United States Senate Committee on Finance

Republican Consensus Recommendations to The Joint Select Committee on Deficit Reduction

October 2011

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Taxation

Put into place nearly a 100 years ago and last reformed 25 years ago, America's individual and corporate tax systems are in need of a significant overhaul that promotes economic growth, fairness and simplicity, and meets the challenges of today's increasingly competitive global economy. America needs a tax system that:

- helps to create a strong, robust, dynamic, job-producing economy;
- recognizes that the vast majority of small businesses are conducted as flow-through business entities, such as S corporations, partnerships, limited liability companies and sole proprietorships;
- recognizes that only 36 percent of all business income today is earned by traditional C corporations;
- allows worldwide American companies to be competitive in our global economy; and
- recognizes that economic growth is of paramount importance.

The following guiding principles and specific proposals constitute the comprehensive tax reform plan (Tax Plan).

Guiding Principles

Comprehensive tax reform should adhere to seven guiding principles.

1. **Economic Growth**: The Tax Plan would significantly reduce much of the economic distortions that are present under the current income tax system. It would eliminate the anticompetitive nature of the current tax system, such as the high U.S. corporate tax rate, which stifles job growth and hinders the creation of a strong economy.

2. **Fairness:** The income tax base, which has become riddled with exclusions, exemptions, deductions, and credits, should be as broad as possible. The Tax Plan would eliminate or reduce a number of tax expenditures, thereby broadening the tax base while simultaneously lowering tax rates. A broad tax base coupled with lower tax rates achieves one of the principal goals of tax reform: fairness.

3. **Simplicity:** The tax code had grown to over 3.8 million words by 2010. Approximately 60 percent of American households (83 million households) use paid preparers to do their individual income taxes and another 29 percent use tax software to assist them. Taxpayers and businesses spend over six billion hours a year complying with tax-filing requirements with compliance costs totaling over $160 billion annually. The annual monetary compliance burden of the median individual taxpayer was $258 in 2007. The Tax Plan would greatly simplify the tax code by eliminating or reducing many tax

expenditures and eliminating the alternative minimum tax (AMT). Simplifying the tax code would result in greater compliance by American taxpayers.

4. **Revenue Neutrality:** Tax reform should be revenue neutral as measured against a current policy baseline. Tax reform should not be an occasion to raise taxes on Americans or U.S. businesses. Since 1971, federal revenues as a percentage of gross domestic product (GDP) have averaged 18.0 percent per year. The Congressional Budget Office (CBO) has projected that, under a current policy baseline, federal revenues will be 18.4 percent of GDP by 2021, which is above the historical average for the last 40 years. Therefore, revenues are already heading higher than their historical average.

5. **Permanence:** The tax code needs certainty. The Joint Committee on Taxation (JCT) lists over 150 provisions expiring from 2010-2020. Individuals and businesses need to be able to rely on provisions in the tax law for personal and business planning. For example, individual income tax rates, which affect all Americans who pay U.S. federal income taxes, are set to increase on January 1, 2013, unless Congress acts to prevent what would be a historic tax increase. The lack of certainty in our tax laws hinders job creation at a time when unemployment is unacceptably high.

6. **Competitiveness:** The combination of a high corporate tax rate, worldwide taxation, and the temporary nature of some tax incentives make U.S. companies less competitive when compared to their foreign counterparts. In addition, worldwide American companies are discouraged or penalized from repatriating foreign earnings because of the U.S. corporate tax that applies at the time of repatriation. The Tax Plan would reduce the high U.S. corporate tax rate and also achieve neutrality through a territorial tax system, thereby placing worldwide American companies on an equal footing with their foreign competitors when conducting business in other countries. The result would be more worldwide American companies establishing or retaining their corporate headquarters in the United States, the creation of more exports to global markets, and the reinvestment of money in the United States rather than abroad, all resulting in the creation of jobs in the United States and a stronger U.S. economy. Lowering the individual and corporate tax rates to a maximum of 25 percent will allow U.S. flow-through businesses and domestic C corporations to be more competitive.

7. **Savings and Investment:** Many aspects of the U.S. income tax system discourage savings and investment by individuals, thereby hindering long-term growth. The Tax Plan would result in a tax system that is more favorable to savings and investment.

