been able to close a $50.1 billion poverty gap. In theory, the $123.9 billion should have been sufficient not only to bring all households to the poverty level but also to have brought these and all other households up to 125% of the poverty level (at an additional cost of about $26.3 billion) -- and still have $47.5 billion left over for other purposes such as reducing the Federal deficit. Since about 75% of means-tested benefits represents Federal funds and about 25% state/local money, the Federal share of the $47.5 billion left over amounts to $35.6 billion. Even if savings are half these amounts, the Federal Government could reduce costs by $17.8 billion in year 1, $19.6 billion in year 2, and $21.5 billion in year 3 (assuming 10% inflation) -- or by $58.9 billion over three years while doing a better job of targeting funds to the truly poor and near-poor.

Major subsidized programs are discussed below.

Social Security

The public perception is that Social Security is self supporting, with payments to beneficiaries met through payments to trust funds set up specifically to meet the financial obligations of Social Security programs. This is no longer true. The following compares payments to Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) beneficiaries with payments made into the trust funds:

[Table on following page]

Social Security
($ Billions)

	Fiscal Year	(1) Trust Fund Receipts	(2) Program Payments	(3) Social Security Surplus/(Deficit) Amount	(4) Social Security Surplus/(Deficit) %
(1)	1958	$ 8.0	$ 8.2	$ (0.2)	(2.4)%
(2)	1970	33.5	29.7	3.8	12.8
(3)	1975	62.5	63.6	(1.1)	(1.7)
(4)	1978	85.4	92.2	(6.8)	(7.4)
(5)	1979	98.0	102.6	(4.6)	(4.5)
(6)	1980	113.2	117.1	(3.9)	(3.3)
(7)	1981	130.2	138.0	(7.8)	(5.7)
(8)	1982	143.5	154.1	(10.6)	(6.9)
(9)	1983E	147.8	168.3	(20.5)	(12.2)
	1983E As A Multiple of:				
(10)	1958	18.5X	20.5X	102.5X	5.1X
(11)	1970	4.4	5.7	ND	ND

Social Security has experienced growing deficits, despite continuously increasing revenues, i.e., revenues in 1983E are up 4.4 times from 1970 but payments are up by 5.7 times. However, these deficits represent only that portion of Social Security benefits subsidized directly by the Federal Government. All current contributors to Social Security are, in effect, subsidizing all current recipients since the benefits paid-out are far in excess of the amounts (employee and employer contributions and accumulated earnings on those contributions) paid-in. For example, Social Security beneficiaries who retired in 1981 receive more than 75% of their benefits in the form of a subsidy, as shown in the following table:

[Table on following page]

Social Security As A Subsidy Program (Constant 1981 dollars)

	(1) Annual Income	(2) Lifetime Social Security Payments(a)	(3) Lifetime Social Security Benefits	(4) Payments As a % of Benefits	(5) Percent of Social Security Benefits Subsidized	Ratio of Benefits To Payments
(1)	$10,000	$27,842	$144,735	19.2%	80.8%	5.2X
(2)	20,000	48,960	217,630	22.5	77.5	4.4
(3)	50,000	55,248	235,581	23.5	76.5	4.3

(a) Paid by the employee and employer and including the value of interest over the period.

To avoid distortions resulting from inflation -- a dollar contributed in 1937 at the outset of the Social Security program was worth 571% more than the dollar paid out in 1981 -- all amounts are in constant 1981 dollars. Said differently, the 1981 dollar was worth 17.5¢ in 1937. As brought out in the preceding, even a beneficiary who made the 1981 dollar equivalent of $50,000 every year of his or her working life and paid the maximum Social Security tax each year receives 76.5% of his/her benefits in the form of a subsidy. In other words, the beneficiary receives benefits 4.3 times the combined value of employee/employer contributions plus interest on these contributions. In FY 1983E, 76%, or $127.9 billion, of total Social Security payments of $168.3 billion represented subsidies to the recipients.

Moreover, this subsidy does not necessarily go to those in need. The following illustrates the impact of total Federal social insurance expenditures -- including Medicare and Railroad Retirement -- on the "poverty gap" of elderly Americans. The poverty gap is the amount by which the incomes of elderly Americans are below the Government's official poverty level. In 1982, the elderly poor had incomes $44.1 billion below the poverty level, as summarized below:

[Table on following page]

		Distribution of Social Insurance Benefits to the Elderly ($ Billions)
(1)	Poverty Gap of Elderly Poor Before Social Insurance (a)	$ 44.1
(2)	Poverty Gap of Elderly Poor After Social Insurance (a)	3.0
(3)	Net Impact on Elderly Poor	$ 41.1
(4)	Total Social Insurance Payments to Elderly	160.2
(5)	Payments to Elderly Not Affecting Elderly Poor	$119.1
(6)	Memo: Percent of Payments to Elderly Not Affecting Poor	74.3%

(a) The cumulative amount by which the incomes of the elderly are below the poverty level, i.e., not the average but the total amount by which individual incomes are below the poverty level.

The two previous tables show that approximately three-quarters of all social insurance payments to the elderly -- mainly Social Security -- are made to those above the poverty level. Since over three-quarters of all Social Security payments represent a subsidy, the three-quarters of Social Security payments in excess of contributions can be viewed as subsidies to elderly Americans above the poverty level.

PPSS recommendations are aimed at improving the efficiency of Social Security Administration (SSA) programs. Legitimate payments, as required by current law, will not be reduced as a result of our recommendations, which include the following:

- Reduce erroneous payments, which totalled approximately $14.6 billion over the FY 1980 to FY 1982 period.
- Close field offices which are no longer cost-effective.
- Restructure the disability appeals process.
- Simplify and condense the 25,000-page Program Operations Manual System.

Erroneous payments, even when ultimately identified and eventually repaid, are still costly. For example, assuming a 10%

interest rate, the $14.6 billion estimated overpayments between 1980 and 1982 cost the Government $1.46 billion in interest.

Q. How did PPSS propose that this situation be corrected?

A. SSA already has the power to sharply reduce erroneous payments. To determine the amount for which a beneficiary is eligible, an Annual Earnings Test, showing the applicant's alternative sources of income, must be submitted. In general, overpayments do not result from inaccurate reporting of income, but because some beneficiaries fail to report income at all.

PPSS recommended two actions:

- SSA should computerize data on all Old Age and Survivors Insurance (OASI) beneficiaries aged 62 to 69, as well as on all Disability Insurance (DI) recipients, to monitor current earnings. This would allow more timely identification of overpayment to OASI beneficiaries and would also bring to light any Disability Insurance recipients who are working and are therefore, by definition, not eligible for DI payments.

- SSA should require prospective income estimates from beneficiaries so that benefits could be adjusted in a timely manner, thus reducing overpayments. To encourage accurate income estimating, SSA should exercise its current authority to charge interest on overpayments.

Q. How much would that save?

A. SSA could reduce costs by $2.977 billion and increase revenues by another $980 million over three years, a combined total of $3.957 billion -- if PPSS recommendations were adopted.

In addition to the OASI and DI trust funds, SSA also administers Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). The AFDC program is administered by the states, but the Federal Government, through SSA, pays for at least 50% of all costs of benefits plus administration. The average cost of administering the AFDC program at the state level varies from a low of $20 to a high of $126 per average monthly case load -- a variance of 530%, i.e., the high is 6.3 times the low. The quality of administration also varies among states, with the Federal share of incorrect AFDC payments estimated at $370 million in FY 1983. By law, the Federal Government is allowed to impose fiscal sanctions on states that have excessive payment error

rates. However, under the current system, 1.5 to 2 years go by before the Federal Government collects this penalty, with resulting interest costs to the taxpayer.

