BIPARTISAN POLICY CENTER

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TO
THE UNITED STATES SENATE COMMITTEE ON FINANCE
JUNE 19, 2012

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for inviting us to testify on the comprehensive budget plan that the Bipartisan Policy Center's (BPC) Debt Reduction Task Force, which we co-chair, has developed.

The testimony we have submitted summarizes more than two years of deliberation by a nineteen-member Task Force representing a diverse cross-section of the nation from different sectors of the economy and with differing political views. It included former senior policy makers, ranging from former mayors of large cities to former governors of both parties, former Cabinet secretaries representing both parties, budget experts, and persons with backgrounds in business and labor.

As we have testified several times during the past two years before various congressional committees, the United States continues to face two monumental challenges. Both are more critical than ever, as we see mounting tension in the global economy, highlighted by the financial challenges confronting Europe.

First, the United States must accelerate economic growth and job creation. The recovery continues to be anemic, especially compared to recoveries from past recessions. We recognize the need for additional growth-enhancing policies to accelerate the economy's return to health and put people back to work.

Second, federal deficits and accumulating debt must be stabilized so that our national indebtedness grows more slowly than future gross domestic product (GDP). Our ratio of debt to GDP is too high and must come down to a less-risky level.

These objectives reinforce each other. Faster growth will reduce deficits, and stabilizing the debt will cut future interest rates, reduce uncertainty, and enhance domestic economic growth. The Senate Finance Committee, with its wide-ranging jurisdiction, will be a key player in addressing both imperatives.

We recognize three realities: discretionary spending through the appropriations process has already been cut approximately to the levels recommended by the BPC plan; no progress has been made on the critical tax and entitlement reform elements of our plan; and, in less than six months, Congress and the American people will face a very serious economic blow, which Fed Chairman Ben Bernanke has characterized as "the fiscal cliff."

Let us look more closely at each of those realities.

The levels for discretionary defense and domestic spending set by the Budget Control Act of 2011, before any action triggered by the looming sequester in January, 2013, are approximately what our Task Force recommended. In short, we believe that further significant cuts in discretionary spending will do little to improve long run fiscal sustainability and risk harming investment, recovery, and future growth. So far, Congress has imposed virtually 100 percent of deficit reduction on less than 37 percent of the budget.

The main drivers of future deficits and debt remain, as they have been for many years now, (a) Medicare, Medicaid, and to a lesser extent Social Security, all of which are within the jurisdiction of this committee, and (b) revenues, also within this committee's purview. We are heartened by the resolve that the leadership of this committee has shown in setting out a path to address fundamental reform in both areas. We hope that our Task Force recommendations prove useful to the committee

