Hospitals & Asylums

2.6% HI Tax Spending Limit FY 18 HA-28-8-17

Tables

A. A Health Department or Public Health Department (PHD) and Department of Human Services (DHS) need to graduate from the Department of Health and Human Service (DHHS) to fulfill the requirements of 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). It has been reported that the Treasury is going to discontinue refundable premium and cost-sharing reduction subsidies (for health insurance corporations with profit margins >10%) under the Affordable Care Act beginning FY 18. Un-redressed CMS accounting error is now the only reason the United States (US) is incapable of joining Hospitals & Asylums (HA) in declaring a federal budget surplus FY 18 under Art. 2 Sec. 2 of the US Constitution. To balance the federal budget, 6% annual growth in Part A tax revenues must run over into 3% health benefit growth in Parts A, B & D benefits from FY 14, effective FY 18. HI tax spending should be < 2.6% of the 2.9% + 0.9% of high income contributors to HI tax spending FY 18?

Health Department Federal Outlays FY 16 - FY 18
(millions)

	FY 16	FY 17	FY 18
Health Department total	979,836	980,599	964,123
Health and Human Services total	1,039,641	1,043,846	1,029,336
Human Services Department total	-58,805	-63,247	-65,213
Public Health Service sub-total	56,436	63,499	57,423

Outlays by Agency			
Human Services Department			
Administration for Children and Families	53,397	57,582	59,482
Administration for Community Living	1,965	1,993	2,043
Substance Abuse and Mental Health Services Administration	3,443	3,672	3,688
Health Department			
Centers for Medicare & Medicaid Services	923,400	917,100	906,700
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
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 Fund	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

Source: HHS Budget Outlays FY 18

1. There have been numerous accounting deficiencies in the budget totals of every HHS and CMS congressional budget requests since FY 14. For instance, 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. 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. Administrative spending cuts, especially for un-discontinued research in contravention to the Nuremburg Code, and FY 17 Part B and D cuts are sustained into FY 18, except for ACF child and family benefits that grow 4% annually plus historical interest in undistributed offsetting receipts and anti-welfare fraud loans of Secretary Price under Sec. 406 of the Social Security Act under 42USC·§606 and 18USC§228. The FY 18 Administration for Families and Children (ACF) congressional budget request is overruled by the ACF FY 17 budget request to redress the failure to pay legal child support obligations under 18USC§228. The dead-beat President is condemned to create an independent Cabinet level Department of Human Services (HS) to sustain 4% family and child benefit spending growth FY 18 under 31USC§101.

B. The FY 18 HHS budget-in-brief has impossibly confused the concept of budget authority with outlays to order spending cuts. Congressional budget authority is however equal to total agency revenues. It turns out HHS has been underestimating congressional budget authority, nearly as much as it has been overestimating federal outlays above 3% annual growth since the last accountable year – FY 14, effective FY 18. A table on congressional budget authority is needed to crunch the national health expenditure table and be finally done with health inflation until 2020. Congressional budget authority is equal to total agency revenues. Congressional budget authority has never been accurately accounted for in the HHS budget-in-brief due to the loss of total revenues, like the loss of total federal outlays, to an unaccountable obsession with benefits by CMS statisticians. The FY 18 HHS Budget-in-brief abused the concept of budget authority to order unjustified spending reductions, probably for the purpose of anti-welfare fraud loans under Sec. 406 of the Social Security Act under 42USC§606. If only everyone could be poor, everyone could be healthy. Medicare premiums and the Hospital Insurance (HI) trust fund tax are hyper-inflationary - "neoplastic". The carcinogen has been identified as 6% growth in HI tax revenues that must be equitably distributed by Medicare Parts A, B and D. Benefits need to be distributed to subsidize reasonably compensated health practices, and hospital administrators with income less than the vice president $161,532 (2017). Untampered Medicaid prices must be the rule for Medicare, private insurance and out-of-pocket health expenditures.

HHS Congressional Budget Authority FY 16 – FY 18
(millions)

	FY 16	FY 17	FY 18
Health Department total	1,161,583	1,170,303	1,258,468

Health and Human Services total	1,220,558	1,233,978	1,323,572
Human Services Department total	-58,975	-63,675	-65,104
Public Health Service sub-total	62,583	61,303	52,468
Centers for Medicare & Medicaid Services	1,099,000	1,109,000	1,206,000
Administration for Children and Families	53,397	57,582	59,482
Administration for Community Living	1,936	1,937	1,851
Substance Abuse and Mental Health Services Administration	3,642	4,156	3,771
Food and Drug Administration	2,725	2,741	1,891
Health Resources and Services Administration	10,777	10,654	10,205
Indian Health Service	4,916	4,953	4,898
Centers for Disease Control and Prevention	8,698	7,696	6,374
National institutes of Health	31,718	31,829	26,049