In the Supplemental Security Income Program (SSI), the Federal Government gives states the option of either administering supplementary state contributions or having the Federal Government disburse the funds for them. SSI provides benefits to the aged, blind, and disabled. Twenty-seven states, including the District of Columbia, have elected to have the Federal Government administer these additional benefits. The Federal Government pays the states for erroneous payments made from these funds. However, the cost of calculating the Federal fiscal liability (FFL), i.e., the amount of erroneous payment made by the Federal Government or the cost of sampling payments for errors, is inordinately high relative to the total amount of state contributions. For example, in two of the 17 states where FFL determinations are calculated for SSI, Iowa and Delaware, sampling costs are 10% of total state SSI payments.

Q. What did PPSS recommend to correct these situations?

A. Where the Federal Government is obligated by law to pay 50% of all administrative and benefit costs, the SSA should more aggressively collect penalties from states and eliminate the current 1.5 to 2 year delay. In the SSI program, where the Federal Government administers the states supplementary contribution, PPSS felt Federal fiscal liability for erroneous payment was unwarranted. If all PPSS recommendations are implemented, $147 million could be saved over three years.

In SSA's current field office system, there are 4,852 offices, 70% of which are contact stations manned by a staff of three to six employees who are expected to be well versed in all SSA programs. However, as the number and complexity of SSA administered programs has grown, this has become less and less possible. Moreover, PPSS found that the personal contacts made at these stations could be handled just as easily over the phone.

Q. How did PPSS recommend the situation be changed?

A. PPSS determined that 4,352, or 90%, of SSA field offices and contact stations could be consolidated into larger district offices, which would reduce personnel and overhead costs by $287 million over three years, or an amount equivalent to the Social Security taxes paid by 177,709 median income families in 1983.

Q. Why hasn't consolidation been effected in the past?

A. PPSS found that many SSA managers have submitted consolidation plans which have been rejected due to political considerations. Closing 4,352 offices in congressional districts across the Nation has political ramifications which tend to overwhelm the financial benefits no matter how obvious they may be.

While the PPSS review concentrated on major areas of potential savings, smaller, more specific possibilities in the Social Security Administration were also examined. For example, PPSS found that SSA's Program Operations System includes a 25,000 page manual that is maintained by approximately 45,000 recipients -- SSA supervisors, claims analysts, etc. It is intended to cover all contingencies related to the processing of an SSA claim. To put the amount of paper involved in perspective, if all 45,000 recipients of this manual stacked their copies atop one another, the pile would be 34 miles high. There are 12,000 pages of revisions to this manual each year, which means 12,000 pages for each of 45,000 manuals, or 540 million pages per year that need to be replaced. (On average, each employee has to insert new pages at a rate of 60 pages per day.) Largely as a result of this manual, SSA printing and reproduction costs have increased at a rate of 12.5% per year in the decade from 1972 to 1982 to $21 million.

Q. How can this situation be corrected?

A. It was readily apparent to PPSS that all 45,000 recipients of this manual do not need the level of detail provided. PPSS recommended that a less detailed version of this manual of about 1,000 pages be distributed to most employees to handle day-to-day problems, while an unabridged version be distributed to about 2,000 supervisory employees.

PPSS estimated savings of $83 million over three years.

The current disability claims system needs improvement. A person denied a disability claim may appeal that decision 3 times within SSA, and another 3 times in the U.S. court system. The first two reviews within SSA are considered as if no previous decisions had been made.

Because cases are considered at each level independently and because inconsistent standards are applied at different levels of review, the reversal rate on decisions is high. At the second level of review, the Administrative Law Judge (ALJ) level, 60% of decisions are reversed. Claimants will naturally appeal adverse

decisions if they have better than a 6 in 10 chance of obtaining a more favorable decision at progressively higher levels of review.

As a result of the high Administrative Law Judge reversal rate, the backlog of cases at this level has grown from 90,000 cases at the end of 1976 to 150,000 cases by 1982 -- an increase of 67% -- and costs at this level of review alone have increased from $76 million in 1975 to an estimated $229 million in 1983.

Q. What is the explanation for the backlog and resulting cost increases?

A. This problem is largely the result of three factors:

(1) Inconsistencies in standards and criteria applied by the different review levels.

(2) Treatment of each review as a new case.

(3) Inability to make final decisions quickly.

Q. What did PPSS recommend to alleviate this problem?

A. The following summarizes PPSS recommendations:

(1) A uniform set of substantive laws, regulations, and rules should cover all levels of appeal.

(2) Appeals should not be handled as if no previous decision had been made. If a decision is reversed, each fact used in the determination at the initial level should be accepted or reversed.

(3) Administrative Law Judges should be able to issue quick summary affirmations of previous decisions. In addition, there should be no oral argument or testimony on disability claims.

(4) Finally, PPSS recommended that there be only one level of appeal within SSA, compared to three levels currently.

PPSS estimates such action would save $3.647 billion over three years.

Food Stamps

The Food Stamp Program began in 1961 as a pilot project to provide supplemental nutritional assistance to families below the poverty line. In 1962, $14 million was spent on the program. In 1982, 20 years later, outlays exceeded $11 billion, summarized as follows:

Food Stamp Program

	Fiscal Year	(1) Outlays ($ millions)	(2) Number of Recipients (000)	(3) Outlays per Recipient
(1)	1962	$ 14.0	143	$ 98
(2)	1982	11,014.1	21,717	507
(3)	Average Annual Percent Increase	39.6%	28.6%	8.6%
(4)	1982 as a Multiple of 1962	786.7X	151.9X	5.2X

During FY 1982, the program cost approximately $11.0 billion and paid benefits to almost 22 million people -- about 10% of the total population. The rate of growth in outlays averaged 40% compounded annually, 1962-1982. Enrollment has grown 29% per year and average outlays per recipient increased from $98 in 1962 to $507 in 1982, approximately 5 times higher. After adjusting for grocery price inflation, average outlays per recipient were 1.7 times higher in 1982 than in 1962.

The Food Stamp Program is extremely large as measured in almost any context. For example, the Food and Nutrition Service (FNS), which administers the Food Stamp Program and other related nutrition programs, spent $15.2 billion in 1982, or 42% of the $36.2 billion total expenditures of the U.S. Department of Agriculture (USDA). FNS spending was almost twice as large as the sales of all McDonald's fast food stores throughout the world. The money spent on FNS programs is as large as the sales of Safeway Stores, the largest retail food chain in the United States.

FNS spending is expected to increase to $17.4 billion in 1983. If FNS were a country, and its expenditures were equivalent to GNP, the FNS would have approximately the 44th largest GNP in the world.

In reviewing the Food Stamp Program and other nutrition programs, PPSS concentrated on two major, interrelated problems:

1) Formulas for nutritional assistance to individuals and families are structured in such a way as to result in overlapping and duplicative benefits.

2) The Food Stamp Program has an excessively high error rate -- 10%, or about twice as high as Medicaid -- attributable to an elaborate and complicated system for determining eligibility and distributing benefits.

PPSS recommended that changes be made in the Food Stamp Program to eliminate overlapping benefits provided by various Federal nutrition programs, and that unnecessary administrative expenses be reduced or eliminated. PPSS believes these objectives can be accomplished without adverse effect on the truly needy.