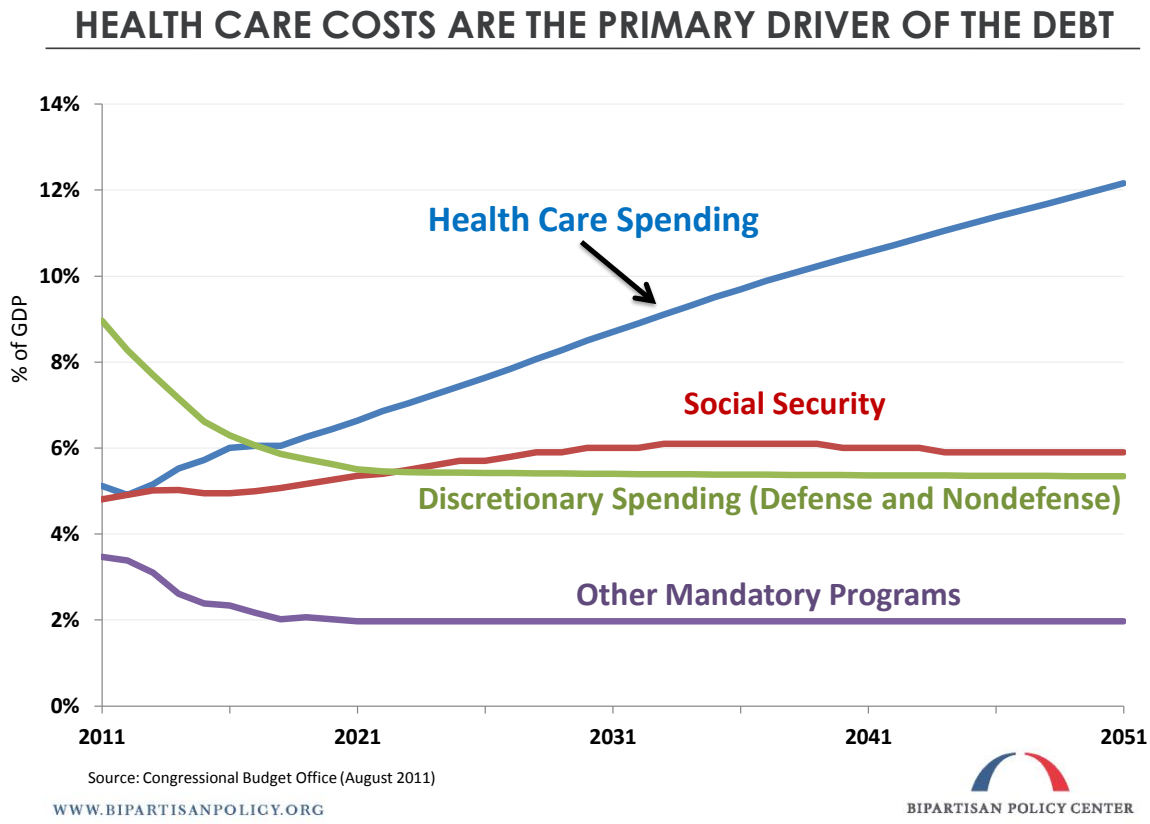
as it tackles these difficult questions. We believe strongly that without fundamental reform in the tax code and in future entitlement benefits, America cannot avoid continuing the steady increase of our federal debt toward 100 percent of GDP in the next decade and 200 percent of GDP a decade later. These are clearly unsustainable levels and normally associated with serious economic and financial difficulties for any nation that strays so far from fiscal responsibility.

Fundamental Health Care Reform

The fundamental problem to be addressed by this committee is that federal spending is both greater and projected to rise faster than revenues for the foreseeable future, leaving a widening gap to be financed by borrowing. The primary drivers of increased spending are the health care programs, including Medicare, Medicaid, and the subsidies to be provided by the Affordable Care Act (ACA). Huge projected increases in the number of older people and persistent increases in health care spending per person account for this upward pressure on spending. Hence, reducing the rate of growth of these programs is essential to any long run debt stabilization plan. (See Chart)

Spending on mandatory healthcare programs is projected to increase from 23 percent of non-interest federal spending in 2012 to 34 percent by 2021. No other programs conceivably could shrink enough to make budgetary room to accommodate health care's growth.

Rising federal spending on health care is, of course, a part of the more general increase in spending for health care in the economy as a whole. Over time, national health spending has grown about 2 percentage points per year faster than GDP. Health care spending nationally is nearly 17 percent of GDP and rising. The objective of reforming federal health programs should not be to shift federal costs onto the private sector but to use the federal programs to lead the way toward more effective and less wasteful delivery of health care, no matter how that care is paid for.



The Task Force plan includes both demand- and supply-side approaches to slowing the growth in overall health spending and federal spending specifically. Some aspects target the health system in general, while others focus specifically on Medicare and Medicaid.

The major demand-side strategy is to cap and then phase out the tax exclusion of employer-sponsored health insurance (ESI) benefits. This policy will result in more cost-conscious choices by purchasers of health insurance.

Also on the demand side is a proposal to modernize patient cost sharing in the Medicare program. The modernized benefit structure will include a combined annual deductible for Parts A and B, more-uniform cost-sharing, and catastrophic coverage – protection that is sorely lacking today – thereby more closely matching recent trends in private health care plans.

The key supply-side strategy is to reform provider payment incentives. Moving payment away from fee-for-service and toward broader payment units will encourage providers to seek more efficient delivery systems. Health reform – i.e., the ACA – took some very important steps toward reforming provider payments in Medicare. The Task Force proposes to build on this by bundling payments for post-acute care into the payment for inpatient care. Many other options for supply-side reform have received bipartisan support – this committee would be wise to select from some of those as well.

For Medicaid, in the short term, the Task Force proposes to remove barriers to greater use of managed care for those dually eligible for Medicare and Medicaid. For the long term, significant changes to the program are needed – both narrowly-targeted and fundamental reform proposals should be given serious consideration.

