SUBSIDY-INDUCED EFFICIENCY LOSSES IN THE NATIONAL HEALTH CARE MARKET

A Thesis
Presented to
the Honors Program
and the Economics Department
of the University of Houston

In Partial Fulfillment
of the Requirements for Graduation
in the University of Houston Honors Program

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by

Jay Reeves Ferry

August 1979

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ABSTRACT

This study determines the approximate efficiency losses that will result from various subsidies in the national health care market. Using demand and supply curves to represent the benefits and costs of health care, this analysis measures the excess costs relative to benefits that accompany subsidy-induced increases in consumption. The measurement, produced by integrating the demand and supply curves over the relevant area, is in excess of fifty billion dollars per year.

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SUBSIDY-INDUCED EFFICIENCY LOSSES IN THE NATIONAL HEALTH CARE MARKET

For over half a century, national health insurance has created considerable controversy in the United States. Current Congressional debate suggests that some form of national health insurance may well be enacted in the near future. For this reason, several recent studies have examined the economics of these proposals.[1] However, none of these studies has attempted to measure the potential loss of economic efficiency in each of these plans. This work attempts to fill the void by measuring the loss of economic efficiency for several hypothetical national health plans.

The plan of work is as follows. The first section summarizes the history and background of national health care with respect to a national health insurance plan. The second explains how an efficiency loss arises. The third outlines this methodology and data used to produce the measurements, and the fourth section presents the results.

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[1]Numerous examples are listed in the bibliography.

Section I

Present national health insurance proposals are not a recent creation. They are the product of a combination of various European experiences and/or various United States endeavors. To gain insight into present proposals, a brief overview of several European programs (West Germany, France, and Great Britian) and a brief history of national health insurance attempts in the United States follows.

Most European national health care systems have followed an early attempt to insure care for the poor, usually in the form of sickness funds. The funds were developed by private and public charities as early as the Middle Ages in an attempt "to provide a minimum level of subsistence for the aged and sick members of the local community."[2] However, for a variety of reasons the eleemosynary approach to health care began to fade in the late nineteenth and early twentieth centuries.

In an effort to fill the void, Chancellor Otto von Bismark developed a plan for Germany which is probably the forerunner of most national health insurance programs. Through compulsory insurance for the general workers, beginning in 1883 Bismark set up a system of decentralized insurance funds to guarantee free services and sickness benefits. Although

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[2]Alan Maynard, Health Care in the European Community, Pittsburgh, University of Pittsburgh Press, 1975, p. 78.

these funds never distributed the services directly, they did issue an illness ticket, a "Krankenschein," that would cover the cost of a private contractor. Financial backing of this ticket came from the employer, sixty-seven percent, and the employee, thirty-three percent, through insurance payments.[3] The burden of payment has increased for the employer and the eligibility requirements have slackened, but the central theme has continued through the generations.

France has had a similar experience with national health insurance. With the exception of the slight revisions of 1945 and 1967, few changes have occurred since its inception. This stable program is a conglomeration of several insurance programs that the public finds advisable to join. Seventy percent of the population is covered by the general plan, régime général, and the other thirty percent falls under the protection of special plans.

The régime général works on a geographic basis, with local funds supporting the costs of health care. These local funds are reimbursed by a central fund, which, in turn, obtains its revenues through insured members and their employers, with employers "paying" approximately three times as much as employees. The major distinction of France's health insurance approach is that the total cost of health

[3]The incidence of the tax was probably all on the worker, although it was not recognized as such.

care is not covered by the fund. The French, in essence, have a co-insurance rate of approximately twenty-five percent for most medical expenditures. The rate is lower, of course, for some individuals who have purchased additional insurance and others that fall under catastrophic illness exemptions.[4]

Great Britian's approach is different in this and many other ways. It chooses to cover the full cost of health care for all recipients. In financing this approach, it uses a general tax to cover eighty-five percent of the cost and a directed tax to cover the remaining fifteen percent. The payments go to hospitals or physicians who keep track of services rendered to the public. This system began in 1946 when

> the provision of a comprehensive system of medical care was entrusted to a nationalized system of hospitals and a system of contracted services from medical practicioners.[5]

With this system, Great Britian has strong control over the suppliers of health care. Facilities for medical practicioners are owned by the state, and for all practical purposes, physicians are state employees. The British system is probably the most "socialistic" of the plans currently existing in Western Europe.

The United States' interest in national health insurance

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[4]Maynard, pp. 130-131.

[5]Maynard, p. 187.

began in the early part of this century, largely as a result of the German experience. Variants of this example appeared in eighteen state legislatures over the period from 1916 to 1917. Even the American Medical Association supported the idea, although numerous local medical communities formed strong opposition. Ironically, though, the opposition's ability to associate the proposals with the successful German model may have caused the proposal's failure, for the United States was preparing for entrance into World War I at the time.[6]

No major attempts followed this setback until passage of the Social Security Act of 1935. Supporters of national health insurance had the framework established in this act to oversee a major national health care system. Resistance, led by physicians, was strong enough, however, to defeat this attempt.

For over three decades following this failure little appeared in the arena of national health care. It was not until the latter part of the 1960's, with the establishment of Medicare and Medicaid, that national health programs made their initial inroads. Medicare is a federal system of health care for the elderly, with federal funds augmented by a payroll tax, deductibles, and premiums covering all costs.

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[6]Arnold J. Heidenheimer, Hugh Heclo, and Carolyn Teich Adams, Comparative Public Policy: The Politics of Social Choice in Europe and America, New York, St. Martin's Press, 1975, p. 18.

Medicaid is a federal assistance program that supplies fifty to eighty percent funding to the states for financing health care for the poor.

This is where the debate on health care stands. Some feel that the Medicare and Medicaid programs meet the government's responsibility for the health of its citizens. Others feel that the present programs do not meet the needs of the poor, stating that twenty-five percent of the poor have no coverage.[7] In fact, some feel that good health care is the right of every citizen, and propose total subsidization of health care by the federal government. Although this idea is not prevalent, subsidies of some form, through national health insurance, are very close to gaining the necessary support of Congress. Therefore, a look at possible subsidies and their effects on the market is essential.

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[7]Louise B. Russel and Carole S. Burke, The Political Economy of Federal Health Programs in the United States: An Historical Review, Washington, D.C., The Brookings Institute, 1978, p. 70.

Section II

Any subsidy has a loss producing quality inherent in the "free lunch effect" associated with it. The "effect" is a misrepresentation of the true benefits of a good as set by the market process. The misrepresentation is committed when the consumer believes that the subsidized benefits are the true benefits. It appears as though a part of a good is free with the subsidy, hence the name "free lunch." This belief that part of a good is free when, in essence, it is a cost to the subsidizer, creates a process of overconsumption and incorrect valuation that results in a loss to society. This misconception of higher social benefits and the lack of knowledge concerning costs (or absence of concern for such costs) both play a part in this incorrect valuation. An example of this misconception follows to clarify the act of misperception and the product of it, the efficiency loss.

The example uses several assumptions: (1) individual Ā is in need of good X, (2) individual Ā values consumption of X at $260, (3) X has a constant price of $300, (4) government subsidies of $50 are available for good X.

Under normal circumstances, Ā will forego the purchase of X, since his expected costs, $300, exceed his expected benefits, $260. After equating true benefits, returns from his consumption of X, with true costs, the market price of X, he foresees a deficit and adjusts his plans accordingly.

Introduction of assumption (4) alters Ā's comparison of benefits and costs. After initiation of the subsidy, Ā's private benefits are the returns from the consumption of X and the subsidy. This differs from society's true benefits because Ā considers the subsidy an increase in welfare, where in society the subsidy merely represents a redistribution of income. As a result, when Ā equates benefits with costs, he over-values the true benefits to society by the amount of the subsidy. In Ā's case, he chooses to purchase X because he expects returns of $310, $260 in consumption and $50 in receipt of the subsidy. Individual Ā reaps benefits of $10 from the transaction, but this is not the case for society in general. For society, benefits remain at $260, and Ā's decision to purchase X is, in essence, a decision of society to use a good valued at $300 to produce returns of $260, a loss of $40.