Specific Proposals

Comprehensive tax reform should achieve the following objectives.

1. **Lower Rates:** The income tax rate for individuals and corporations should be no higher than 25 percent. U.S. corporations are subject to the highest federal corporate tax rate in the world. The current top corporate tax rate of 35 percent is clearly too high in today's global economy. The average corporate tax rate in the Organization for Economic Cooperation and Development (OECD) countries is about 24 percent.

2. **Repeal of Health Spending Law and Tax Increases:** The Patient Protection and Affordable Care Act (PPACA) significantly increased taxes in order to pay for the law's expansion of government. PPACA should be repealed in its entirety, including a repeal of all of the law's tax increases.

3. **Alternative Minimum Tax (AMT) Repeal:** The AMT should be repealed. Congress enacted the AMT in 1969 to address the issue of 155 Americans earning more than $200,000 and paying no federal income taxes. Today, the AMT has become an albatross around the neck of millions of American taxpayers.

4. **Territorial Tax System:** Corporate tax reform should adopt a territorial tax system. A fundamental principle of a territorial tax system is that business income earned abroad should not be subject to tax by the United States either at the time the income is earned or when the earnings are brought back to the United States.

5. **Small Business Income:** Small businesses should remain subject to only a single level of tax, computed with a minimal amount of complexity.

6. **Joint Committee on Taxation Estimates:** As part of its conventional revenue estimates, JCT includes taxpayer behavior in its model. But JCT assumes that a proposal will not change total national income, meaning that economic growth is fixed as part of its model. As a result, JCT does not incorporate macroeconomic feedback (sometimes referred to as "dynamic estimates") in its estimates of tax policy changes. The Tax Plan would require JCT to include macroeconomic feedback in its revenue estimate of any comprehensive tax reform plan, including the Tax Plan.

Health Care and Welfare

The Unsustainable Trajectory of Health Care Entitlement Spending

This year, the first baby boomer will become eligible for Medicare. The number of Medicare beneficiaries will almost double in the next two decades – from 47 million in 2010 to almost 80 million by 2030. Consequently, as these new beneficiaries come online, federal spending will continue to sky-rocket consuming a greater percentage of America's GDP with each passing year.

The Urban Institute, in a recent study, found that an average single earner couple, turning 65 this year, will likely have paid $55,000 into the Medicare program over the course of their lifetime, but will receive over $340,000 in benefits – nearly 6 times what they contributed. The system must be reformed to ensure that we can continue to provide important benefits for America's senior citizens. According to CBO, Medicare will be insolvent by 2020, and according to this year's Medicare Trustees Report, Medicare is currently facing a $38 trillion unfunded liability. To put this in perspective, this translates into an obligation of $353,350 per household.

PPACA provided Congress with an important opportunity to make tough decisions to maintain the long-term solvency of both Medicare and Medicaid. Unfortunately, this partisan health law instead raided the broken Medicare program for more than $500 billion, almost doubled the size of the Medicaid program and raised taxes by over $1 trillion to finance new entitlement spending. According to the Senate Budget Committee, the true cost of the new health law stands at an astonishing $2.6 trillion over ten years when fully implemented.

Medicaid is another example of a broken program. Designed to be a limited safety net program, it has expanded to nearly 70 million enrollees – almost one in four Americans. The federal government alone will spend nearly $280 billion on Medicaid this year and $4.6 trillion through 2021 – a substantial contributor to the growing national debt. This spending does not even include the state share of the program's costs that routinely crowd out local priorities such as education and law enforcement. Half of the individuals newly insured under the new health law will be enrolled in Medicaid – further exacerbating the program's fiscal challenges.

If Medicare and Medicaid are to be more than just a broken promise to seniors, then it is time for an honest discussion to find ways to fix these programs. As CBO Director Douglas Elmendorf recently testified to the Joint Select Committee on Deficit Reduction (JSC), the current trajectory of government spending, deficits, and debt are clearly unsustainable. Doing nothing puts seniors at risk. Doing nothing ensures that our children and grandchildren will continue to foot the bill for our inaction. Doing nothing is not an option. The time for action is now.