Although each of these proposals will have beneficial effects for the national healthcare system and help control federal costs, much of the long-run savings in the Task Force plan will come from transitioning Medicare from limited beneficiary choice to a defined support option. This new system will marshal both demand- and supply-side leverage to transform the national healthcare infrastructure into a more efficient and effective vehicle. As such, the Domenici-Rivlin Protect Medicare Act is the proposal on which we primarily will focus today, details of which can be found below.

Finally, in addition to the health reforms proposed by our Task Force, we plan to collaborate with Senators Tom Daschle and Bill Frist on a complementary project over the course of the coming year. The BPC Health and Debt Joint Project will explore, discuss and analyze various health care cost containment policy options and strategies.

Domenici-Rivlin Protect Medicare Act

(Released November 1, 2011)

(Updated June 15, 2012)

The principal driver of future federal deficits is the rapidly mounting cost of Medicare. The huge growth in the number of eligible seniors over the coming years is due to both increasing life expectancies and the retirement of the baby boomers. Then, that beneficiary growth is multiplied by continuing increases in the cost of health care per enrollee. Without a significant change in this trend, the cost of Medicare will continue to rise faster than the economy can possibly grow. Even if revenues are raised and other spending is restrained (both of which the Bipartisan Policy Center supports), the exploding cost of Medicare is unsustainable.

Simply put, there can be no lasting solution to the U.S. debt crisis without structural changes in the Medicare program to slow its cost growth. This can be accomplished through our proposal to transition Medicare to a "defined support" plan in 2016. Such a system would provide strong incentives to increase the efficiency and effectiveness of health care delivery to seniors, without abolishing current Medicare, or forcing any beneficiary to move to a different plan.

The Domenici-Rivlin defined support proposal would preserve Medicare for future generations. It would allow beneficiaries who wish to stay in traditional Medicare to do so, but also would present them with competing private plans as alternative options. It would restrain the growth in total Medicare spending while protecting low-income beneficiaries from any increases in their cost above current law. In short, the Domenici-Rivlin plan both would preserve Medicare as a choice and also save money by flattening the steeply-rising projected Medicare cost curve.

The Domenici-Rivlin proposal restructures Medicare to achieve fiscal soundness in two ways:

1) New federally-run Medicare exchanges would provide beneficiaries with a truly competitive marketplace in which they can choose among private healthcare plans and traditional fee-for-service (FFS) Medicare. Participating

private plans would be required to accept all applicants and would be prohibited from "cherry picking" the youngest or healthiest seniors. Every private plan would be required to provide benefits that have at least the same actuarial value as FFS Medicare. The plans would have to include a specific base set of services, and the federal support that each plan is provided with would be adjusted for the age and health status of its enrollees. The exchanges would provide understandable information about the costs and quality of plans so that beneficiaries could choose options that are best for them. Beneficiaries would have the opportunity to change plans in an annual open season.

2) Through competitive pricing by all plans, the federal contribution in each market area would be tied to the cost of the second-least expensive approved private plan or FFS Medicare, whichever is less expensive (subject to the two lowest-price plans combined having enough capacity to handle expected enrollment). Thus, the government would no longer have to pay extra to private healthcare plans in areas where the public FFS Medicare plan provides lower-cost coverage, nor would the government have to overpay to provide FFS Medicare in areas where two or more approved private plans offer equivalent care at a lower cost. These competitive enhancements would incentivize healthcare plans to innovate in every facet of their operations and benefit designs — subject to regulations – to keep premiums down and quality of care up.

These two features should significantly curb Medicare costs. We have every confidence that they by themselves would slow the growth of Medicare spending significantly – sufficiently, in fact, to make Medicare's full contribution to overall budget stabilization that we prescribe in the complete BPC debt-reduction plan.

However, the savings from competition are very difficult to prove to the satisfaction of the scorekeepers who must estimate the impact of budget legislation on deficits. So, to provide verifiable budget savings – which, to repeat, we do not believe will prove necessary in actual operation – the Protect Medicare Act also would cap the increase in the federal contribution per beneficiary. The new