PPSS focused on the following procedural and administrative aspects of the Food Stamp program:

- updating the base for computing Food Stamp benefits;
- eliminating overlapping benefits from various nutrition programs;
- utilizing alternative Food Stamp distribution systems; and
- correcting administrative shortcomings of the program.

The Food and Nutrition Service (FNS) provides Food Stamp benefits through allotments or payments to qualified recipients. These payments are based on the FNS Thrifty Food Plan (TFP). The Thrifty Food Plan is a profile which determines the Food Stamp allotments necessary to meet a typical or average family's nutritional requirements. Currently, the base is a family of four consisting of a man and a woman (both 20-54 years old), one child 6-8 years old, and another 9-11 years old. The individual allotments for these four persons are added together, and this average family's food allotment is used to determine benefits. Benefits for smaller and larger households are calculated from this base, and are adjusted for differing family sizes by using economies of scale adjustment factors computed by FNS. Basically, these adjustment factors recognize that smaller households require more dollars per individual than larger households.

Q. What problems were identified by PPSS in the procedure for determining Food Stamp benefits?

A. Since the TFP base "family" was established in 1971, the average Food Stamp household has changed from the so called "family of four" to only 2.6 persons. The system based on the outdated family of four should be redesigned to account for this demographic change.

PPSS recommended calculating a new weighted-average benefit per person by using the individual allotments and frequency distribution, i.e., participation by age/sex grouping tabulated by FNS and then multiplying it by four to create a weighted average family of four that will serve as the new TFP base.

The TFP base allotment for a family of four, which consists of a man and a woman both 20-54 years old, a child 9-11 years old and a child 6-8 years old, total $253/month. PPSS proposed computing an individual allotment based on a weighted average recipient profile. This average would be $237/month for a family of four.

This is a simple method and realistically reflects the individual characteristics of beneficiaries. Depending on family size, monthly benefits would be reduced by $4 to $28. Savings of $3.439 billion would accrue over a three-year period if this change were adopted.

Q. What else did PPSS recommend to reform benefit formulas?

A. PPSS also recommended changing the Thrifty Food Plan economies of scale adjustment factors. FNS applies those factors to the allotment of the base family of four to adjust for differing family sizes. The economies of scale factors in the TFP assume that large households have lower food costs per person than smaller households. Studies indicate this may be the result of food substitution as well as economies, and may also reflect the fact that smaller households simply consume larger quantities of food per person. PPSS recommended that adjustment factors be based on how people should, rather than how they do, spend their Food Stamp money.

Using results of a study on differences in purchasing power by family size, large households would gain $12 to $31 per month, but the more numerous small households would lose $7 to $8. Savings are expected to be $835 million over three years.

It is possible to meet the income eligibility requirements for the Food Stamp Progam and yet still have too much income to qualify for any Food Stamp benefits. However, minimum monthly Food Stamp benefits of $10 are provided to one- and two-member households even if their benefits calculate to zero. The minimum benefit was intended to increase the Food Stamp participation rates of the elderly, but it has not been successful. One- and two-person households that meet eligibility qualifications will receive $10 in Food Stamps even if their benefits calculate to zero. Currently, 240,000 households whose calculated benefit is zero are receiving the $10 minimum. An additional 195,000 one- and two-person households whose benefits should be between $1 and $9 receive the

$10 minimum. PPSS recommended eliminating the $10 monthly minimum, for savings of $138 million over three years.

Q. Why hasn't the minimum benefit been successful in increasing the participation rate of the elderly?

A. Approximately 50% of the elderly who qualify for Food Stamps do not participate in the program, due to reluctance to undertake what is perceived to be the complex qualifying procedures. The elderly also frequently cite embarrassment and moral opposition as reasons for avoiding the program. Payment of minimum benefits does nothing to overcome these reasons for failure to participate.

Only 35% (1,466,000) of all one- and two-person households in the Food Stamp Program contain elderly persons. The remaining 65% (2,758,000) do not contain elderly individuals, but, if qualified, would be entitled to receive the $10 minimum benefit.

PPSS also recommended changes to eliminate the payment of overlapping benefits under the Food Stamp program and other nutrition programs offered by the USDA. The following table shows the expenditures of FNS by program:

FNS Outlays by Program - FY 1982

		(1) Amount ($ millions)	(2) As a % Of Total
(1)	Food Stamp Program	$11,014	72.5%
(2)	Child Nutrition Programs	3,020	19.9
(3)	Special Supplemental Food Programs (WIC)	930	6.1
(4)	Food Donations Program	121	0.8
(5)	Food Program Administration(a)	88	0.6
(6)	Special Milk Program	23	0.1
(7)	Total FNS Outlays	$15,196	100.0%

(a) Overall administrative expenses of the Food and Nutrition Service; the Federal portion of state administrative expenses are included in the totals for each program.

In addition to $11.0 billion spent on Food Stamps, spending on Child Nutrition Programs totalled $3.0 billion, or 20% of total FNS spending of $15.2 billion in 1982. Expenditures for Child Nutrition Programs include School Lunch, School Breakfast, Special Meal Assistance, Child Care Feeding, Summer Feeding, and other nutritional assistance and administrative expenses.

Special Supplemental Food Programs (WIC) outlays in 1982 were $930 million, or 6.1% of total FNS spending. These programs provide benefits to pregnant and breastfeeding women, infants, and children (WIC) who are at nutritional risk and have inadequate incomes.

PPSS examined child nutrition programs and recommended eliminating the overlapping benefits paid under various FNS programs.

Q. What specifically did PPSS recommend?

A. PPSS recommended elimination of the overlapping benefits provided by the School Lunch and Food Stamp Programs. Currently, Food Stamp laws do not take into account other Food and Nutrition Service programs, such as school lunches, when determining the Food Stamp benefit. In computing Food Stamp benefits practically every other type of benefit provided by the Federal Government (e.g. Aid for Families with Dependent Children and Social Security) is included as income. Overlap of approximately $1.7 billion in benefits exists for children covered by school lunch and Food Stamp programs. PPSS recommended including school lunch benefits as income when determining Food Stamp eligibility and benefits. This results in a Food Stamp benefit reduction of $7 per month per child, although each child would continue receiving $25 worth of food through the school lunch program. Savings of $1.724 billion are expected over three years.

In addition, PPSS recommended inclusion of other child nutrition benefits as income in calculating Food Stamp entitlements. As previously stated, current laws mandate that other child nutrition benefits, such as School Breakfast, Child Care Food, and the Summer Food Service Program, not be taken into account when determining Food Stamp eligibility. However, 69% of households in which children receive school breakfasts also receive school lunches and Food Stamps. PPSS recommended adding other FNS benefits as income when determining Food Stamp benefits, specifically, School Breakfast, Child Care Feeding, and Summer Feeding. Food Stamp benefits would be reduced by 30% of the value of child nutrition programs. Savings of $536 million are expected over three years.

Q. Why is PPSS advocating benefit cuts?

A. PPSS does not advocate cutting benefits to the truly needy. PPSS does, however, urge strong action to reduce the amount of benefits paid to those who do not require subsidies for their nutritional well being.

Of the total of 6,769,000 households receiving Food Stamps in 1980, 34.5% had incomes above the poverty line.

It should be noted that Food Stamps are only one element of means-tested benefits and, more specifically, of the non-cash or in-kind benefits available, e.g., housing assistance, Medicaid, etc.