Agency for Healthcare Research and Quality	334	333	0
Office of the National Coordinator	60	60	38
Medicare Hearing and Appeals	107	107	242
Office for Civil Rights	38	38	33
Departmental Management	478	578	270
Public Health and Social Services Emergency Fund	1,948	1,530	1,663
Office of the Inspector General	77	77	68
Program Support Center	707	707	737
Total HHS Congressional Budget Authority	1,220,558	1,233,978	1,323,572

Source: FY 18 HHS budget-in-brief, ACF and CMS adjusted

1. Because of the existence of a disputed inequality regarding whether federal outlays for Medicaid payments should be reduced from 90-100% to 50% or 60%, it is necessary to exclude State Medicaid spending as a component of congressional budget authority, for the time being, state Medicaid and CHIP spending is necessary for estimating national health expenditures. Because 10-20% state shares would reduce national health expenditures from the threatened return ACA enhanced 50-40% state share, they are not terrorist demands, 10% state share is due process in the national health expenditure table, independent of congressional budget authority. Ultimately, to reduce national health expenditures to less than 10% of GDP, it will be necessary to error on the side of 3% health benefit inflation since the last accountable year FY 14, beginning as soon as possible, FY 18. With this federal budget surplus the federal government must guarantee states feel safe to publish budgets with as little as 10% health spending, down from 50% hypochondria. Federal-state identity theft tends to unconstitutionally perpetuate the Volstead Act, ie. exclusion of marijuana pregnancy test under 42USC§2000a(a). Fatal opiate overdoses lend credence to the legal theory of tampered evidence under 18USC§1512. Medicaid sets the fee-for-service and seems to pay Medicare premiums and pick up the co-pay and deductibles for Medicare resulting in free health care for the patient. Medicaid is a great program, patients and medical providers are happy with it.

C. The Centers for Medicare and Medicaid Services (CMS) was created in the Social Security Amendments of 2000 by changing the name of the Health Care Financing Administration (HCFA) that was created in 1977. Medicare and Medicaid locally shall be appointed by the Secretary from a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area. At least one consumer shall also participate in the board to assure that adequate peer review is provided by the administrators of Medicare and Medicaid to the various medical specialties and subspecialties to ensure that services and items paid for were reasonably and medically necessary under Sec. 1154 of the Social Security Act under 42USC(7)XI-B§1320c-3.

1. Due diligence of the trillion dollar federal health outlay limbo bar until 2020 is needed to boost morale for long-term reductions in national health expenditures of all types to less than 10% of gross domestic product (GDP). The FY 15 Medicaid overpayment precipitated a relapse of premium hyper-inflation beginning 2016. Medicare premium revenue inflation has become un-audit-able. To reconcile national health accounts and redress medical hyper-inflation, it is essential that inflation in federal health budget requests be re-estimated at a rate of 3% annual growth from FY 14, effective FY 18. As always Medicare must prioritize reduction psychiatric spending with Amantadine (Symmetrel) to cure flu and potentially fatal extra-pyramidal side-effects of antipsychotic drug consumption and Metronidazole (Flagyl ER) to cure the gastrointestinal infection (GI) underlying most generalized anxiety disorder aggravating potentially violent anti-depressant addicts. Can Dr. Price's opiate-inion get federal health outlays under the $1 trillion limbo bar without cheating? Or do hospitals continue to bill $1,000 a night for medical residents, supposedly back to working 100 hours a week, to prescribe outpatients over age 8 unadulterated doxycycline 100 mg, the once a day antibiotic, treat children and pregnant women with Clindamycin, to cure chest and other excruciating pain from hospital acquired Methicillin resistant *Staphylococcus aureus* (MRSA) + pyromaniac acquired *Streptococcus pyogenes* = toxic shock syndrome?

2. Federal outlays for Medicare are estimated by Part A payroll tax revenues and Part B & D general revenues from the *2017 Annual Report of the Board of Trustees of the Federal Hospital Trust Fund and Supplemental Medical Insurance Trust Fund* FY 14-17 after which time FY 14 becomes the baseline for sustainable 3% annual growth. Federal outlays are estimated for Medicaid from *2016 CMS Statistics* with 3% benefit spending and 2.5% administrative spending growth from FY 14, as is believed to have actually occurred due to the law of diminishing returns, any extra federal Medicaid spending due to the unequal state share can just be written off as money-printed. Medicaid accounting hasn't recovered from when the FY 14 15.9% expansion of the Medicaid population caused a -6% decrease in the health care work force who actually benefit from health insurance payments. Rows containing duplicitous inter-agency transfers such as Health Care Fraud and Abuse (HCFA) are deleted from the Medicaid federal outlay ledger. Low estimates of federal outlays are needed for administration and Children's Health Insurance Program (CHIP) due to off-budget and state revenues.