legislation would strengthen the enforcement mechanism for the cap on Medicare growth that was introduced in the Patient Protection and Affordable Care Act (PPACA). For Parts A, B, and D of Medicare combined, the cap would continue to limit the cumulative annual growth in per-beneficiary federal support to one percentage point faster than the per capita growth of the economy – "GDP+1%" – although, under current law, costs are projected to grow more slowly than that rate, on average, for the next two decades. However, if costs rise faster than the established limit and the Independent Payment Advisory Board's (IPAB) reforms are inadequate, Medicare beneficiaries with incomes above 150 percent of the federal poverty level (FPL) would pay higher premiums. (Those with incomes below 135 percent of the FPL would continue to receive zero-cost coverage paid for by Medicaid, and enrollees with incomes between 135 and 150 percent of the FPL would be protected from any premium increases.) Additionally, to smooth the transition to the defined support system, current beneficiaries with incomes below 150 percent of the FPL would be guaranteed access to either traditional Medicare or a private plan of the same cost – at their choice – with no additional premiums. This "hold harmless" provision would phase out at higher income levels.

How the Exchanges Work

In each regional market – be it a metropolitan area, or a multi-county rural area – each private healthcare plan and traditional FFS Medicare would submit its price to provide a benefit package equal in actuarial value to that of FFS Medicare for Parts A and B, including a specific base set of services, to a standard (average-risk) beneficiary for a year. The FFS "price" would be based on average FFS Medicare costs for the same standard beneficiary in the market area. The amount that the government contributes to premiums in that region would then be based on the second-lowest private plan price or FFS Medicare's price, whichever is lower (subject to the two lowest-price plans combined having enough capacity to handle expected enrollment). This would be referred to as the "benchmark" price.

Beneficiaries who choose to enroll in a plan that is more expensive than the benchmark – even if that plan is FFS Medicare – would be required to pay the

incremental additional cost. A beneficiary who enrolls in the plan with the lowest price would be rebated the full difference in cost from the benchmark. Private plans also could offer additional products with expanded benefits (as they do now), subject to review concerning the premiums having an appropriate relationship to their price for a plan with standard benefits.

The exchanges would be federally run (either by the Centers for Medicare and Medicaid Services (CMS) or a separate entity), require guaranteed issue and community rating (under which insurers must offer coverage to every senior in the geographic area for the same price, regardless of age, gender, or health status), and enforce guidelines for the structure of the benefit package. The exchanges also would utilize a risk-adjustment mechanism to distribute the government subsidy among insurers according to the age and health status of those whom they enroll. Methods used in Medicare Advantage (MA) would be a starting point, but efforts to develop tools that do this more effectively should be ongoing.

The MA risk adjustment is the most sophisticated method in use, but it is not perfect. To further mitigate adverse selection by private plans, the Domenici-Rivlin proposal would require all plans on an exchange to offer a specific core set of benefits and have an actuarial value at least as high as traditional Medicare's. This would preclude the possibility of "bare-bones" plans attracting healthier people in ways not fully offset by the risk adjustment. Moreover, the federal government would enforce rules on plans' reserves for solvency, accuracy of promotional materials, and network adequacy. The administrating agency also would be able to block benefit designs that it deems likely to disproportionately attract healthy people – just as the Office of Personnel Management (OPM) does for the Federal Employees Health Benefits (FEHB) program.

Why is this proposal an improvement over the current Medicare system?

Currently, Medicare benefits are predominantly delivered through the traditional fee-for-service plan, which allows patients to see nearly any doctor they choose so long as that doctor accepts Medicare's payment rates. Because FFS pays separately

for each service, providers have an incentive to provide more services, driving up program costs. This is a significant issue for traditional Medicare.

Medicare FFS has some promising pilots to reform provider payment under way, such as Accountable Care Organizations, per-episode payment, and patient-centered medical homes. Because the traditional program continues under this proposal, success from initiatives such as these will be influential in determining future market shares of FFS and private plans.

Medicare also offers private Medicare Advantage plans, which receive a fixed monthly payment from the government to care for each enrollee. MA plans, therefore, have a strong incentive to work with doctors and hospitals to manage care efficiently. Although this incentive structure helps to mitigate the overtreatment (i.e., "paying for quantity") problem faced by FFS, the current MA system has certain structural flaws.

Most significant is that MA uses administered pricing rather than competitive pricing to set the amount of government support. As the result of years of changes in the pricing formula, MA plans, in the aggregate, were paid more than FFS Medicare. When administered prices are high, incentives for plans to become more efficient are reduced. PPACA phased out much of this overpayment, but many private plans continue to be paid more than FFS Medicare. Another flaw is that MA plans with premiums below the level of this support are currently taxed between 25 and 50 percent on any rebate that they offer to beneficiaries. Taxing low prices discourages the plans from offering them.