Medicare

Medicare promotes over-utilization of health care services and does not appropriately reward quality and efficiency. However, Medicare reform cannot simply be about payment cuts. America's current system has shown that government central planning and arbitrary price controls simply do not work. Reform must focus on achieving better value for the dollar, promoting a more efficient program, and raising the quality of care for our seniors.

The path forward must bring strong competition to the Medicare program. Empowering providers and beneficiaries with better information is essential so better choices can be made about care. A model framework is the Part D program, which has created a competitive market in Medicare for prescriptions drugs. In beneficiary surveys, the program continues to be very popular and comes in more than 40 percent below original estimates. It is proof that Medicare can be reformed, important program savings can be achieved, and the delivery of high quality care for seniors can be ensured.

Finally, efforts to fight fraud and abuse in the Medicare program must be strengthened. Every dollar lost to fraud and abuse is one less dollar spent on care for our seniors.

Program Recommendations

- ***Address the Eligibility Age***

  Medicare spending has grown from $37 billion in 1980 to $514 billion in 2010, a 13-fold increase. Currently, once seniors turn 65, they are eligible to receive Medicare benefits. Similar to the proposals put forth by the President's budget, as well as other deficit discussion groups, the JSC should address the Medicare eligibility age.

  When Medicare was created in 1965, the average life expectancy was 70 years of age, and today, the average life expectancy is 79 years of age and increasing as health care improves. With the baby boomers coming on line, there are simply not enough younger workers paying into the system to be able to sustain the program. Fifty years ago, there were five workers paying the benefits for each retiree. Today there are only three workers paying the benefits for each retiree, and in 20 years that number will decrease to two. This is an important issue to be examined in addressing the long term solvency of the Medicare program.

- ***Evaluate the Impact of Supplemental Coverage***

  According to CBO, supplemental health coverage policyholders use about 25 percent more services than Medicare enrollees who have no supplemental coverage. The JSC should further examine the issue of over-utilization. The President's Fiscal Commission, as well as subsequent deficit proposals, have offered alternatives.

- ***Establish a Uniform Deductible***

Currently, beneficiaries pay a deductible for both inpatient and outpatient services. The Part A deductible is approximately $1100 with a co-payment applied after 60 days of hospital stay. Outpatient co-payments generally cost about 20 percent of Medicare allowed rates. The JSC should examine a unified deductible covering Part A and Part B services, as well as a uniform coinsurance rate for amounts above the deductible, and an annual cap to protect seniors' financial exposure.

- ***Strengthen Efforts Against Fraud, Waste, & Abuse***

The Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG) continually make program recommendations to address waste in the Medicare program. The JSC should evaluate the proposals that have been publicly released by the GAO and OIG to CMS to help significantly strengthen the Medicare program. Many of these proposals would result in significant savings. In particular, proposals that focus on pre-payment review activities, stronger enforcement penalties, and operational or programmatic efficiencies are all areas where those recommendations could translate into significant savings.

Medicare Part A

Medicare Part A covers inpatient hospital care, as well as post-acute care for seniors. Post-acute care encompasses skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), home health (HHAs), and hospice. Outpatient hospital services are paid under Medicare Part B.

Of total Medicare spending, 34 percent is on hospital care, 7 percent is on home health and hospice care, 5 percent on SNF care, and the rest is on Parts B, C and D. In 2010, Medicare spent $57.2 billion on post-acute care; $26.4 billion in SNFs; $19.3 billion in HHAs; $6.4 billion in IRFs; and $5.1 billion in LTCHs.

In 2009, 4,846 hospitals participated in Medicare and for seven consecutive years, the number of hospitals opening exceeded those which have closed.

Future adjustments in payments are legitimate, but must be used to shore up the solvency of the Part A Trust Fund. Unfortunately, PPACA slashed Medicare by over $500 billion and used it mostly to finance new entitlement spending. Nearly every deficit reduction group has included a range of options for adjusting payments to providers.

The JSC should examine payment adjustments in an appropriate manner that promotes the goal of maintaining access to quality care for beneficiaries while reducing unnecessary health care expenditures.