Only 21.2% of Food Stamp households received Food Stamps alone, i.e., no other form of non-cash assistance. The majority of Food Stamp households -- 78.8%, or 5,337,000 in 1980 -- received additional forms of non-cash assistance. Further, of the 6,769,000 households receiving Food Stamps in 1980, 4,208,000 households, or 62.2%, also received public assistance in cash in the form of Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), or other cash assistance.

The Food Stamp Program has suffered from widespread and highly publicized abuse. Federal estimates of erroneous payments are about 10% of total program costs. This high error rate is primarily attributable to the complex benefit formula, administrative difficulties due to complicated eligibility requirements, and an inadequate delivery system for distributing benefits.

FNS prints and distributes food coupons to the states and monitors participation in the program by retail food outlets and other eligible establishments. Although funding and eligibility requirements come from the Federal Government, the program is administered at the state and local levels. In general, Federal and state Governments share expenses equally for administering the program. Exceptions to this 50-50 match include higher Federal payments (75%) for establishing automated systems and fraud-control activities.

By providing benefits in the form of food coupons to ensure that recipients purchase food, an elaborate system has been developed. These distribution systems include ATP (Authorization to Participate) cards, direct mail, direct pick-up, and on-line computer authorization. The potential for theft and fraud is greater in ATP and direct mail distribution systems than with the use of checks because coupons provide a less effective paper trail.

The following shows the proportion of benefits delivered by each method:

[Table on following page]

Distribution of Food Stamps

		% of Total Benefits
(1)	An authorization to receive Stamps is delivered by mail (ATP)	59%
(2)	Stamps are delivered by mail	26
(3)	Direct pick-up and other distribution of Stamps	15
(4)	Total	100%

In the ATP (Authorization to Participate) method participants receive a card (ATP) through the mail which entitles them to Food Stamps. The card can be redeemed at an eligible distribution center such as a bank or the local project office for Food Stamp coupons.

According to the FNS, 9.75% of the dollar value of Food Stamp benefits are erroneous payments. This breaks down as follows:

(1)	Certification of ineligible recipients	4.61%
(2)	Overissuance of benefits to eligible recipients	5.14
(3)	Total error rate	9.75%

Based on FY 1981 Food Stamp expenditures of $10.7 billion excluding administrative costs, errors resulted in estimated losses of over $1 billion.

Error rates in the Food Stamp Program of 9.75% are high in comparison to other programs such as Medicaid and AFDC (Aid to Families with Dependent Children):

		(1) Error Rate	(2) Food Stamps as a Multiple of Other Programs
(1)	Food Stamp	9.8%	1.0X
(2)	AFDC	7.3	1.3
(3)	Medicaid	4.1	2.4

The high level of erroneous payments in the Food Stamp Program results, in part, from the complex eligibility

requirements. Equally important, however, is the fact that states do not suffer financial losses from these overpayment errors, since funding comes from the Federal Government. Because states share 50% of the administrative expense, any efforts to improve eligibility certification, and thus reduce errors, may result in higher state expenditures. There is very little incentive for states to reduce these errors because of the potentially higher administrative costs that may be incurred.

Q. How can $1 billion in Food Stamps, or 10% of the total, be erroneously paid?

A. Most errors result from poor state and local administration. New York City, for example, issued 27,000 replacement ATP cards in a single month without checking or verifying that the orginal cards were not in use.

Q. How do some people qualify when they shouldn't?

A. Some recipients understate their income and overstate family size to increase their allotment of stamps. Cheats have also concocted phony names, worn disguises, invented entire families, and collected benefits for years from more than one welfare office county or state. For example, between April and September 1981, a Minneapolis man was on the Food Stamp rolls of 13 counties in Iowa, Minnesota, North and South Dakota, and Wisconsin.

Much of this fraud goes undetected because most welfare offices lack facilities to verify claims.

Q. What's being done to mitigate abuses of the Food Stamp Program?

A. In 1980, Congress enacted 14 anti-fraud provisions. However, it took the FNS nearly two years to implement all the anti-fraud measures.

Specifically, where computers were used to match lists of Food Stamp recipients with tax and unemployment rolls, more fraud indictments and convictions were obtained. As a result of computer matching, 83 convictions were made in Memphis. In Los Angeles, over 1,600 cases of potential fraud are identified every month by computer matching. According to a regional inspector of the USDA:

> The court system can't accommodate the hundreds of cases we have under review. But indictment puts cheats on notice that we are serious about going after fraud.

In certain areas, recipients must present I.D.'s with photographs in order to receive Food Stamps.

Also, all states are required to check information from tax or unemployment offices against Food Stamp rolls. States must also require that Food Stamp households report monthly on changes in family size and income.

In addition, experiments are now under way to use a magnetically encoded photo I.D. card that can be checked through a central computer to make sure that the holder receives the proper Food Stamp allotment.

Q. There are a number of alternatives to distributing Food Stamps that have been suggested. What did PPSS recommend?

A. PPSS recommended that pilot projects aimed at developing alternatives to Food Stamps as a means of providing nutritional assistance be continued on an accelerated basis. Some of these projects include the cash-out approach (direct payment of cash instead of coupons), electronic benefit transfers, and block grant programs. Although savings have not been quantified, the successful development of a better distribution system would reduce improper benefit (i.e., fraud, abuse, and errors) and reduce administrative costs.

In the area of administration, PPSS recommended the establishment of a Combined Welfare Administration (CWA) which would reduce costs by providing an umbrella agency to distribute benefits and administer programs such as AFDC, Medicaid, and Food Stamps.

The average monthly cost per case by program varies widely by state. For example, from state to state the average monthly cost per case ranges from a low of $9 to a high of $94 in the Food Stamp program. This compares to $20-$126 in the AFDC program and $18-$91 in the Medicaid program. Combining welfare programs under a single agency would reduce administrative costs.

In addition, using computer models would enhance the ability of state and local officials to verify recipient-supplied information. This would reduce the costs associated with increased participation in other programs. Computer models would greatly facilitate the use of a central data bank so states could obtain information on a particular applicant at one point. This would be accomplished by permitting disclosure of wage data maintained by Social Security and the IRS. Use of Social Security numbers and copies of income tax returns should be a condition of eligibility for these programs. The use of standardized data would ensure that income verification procedures are consistent throughout all localities and that information is used efficiently. Results from pilot projects that utilize computer matching yield benefit/cost ratios as high as 20:1.

As discussed above in the Overview, PPSS recommended consolidating benefit programs and integrating reporting systems so that total benefits provided to subsidy recipients can be determined.

To summarize, current Food Stamp benefits are subject to waste, fraud, and abuse; overlap other nutrition programs; and are difficult to administer. Revising the benefit formula, eliminating overlapping benefits, and reducing erroneous payments will not only save money but also help redirect aid to those who still suffer nutritionally.

Health Care

Total U.S. health care expenditures have grown 8 times from $41.7 billion in 1965 to $322.4 billion in 1982, or by 12.8% per year -- an increase of $280.7 billion, or $16.5 billion per year. This growth rate in total health care expenditures was about 40% faster than the overall economic growth rate of 9.2% in total GNP. Consequently, health care costs have absorbed a larger and larger portion of total GNP, increasing from 4.4% in 1950 to 6.0% in 1965 and 10.5% in 1982.

Based on population trends and expected advances in technology, it seems likely that total U.S. health care expenditures will continue to grow considerably faster than the total economy. Based on present Government financing arrangements, this would, in effect, tie Government health care expenditures to a dynamic growth industry, since the Federal, state, and local Governments pay for a substantial share of total health care costs. In 1982, Federal Government spending financed 28.9% of total U.S. health care costs, and state and local Governments another 13.5%. Thus, tax levy funds financed 42.4% of the country's total $322.4 billion health care bill, or $136.7 billion.