Instead, the new Medicare exchange would utilize a competitive pricing process, and would present information on the various plan offerings in a clear, concise manner. Setting the federal contribution at the cost of the second-least-expensive health plan or FFS in an area also would increase the connection between the price charged and enrollment. By increasing the reward for a low price, the defined support system provides strong incentives for healthcare plans to manage care delivery efficiently, innovate in their benefit designs, and to offer evidence to the public that they achieve quality outcomes at low cost.

The Congressional Budget Office, in a 2006 report, hypothesized that competitive pricing as structured in the Protect Medicare Act could lead private health plans, on average, to lower their current prices by 5 percent, which would greatly increase the savings and effectiveness of this proposal.

While MA plans are paid more than the cost of FFS Medicare in some areas, in other regions, even if multiple private plans are able to provide the same services as FFS for less money, the government still must contribute the full cost of the public FFS plan. Moreover, in these areas where FFS Medicare is relatively costly, beneficiaries who enroll in private plans receive a host of free supplementary benefits or generous rebates, financed by the government. There is no policy justification for selectively offering free, government-financed supplementary benefits to beneficiaries in some geographic regions but not others.

The Protect Medicare Act would change this. The government would no longer have to pay extra to private healthcare plans in areas where FFS Medicare provides lower-cost coverage, nor would they have to overpay to provide FFS Medicare in areas where approved private plans offer equivalent care at a lower cost. The new system would create a level playing field for competition between FFS Medicare and private plans. The efficiencies produced would save money and improve care for enrollees. This change alone, even after providing transitional support to many beneficiaries and without accounting for any dynamic effects such as those hypothesized by CBO, would save the government roughly $20 billion in its first year of implementation and around $300 billion over ten years.

Currently in some parts of the country, at least two private healthcare plans are less expensive than FFS Medicare and the quality of care is as good.[1] In other parts of the country, FFS is cheaper. Despite the common refrain that traditional Medicare is significantly less expensive than private plans, according to MedPAC's 2011 Data Book, on an apples-to-apples basis, the private plans serving Medicare patients provide the entitlement benefit package for exactly the same cost as the traditional program. More specifically, the HMOs participating in MA, which have

[1] Robert H. Miller and Harold S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997–2001," *Health Affairs* 21, no. 4 (July/August 2002): 63–86.

by far the largest MA enrollment, provide equivalent coverage for 97 percent of the cost of traditional Medicare. Moreover, approximately 88 percent of beneficiaries live in regions where two or more private plans offer the Medicare benefit for less than FFS, according to a recent analysis by Robert Coulam, Roger Feldman, and Bryan Dowd based on CMS data.

