COOPERATIVE LEAGUE OF THE USA

Washington Marriott Hotel
Tuesday, October 25, 1983
TALKING POINTS

Domestic Farm Issues

o Dairy Compromise: Passed Senate before Columbus Day recess. House voted 208-188 to reject Ag Committee effort to go straight to Conference. Expect compromise to come up next week, with Conference before adjournment on the 18th.

Compromise never was exactly what every group or dairy farmer wanted. But it has retained the support of dairy cooperatives, milk industry users, consumer organizations, since April.

If the package is changed on the House floor or in Conference, it won't be the end of the world. Livestock industry is still concerned over impact of paid diversion on beef and pork prices next year.

o Target Prices/1984 Programs: Have tried three times since July to work out compromise to reduce scheduled 1984 target price increases and improve the wheat program. Still ready, but doubt that Senator Melcher has any better reason to move now than before.

Rep. Foley's Subcommittee will mark-up a wheat bill on Thursday. Basically the same as the Dole compromise, with an increase in the target price for 1985 and advance deficiency and diversion payments. Foley's bill may pass the full Ag Committee and even the House floor before adjournment.

Wheat and feed grain program sign-up is set for January 16 to February 24, 1984. Action on legislation probably not feasible next year.

International Farm Issues

o P.L. 480: Important program which has been neglected. Could be reviewed and reinvigorated as part of overall U.S. trade policy revamping.

Period from 1954 to 1980 saw U.S. farm productivity and exports keeping pace with foreign demand. Post-embargo period has seen continued high production and slumping exports. Food aid and other assistance programs may need to be adjusted accordingly.

o Export Competition: There are no winners in a trade war. Need to continue to meet, not beat, the competition to convince the EEC and others to reform their internal agricultural policies.

ALCOHOL FUELS TAX EXEMPTION

Ethanol Fuel Incentives

- One set of tax incentives that I believe experience has clearly proven to be economically efficient are the incentives for the domestic production of alcohol fuels.

- I am proud to have one of the original authors, along with Senators Carl Curtis and Birch Bayh, of the legislation in 1978 that established the exemption for alcohol fuel from the 4-cent per gallon gasoline tax.

- Since 1978 we have improved on the original excise tax exemption.

- In 1981, we extended the 4-cent per gallon alcohol fuel exemption through 1992, added an optional production tax credit for alcohol fuels, extended the energy tax credit for alcohol fuel production equipment and streamlined some of the regulatory requirements that had proven to be an impediment to expanding alcohol fuel production.

- Last year as part of the gas tax bill, we are able to increase the alcohol full exemption to 5 cents per gallon.

- The response to these tax incentives has proven to be nothing short of miraculous since we have witnessed the birth of a significant and growing new energy industry.

- Since these incentives were enacted, the alcohol fuels industry has invested hundreds of millions of dollars in nearly 100 commercial facilities. Fuel ethanol blend sales will exceed 4 percent of the total gasoline pool in 1983, with over 5 percent or 5 billion gallons expected to be sold in 1984.

Alcohol Fuels

- In addition, I know that many of you are interested in S. 1931, the Renewable Fuels Tax Incentive Act, introduced by Senator Durenberger.

- S. 1931 would increase the excise tax exemption for alcohol fuel blends to 9 cents per gallon and would reimburse the Highway Trust Fund for the revenue loss of the increased exemption from the "Windfall Profit Tax" account of the general fund.

- I have long supported increasing the alcohol fuel excise tax exemption to 9 cents per gallon. The Senate version of the gas tax bill passed last December increased the exemption to 9 cents, but that figure was reduced in conference to 5 cents because of strong House opposition.

- I continue to strongly support increasing the alcohol fuel exemption to 9 cents. Nevertheless, achieving this legislative goal will not be easy.

- However, I cannot support the provision in S. 1931 that would reimburse the Highway Trust Fund from the Windfall Profit Tax for the revenue loss of the increased fuels tax exemption for alcohol fuels.

- Every legislative effort to assist the alcohol fuel industry has originated in the Senate.

- If we are going to be successful in increasing the exemption, this industry is going to have to neutralize the intense opposition of senior members of the House Ways and Means Committee.

TALKING POINTS ON HEALTH CARE

- Recent estimates show the medicare hospital trust fund as being depleted as early as 1990. This financing problem is more than anything else, the result of rapidly growing hospital costs. Such costs are expected to increase at an average annual rate of 10.5 percent from now until 1995, while the basis for trust fund income is expected to grow at an annual rate of only 7.0 percent.

- Hospital costs are not the only element of the medicare program that have and are expected to experience rapid growth. Physician fees under Part B of the program have increased at an annual rate of over 11 percent in recent years.

- The cumulative projected deficit in the HI trust fund is so large--$300 to $400 billion by 1995--that to maintain solvency will require substantial policy changes. To bring the hospital insurance program into close actuarial balance, either outlays will have to be reduced by 30 percent or income increased by 43 percent.

- Increased beneficiary cost sharing, benefit reforms and higher payroll tax rates are but three options likely to be considered by the Congress to close the gap between expenditures and revenues.

- However, the high cost of health care in this nation, not just the cost of medicare, is a real problem. A problem for which everybody has someone to blame. We have heard that it's the hospitals, the growing number of elderly, improved technology, the physicians, third party coverage, government regulations, etc. Clearly it's a problem in which all these things share some blame.

- Today any broad discussion about health care quickly evolves into a narrower discussion about health care costs. This is true of not only medicare and medicaid, but of any payment source. Needless to say, how we pay for services plays an important part in these discussions.

- Expenditures on all types of medical care have risen from $39 billion in 1965 to approximately $287 billion in 1981--from 6 to 9.8 percent of the GNP.

- Health care expenditures amounted to $1,225 per person in 1981. 42.7 percent of these dollars came from public funds.

- This year the Federal Government will spend approximately $58 billion dollars on the medicare program. Of this amount, approximately $37 billion will be spent on hospital services. We expect to spend $19 billion for services to the poor under the medicaid program. The States will spend

another $16 billion. In summary, the Federal Government will spend approximately $75 billion this year for these two programs.

- The health care market itself is atypical of the perfect market for goods land services envisioned by standard economic theory. More than any other market, it is dominated by third-party payers, that is, by persons or organizations who purchase care on behalf of those who consume it. In 1981, two-thirds of personal health care expenditures were made by the government or by private health insurance. To that extent, consumers of health care are isolated from the true price of health care, and tend to consume more care than they would were they to pay directly the full price of the goods and services they receive.

- A second sense in which the health care market diverges from the pefect market of economic theory is that, unlike most other markets, the consumers of health care lack full information when decisions are made to purchase health care. For example, hospital admission is usually made upon the decision of a seller of health care (a physician) rather than by the consumer of hospital services (the patient), or by the purchaser of the service (the government, private health insurers, or the patient). Whether the patient would choose the same types and quantities of care if complete information were available is an issue yet to be answered.

- We need the cooperation of business and labor in solving these problems. We cannot be expected to ask medicare beneficiaries to pay more out of their pockets, and have their benefits changed, if those who are covered by private insurance are not asked to do the same.