If this type of loss was restricted to just a few individuals, little harm would occur. In this situation, however, as in any subsidy-affected area, all consumers will seek goods until their benefits from the good and the subsidy equal their costs. Thus, in the example, any individual expecting returns from X of at least $250 would enter the market.

When attempting to visualize this loss, graphs of supply and demand responses in the X market are very helpful. The demand and supply curves that represent these responses are closely related to perceived benefits and costs in the market.

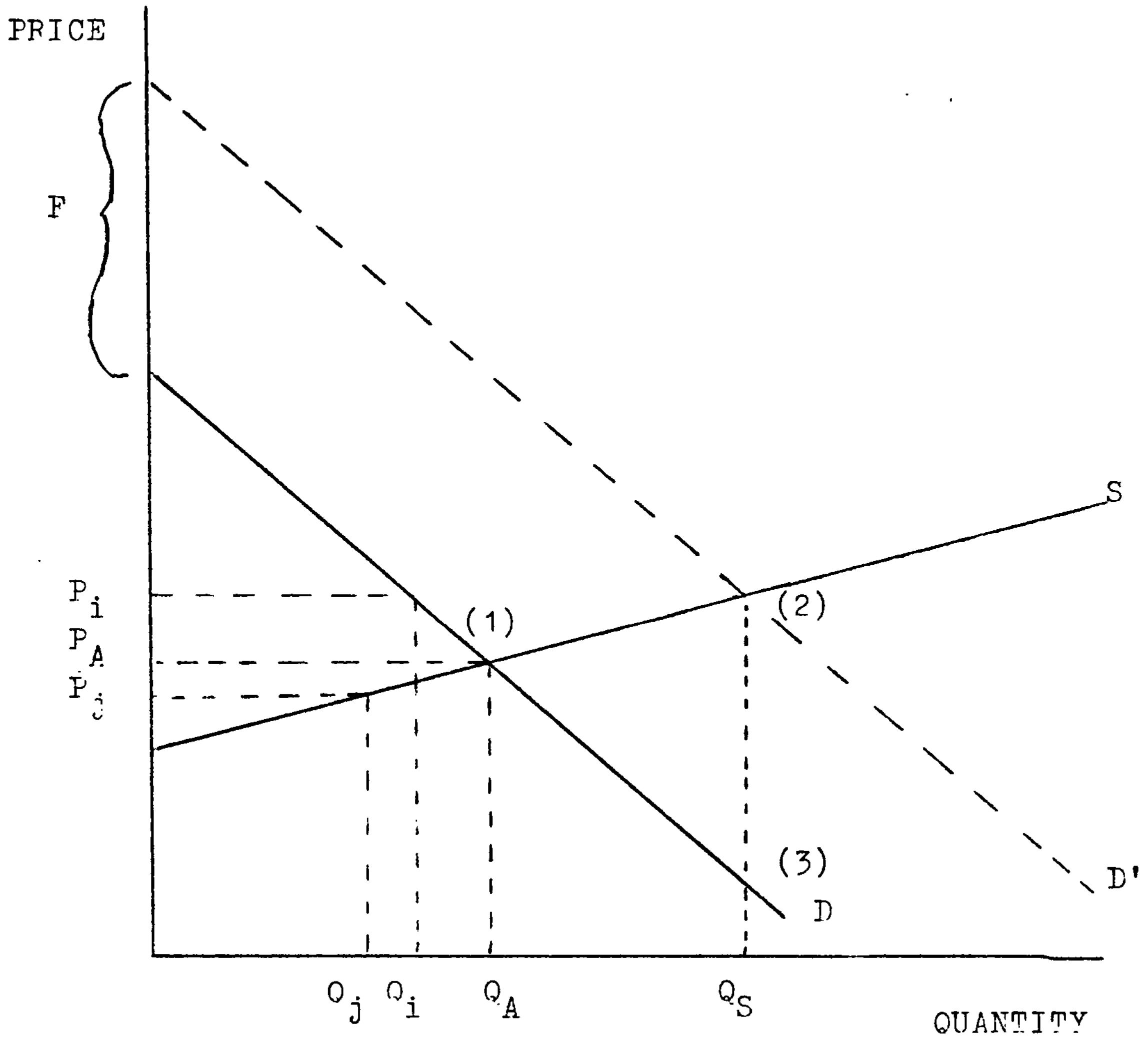
Figure 1 presents an example of supply and demand curves in a given market. At each point (P_i, Q_i) on the demand curve, society is willing to pay up to P_i for the Q_ith unit of the relevant good. In other words, society's expected benefits for consuming the Q_ith unit of a good is presented by the height, P_i, of the demand curve. In a like manner, the area under the demand curve from Q_o to O_i represents the perceived benefits of consuming Q_i units of the good.

At each point (P_j, Q_j) on the supply curve, society expects to receive at least P_j for producing the Q_jth unit of a good. Society's cost for supplying the Q_jth unit of the good is the height, P_j, of the supply curve. It also follows that the area under the supply curve from Q_o to Q_j represents the costs of producing Q_j units of the good.

For any good purchased up to Q_A P_A, it is apparent that benefits exceed costs. Any move from the left of Q_A to Q_A, such as from Q_j to Q_A, produces an increase in the benefits for society, relative to costs, an efficiency gain. Any move from Q_A to the right, such as to Q_s, represents an increase in costs for society, relative to benefits, an efficiency loss.

It is this move from Q_A to the right that may represent the loss due to subsidization. As is seen in Figure 1, a

FIGURE 1



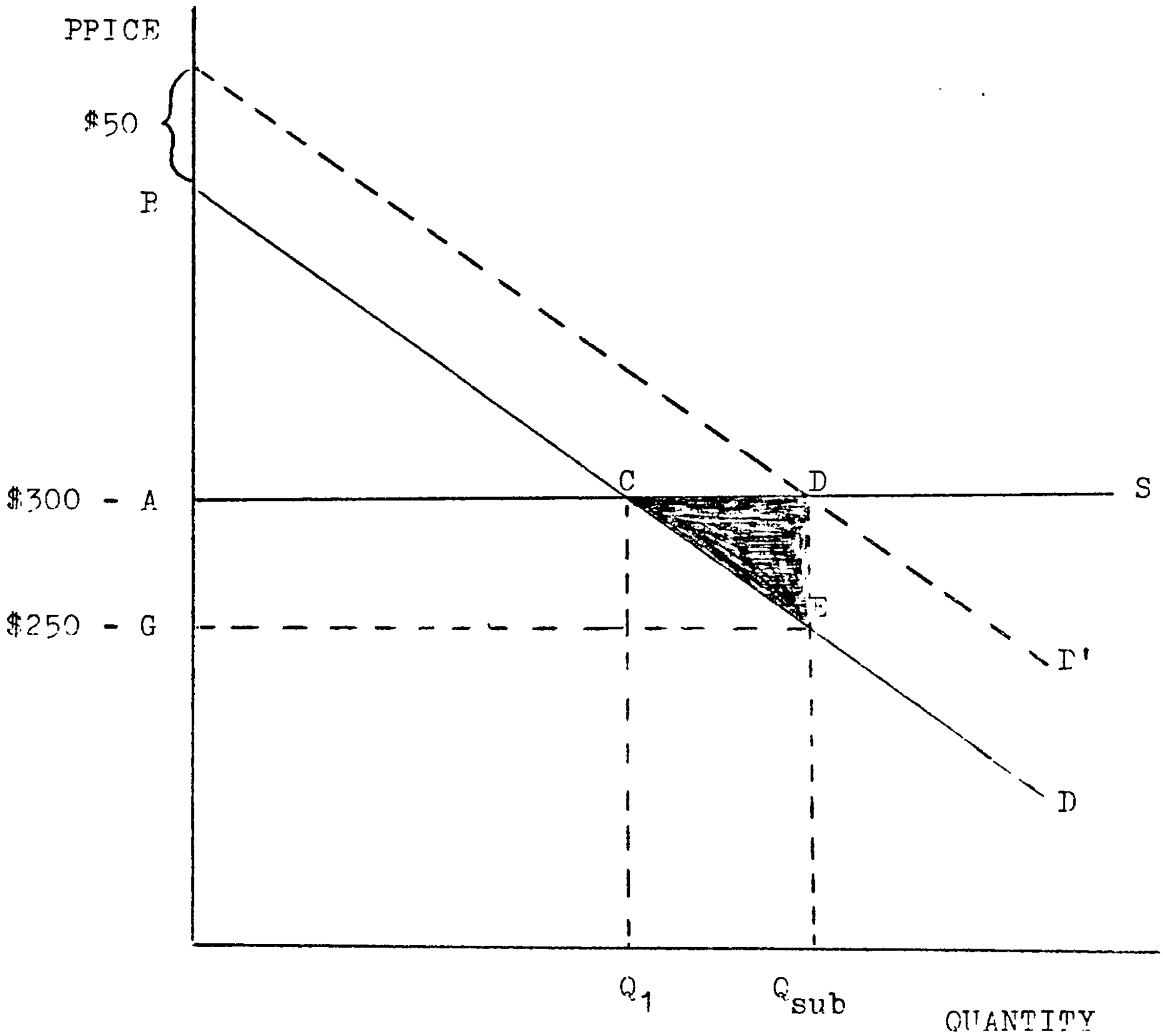
subsidy F creates the illusion of greater benefits for society, D', by making the perceived benefits at each quantity appear to increase by the amount of the subsidy. As is expected, consumers respond by increasing purchases by $Q_S - Q_A$. The resultant relative increase in costs to society creates an efficiency loss, triangle (1)(2)(3).