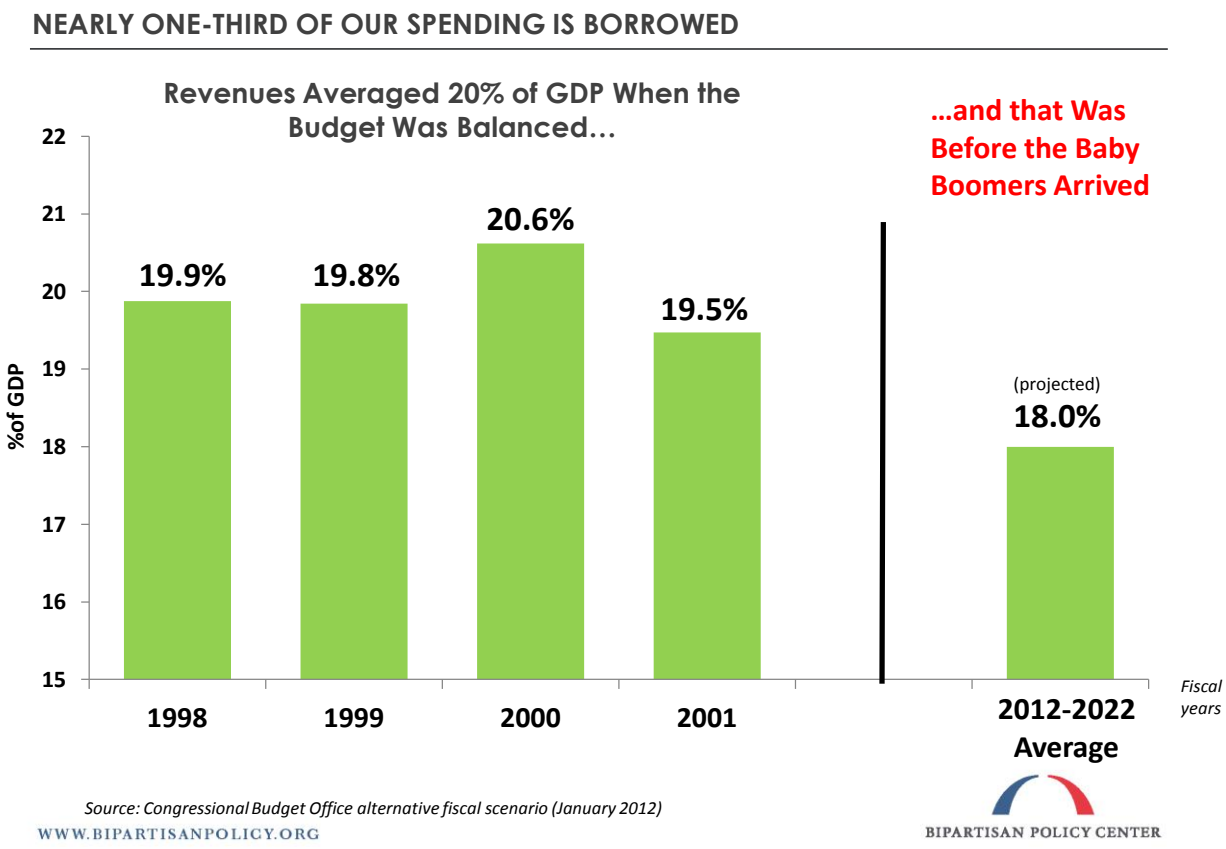
While changes made to the traditional FFS plan in PPACA plus further reforms would likely make it even more competitive, the fact remains that private plans are the least expensive in some geographic areas and FFS is the least expensive in others. In such a hybrid public-private Medicare system, the Protect Medicare Act ensures that taxpayers get the best value per dollar.

Estimated cumulative savings from CBO's Current Law baseline in billions of dollars, 2016 through:	**2022**	**2025**	**2032**	**2042**
Transition Medicare to a Defined Support Structure in 2016	$187	$369	$875	$2,936

Estimated cumulative savings from CBO's Alternative Fiscal Scenario in billions of dollars, 2016 through:	**2022**	**2025**	**2032**	**2042**
Transition Medicare to a Defined Support Structure in 2016	$191	$408	$1,475	$5,378

Fundamental Tax Reform

In addition to reining in spending, reducing our debt will require raising additional revenue. Under current policies, CBO projects revenue to average only 18 percent over the next decade. Yet, the last time our budget was balanced, from 1998-2001, revenues averaged 20 percent of GDP, and that was before the baby boomers reached retirement, driving up costs for Medicare and Social Security just to provide the same services.



However, new revenue to help pay down our debt can be raised through fundamental tax reform that will drastically simplify the code and promote growth. Below is the plan that our Task Force created:

Bipartisan Policy Center (BPC) Tax Reform
Quick Summary

The BPC Tax Reform Plan represents a radical simplification of the current tax code and contributes to our plan's target of deficit reduction. In fact, to best explain it, forget what you know about the complexities of the current tax system, and start fresh. Outlined below are the core elements of the plan:

- A **two-bracket income tax with rates of 15% and 28%**. Because there is no standard deduction or personal exemptions, the 15% rate applies to your first dollar of income.[2]

- The **corporate tax rate will be set at 28%**, instead of the current 35% level.

- Capital gains and dividends will be taxed **as ordinary income** (**at the 15% and 28% rates**), excluding the first $1,000 of realized net capital gains (or losses).[3]

- To replace the overly complex Earned Income Tax Credit (EITC) and to help offset the elimination of personal exemptions, the standard deduction and the child credit, the BPC Plan will establish:
    - A flat **refundable per child tax credit of $1,600** (higher than current law); and
    - A **refundable earnings credit**[4] similar in structure to the recent Making Work Pay credit, but substantially higher.