Tying Government expenditures to the dynamic health care sector has, of course, led to a rapid increase in Federal expenditures. From a base of $5.5 billion in 1965, Federal expenditures on health care increased to $93.1 billion by 1982, up 16.9 times, or by 18.1% per year. These increased Federal expenditures played a crucial role in extending medical insurance coverage to population groups needing improved health care -- particularly the poor through Medicaid and elderly and disabled people through Medicare -- and in promoting scientific research which has contributed to advances in medical technology.

However, over the long term, it would not seem to be desirable to continue to tie together Federal spending and health care expenditures under the present reimbursement financing arrangements. The current system raises several key long-term issues:

- What can be done to address the fiscal problems caused by rapid growth in health care spending?

- How can Federal budget problems be addressed without destroying the fundamental social, economic, and technological advances which underlie growth in health care expenditures?

Potential savings of $28.900 billion are the estimated results of proposed long-term changes in Federal health care financing and reimbursement systems.

The key factors underlying these expected savings are changes in Federal programs intended to create effective competitive markets for the delivery of health care by:

- Increasing the latitude of consumer choice in making decisions on the scope of health insurance coverage and treatment plans.

- Creating profit/(loss) incentives for providers to undertake the competitive bidding risks involved in making financial commitments to deliver health care to the beneficiaries of Federal programs.

Q. PPSS proposed long-term reforms in Federal health care financing systems which target savings of $28.9 billion over three years. What are the major changes proposed versus current Federal spending practices?

A. PPSS recommended that Federal spending on all health care programs be controlled by a "prospective" budgeting system based on the following key elements:

- Total Federal spending on all health care programs combined should be limited to yearly spending increases which do not exceed the overall growth rate in the total U.S. economy.

- Within this budget constraint, the available Federal dollars would be allocated to each Federal program based on the number of persons served by Medicare and Medicaid in each region. Per capita spending rates may differ among programs.

- Federal funds made available for each program would be used to finance the medical care needs of the populations served by means which promote competitive bidding and the development of effective markets for health care. A primary means for doing this would be the use of prepaid health plans, such as Health Maintenance Organizations (HMO's) and vouchers, which provide for the total health care needs of their participants.

Total health care expenditures, as noted, have risen from $41.7 billion in 1965 to $322.4 billion in 1982, an increase of 12.8% per year. Meanwhile, Federal spending on health care has grown from $5.5 billion in 1965 to $93.1 billion in 1982, up 18.1% per year; up from 13.2% of total national health care expenditures in 1965 to 28.9% in 1982.

Q. What has accounted for the increased expenditures on health care on both the national and Federal levels?

A. Increased expenditures on health care have resulted from many factors, e.g., general inflation, health care price inflation in excess of general inflation, population growth, increased usage of health care services per person, rapidly changing medical technology, and the intensity of medical services provided.

Q. Why hasn't there been more consumer resistance to rapidly escalating health care costs?

A. Most consumers have been insulated from much of the rising cost of health care through third party insurance coverage. Private and Government insurance reimbursement, e.g., Medicare and Medicaid, pay for 88% of total hospital care and 63% of doctors' services and about 70% of all medical care. Most reimbursement rates are essentially based on costs, another inflationary factor. In addition, doctors, hospitals, and other providers get paid usually on a fee-for-service basis, i.e., for each treatment. Thus, costs are on a piece-work basis, and encourages delivery of more services, for which consumers are usually covered.

Q. What does the word "prospective" mean as applied to health care reimbursement and/or budgeting?

A. Prospective means setting the reimbursement rate and/or the total amount to be spent at the beginning of a period. Thus, prospective means setting the financial limits before the expenditure takes place. This approach can be used as a powerful restraint on health care costs, as compared with the present practice of basing reimbursement rates and total spending on costs. In other words, a prospective system of budgeting would do away with inflationary, open-ended spending resulting from the reimbursement of costs.

Q. Isn't this same objective met by the expanded use of Diagnosis Related Groups (DRGs)?

A. New regulations were recently passed which required the Secretary of Health and Human Services (HHS) to establish prices for inpatient hospital stays of Medicare patients. Prices are set for 470 Diagnosis Related Groups (DRGs). Each hospital stay will be classified into one of these 470 DRGs, based on the principal diagnosis or illness treated during a given episode. Thus, for Medicare, the Secretary

will be setting the price paid to the hospital for every type of illness, in every part of the U.S. Similar approaches are being considered for setting other types of third-party hospital and doctor fees.

PPSS has endorsed the prospective rate system being implemented for Medicare and recommended that it be extended to other forms of hospital care and doctors' fees. PPSS continues to support these initiatives as a short-term response to what is perceived to be a financial budget crisis. However, in the longer term, the key effort will need to be directed at correcting the underlying causes of medical care inflation and, with it, the replacement of cost-based, fixed-rate pricing.

While DRGs are a step in the right direction, they are still a cost-based reimbursement system. In order to more effectively restrain health care costs, control will have to be placed on per capita usage and wider and intensive use of medical technology. As documented and noted further on, most of the increase in health care expenditures in excess of inflation has resulted from increased volume and technological complexity of medical services rendered, not health care prices rising at rates faster than inflation. During the period 1960-1982, health care expenditures rose from $26.9 billion to $322.4 billion, an increase of $295.5 billion. While general inflation accounted for 46.6% of the increase, health care increases in excess of general inflation accounted for only 9.2%. Increased usage and technology accounted for 44.2%.

Q. Why aren't DRGs the long-term solution to rising health care costs?

A. Hospitals will be forced to "unbundle" all or most of the multiple diagnoses now treated during single hospital admissions. This will increase costs, decrease efficiency, and may lead to unnecessary multiple admissions. Also, even where a single illness is the cause of an admission, the elderly and poor may experience the adverse effects of the financial pressures on hospitals to reduce lengths-of-stay under the DRG system.

Q. Why won't price constraints be enough to control costs?

A. Because about 70% to 80% of the increase in health care costs over the period from the mid-1960's to 1982, in excess of the general inflation rate, was due to increased usage in real terms and new technology, not price inflation. This is summarized in the following table:

[Table on following page]

		(1)	(2)	(3)
		Health Care Expenditure Increases in Excess of General Inflation		
	Portion of Total Cost Increase Due To:	1960-1982 Increase	1965-1982 Increase	1975-1982 Increase
(1)	Health Care Price Increases in Excess of General Inflation	17.3%	19.8%	27.3%
(2)	Volume of Usage and Technology	82.7	80.2	72.7
(3)	Total	100.0%	100.0%	100.0%

The key point is that in order to restrain the growth in health care expenditures over the period since 1960, it would have been necessary to reduce the volume of services provided and the use of new technology, not health care prices alone.

Q. But wouldn't price constraints have discouraged usage and the diffusion of new technology?

A. Very likely. For example, if this had been done over the period since the 1960's, in order to have made a major impact on total health care costs, Federally set price constraints may have had to substantially reduce the usage of seven major new technologies which accounted for an estimated 30%-35% of the increase in real health care costs in excess of general inflation. These seven new technologies which have been introduced into medical practice in the late fifties and early sixties are:

[Table on following page]

	Est. 1982 Hospital Costs ($ Millions)
End stage renal disease treatment - dialysis and kidney transplants	$ 1,600
New diagnostic imaging - CAT scanning, nuclear medicine and ultrasound	3,430
Neonatal intensive care	2,100
Major cardiac surgery - bypass, valve and pacemaker installation	4,615
Hip and other joint replacements	1,680
Adult intensive care (ICU & CCU)	6,775
Inpatient parenteral nutrition	225
Total Seven Technologies	$20,425

To effectively contain costs in the period 1965-1982, Federal regulators would have had to set prices to discourage the use of these seven new technologies and other forms of real usage.