In looking back to the good X example, the losses due to subsidization are easy to recognize. The only variation is that the supply curve is horizontal, perfectly elastic, as is seen in Figure 2, a graph of the X market. Before the subsidy, society benefits by triangle ABC, the difference between the costs to society and the benefits to society. After the $50 subsidy, shifting demand from D to D', society's benefits fall to triangle ABC-triangle CDE. Society loses some of its resources to a market where goods are provided for less than their true value.

This mistake in valuation is made in a number of markets. Research to determine these losses and response to discovery of such losses occurs frequently. One example of this is found in the telephone industry.

The telephone industry has offered free directory assistance for a number of years. It allows all consumers to pay for the costs of directory services by distributing it in an even charge among all. Since directory service is, at most, used by ten percent of the telephone customers, the even charge simulates a tax to permit subsidization of directory

FIGURE 2



services.[8] This subsidization is a producer of enormous losses for society, with estimates ranging up to $750 million per year.[9] Recognition of this loss and response to other factors is bring about steps to eliminate or, at least, partially eliminate it with "use-sensitive charges." The important factor in this example, however, is that subsidies produce a considerable losses in this industry that warrants measures to stop them.

In an industry where subsidies are impending, avoidance of such necessary action as the aforementioned is facilitated by predicted measurements of losses that will occur. With these predictions, an assessment of society's losses will result, and then an accurate decision on the results of the subsidy is possible.

This is the reason for such an estimate with respect to national health insurance subsidies. With health care expenditures over $142 billion in 1977, the possibility of a sizeable loss in efficiency is great with any subsidization. As stated earlier, some proposals support total subsidization of health care, thus insuring the maximum possible efficiency loss. Therefore, in the following section, one method of measuring this loss is presented. Although only an

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[8] George Daly and Thomas Mayor, "Estimating the Value of a Missing Market: The Economics of Directory Assistance," August, 1978, p. 27.

[9] Daly and Mayor, p. 26.

approximation, the measurement can fulfill the initial needs in looking for one more input in making an accurate choice for a national health care program.

Section III

As is apparent in the previous chapter, recognition of efficiency losses often has a profound effect on how the market is dealt with in the future. Estimates of losses associated with various subsidies may produce second thoughts about pending proposals or alternative approaches to the situation. The possibility of such actions clarifies the necessity for determination of likely losses in the national health care market.

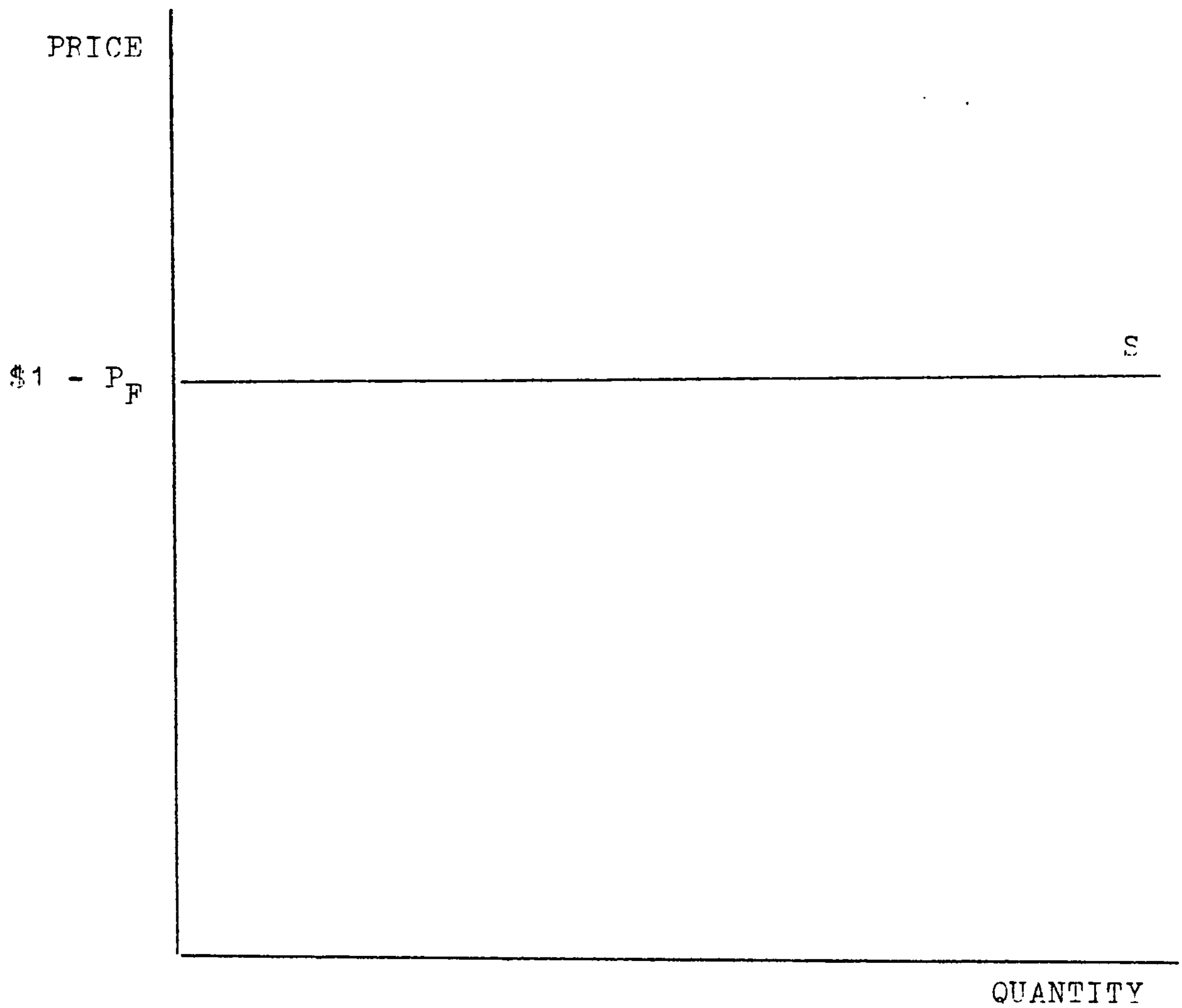
Surprisingly enough, this necessity has not provoked a response in the form of a concrete measurement. Several reasons for this apparent apathy are available, but none are suitable as an explanation for the lack of approximations. It is to this end that the author has set his sights. Several biases are discounted and several assumptions are made, producing reasonable estimates that give some idea as to the nature of these losses.

The method used to obtain these approximations is closely related to the graphical interpretation of subsidy losses in Section II. In that section, an area was produced representing the losses due to subsidization, triangle (1)(2)(3) in Figure 1 and triangle CDE in Figure 2. Following the same idea, the area representing the efficiency losses that result from national health care subsidization is determined in this section.