CMS Total Federal Outlays 2014-2020
(billions)

Year	2014	2015	2016	2017	2018	2019	2020
Total CMS	805.7	855.2	923.4	917.1	906.7	933.8	962

Part A	227.4	241.1	253.5	267.2	255.9	263.6	271.5
Part B	188.4	203.9	235.6	215.5	212.1	218.4	225.0
Part D	58.1	68.4	82.4	71.9	65.4	67.4	69.4
Sub-Total Medicare	473.9	513.4	571.5	554.6	533.4	549.4	565.9
Medicaid	316.7	326.2	336.0	346.1	356.5	367.1	378.2
CHIP	9.0	9.3	9.5	9.8	10.1	10.4	10.8
Administration	6.1	6.3	6.4	6.6	6.7	6.9	7.1
Total CMS	805.7	855.2	923.4	917.1	906.7	933.8	962
Total HHS	910	1,010	1,039	1,043	1,029	1,049	1,080
Total Human Service Department	-55	-57.1	-59.0	-63.7	-65.3	-67.5	-69.7
Total Health Department	855	952.9	980	979.7	952.7	981.5	1,010

Source: 2016 CMS Statistics. CMS Office of Financial Management. March 2017; 2017 Annual Report of the Board of Trustees for the Federal Hospital Insurance Trust Fund and Federal Supplemental Medical Insurance Trust Fund. July 2017

3. FY 14-17 Medicare spending is defended by the Part A HI payroll tax and Part B & D general revenues in the *2017 Annual Report of the Board of Trustees for the Federal Hospital Insurance Trust Fund and Federal Supplemental Medical Insurance Trust Fund* of July 2017. The HI payroll tax is growing 6% annually and HI spending has stabilized at 2.1% growth. After experimentally reducing Part B & D outlays FY 17, federal outlays must go down in all three federally financed Medicare plans FY 18 before they begin growing 3% annually from FY 18. Surplus FY 18 HI revenues must either run over into Medicaid price-controlled Part B & D payments or the $281.7 billion generated by the 2.9% HI tax rate must be somehow reduced to $255.9 billion, a tax rate of 2.6%, keep the 0.9% tax on the incomes of the rich - 15.0% Federal Income Contribution Act (FICA)? Does CMS have any undistributed offsetting receipts to report left over from the $917.1 billion federal outlays estimated to be administered FY 17 and $906.7 billion FY 18 from Oct. 1 under 31USC§1106? Total spending for all Medicare programs should go down FY 18 to $907 billion until health prices stabilize at a sustainable 3% rate of growth FY 19. Medicaid prices for all!

CMS Congressional Budget Authority FY 16 – FY 18
(billions)

Year	2016	2017	2018
Total CMS			
Part A	290.8	306.0	324.0
Part B	313.2	302.8	353.7
Part D	106.2	98.7	103.4

Sub-Total Medicare	710.2	707.5	781.1
Medicaid Federal	368.3	378.5	407.6
Medicaid State excluded	0	0	0
CHIP Federal	9.5	9.8	10.1
CHIP State and Other	4.9	7.1	1.9
Administration	6.5	6.0	5.6
Total CMS	1,099.4	1,108.9	1,206.3
Total HHS	1,335.4	1,304.8	1,409.3
Total Human Service Department	-58.6	-60.2	-52.2
Total Health Department	1,276.8	1,244.6	1,357.1

Source: 2017 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and Federal Supplemental Medical Insurance Trust Fund. July 14, 2017

4. The only problem with the format of the CMS budget ledger is that it underreports Medicare costs by concealing the revenues of the 2.9% HI tax from being added as federal outlays for the benefit of the HHS budget-in-brief and Office of Management and Budget (OMB). 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-fourth by premiums and three-fourths by appropriations from government revenues. The CMS annual congressional budget justification has to add total HI tax revenues to the Grand Total to produce total federal outlays. The FY 17 CMS Budget request has been overruled by Part B & D cuts to General Fund appropriations, going into a second year of cuts FY 18 including the distributing the difference between the 2.9% HI tax and 2.6% of taxable wage HI spending limit, before 3% annual health inflation becomes the generally accepted accounting practice (GAAP).

