Hospitals & Asylums

Graduation of the Health Department HA-9-7-17

A. A Health Department or Public Health Department (PHD) and Department of Human Services (DHS) need to graduate from the Department of Education Re-organization Act of May 4, 1980 under 20USC§3508. The foundation of the public health service is typically attributed to July 16, 1798, when President John Adams signed a bill into law that created what we now know as the U.S. Public Health Service by establishing the U.S. Marine Hospital Service, predecessor to today's U.S. Public Health Service, to provide health care to sick and injured merchant seamen at naval hospitals under 24USC§14. Medical bills cause an estimated 67% of bankruptcies today, up from 8% in 1980 and it is necessary to nullify and repeal 'Medical records and payments' from the Fair Credit Reporting Act under 15USC§1681a(x)(1) like legal bills in 2009; student loans never sent a bill without murder tampering under 18USC§1512. The President's Budget FY 18 request for HHS proposes $69 billion in discretionary budget authority and $1,046 billion in mandatory funding, that comes to $1,115 billion FY 18. The budget-in-brief requests $1,113 billion to comply with CR 17 budget authority, but actually demands a total of $1,131 billion FY 18 when outlays are added, $18 billion, 1.6% more than CR 17. It is proposed that CMS spending grow 3% annually from FY 14 and FY 17 CMS would begin to limit inflation to 2.5%-3% with 0.5% est. undistributed offsetting receipts left over at year end. Graduating HS FY 18 with a 4% growth potential average, would keep federal public health expenditure estimates <$1 trillion for a few years of health budgeting to limit national health expenditure to <10% of GDP by 2030.

Health Department Budget FY 16 - FY 18
(millions)

	FY 16	FY 17	FY 18
Total Health Outlays CMS 3% (2014), HS Subtracted	905,496	938,031	958,191
Undistributed Offsetting Receipts	0	9,427	4,791
Total Health Outlays CMS 2.5% (2014), HS subtracted	893,436	920,499	935,848
HHS OMB Outlays	1,110,423	1,144,690	1,170,257
FY 18 Budget Authority	1,119,116	1,126,789	1,112,883
FY 18 Total Outlays	1,103,145	1,130,835	1,113,256
FY 18 Outlays added	1,102,876	1,130,535	1,130,986
Total Human Services Outlays	56,320	60,107	53,912

Full-time Equivalents	77,499	79,505	80,027
Food and Drug Administration	2,566	2,698	2,080
Health Resources and Services Administration	10,263	10,372	10,828
Indian Health Service	4,682	5,191	4,939
Centers for Disease Control and Prevention	7,504	7,920	7,275
National institutes of Health	29,280	32,117	30,195
Centers for Medicare & Medicaid Services	644,645	681,609	698,649
Office of the National Coordinator	85	128	43
Medicare Hearing and Appeals	107	107	242
Office for Civil Rights	16	41	33
Departmental Management	889	1,956	576
Public Health and Social Services Emergency Fun	1,516	2,792	1,736
Office of the Inspector General	82	107	84
Program Support Center	546	1,568	760
Offsetting Collections	-975	-1,373	-1,243
Other Collections	-125	-125	-125
Total Health Outlays CMS 3% (2014), HS Subtracted	905,496	938,031	958,191
Total Health Outlays CMS 2.5% (2014),	893,436	920,499	935,848

HS subtracted			
Substance Abuse and Mental Health Services Administration	3,443	3,672	3,688
Administration for Children and Families	50,905	54,479	48,289
Administration for Community Living	1,972	1,956	1,935
Human Service total	56,320	60,107	53,912
Total HHS Outlays CMS 3% (2014)	961,816	998,138	1,012,103
Total HHS Outlays CMS 2.5% (2014)	949,756	980,606	989,760