To measure this area, as in Section II, various parameters are necessary to construct the relevant demand and supply curves. Prior to this, a unit of measurement is needed for the price and quantity axis. There is little to restrict this selection, as long as the choice is consistently applied to all points in the graph and the result of a specific price and quantity combination is the sales for a given year. In an effort to remove some of the complexity of the measurement, the price is established at $1. With this as a full price, quantity at the dollar unit of medical services should supply the aforementioned sales point. Another assumption states that the health care supply curve is infinitely elastic; in other words, unlimited services are supplied at one particular price. The proposition is defended on the basis of long run supply responses to shifts in demand. In such responses, little price change occurs. As a result, variations in the supply curve slope have only minor effects on the loss total as shown in Chart I in the appendix. The supply curve is illustrated in Figure 3, labelled S, with its vertical height at the normalized full price of $1.

To develop the demand curve for health care, certain specifics of its market are necessarily included. These specifics give the demand curve a unique shape. One, the necessity of health care for survival of certain recipients, keeps demand fairly high even at high prices. This trait is

FIGURE 3



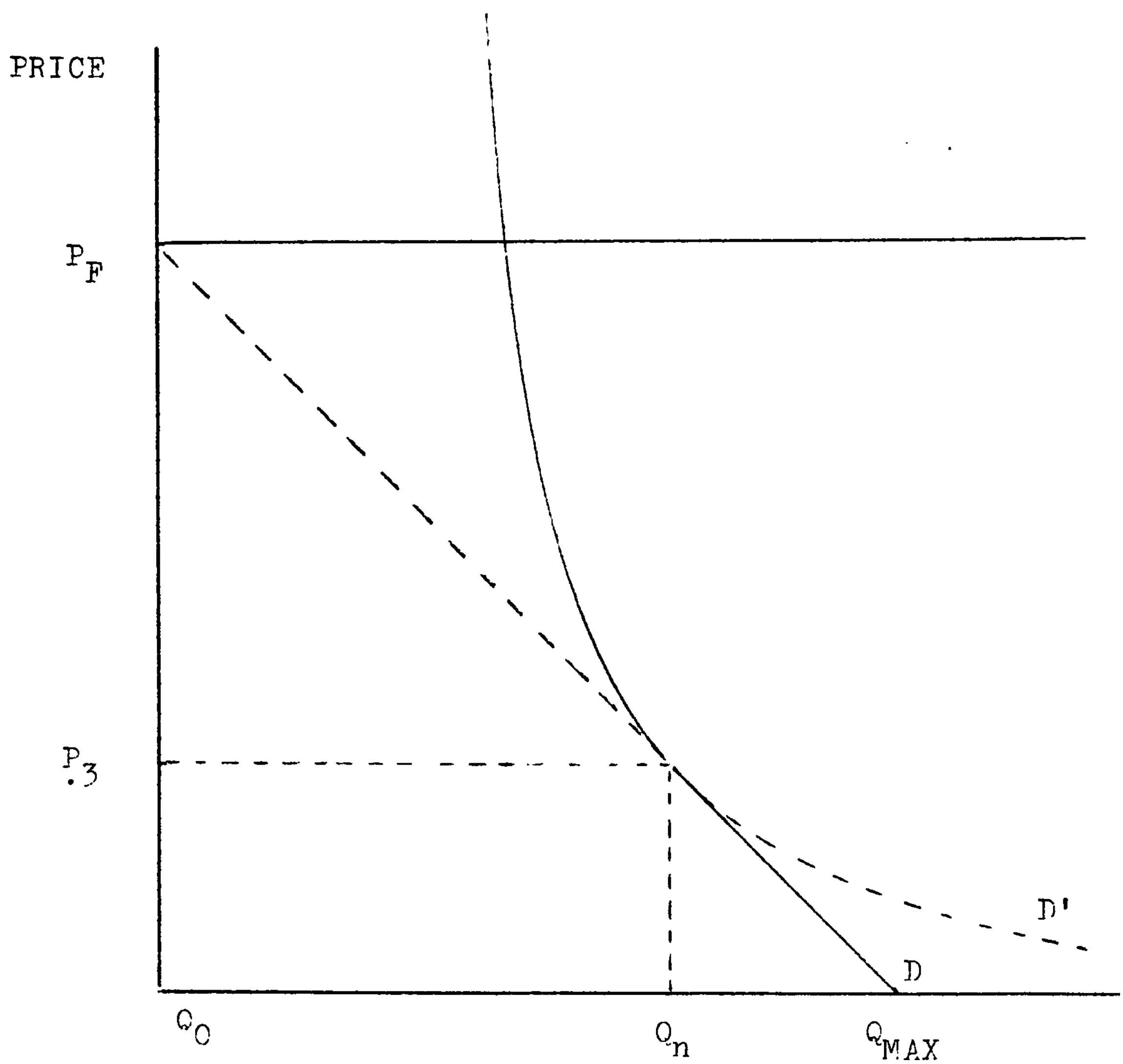
easily represented by use of a constant elasticity curve; therefore, the demand curve is represented by it in the lower quantity range. An example of this is a solid line between Q_o and Q_n in Figure 4.

Another specific is the unavoidable time cost associated with receiving health care. This is one of the more important factors in limiting the demand for health care as the price approaches zero. The resultant maximum quantity, in itself, negates the possiblity of a constant elasticity demand curve over the whole range of quantities in the health care market. It does suggest, however, an approximate linear shape for the curve in the range of large quantities; therefore, this shape is used for the demand curve from Q_n to Q_{MAX}. The solid line in Figure 4 over this range exemplifies this portion of the demand curve for health care.

This approximation completes the shape of the demand curve; however, various other specifics demand attention. At what point do the two components meet? What is the slope of the linear portion? What is the elasticity of the constant elasticity portion? At what point do the supply and demand curves meet? What is the maximum quantity, Q_{MAX}, demanded?

These questions are answered with results from various studies and surveys. "Age Differences in Health Care Spending, Fiscal Year 1977," Social Security Bulletin, January 1979, provides both the sales for 1977 and information to derive the national co-insurance average. Sales in 1977