Recommendations

- ***Reduce Variations in Spending***

  Health care experts and economists have found that too much variation in spending exists throughout the country. In many parts of the United States, spending is over 50 percent higher for the same services than in lower-cost areas. The Dartmouth Atlas of Health Care estimates that Medicare spending could decrease by at least 29 percent if higher-cost areas could bring their spending more in line with lower cost areas. The JSC should examine proposals to address this variance without adversely impacting access to quality care.

- ***Provider Payment Realignment***

  Recent policy initiatives to reduce provider payments in one area simply result in cost shifts to other areas. For example, if provider payments are reduced in skilled-nursing facilities, more services shift to home health services and increase spending in that sector. Providers have long advocated for providing "the right care, at the right time, in the right place." The JSC should examine policies that address the providers' desire to be paid for the appropriate services, regardless of where they are provided. Paying for services in this manner will bend the cost curve downward.

  Furthermore, the JSC should recommend a thorough review of ALL provider payments made by Medicare. All payment policy should be based on empirical data to prove that a specific need is being met.

- ***Evaluate the Existing Cost-Sharing Structure***

  The JSC should evaluate the current cost-sharing structure for post-acute services to balance the need to address a rapidly depleting Part A Trust Fund and to maintain access to quality care and services for our seniors.

Medicare Part B

Medicare Part B is the part of the Medicare program that covers physician, laboratory, and outpatient services, as well as durable medical equipment, some prescription drugs, and some home health visits.

Of the $514 billion in total Medicare cost in 2010, $212.9 billion was spent on Medicare Part B enrollees, and is expected to reach $228 billion in 2011. The Part B program is financed through a combination of monthly beneficiary premiums (25 percent) paid by current enrollees and general revenues (75 percent). The income from these sources is credited to the Supplementary Medical Insurance (SMI) trust fund which means that this program is primarily supported through federal general revenues. The monthly premium for Part B is $96.40 for 2011. Beneficiaries who have higher annual incomes (over $85,000/individual, $170,000/couple) pay a higher, income-related monthly Part B premium.

Recommendations

To ensure the long-term health of the SMI Trust Fund, the JSC should evaluate and examine the current Part B cost-sharing thresholds, including those for high income seniors, with the goal of strengthening the Medicare program for every senior.

Medicare Part C

Nearly one in four seniors choose to receive their Medicare benefits through a Medicare Advantage (MA) plan that offers better benefits, enhanced care coordination, and higher quality coverage. The majority of private plans bid well below the payment levels determined by traditional Medicare spending and any "extra" payments are given to beneficiaries through additional benefits or returned to the Treasury. Unfortunately, PPACA cut more than $200 billion from this private sector alternative to traditional fee-for-service Medicare. According to CBO, new enrollment in this popular program will be reduced by half once the cuts are fully implemented.

Recommendations

Rather than PPACA's arbitrary cuts to this popular program, the structure of Medicare Advantage should be improved as it represents the private-sector foundation of a sustainable Medicare program.

In order to deliver higher quality comprehensive care to seniors and better results for taxpayers, many of Part D's design features – such as plan competition and beneficiary choice – should be considered by the JSC in improving Part C. The JSC should examine approaches that competitively set reimbursements to plans and simultaneously preserve access in rural areas. Additionally, reforms that promote more innovative plan designs that better meet beneficiary needs should be considered. These improvements would create more choices for American seniors much like the Federal Employee Health Benefit Program, the model used to provide health care benefits to Members of Congress.

Medicare Part D

Part D is the part of the Medicare program that covers prescription drugs. Part D was established by the Medicare Modernization Act of 2003 (MMA) and launched in 2006. The benefit is delivered through private plans that contract with Medicare and is delivered in two forms: either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MAPD) plans. Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are tied to plan bids. Plans bear some risk for their enrollees' drug spending. Part D is funded by general revenues, beneficiary premiums, and state payments, and accounted for 10 percent of benefit spending in 2009. As of April 2010, 27.6 million beneficiaries are enrolled in a Part D plan.

In 2010, Part D spending totaled $61 billion. Beneficiary premiums account for approximately 10 percent of Part D financing (this number is adjusted to account for program subsidies), 82 percent comes from general federal revenues. An additional 8 percent comes from the states and other sources. As with Part B, wealthy retirees pay higher premiums, up to 80 percent of the costs of the benefit. The Part D program is the fastest growing program in Medicare. The unfunded liability for the Part D program is $7.2 trillion.