- Instead of the current system of itemized deductions, which disproportionately subsidizes the housing consumption and charitable giving of upper-income taxpayers, the BPC Plan will:
    - Provide a **flat 15% refundable tax credit for charitable contributions** and for up to $25,000 per year, not indexed, **mortgage interest on a primary residence**.
    - Eliminate the deduction for state and local taxes.
    - Provide a flat, **15% refundable tax credit** or a deduction (for those in the higher bracket) **for contributions to retirement saving accounts** up to 20% of earnings or a maximum of $20,000.

- Include 100% of Social Security benefits in taxable income, but:

[2] The 28% rate applies approximately to income above $51,000 for single filers and $102,000 for couples.
[3] $500 for singles and heads of household
[4] The refundable earnings credit is equal to 17.5% of the first $20,000 of earnings.

    - Create a non-refundable credit for Social Security beneficiaries equal to 15% of the current standard deduction; and
    - Create a non-refundable credit equal to 15% of an individual's Social Security benefits.

- Effective in 2015, cap and then phase out over 10 years the tax exclusion for employer-sponsored health insurance benefits.

- Allow deduction of medical expenses in excess of 10% of AGI (as in current law).

- Allow deduction of miscellaneous itemized deductions in excess of 5% of AGI.

The BPC Plan achieves a massive simplification of the tax code by **aligning the top individual, capital gains and dividend tax rates, significantly reducing the corporate tax rate, and eliminating the AMT**. Additionally, **most individuals will no longer have to file an annual tax return**[5] beyond an initial declaration of status because the most commonly taken deductions have either been turned into refundable credits, determined solely based on the number of children and earnings, or can only be deducted above a substantial floor. Despite a low top rate of 28%, the new tax system created under the BPC Plan will be **more progressive than the current system** and **raise the requisite revenue to achieve our debt-reduction goal**.

Action in 2013

With the failure of the Joint Select Committee on Deficit Reduction to reach an agreement on a $1.2 trillion deficit reduction plan, current law provides that unless Congress acts, an across-the-board cut to some mandatory programs and to discretionary spending will occur on January 2, 2013. Our analysis of the sequester impact reveals that the size of the cuts will be approximately 15 percent in defense

[5] According to Tax Policy Center projections, only 50% of tax units would be required to file tax returns, as opposed to 88% under the current tax system.

spending and about 12 percent in domestic discretionary spending. If such cuts occur, the Bipartisan Policy Center's analysis, based on CBO data, is that GDP growth in 2013 will be one-half of one percent lower than projected.

Not only will the cuts be across-the-board, they will be carried out on a very detailed level, called the Program, Project, and Activity (PPA) level. While final determination of the size of the cuts, at what level of granularity, and instructions on how to carry out such reductions will be made by the Office of Management and Budget, our analysis predicts serious disruption to governmental activities and to government contractors. Our best present estimate is that about 1 million jobs will disappear from the economy just from the action of the 2013 sequester.

But, the fiscal cliff is much more than the sequester of January, 2013. The cliff contains many other elements:

1. Expiration on January 1, 2013, of the 2001, 2003, and 2010 tax cuts, which will increase revenues by approximately $3 trillion in the next decade;
2. Alternative Minimum Tax expansion will occur unless once again "patched;"
3. Expiration of the Unemployment Insurance extended benefits at the end of this year;
4. A series of so-called "tax extenders," which have already expired, will continue to lapse;
5. A reduction of approximately 30 percent in reimbursement to Medicare providers;

The fiscal cliff, in reality, starts well before the end of the year. CBO projects that the very possibility of these events occurring will lower GDP growth by another one-half of one percent in the remainder of 2012. Congress has yet to pass any FY 2013 appropriations bill, and most analysts believe that the likely outcome of the process this year will be a continuing resolution for appropriations at something near the

continuing resolution level for FY 2012. Appropriations must be addressed in some fashion by Congress before October 1 of this year, which we believe is the first step toward averting the fiscal cliff.

Estimates vary, but most economic analysts believe that if Congress fails to act on the fiscal cliff early in 2013GDP growth would be negatively affected and it seems likely that the nation would fall again into a recession.

We urge Congress to act quickly, now, using perhaps the continuing resolution for FY 2013 as the legislative vehicle that would contain language to avoid the fiscal cliff and, at the same time, set in motion a process that would yield a comprehensive fiscal plan along the lines that our Task Force has recommended and those of the Simpson-Bowles Commission. Waiting until an always difficult lame duck session may establish inaction as the default position, which could lead the nation directly over the fiscal cliff.

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