FIGURE 4

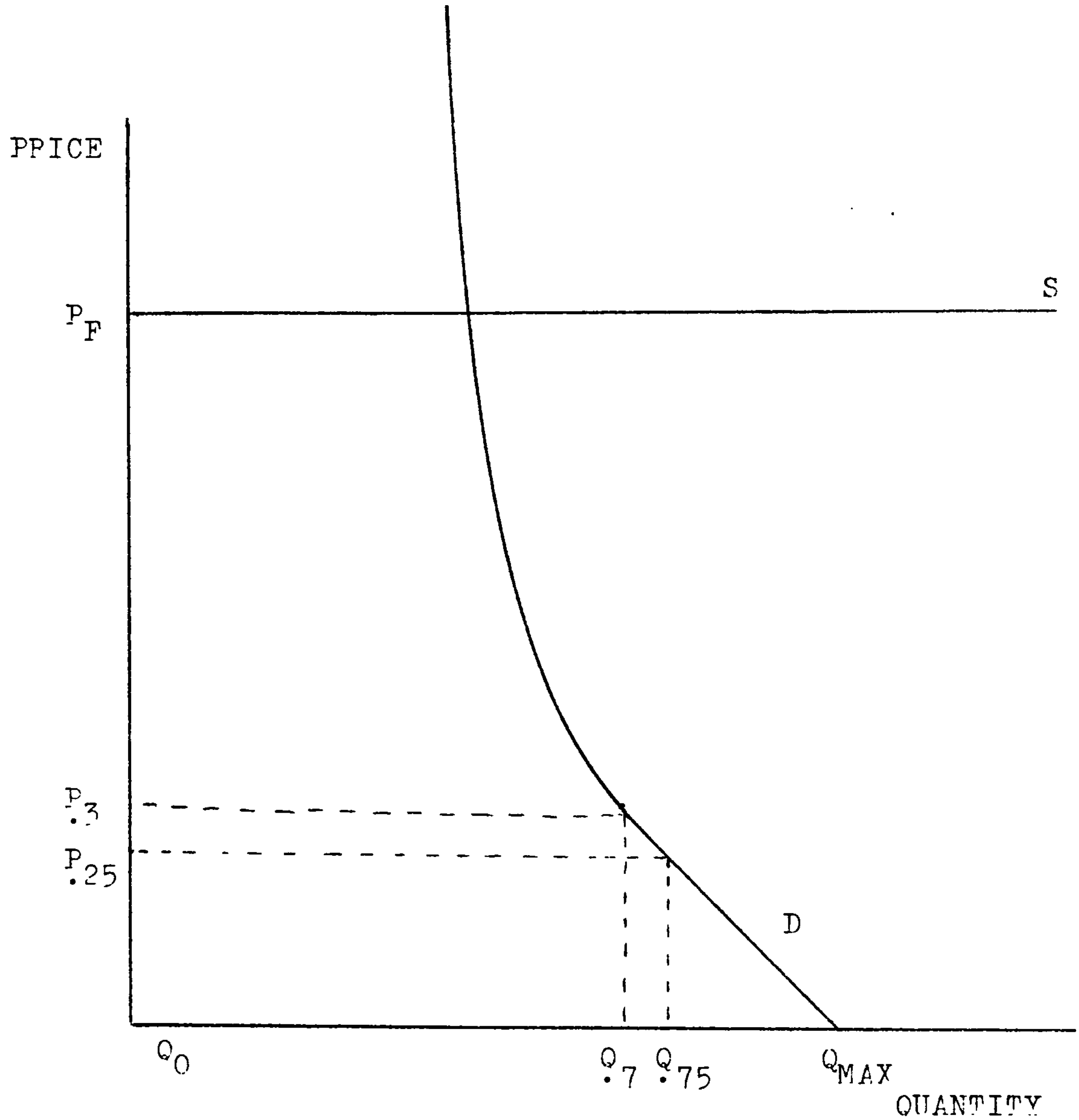


in the national health care market were nearly $143 billion. When this figure is combined with the average national coinsurance rate of thirty percent (direct payments ÷ total payments), the point on the demand curve with price $.3 and quantity 142,586 million is determined. It is shown in Figure 5 as point A.

In another study, "The Effects of Coinsurance on Demand for Physician's Services," by Charles E. Phelps and Joseph P. Newhouse, it is shown that a change from zero to twenty-five percent coinsurance will decrease demand by twenty-five percent. This result determines the slope of the linear portion of the demand schedule. If the relationship found by Phelps and Newhouse is continuous near the substantiated points, the sales for 1977 is at the point on the demand curve where thirty percent of the price brings about seventy percent of the quantity. Since the study has shown that P = $.3 and Q = 142,586 million in 1977, it is possible to find the maximum quantity, which is 204 billion, and the slope of the linear segment, which is -4.91×10^{12}. The result of these conclusions is an approximate function for the linear portion of the demand curve, $P = (-4.91 \times 10^{12})Q + 1$. It is applied to the range from $Q_{.7}$ to Q_{MAX}. This is slightly beyond the substantiated range given by Phelps and Newhouse, but its simplification of the loss measurement greatly outweighs the minor changes it brings in the results.

Although losses from Q_0 to $Q_{.7}$ are, so to speak, water

FIGURE 5



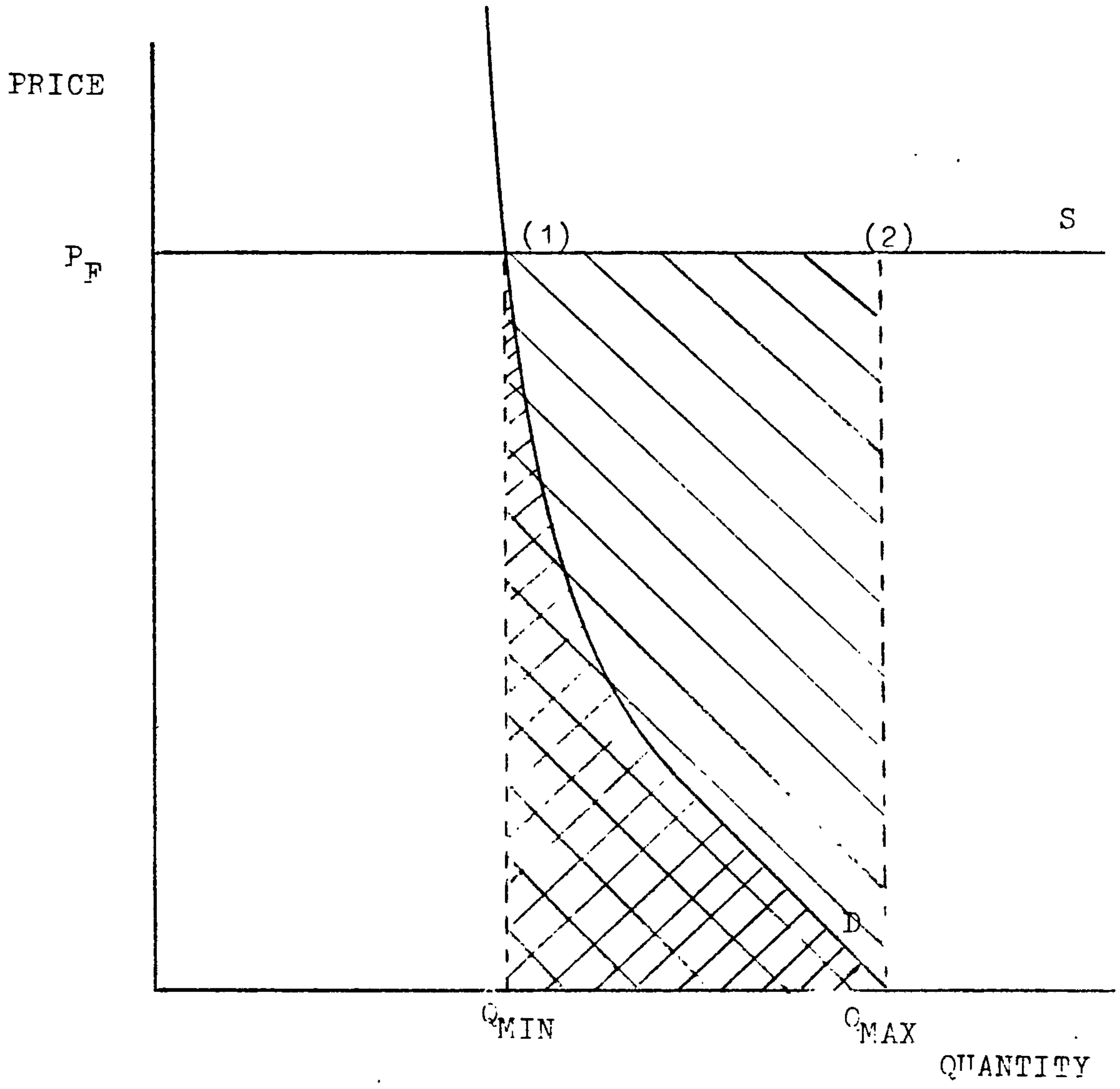
under the bridge, comparision of new losses with losses that have occurred may provide valuable information. The study of the total loss may also provide useful data. Therefore, these losses are also determined.

As suggested earlier, the demand curve at higher prices is characterized by a constant elasticity. The function $P = B^{1/n}Q^{-1/n}$, with n representing that elasticity, defines the appropriate curve. B represents the constant that will take the curve through a given point; therefore, if $B = 1.295 \times 10^{11}$, the curve will go through point A ($Q_{.2}$, \$.3) in Figure 5. This is, of course, dependent upon the elasticity that is chosen. Results from "Coinsurance and the Demand for Medical Services," by Joseph P. Newhouse and Charles E. Phelps, suggests n = .08 as the most suitable choice. Although restrictions set forth by Phelps and Newhouse do not suggest its application in the market above a twenty-five percent coinsurance rate, the figure should suffice in these approximations. With this elasticity, the curve from Q_o to Q_7 is defined as $P = (1.295 \times 10^{11})^{12.5}Q^{-12.5}$ and is shown in Figure 5 as the solid line from Q_o to $Q_{.7}$.

The point where demand equals supply is all that remains in defining the area of the loss. This is determined by putting P = \$1 into the constant elasticity equation and solving for Q. The result is $Q_{MIN} = 1.295 \times 10^{11}$. With this, the necessary specifics for determination of the efficiency loss are provided.