The Medicare Part D program remains a great success at utilizing market forces and competition to reduce costs. Plan sponsors must be afforded the freedom to continue to innovate. The JSC should avoid budget solutions that interfere with the proven results of private sector negotiations or impose government dictated price controls.

Recommendations

The JSC should reevaluate and examine the current Part D cost-sharing thresholds, including those for high-income seniors, with the goal of strengthening the Medicare program for every senior.

Medicaid

Medicaid provides acute and long-term care services for low-income, elderly, and disabled individuals. Each state runs its own Medicaid program and is required to cover certain populations up to specified income levels for certain services, but may also choose to cover "optional" populations and services. The federal government pays an average of 57 percent of Medicaid spending, and states finance the rest of the costs.

Medicaid spending is a significant driver of both federal and state deficits. It will consume $4.6 trillion in federal spending over the next 10 years and currently consumes 22 percent of state budgets.

In addition to fiscal burdens on taxpayers, the current program is failing its patients on many key quality indicators. According to data from the National Center for Health Statistics, Medicaid patients are more likely to end up in the emergency room than privately insured and even uninsured patients. Additionally, peer-reviewed medical literature consistently shows that Medicaid patients fare worse than privately insured patients. For example, a 2005 study in the Journal of the American College of Cardiology revealed Medicaid patients were nearly 50 percent more likely to die after a heart surgery compared to patients with private coverage or Medicare. Medicaid beneficiaries deserve better.

The Medicaid program represents a $380 billion target for fraud, waste, and abuse. GAO has consistently put Medicaid on its list of high-risk programs, with its improper payment rates among the worst of all federal programs. Medicaid program integrity risks are not even fully known as CMS' antiquated databases do not reconcile reported expenditures with actual services provided.

Recommendations

In order to place the program on a sustainable fiscal path and better serve the country's most vulnerable citizens, the Medicaid program must be modernized. The bipartisan Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) of the 1990s should serve as a successful model for entitlement reform. Solutions for sustainable welfare reform came from the states – not just Washington – and that model will work to fix Medicaid. Many states have pioneered Medicaid reforms, and governors know what has worked and what has not. The goal is to empower the states to design and implement innovative Medicaid solutions that work for their states.

In response to requests from House Energy and Commerce Chairman Fred Upton and Senate Finance Committee Ranking Member Orrin Hatch, the majority of the nation's governors shared specific recommendations for Medicaid reform on August 30, 2011. The governors' report noted, "the PPACA expansion of the Medicaid program is the largest expansion of this program in history. As a result, we are deeply concerned the existing challenges Medicaid faces today will be exacerbated by the program's unprecedented growth over the next few years. We must think about a new Medicaid program—one that more easily adjusts to the needs, ideas and culture of each state...Bending the unsustainable trajectory of the Medicaid program will require flexibility, accountability and innovative solutions at the state level."

Specifically, the governors outlined seven principles for Medicaid reform:

1. States and territories are best able to make decisions about the design of their health care systems based on the respective needs, culture, and values of each state.
2. States and territories should also have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and that hold states accountable for efficiency and quality health care. Such mechanisms may include a

block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches.

3. Medicaid should be focused on quality, value-based and patient-centered programs that work in concert to improve the health of our states' citizens and drive value over volume, quality over quantity, while at the same time containing costs.

4. States and territories must be able to streamline and simplify the eligibility process to ensure coverage for those most in need, and states must be able to enforce reasonable cost-sharing for those able to pay.

5. States and territories can provide Medicaid recipients a choice in their health care coverage plans, just as many have in the private market, if they are able to leverage the existing insurance marketplace through innovative support mechanisms.

6. Territories must be ensured full integration into the federal health care system so they can provide healthcare coverage to those in need with the flexibility afforded to the states.