The PPSS recommendations reflect the efficiency of free markets in accomplishing complex resource allocations.

In summary, PPSS recommended the following long term improvements in Federal budgeting practices for health care spending:

- Restricting Federal Government spending on health care to a rate of increase in line with the overall growth rate of the U.S. economy.
- The goals of the major Federal entitlement programs would remain in force, for example, to ensure an acceptable and adequate level of health care coverage for the elderly, poor, and disabled. However, the Federal Government would be charged with the mission of accomplishing these basic goals within the budget restraint of increasing Federal expenditures no faster than the overall economic growth rate.

In addition to PPSS recommendations concerning long-term improvements in Federal health care financing through Medicare/

Medicaid reimbursement, PPSS has analyzed other areas for improving Federal health care administration, as follows:

- Excess hospital bed capacity in both private and Veterans Administration (VA) facilities, which results in duplication of services and staff. VA hospitals operate at 75% of capacity, and some of the patients don't require intensive care hospitalization, but rather long-term care or outpatient treatment. The average hopital stay in a VA facility is 21 days compared to 7.2 days in a private hospital. There is a definite need for better planning and resource allocation in VA health care facilities. In addition, liberal reimbursement from Medicare and Medicaid for hospital construction encourages hospitals to build additional excess capacity. Hospitals can finance 50% or more of construction with debt capital from Medicare or Medicaid.

- Duplicate payments in the Department of Defense (DOD), VA and Indian Health Service (IHS). It is estimated that 15%-20% of all VA and IHS medical claims result in duplicate or erroneous payments -- the same service is paid for twice, payment is made for unauthorized service, or service is billed to a third party such as Medicare. The DOD pays up to 80% of the health care costs of military dependents through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). However, many persons eligible for CHAMPUS are also eligible for private health care cost coverage. The DOD does not actively pursue private insurers to regain the cost of medical care, even though it is, by law, the payor of last resort.

- Duplicate facilities and services managed by each branch of the military and by the VA. As currently structured, the Army, Navy, and Air Force each maintain separate hospital and medical service facilities under DOD's Military Health Care System (MHCS). The MHCS operates 161 hopitals and 310 outpatient clinics. In addition, the VA operates 172 hospitals, 276 outpatient clinics and 109 nursing and domiciliary care facilities. Both the VA and MHCS systems are underutilized and duplicative, and budgeted expenditures have increased over 400% over the past decade to $11.5 billion in FY 1983.

PPSS recommendations to improve efficiency of Federally administered health care can save $10.975 billion over three years. Major recommendations included the following:

- Limit future excess hospital capacity by restricting incentives to expand. Develop regulations that allow payments for closing or converting current excess capacity; limit reimbursement for interest and

depreciation for underutilized hospitals; make construction financing less attractive. Cost savings are estimated to be $939 million over three years. In addition, the VA should convert its excess hospital capacity to long-term care facilities, substitute less costly outpatient care where appropriate and transfer patients who no longer require acute care to nursing homes.

- Use fiscal intermediaries to process VA and IHS insurance claims. Medicare and private sector claims are processed through a computerized system which automatically screens applicants to eliminate duplication. Fiscal intermediaries can process VA and IHS claims through a computer which will coordinate benefits across all medical claims programs, uncover duplication and significantly cut the cost of processing. Savings are estimated to be $1.131 billion over three years. In addition, to recover costs under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), treatment and admission forms should be revised to include questions concerning health insurance coverage, and the DOD should actively pursue third party payors to recapture the cost of providing health care for military dependents with duplicate coverage. The Federal Government could recover $1.211 billion in costs over three years by adopting this recommendation.

- Promote shared resources between the VA and the DOD to minimize duplication and underuse of health facilities and personnel. These agencies could conceivably halve their costs by avoiding duplication.

Excess capacity results in duplication of services and staff, which drives up cost. In addition, excess capacity results in unnecessary utilization -- admittance to the hospital though the illness doesn't really require hospitalization, or hospital stays that are longer than necessary.

A steady increase in capacity despite declining occupancy rates suggests an overbuilding of capacity during the last 15 years. In 1969, the occupancy rate was 78.8%, in 1980 that rate was 75.4%, a decline of (4.3)%. Even though utilization has been dropping, capacity has been increasing.

Excess hospital beds across the U.S. have been estimated to range from 68,887 to 264,000, and it is also estimated that each of these beds costs $33,281 annually -- all of which must be covered in hospital charges to occupied beds. That means everyone is paying more for a hospital stay because of excess capacity.

Q. Why do hospitals build more capacity when the current capacity is underutilized?

A. Guaranteed reimbursement by Medicare and Medicaid of interest, depreciation, and amortized construction costs is the single most important incentive to build new, but unneeded, capacity. Hospitals can finance 50% or more of construction with debt capital from Medicare and Medicaid.

Q. That seems to be counterproductive. What did PPSS recommend to reduce this excess capacity and halt additional unnecessary construction?

A. PPSS recommendations were aimed primarily at limiting future excess capacity by restricting incentives to expand. First, develop regulations that allow payments to hospitals for closing or converting underutilized capacity -- such hospitals are actually penalized under the current system. Second, limit reimbursement for interest and depreciation at hospitals where capacity falls below 85%.

PPSS also made recommendations aimed at halting new capacity by making financing less attractive, such as:

- Debt ratios for hospital construction of 80% or more are not uncommon. While it is unrealistic to penalize current indebtedness, standards for future debt levels should be incorporated into Medicare/Medicaid reimbursement formulas.

- Establish interest cost maximums in relation to the prime lending rate to finance new capital debt.

Q. How much would be saved by closing down excess capacity and limiting financing for new construction?

A. PPSS estimated cost savings of $939 million and revenue increases of $662 million over three years.

Q. Could the problems PPSS found in VA planning and resource allocation be elaborated?

A. The budget of the VA health care system has grown from $1.7 billion in 1970 to over $7 billion in 1983. Bed capacity -- the number of beds available -- has declined by 25% since 1966; but, even with declining capacity, the VA hospitals are operating at only 75% of capacity. And a large proportion of that capacity utilization may be unnecessary -- patients' stays in VA hospitals average 21 days compared to 7.2 days in private hospitals. Some of these patients don't need hospitalization but long term care facilities, and some could be treated at a lower cost as outpatients.

PPSS recommended that VA adopt case-mix/resource allocation and planning processes -- i.e., minimize the length of stay for in-patient care, substitute less-costly outpatient care for services which do not require hospitalization, and transfer patients who no longer need an acute level of medical and nursing care to less costly nursing homes. In addition, the VA should convert underutilized hospitals to long-term care facilities. Savings are estimated at $4.888 billion over three years.

It is estimated that 15-20% of all Veterans Administration (VA) and Indian Health Service (IHS) medical claims result in duplicate or erroneous payments -- the same service paid for twice, payment made for unauthorized service, or service also billed to a third party, such as Medicare.