Use of integration is the simplest method for determining the area of loss. The range for this integration is Q_{MIN} to Q_{MAX}. The reason for this range is the lack of market for quantities greater than Q_{MAX} and the lack of possible subsidy losses for quantities smaller than Q_{MIN}. The area under the demand curve from Q_{MIN} to Q_{MAX} is determined by integration of the linear curve from $Q_{.7}$ to Q_{MAX} and by integration of the constant elasticity curve from Q_{MIN} to $Q_{.7}$. The resultant area is shown in Figure 6 as the space bounded by the line segment from (1) to Q_{MIN} on one side, by the curve from (1) to Q_{MAX} on the other side, and by the line segment from Q_{MIN} to Q_{MAX} on the remaining side. It represents the benefits obtained from consuming Q_{MIN} to Q_{MAX} of the good. The area under the supply curve from Q_{MIN} to Q_{MAX} is obtained by integrating the supply curve function $P = 1$ over this range. The result is the rectangle Q_{MIN} (1)(2) Q_{MAX} shown in Figure 6, representing the costs incurred in producing Q_{MIN} to Q_{MAX}. The difference between the two areas, the compliment of the intersection in Figure 6, is the loss that occurs from total subsidization. Since the area under the demand curve from Q_{MIN} to Q_{MAX} is \$16.7 billion and the area under the supply curve over the same range is \$74.2 billion, the area of loss is \$57.5 billion per year. This is the dollar figure of efficiency losses due to total subsidization of the health care market under 1977 figures. It is an increase of \$52 billion P.Y. over existing efficiency losses in 1977.

FIGURE 6



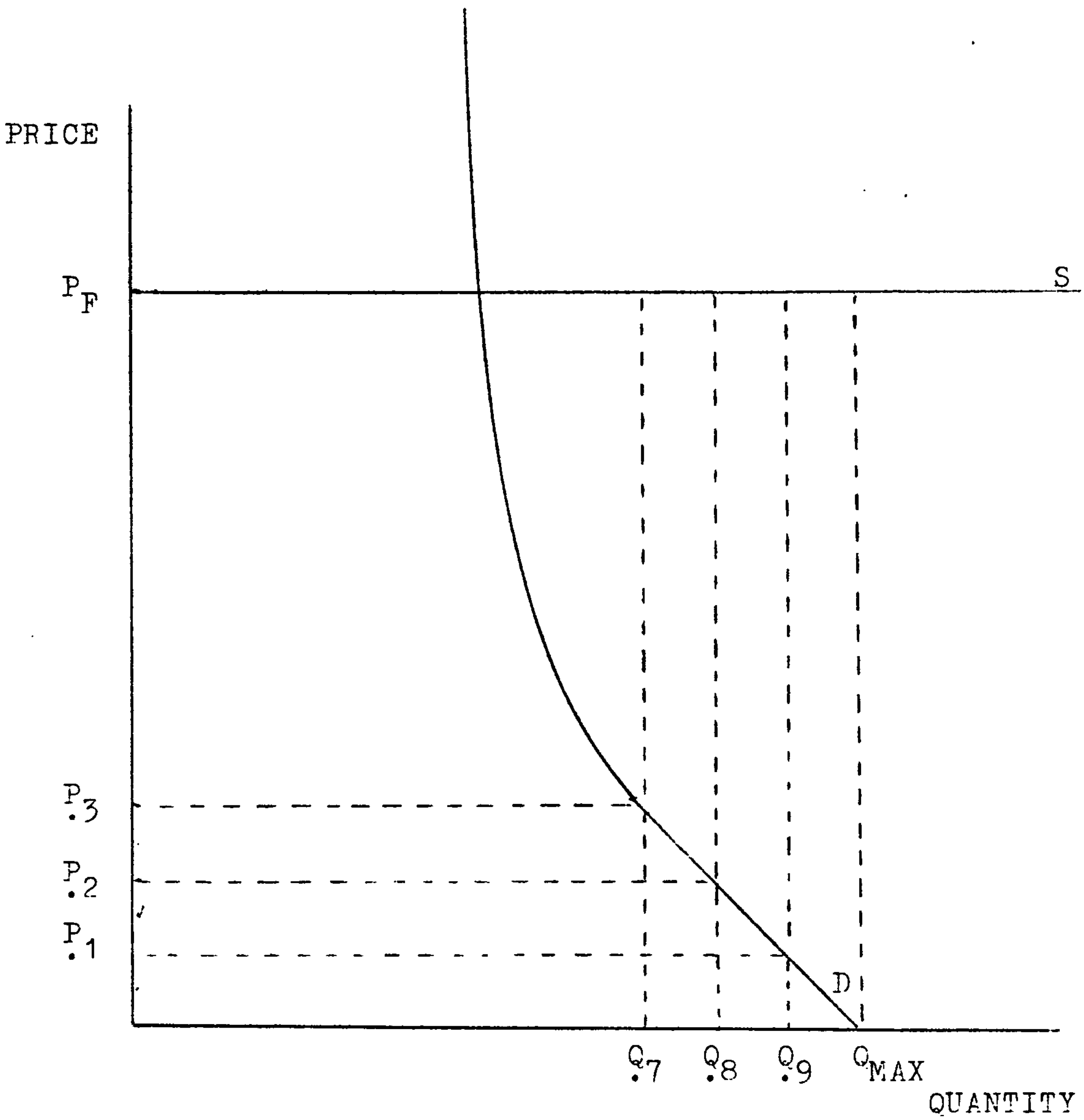
Section IV

The results in Section III defined the efficiency losses in health care due to total subsidization, a market situation much like that found in Britian today. Measurements of these losses at other subsidization levels is necessary, since all proposals do not suggest this total approach.

Establishing these losses of various coinsurance rates requires an adjustment of the range over which the loss is analyzed, as is seen in Figure 7. With this adjustment, the derivation of the loss for each subsidization rate follows the same pattern as that used in Section III. Chart II gives a breakdown of these losses in five percent intervals from zero to thirty percent coinsurance rates or seventy to one hundred percent subsidization.

Although the results stated in Chart II were the best possible measurements at this time, certain biases make the results, at best, an approximation. It is felt that these approximations need little supportive evidence against criticisms due to data bias, since the results of the measurements respond only slightly to small variations in the inputs, as is shown with several charts in the appendix. A quick review of the bias, however, does serve as an indication of the necessary changes in data collection or the necessary adjustments in the efficiency loss quantifications needed to produce a more exacting measurement.

FIGURE 7



Two biases resulting from data collection have to do with the limited availability of information on the effects of coinsurance rate changes on demand. The determination of the demand curve relies on material that was taken in a relatively small region over a relatively short period of time. If the region or the time period has peculiarities that cause it to vary from the national average, a bias will appear in the final measurement. The effect is avoidable if the variance is determined and allowed for or if the national averages of the various inputs are derived.

Some other areas of bias deal with the effects of insurance. Self-selection by insurance purchasers may result in national sales exceeding expected values for a given national coinsurance rate. Determination of a national coinsurance average in itself is susceptible to bias if there is a peculiar distribution of coinsurance rates for the population. In order to deal with any resultant variation, a proper adjustment of the sales-coinsurance rate relationship will suffice.

Another bias is an income effect from tax increases used to finance the national health care bill. The drop in income will slightly decrease demand if taxation foots the bill, but the fall is relatively insignificant since national health care makes up less than 10 percent of the gross national product. Adjustments are still possible, however, to avoid any effect on the final measurement.

Without avoidance of this effect or the others, a possible variation in the final measurement is conceivable. This variation, however, is still small enough to consider the approximations valid. Thus, the loss measurements in Chart II present a fairly accurate picture of the possible results inherent in the numerous proposals before Congress at this time.

Conclusion

The study has revealed a significant result of any subsidization in the national health care market. The range of losses is from $5.5 billion to $57.5 billion, so the choice of a national health insurance system is very important. As in any market, the costs of insuring an individual's right to health care must be weighed against the costs of implementing a national health care proposal. The inclusion of the efficiency loss is imperative in this comparison. Without it, the public may get a much larger program than they really desire.

At present, this feared negligence is occurring. The lack of work in this area reflects the concern of the researchers for this possible effect; it is non-existent. Hopefully, this study will initiate a proper investigation into the important effect of national health insurance proposals.