Source: HHS Budget Outlays FY 18

B. To reduce CMS outlay growth from 5.5% to 2.5%-3% FY 18 the federal share of Medicaid payments should be reduced from 90% or 100% to 50% or 60% or so and the 115th Congress must cease to cave into terrorist demands with the Treasury. Medicare needs to be abolished so that the Medicare premiums and the Hospital Insurance (HI) trust fund tax would be distributed to subsidize reasonably compensated health practices, and hospital administrators with income less than the vice president $161,532 (2017) and health insurance corporations with profits <10% by one Center for Medicaid Services (CMS). Untampered Medicaid prices must be the rule for Medicare, private insurance and out-of-pocket health expenditures. Ultimate Assumptions in Table II C1 of the Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, are wrong to makes estimates regarding consumer price index CPI (2.7%) + 2.5% = 5.2% growth is neoplastic. Whereas national health expenditures are reported to be 18% of GDP and add up to 15%, it is has been held that a 2.5% health annuity should arbitrarily be imposed from 2014 as punishment for hyperinflation until national health expenditures are <10% of GDP. It has however been difficult to come to a lasting agreement with CMS regarding the $1 trillion limbo bar directing budget negotiations at this time, and the natural rate of health spending growth is 3%. It is therefore proposed that CMS spending grow 3% annually from FY 14 and FY 17 begin to to limit inflation to 2.5%-3% with 0.5% est. undistributed offsetting receipts at year end. Graduating HS FY 18 with a 4% growth potential average in TANF, would keep federal public health expenditure estimates <$1 trillion for a few years of simplified health budgeting to limit national health expenditure to <10% of GDP by 2025.

1. The CMS Justification of Estimates for Appropriations Committees are much lower than reported by the HHS FY budgets. FY 17 the difference is $805 billion CMS and $1,113 billion or $1,130 billion HHS addition error. The only problem with the CMS budget is that it underreports Medicare costs. Medicare is comprised of the Hospital Insurance program (Medicare Part A) that is financed with a 2.9% payroll tax, split 1.45% between employers and employees and the Supplementary Medical

Insurance program (Medicare Part B and D Prescription Drug Coverage) that are financed one third by premiums and two thirds by appropriations from government revenues. Estimated FY 17 tax revenues of the HI trust fund are $320.4 billion with an end-of-year balance of $242 billion. It is this $320.4 billion in HI revenues that brings total CMS spending to over $1 trillion. Estimated FY 17 cost of the SMI trust fund is $308 billion, an estimated $203 billion to the federal government and $105 billion premiums that are attributed with defraying one third of the cost, CMS reports $283 billion FY 17 SMI outlays. It should be a simple matter for CMS to re-estimate 3% annual growth from 2014 with a minimum of subsidies for compensation in excess of the salary of the vice-president, currently $161,538 a year under 39USC§3686(d) and profits of subsidized health care and insurance corporations >10% may be considered overpayments under 26USC§6401.

CMS Annually Appropriated Accounts FY 2012-17
(in millions)

Accounts	2012	2013	2014	2015	2016	2017	Change	16-17 % Change
Program Management	3,820	4,821	5,217	3,975	3,975	4,110	135	3.4%
HCFAC	581	610	311	672	681	725	44	6.5%
Medicaid Grants to States	270,724	251,359	248,209	354,917	356,818	377,587	20,769	5.8%
Payments to Health Insurance Trust Funds	230,741	251,359	255,185	268,212	283,172	299,188	16,016	5.7%
Grand Total	505,867	526,195	548,900	627,776	644,645	681,609	36,964	5.7%
Correction			FY 14	FY 15	FY 16	FY 17	FY 18	0.5% Undistributed Offsetting Receipts end FY 17
Program Management			5,217	3,975	3,975	4,110	4,233	21
HCFAC			311	672	681	725	747	4
Medicaid Grants to			248,209	255,655	263,324	271,224	279,361	1,356

States 3%						
Payments to Health Insurance Trust Funds 3%	255,185	262,841	270,726	278,848	287,203	1,394
Grand Total	508,922	523,143	538,706	554,907	571,544	2,775

Source: Slavitt, Andrew M. Centers for Medicare and Medicaid Services (CMS). FY 2017 Justification of Estimates for Appropriations Committee. Department of Health and Human Services. 2016; Tavenner Mary. CMS. FY 2013-16 Justification of Estimates for Appropriations Committee. Department of Health and Human Services. 2012-16