Duplicate payments persist because there are no procedures to identify patients with dual eligibility, and no efficient procedure for authorization of payments. To stop duplication, these two situations have to be rectified.

Q. How do you identify persons with dual-eligibility?

A. The best way is to use a compatible computer system for all health care programs and identify patients by Social Security numbers. The key is shared information among the programs.

Q. Are medical programs -- Medicare, private insurers, Medicaid, VA and IHS --computerized now?

A. Medicare and private sector claims are processed through a computerized system, and are automatically screened to eliminate duplication. The VA and IHS process claims manually, a very costly procedure. Currently, it costs VA up to $140 and IHS as much as $200 to process a claim. Private insurance companies and fiscal intermediaries expend about $6 per claim. A computer system compatible with Medicare is one solution to these high costs, but a more efficient solution is to use fiscal intermediaries (FI).

Q. What are fiscal intermediaries?

A. Fiscal intermediaries (FI's) are private sector insurance processing firms with the computer capability to process claims and uncover duplication. Utilizing FI's would enable VA and IHS to impose safeguards, conduct pre- and post-audits, and coordinate benefits across all medical claims programs. PPSS estimated potential savings from reduced processing costs and elimination of duplication of

$1.131 billion over three years -- that's equivalent to the annual medical care costs of one million lower income retired couples in 1981, or 450,000 average hospital stays ($2,500 per stay).

DOD's Military Health Care System (MHCS) is comprised of the three separate hospital systems of the Army, Navy, and Air Force. The MHCS operates 161 hospitals and 310 outpatient clinics staffed with 151,000 personnel throughout the world. The total direct health care budget for FY 1983 was $4.5 billion. VA is a multifaceted health care system that provides a broad range of health services to an aging veteran population. The VA hospital system is characterized by inordinate length-of-stay averages that imply a large number of long-term patients occupying acute-care beds. PPSS recommended that VA and the Department of Defense (DOD) share their health resources. In addition both VA and DOD should improve their procedures for recovering medical costs from third party payors.

Q. What are the savings from sharing resources?

A. PPSS didn't quantify savings for this issue, but these agencies could conceivably halve their costs by avoiding duplication. The essential aspect of sharing health resources is the ability to more readily operate medical facilites at an effective occupancy rate, which would limit costly construction of new facilities and be a significant step toward a well-planned, consistent health policy.

Q. PPSS also recommended that VA and DOD improve procedures to collect medical costs from third party payors. Is this an example of dual eligibility problems?

A. Yes. There are many persons eligible for DOD and VA health care who also are eligible for other health cost coverage -- military dependents, inactive military personnel and veterans. In fact, in 1981, only 33% of DOD hospital admissions were active duty personnel. The other 67% were dependents of active, retired and deceased military personnel.

Q. If the DOD doesn't provide hospital care for military dependents, who does?

A. Private medical care is available through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS assists eligible beneficiaries by reimbursing up to 80% of the cost of such care, depending on the type of beneficiary and applicable deductibles. However, unlike direct care provided to inactive beneficiaries, CHAMPUS is, by law, the last payor of this

medical care. Thus, when a beneficiary is covered by private health insurance, the private insurance carrier is obligated to pay for such medical care. CHAMPUS, in turn, reimburses the beneficiary for any cost remaining after the applicable deductible has been satisfied.

Q. What PPSS concluded was that private health insurance and CHAMPUS cover military dependent hospital costs in private hospitals, but not in military hospitals. Is that correct?

A. Yes. But one of the main reasons is simply that DOD doesn't pursue third party payors when care is provided in military hospitals.

Q. What did PPSS recommend to collect funds from private insurers for care given in military hospitals?

A. PPSS recommended revising military health care system treatment and admission forms to include questions concerning health insurance coverage, revising DOD procedures to include recovery from privately insured inactive beneficiaries, proposing legislation to prohibit insurance company exclusionary clauses and developing a cost system that reflects the real cost of medical care.

Q. How much could be recovered in military medical expense by implementing PPSS recommendations?

A. PPSS estimated that the Federal Government can recover $1.211 billion in costs over three years.

The three-year total of all the recommendations in this section, after elimination of duplication and overlap among issues, is $115.361 billion -- equal to the three-year taxes of 17.3 million median income families.

Government Lending Programs

PPSS reviewed the Federal Government's management of its lending programs and associated debt collection activities. Government lending programs are geared toward loan origination rather than loan management which is reflected in unacceptably high default rates in comparison to private sector standards. Despite these default levels, the magnitude of Federal credit supplied continues to increase -- outstanding loans have increased by $307.7 billion or 45.5%, 1981-1984, from $676.3 billion to $984.0 billion.

PPSS recommended that loan program priorities be shifted from loan origination to loan management by providing increased incentives to Government loan officers to reduce defaults, by expanding the use of private sector collection agencies and reducing Federal direct lending by increasing the ratio of guaranteed-to-direct lending.

In FY 1983, the Government spent $31.1 billion in the specific areas covered by PPSS recommendations, with spending estimated to increase to $90.8 billion by the year 2000 if present policies are continued. Implementing PPSS recommendations would reduce spending to $29.4 billion in 2000, a saving of $61.4 billion, or 67.6%.

Direct and guaranteed loans outstanding under Federal lending programs are approaching $1 trillion, as follows:

[Table on following page]

Loans Outstanding Under
Federal Lending Programs
($ Billions)

		(1)	(2)	(3)	(4)
		Direct Loans			
	Fiscal Year	Federal On & Off Budget	Government Sponsored Enterprises	Federally-Guaranteed Loans	Total Credit Outstanding Under Federal Progams
(1)	1981	$185.0	$182.3	$309.0	$676.3
(2)	1982	207.8	225.6	331.2	764.6
(3)	1983E	227.4	281.1	387.0	895.5
(4)	1984B	210.9	337.3	435.8	984.0
	Average Annual Percent Increase				
(5)	1981-1984B	4.5%	22.8%	12.1%	13.3%

Direct lending by the Government starts out the same way as direct lending by a commercial bank -- someone applies for a loan and is either accepted or denied -- but that's where the similarity ends. Generally, interest rates on Federal loans are substantially below market rates, e.g., the average interest rate on the Farmers Home Administration's (FmHA) $20 billion housing loan portfolio is only 2.7%. New FmHA housing loan rates are 11 7/8%, which compares to current mortgage rates in the private sector of 13% to 14%. In addition, loan officer performance criteria in the Government are quite different from those applied to a private sector loan officer. In the Government, it's the number of loans in an employee's portfolio. In the private sector, it's how well the loans perform. To illustrate how these differing viewpoints affect loan quality, using FmHA as an example, 43% of its farm loans are delinquent, more than 10 times the average delinquency rate in the private sector.

The Government's loan programs perform poorly for several reasons. First, loan quality is not the foremost concern in the public sector. Indeed, many Federal lending programs establish as a prerequisite the denial of credit by a private sector lender. Second, once the Government's loan officers make a loan, its repayment is not nearly as important to them as it would be to a private sector lender. For example, when a loan made by the Department of Housing and Urban Development (HUD) is delinquent, HUD usually makes three attempts each year to collect the money, while in the private sector 24-36 attempts are made. In part, because the private sector is more aggressive in collecting its delinquent receivables, its success rate is 80%-85%, while the success rate of the Government is only 15%-20%.