Appendix

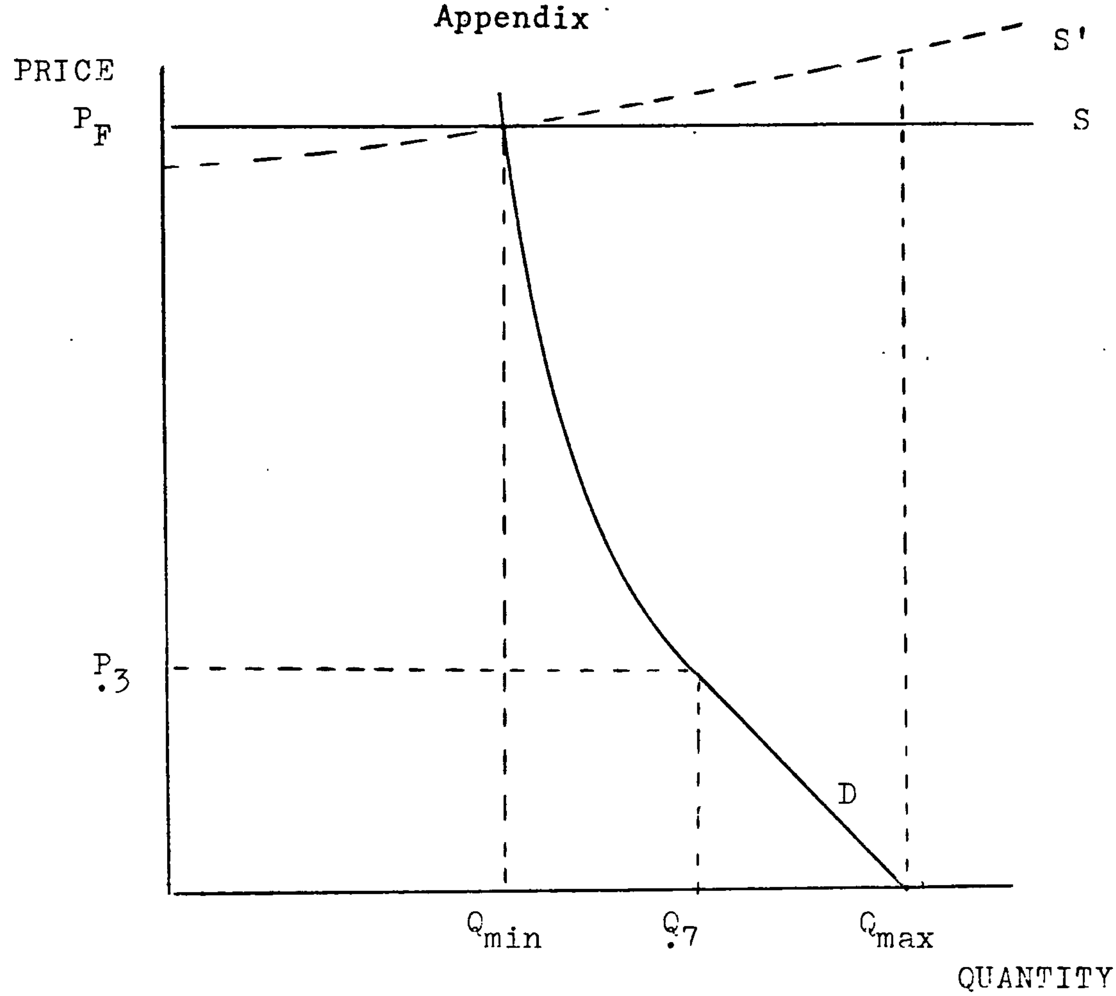


Chart 1 - This chart shows the sensitivity of measurements of the efficiency loss to changes in the assumption that the supply curve is perfectly elastic. The graph to the right exemplifies the results of these variations.

Elasticity	Loss Total	Loss Increase	% Increase
∞	\$74.2 billion[10]	0	0 %
1000	\$74.22 billion	\$20 million	.03%
100	\$74.38 billion	\$180 million	.24%
10	\$76.04 billion	\$1.84 billion	2.48%
8	\$76.5 billion	\$2.3 billion	3.1 %
6	\$77.29 billion	\$3.09 billion	4.16%
4	\$78.9 billion	\$4.7 billion	6.33%
2	\$83.98 billion	\$9.78 billion	13.2 %
1	\$95.46 billion	\$21.26 billion	28.65%

[10] All figures in the appendix are given at a per year basis

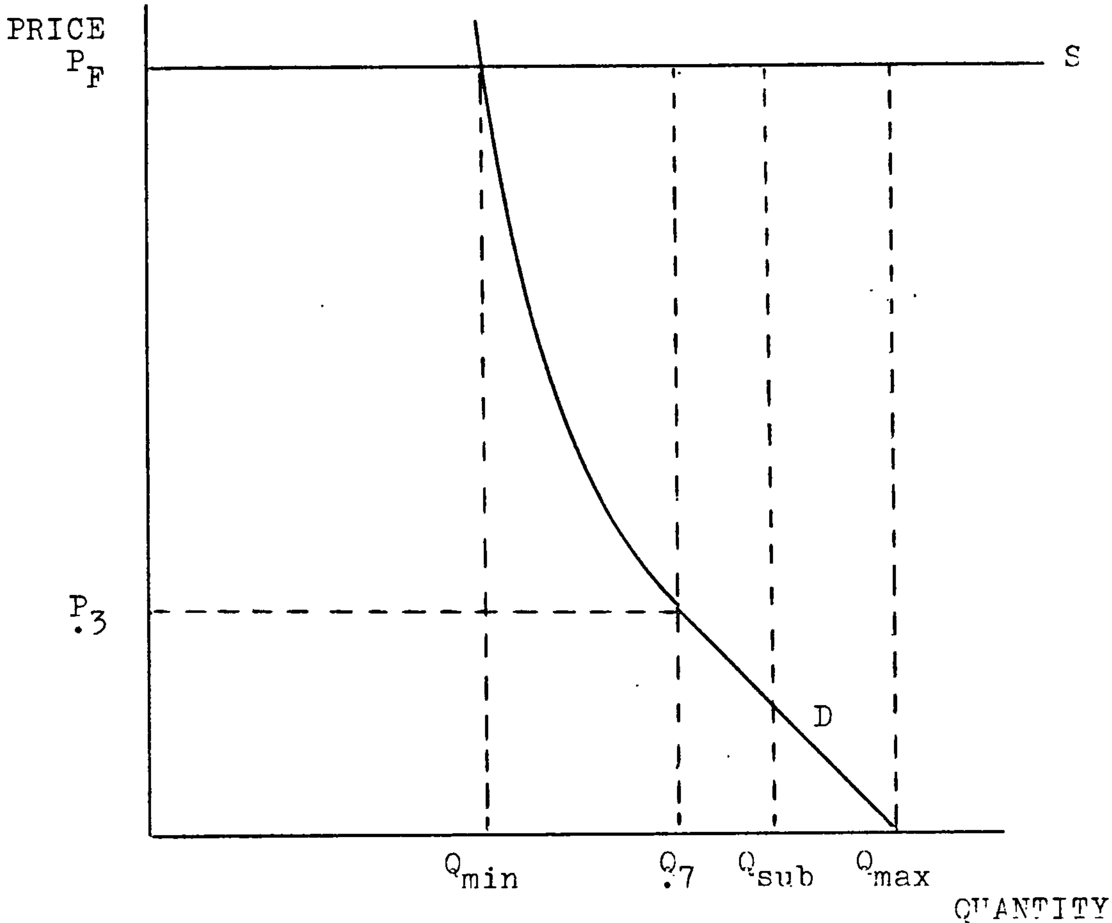


Chart 2 - This chart gives a breakdown of the possible efficiency losses at various subsidies. It is only given over the range from zero to thirty percent coinsurance rates, since the present national rate is thirty percent.