C. Whether or not Medicare credits Medicare Part B and ACA premium payers for any overpayment of the 3% health annuity since $104.90 in 2013 to $120.65 five years later in 2018 under 26USC§6402(a) Medicare must be abolished to insure the health of all social security beneficiaries with free Medicaid policies. The Actuary admits, Part B premiums may vary from the standard rate because a hold-harmless provision can lower the premium rate for individuals who have their premiums deducted from their Social Security benefits. On an individual basis, this provision limits the dollar increase in the Part B premium to the dollar increase in the individual's Social Security benefit, the person affected pays a lower Part B premium, and the net amount of the individual's Social Security benefit does not decrease despite the greater increase in the premium. Because of the adverse "no COLA" declaration for 2016 there was no increase in costs, however Table VE2 SMI Cost-sharing and Premium Amounts is the cruelest and most unusual cost increase ever. Many defected to Medicaid. If social security benefits increased at 3% annually, Medicare premiums could increase 3% annually, except that the general feeling is that Medicare premiums and the Hospital Insurance (HI) trust fund tax should be distributed to reasonably compensated health practices with profits <10% by one Center for Medicaid Services (CMS).

D. Enrollment in private health insurance programs, including the Affordable Care Act (ACA) was 204 million in 2014, up 14.6% from 178 million in 2013. Under the ACA the number of uninsured people is expected to decline from 45 million people in 2012 to 23 million people by 2023. In 2014 the number of uninsured adults went down from 22% to 16%. Health insurance is a major determinant of access to health care. The percentage of adults aged 18–64 who were uninsured increased from 2004 (19.3%) to 2013 (20.5%) and then declined through June 2015 (12.7%) Among adults aged 18–64, the percentage with private coverage declined from 2004 (71.1%) to 2012 (65.1%) and then increased through June 2015 (70.6%). As of June 2015, 8.9 million adults aged 18–64 were covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges (36). The percentage with Medicaid coverage increased from 2004 (6.8%) to June 2015 (12.2%). Effective 2011 the ACA allows most young adults to remain on their parent's coverage until age 26. The percentage uninsured for those 19–25 declined 28% between 2013 and the second quarter of 2014, to 19.2%. Between 2004 and 2014, among children in families with income of 100%–199% of the poverty level, the percentage of uninsured children under age 18 decreased from 15.1% to 8.7%, while Medicaid or Children's Health Insurance Program (CHIP) coverage among children in families with income of 100%–199% of poverty increased from 40.2% to 60.0%. In 2014, Massachusetts (3.9%), Vermont (5.4%), Hawaii (5.7%), and the District of Columbia (6.1%) had the lowest percentages of

persons uninsured (i.e., without public or private coverage) among those under age 65, while Alaska (19.2%), Florida (20.1%), and Texas (21.2%) had the highest percentages uninsured. Consumers are due credit for health insurance premiums inflation in excess of the 2.5% health annuity. A side effect of the ACA is that it reduced the healthcare workforce by -6.4%, from 11 million to 10.3 million in 2014. The Bureau of Labor Statistics reported that as the largest industry in 2006, health care provided 14.4 million jobs, 13.6 million jobs for wage and salary workers and about 438,000 jobs for the self-employed. Subsequently, there was a -35%, -6% average annual, decline in the number of health professionals to 9.3 million in 2012, up 18% to 11 million in 2013 when ACA estimates were made, then down -6.4% to 10.3 million in 2014. In 2012, there were 26.9 physicians in patient care per 10,000 population in the United States. Health employment statistics since 2014 have not been reviewed. Unjust enrichment is revealed in the hyperinflation in CMS spending and health care prices >3% for a healthcare workforce that decline(d)s at the average annual rate of -6% from 2006 without a Democratic-Republican (DR) Congress to interest the excessively subsidized health licenses and insurance corporations with >10% profits. Subsidies for compensation in excess of the salary of the vice-president, currently $161,538 a year under 39USC§3686(d) and profits of subsidized health care and insurance corporations >10% must be considered overpayments under 26USC§6401.