CMS Annually Appropriated Accounts FY12 - FY17
(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%

General Revenues Total	505,867	526,195	548,900	627,776	644,645	681,609	36,964	5.7%
General Revenues Total added	505,866	508,149	508,922	627,776	644,646	681,610	36,964	5.7%
HI Tax	205,700	220,800	227,400	241,100	253,500	267,200	13,700	5.4%
CMS Federal Outlays	711,566	728,949	736,322	868,876	898,146	949,810	51,664	5.8%
Correction			FY 14	FY 15	FY 16	FY 17	FY 18	0.5% Undistributed Offsetting Receipts 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 States 3%			248,209	255,655	263,324	271,224	279,361	1,356
Payments to Health Insurance Trust Funds 3%			255,185	262,841	270,726	278,848	287,203	1,394
General Fund Total			508,922	523,143	538,706	554,907	571,544	2,775
HI Tax			227,400	241,100	253,500	267,200	281,700	1,409
CMS Federal Outlays			736,322	764,243	792,206	822,107	853,244	4,184

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, 2017 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and Federal Supplemental Medical Insurance Trust Fund. July 14, 2017 pg. 54

D. The United States needs to reduce health spending to less than 10% of GDP. 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 inception of the HI tax in 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 2012-2016, when hyper-inflation again reared its ugly head, and government health budgets began to be cut. Medicare spending has increased as state payments for Medicaid expansion patients dwindled from 40-50% to 10%, estimated at 11% of federal outlays for Medicaid. FY 17 and FY 18 Medicare cuts regain

some control over, at least, the government budget aspects of neoplastic health inflation.

National Health Expenditure Account Balance 2013-2018
(billions)

	2013	2014	2015	2016	2017	2018
Private Health Insurance NAIC Net Premiums	451	525	541	557	573	591
Administration and net cost of private health insurance	127	130	133	137	140	144
Medicare	582	600	638	694	708	669
Federal	235	317	326	336	346	357
State	172	34.9	35.9	37.0	38.1	39.3
Federal	7.8	9.0	9.3	9.5	9.8	10.1
State	3.5	3.6	3.7	3.8	3.9	2.7
Other health insurance programs	89	92	94	96	99	101
All Health Insurance Payments Subtotal	1,667	1,712	1,781	1,870	1,918	1,914

Other third party payers and programs	221	227	232	238	244	250
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
Total National Health Expenditures	2,619	2,686	2,777	2,888	2,960	2,978
Gross Domestic Product 3%	16,768	17,271	17,803	18,472	19,303	20,130
NHE as % of GDP	15.6%	15.5%	15.6%	15.6%	15.3%	14.8%

Source: *2017 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and Federal Supplemental Medical Insurance Trust Fund*, July 2017. *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. OMB FY 17 Table 10.1

1. 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. *Health, United States*, 2014 is the last credible report on national health expenditure. Editors must abolish the GDP deflator, plug in private health insurance estimates from the *2014 Health Insurance Industry Analysis Report of* National Association of Insurance Commissioners and Center for Insurance Policy and Research for a proven NHE of 15.6% FY 13 and 15.5% FY 14, that inched back-up to 15.6% FY 15 & 16 before Medicare and public health service spending cuts reduce spending to 15.3% FY 17 to 14.8% FY 18 with a 2.6% HI tax-spending rate. 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. It is against the 2.7% average consumer price index (CPI) inflation for health insurance premium prices to increase more than 3%. 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. For instance, in 2000 the United States had the highest birth rate (12.5 per 1,000 population), infant mortality rate (6.1 infant deaths per 1,000 live births and 8 under age 5 deaths per 1,000) and maternal mortality rate (32 deaths per 100,000) of any industrialized nation. It is essential that the United States

has the goal to reduce national health expenditures to less than 10% of GDP by 2030. Only Great Britain spends more than 10% of GDP on health, and they are reported to be unpleased with their national health service. Let's see what state Medicaid cuts to 10% of the federal share FY 15-18 do to 3% annual growth from *Health United States, 2014*. Let's also see what Medicare spending increases did until they began to be brought under control with spending cuts FY 17 and FY 18.

2. 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%. A side effect of the unexplained total Medicare spending cut, due to relief to state for the 2014 Medicaid expansion, the ACA 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. Not such a growth industry, after all.

3. SMI premium inflation has become virtually un-audit-able since 2016 and is aggressive at 10% because FY 17 Part B & D general fund cuts did not adequately protect consumer prices against inflationary neoplasm with 3% annual growth limit on health insurance premium inflation, pegged to a 3% cost-of-living adjustment (COLA) for social security beneficiaries, so workers and the self-employed could purchase SMI policies on-line. 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 per benefit spending growth equation regarding consumer price index CPI (2.7%) + 2.5% = 5.2% growth equation that must be treated as neoplastic, and must excised by wide-rescission FY 17 – FY 18. 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 >4% and insurance corporations >10% must be given due process as overpayments under 26USC§6401.