Subsidy	Quantity Demanded	Total Loss	New Loss
100%	203.7 billion	$57.5 billion	$51.95 billion
95%	193.5 billion	$47.56 billion	$42.01 billion
90%	183.3 billion	$38.13 billion	$32.58 billion
85%	173.1 billion	$29.20 billion	$23.65 billion
80%	163.0 billion	$20.87 billion	$15.32 billion
75%	152.8 billion	$12.96 billion	$7.413 billion
70%	142.6 billion	$ 5.55 billion	$ 0

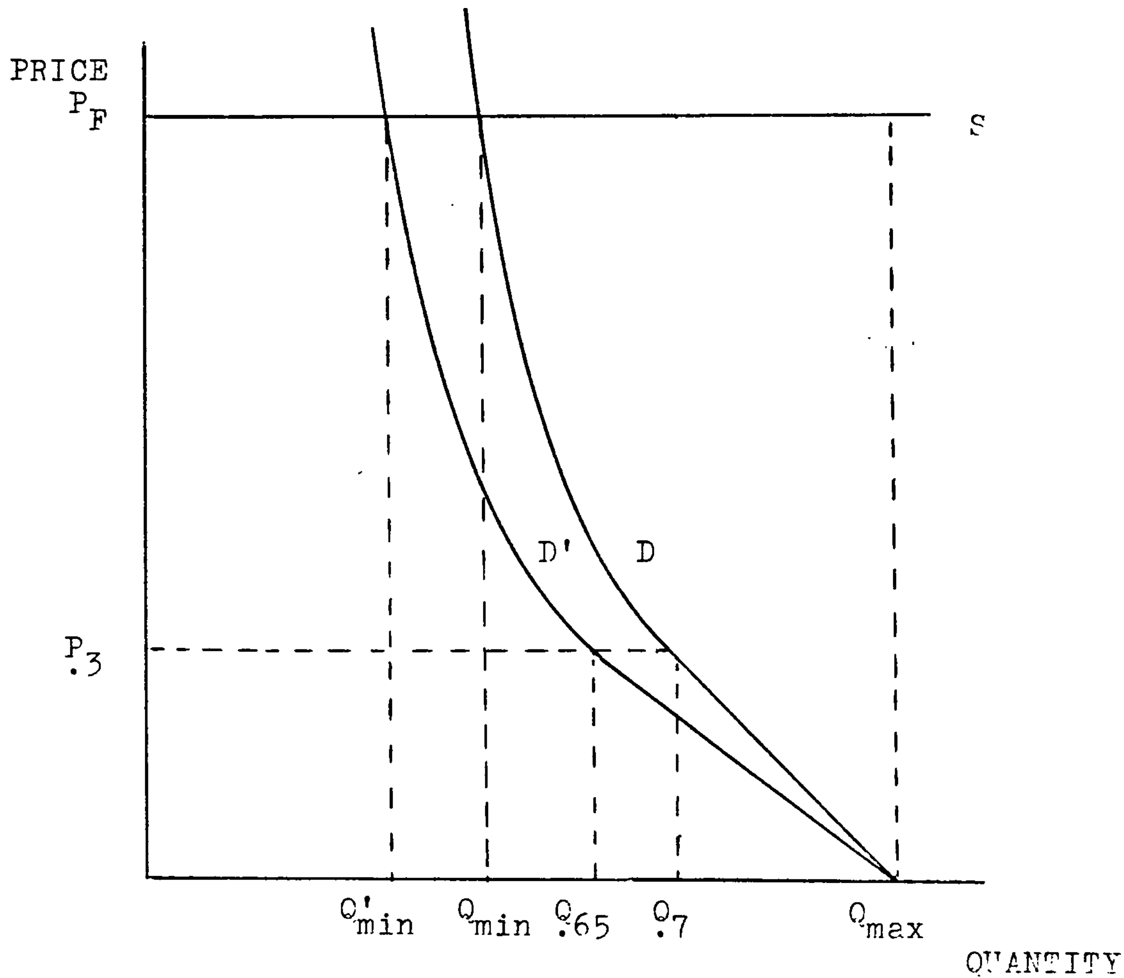


Chart 3 - This chart shows the sensitivity of the efficiency loss measurement to variations in the linear slope assumption. The loss over the constant elasticity range remains the same.

If a 30% increase in price induces a	m = Slope	Maximum Loss
35% decrease in Q	-4.208×10^{-12}	\$55.97 billion
34% decrease in Q	-4.329×10^{-12}	\$56.27 billion
32% decrease in Q	-4.601×10^{-12}	\$56.89 billion
30% decrease in Q	-4.908×10^{-12}	\$57.44 billion
28% decrease in Q	-5.263×10^{-12}	\$58.13 billion
26% decrease in Q	-5.66×10^{-12}	\$58.69 billion
25% decrease in Q	-5.894×10^{-12}	\$59.66 billion

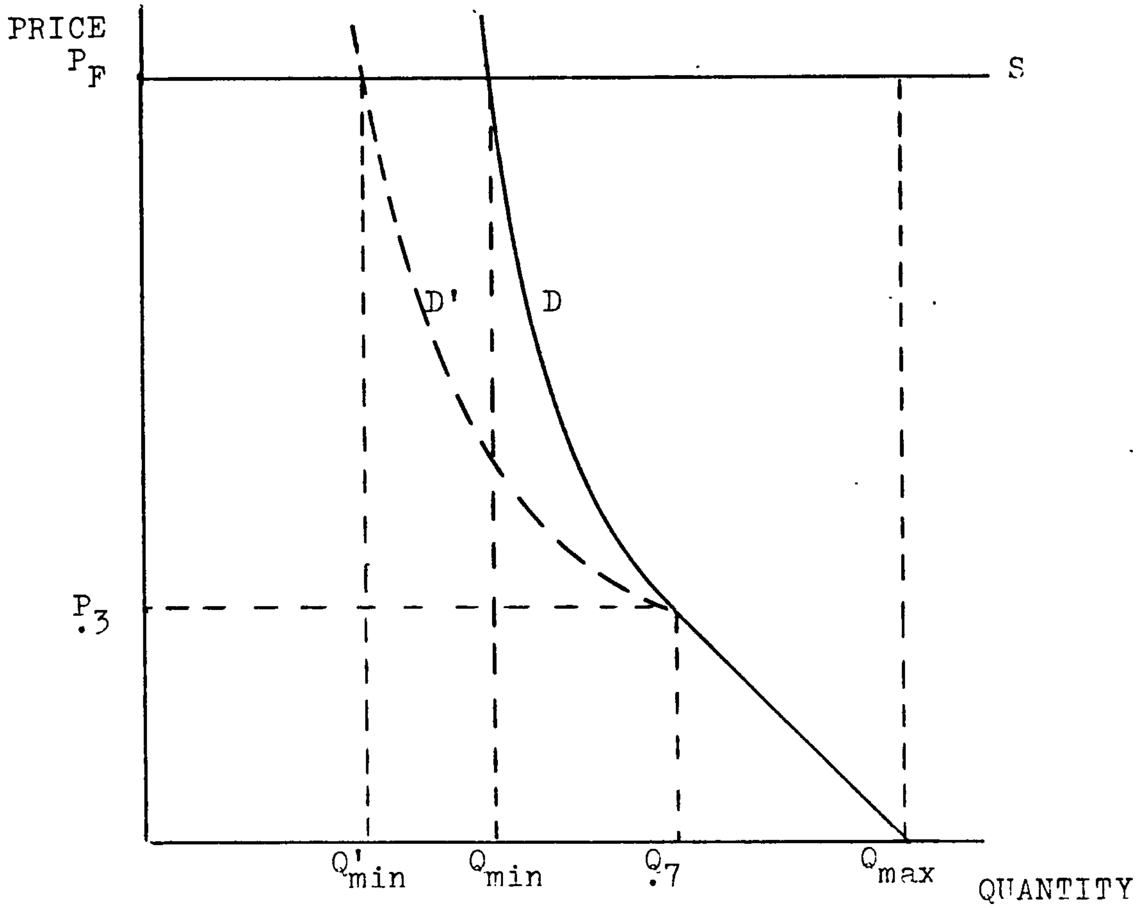


Chart 4 - This chart presents various possible elasticities for the constant elasticity portion of the demand curve, showing the responsiveness of the efficiency loss variation to these changes. The loss over the linear portion is not altered.

Elasticity	Loss Over Constant	Increase in Sales
.05	$3.484 billion	$-2.063 billion
.08	$5.547 billion	$ 0
.10	$6.442 billion	$ 895 million
.25	$16.16 billion	$10.61 billion
.50	$29.17 billion	$23.62 billion
.75	$39.69 billion	$34.14 billion
1.00	$47.80 billion	$42.25 billion
2.00	$69.88 billion	$64.33 billion

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