E. National health expenditure as a percent of GDP increased from 5.6% in 1965, to 7.1% in 1970, to 8.9% in 1980, to 12.6% in 1990 to more than 16% in 2000 to as high as 17.8% without applying the GDP deflator in 2013 and 17.5% in 2016 with the new 17.3% deflator 2009-2013. Since the 1970s, national health care spending has on average grown nearly twice as fast, about 2.5 percentage points faster than the economy, that has grown at a rate of 3 percent annually since all other forms of inflation worldwide were brought under control since 1980. After four decades of high inflation averaging 8.9% annually for Medicare and 9.8% annually for private health insurance between 1970, when inflation was over 20% and 2005, when it was about 6.6%, the inflation in health care prices has nearly been brought under control- defined as less than 3% annual inflation since 2012. In 2005, national health expenditures totaled $2 trillion or 16 percent of the GDP, and grew to 17.4 percent of the GDP where it stayed from 2009 to 2013, as the result of the application of a GDP deflator by the CMS Actuary. In 2013, personal health care expenditures in the United States totaled $2.5 trillion, a 3.8% increase from 2012, mostly driven by 4% growth in private health insurance premiums. The per capita personal health care expenditure for the total U.S. population was $7,826 in 2013, up from $7,597 in 2012. Despite the high cost, the U.S. does not appear to provide greater health resources to its citizens or achieve substantially better health benchmarks compared to other developed countries.

National Health Expenditure Account Balance 2013-2020

(in billions)

	2013	2014	2015	2016	2017	2018
Private Health Insurance non-add	846					
non-add Administration and net cost of private health	211					

insurance						
Private Health Insurance Deflated '13 non-add	506	519	532	545	559	573
Private Health Insurance NAIC Net Premiums 2.5% inflation 3% growth '15	451	525	541	557	573	591
Administration and net cost of private health insurance 0.6 deflator '13, 2.5% non-add	127	130	133	137	140	144
NAIC Capital & Surplus 1.1% growth	111	112	113	115	116	117
Medicare	551	564	578	593	608	623
Federal non-add	500	513	526	539	553	566
Medicaid non-add	407	413	423	434	445	456
Federal	235	242	248	254	261	267
State	172	171	175	180	184	189
CHIP non-add	11.3	11.6	11.9	12.2	12.5	12.8
Federal	7.8	8.0	8.2	8.4	8.6	8.8
State and local	3.5	3.6	3.7	3.8	3.9	4.0
Other health insurance programs	89	92	94	96	99	101
All Health insurance Payments	1,937					
All Health Insurance Payments Deflated	1,597	1,638	1,679	1,721	1,765	1,809
Other third party payers and	221	227	232	238	244	250

programs						
Out-of-pocket payments	339	348	357	366	375	384
Investment	152.5	153.9	156	157	159	160
Public Health	239	245	251	257	264	270
National Health Expenditure Gross	3,258					
National Health Expenditure Deflated	2,516	2,574	2,645	2,698	2,766	2,830
Gross Domestic Product 3%	16,768	17,271	17,789	18,323	18,873	19,439
NHE as % of GDP	15%	14.9%	14.9%	14.8%	14.7%	14.6%

Source: Tables 102 & 104; Health, United States, 2014. Daveline, Dan; Koenigsman, Jane; Rivers, Bill. 2014 Health Insurance Industry Analysis Report. National Association of Insurance Commissioners and Center for Insurance Policy and Research. 2015

1. For the time being it seems sufficient for Health United States to desist in the use of the GDP deflator and update private insurance estimates extrapolated from the NAIC report of 2015, or credible update, from whence health insurance company surplus is thought to both have deviated exponentially upward and be challenged with an overpayment ruling from the ACA refundable premium and cost-sharing reduction under 26USC§6401. When updating the national health expenditure table in the future care must be taken to adjust CMS spending downward to 3% annual growth from 2014. 4.1% inflation in hospital bills is ridiculous. The most important thing the Congress can do to reduce national health expenditure as a percentage of GDP is that 'medical records and payments' must be repealed from the Fair Credit Reporting Act 15USC§1681a(x)(1). Private insurance and out-of-pocket expenses must be regulated by Medicaid prices. Ultimate Assumptions in Table II C1 of the Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, are unlawful to order hyperinflation in health care with a strange consumer price index CPI (2.7%) + 2.5% = 5.2% growth equation that must be treated as neoplastic. To cure the cancer of health inflation in the budget totals, it is advised that CMS spending growth be guided by 0.5% undistributed offsetting receipts saved at year end by paying 2.5% growth in outlays beginning FY 17 from 3% growth in budget since FY14, to achieve national health expenditures <10% of GDP by 2030.