Federal lending by on- and off-budget agencies is fairly straightforward. Not so clear are the lending activities of Government-sponsored enterprises. These agencies were created by the Government to fulfill specified credit functions -- e.g., the Farm Credit Administration -- and later to become "privately" owned. Privately owned means their activities are no longer controlled by the Government. However, these enterprises still carry out Federally-designed programs and receive special benefits from their close association with the Government, such as tax exemptions -- the enterprises are exempt from Federal income taxes, and interest on their debt securities is exempt from state and local income taxes. Because of these special benefits and because these enterprises are perceived as being backed by the Government, they can generally borrow funds at rates only slightly higher than those of the Treasury. The Government estimates that these advantages save the enterprises one to three percentage points on their cost of borrowing.

While the Reagan Administration has attempted to control the growth of its direct lending programs, Government-sponsored enterprises have increased their loan portfolios by 22.8% per year, 1981-1984, to a budgeted $337 billion in FY 1984 -- 1.6 times the level of total Federal direct loans outstanding. PPSS recommended that these enterprises go fully private, e.g., be taxed, to disassociate themselves from the Federal Government. To encourage this action, PPSS recommended institution of a fee which would increase each year that an enterprise continues to use the special privileges currently afforded. Ultimately, this change would put Government-sponsored lending on an equal footing with private sector lending in its ability to raise funds.

The third Federal credit program is Federally-guaranteed lending. This is an increasingly popular way for the Federal Government to provide credit to selected sectors of the economy, primarily for two reasons. First, it does not require the up-front use of Federal funds and, second, it reduces the overall risk to the Government. In loan guarantee programs, a private sector lender provides the money for the loan. The Federal Government then makes itself liable for the guaranteed portion of the loan if the borrower defaults. The private sector lender benefits because it has made a very low-risk loan and the Government benefits because it has not tied up its funds.

PPSS has made recommendations that would improve all three types of Federal credit programs. For example, PPSS recommended that interest rates on new direct Government loans be tied to the Treasury cost of borrowing.

Q. How would that reduce costs to the Government?

A. Currently, the Government may borrow in short term markets -- with more volatile interest rates -- and use the money to fund loan programs such as Veterans Administration

mortgages which may have 30-year maturities. As interest rates climbed in the 1970's, the spread between the Government's cost of borrowing and the interest rates on its loans widened, resulting in huge unanticipated costs and violating a basic banking principle -- "never borrow short and lend long." PPSS recommended that the Government match the maturities and interest rates of its lending to those of its borrowing.

Q. How much difference would this change make?

A. PPSS estimates that it would generate $2.371 billion in additional interest revenue over three years. Revenues would increase in subsequent years as more and more loans are adjusted to higher interest rates.

Q. Did PPSS find loan programs which would be better administered by the private sector?

A. PPSS found that the Government was generally ill-suited to administer loans in comparison to private-sector lenders. Specifically, Farmers Home Administration direct loans and business loans made by the Small Business Administration should be phased out and replaced by guaranteed loan programs. Savings: $1.826 billion over three years.

At the same time these programs are being phased out, PPSS recommended that all other direct loan programs be reviewed for possible conversion to guaranteed loans.

Q. Should the Government be in the loan business at all?

A. As stated previously, the Government is the lender of last resort. When other sources of credit are unavailable, it makes loans to selected eligible borrowers. However, at the earliest time that loans prove to be viable, they should be transferred ("graduated") to the private sector. In this way, the Government ceases all its administrative responsibility for as well as any risk associated with the loan.

This action rarely takes place as planned for several reasons. Of most importance is the lower interest on most Government loans. Although interest rates rose during the 1970's, Federal loan rates generally did not adjust. As a result, Federal loans became more and more popular -- the less the adjustment, the greater the popularity. This can be seen in the amount of Farmers Home Administration (FmHA) loans outstanding, which rose from $6.5 billion in 1970 to $58 billion in 1982 -- up 8.9 times in only twelve years. Another indicator of the popularity of Government loans is that 70% of borrowers from FmHA are not farmers. Remember FmHA is the Farmer's Home Administration.

Q. What can be done?

A. One alternative, as mentioned previously, is for FmHA to guarantee loans only. In this way, loan administration as well as part of the risk would be transferred to the private sector. Another alternative that PPSS recommended is a firm policy that, for each loan made by the FmHA, one of its outstanding loans must be graduated, i.e., it must be sold to a private sector lender. Graduation would be on a loan for loan basis regardless of dollar amount. This would result in combined administrative and interest cost savings of $768 million over three years.

Q. PPSS recommended that Government-sponsored enterprises pay a fee for the special privileges that are now granted. Why is this recommendation being made if loans made by the agencies are not backed by the Government?

A. PPSS found these enterprises increased their lending 5.1 times faster than direct lending by the Government over the 1981-1984B period. Providing these agencies with easy access to lower cost credit distorts markets in favor of their activites, including home mortgages, student loans, and farm credit.

Q. What will happen to Government-sponsored enterprises if the PPSS recommendation that they go fully private is implemented?

A. They would become like any other financial institution with the same costs and the same opportunities to raise funds. In addition, until they go fully private, the Government would gain estimated revenues of $724 million over three years from the "special privileges" fee which was discussed previously.

Q. Guaranteeing lending programs appears to be a safe way for the Government to target credit. What did PPSS recommend in this area?

A. By guaranteeing a loan, the Government is agreeing to pay some portion of the principle, up to 100%, if the borrower defaults. Generally, the Federally-guaranteed portion is 90%. In addition, although it is common practice for private sector lenders to charge loan origination fees or points for loans made. There is no standard loan origination fee in the various Government lending programs.

PPSS believes that if Federal guarantees were lowered from 90% to a maximum of 75%, the benefits would be twofold. First, this would decrease Federal exposure on guaranteed loans. Second, it would provide the lender with greater incentive to collect on loans that are delinquent, by making the lender responsible for a greater portion of the loan principle.

Q. As of September 30, 1982, $6.5 billion, or 16.7% of the $38.9 billion in Federal loans which were classified as current receivables on that date were delinquent. What can be done to improve debt collection efforts?

A. As part of an overall effort to improve the management of all Government receivables, the following actions are recommended:

1. Develop uniform definitions for terms such as debt, delinquent debt, allowance for doubtful accounts, and write-offs. Establish allowances for potentially uncollectable accounts and write off accounts that are determined to be uncollectable.

2. Coordinate debt collection efforts and establish uniform procedures among Government agencies. Establish a separate credit department in each agency.

3. Identify loans due by degree of collectability, segregating accounts that are virtually uncollectable from those that could be collected through vigorous collection efforts. This will require computerizing current manual records and updating computer equipment; about half of the Federal Government's 17,000 computers are obsolete.

4. Establish incentives for debt collection, tied to both individual and agency performance, e.g., allow agencies to retain a portion of the payments collected.

Q. How much would this save?

A. PPSS conservatively estimated that delinquent debt, other than that owed to the Internal Revenue Service, could be reduced by 25% over three years. This would accelerate collections by $8.1 billion and earn interest of $1.2 billion over three years.

In addition, PPSS noted that delinquencies and defaults on Federal loans are not reported to credit bureaus. Thus, the borrowers' credit ratings remain unimpaired, allowing them to be eligible for additional Federal and private sector loans. As an incentive for borrowers to repay Federal loans, PPSS recommended that delinquent debtors be reported to credit bureaus. In addition, when all other means of collecting debt are exhausted, PPSS recommended that private sector collection agencies be used. These measures would increase collections by $1.489 billion, earning interest of $307 million over three years.

Q. Are there any other general measures that can be taken to encourage debtors to repay their loans on time?