7. States must have greater flexibility in eligibility, financing, and service delivery in order to provide long-term services and support that keep pace with the people Medicaid serves. New federal requirements threaten to stifle state innovation and investment. In addition, since dual eligibles now constitute 39 percent of Medicaid spending, Medicare policies that shift costs to the states must be reversed and the innovative power of states should be rewarded by a shared-savings program that allows full flexibility to target and deliver services, which are cost-effective for both state and federal taxpayers.

Based on these recommendations from the nation's governors, the JSC should strongly consider modernizing Medicaid's financing structure and giving states new tools to implement patient-centered reforms. One such approach would be to give each state a defined budget to provide health care services to their vulnerable populations. This approach will give certainty to both the federal and state budget processes. It will also better align state incentives to implement innovative and cost-effective solutions for their citizens. Along with defined funding streams, the federal government should work with the states to set clear transparent goals and then monitor specific metrics on quality, access, and coverage.

The JSC should also consider proposals to empower states to implement innovative solutions that meet the unique needs of their populations. This new state flexibility would include the ability to 1) modernize eligibility determination, including the repeal of the onerous maintenance of effort requirements, to ensure that scarce resources are targeted to the most vulnerable populations, 2) develop and implement provider reimbursement systems that encourage value over volume of services; 3) design benefits that comport with private-sector coverage, encourage healthy beneficiary behavior, and better manage chronic disease; 4) provide long-term care benefits with approaches that promote cost-effectiveness and self-

directed services; and 5) partner with the federal government in providing more coordinated care for beneficiaries eligible for both Medicare and Medicaid.

Repeal the Patient Protection and Affordable Care Act

PPACA is the largest expansion of the federal government in a generation – adding to the nation's debt, raising taxes on most Americans, and threatening job creation at a time when the nation's economy remains weak.

According to the House Budget Committee, the true cost of PPACA stands at $2.6 trillion over 10 years once fully implemented. The same analysis also reveals that the law will increase the deficit by $701 billion and continue to add to our nation's growing debt.

The impact of the law on job growth can be seen in the $1.094 trillion in new taxes and penalties that individuals and employers will have to pay. These taxes will prevent employers from hiring new workers. The CBO Director testified before the House Budget Committee earlier this year and confirmed that the law would result in a reduction of 800,000 new jobs in the future due to the increase in marginal tax rates. Moreover, a recent report issued by the International Franchise Association estimated that the new health law is putting nearly 3.2 million full-time jobs at risk.

According to CBO, PPACA will also increase health care premiums for families purchasing insurance on their own by $2,100. In fact, a recent survey conducted by the Kaiser Family Foundation found that since 2010 average premiums increased by 9 percent for family coverage, which is "significantly greater than the 3% family premium increase between 2009 and 2010." The President promised more than a dozen times to reduce premiums by $2,500, yet the law has accelerated the growth of health care premiums and overall health care expenditures. According to the President's own Chief Actuary the law will increase health care costs by $311 billion. A study published in *Health Affairs* earlier this year estimates that premiums in 2014 will increase by 9.4 percent and notes that this is 4.4 percent higher than what estimates of premium increases had PPACA not become law.

The law will also hit already cash-strapped states with $118 billion in new costs through an expansion of the Medicaid program, according to a joint report issued by the House Energy and Commerce Committee and the Senate Committee on Finance. The report also noted that states are faced with a collective $175 billion budget deficit. States need relief from unfunded mandates and flexibility to run their own health programs to fit the needs of their own state demographics.

PPACA also slashed $529 billion from a broken Medicare program to finance new entitlement spending, while failing to address some of the biggest challenges facing the program, like the broken physician payment system. There is little question that these cuts will impact access to

care for seniors. Medicare physicians are facing an almost 30 percent cut in their payments beginning in 2012.

The JSC should strongly consider repealing this flawed and partisan health law as an essential step in improving our nation's future economic and fiscal outlook.

Welfare and Related Programs

The federal government provides a financial safety net of supports to states and individuals in need. These include food assistance, child care assistance, welfare, housing and energy assistance, and other social services.

However, many of these programs operate in isolated "silos" relative to program purposes. The federal and state administration of these programs is often done in isolation. Social safety net programs are rarely coordinated. The result is duplicative services that fail to provide improved outcomes for vulnerable children and families.

The JSC should examine ways to coordinate federal funding streams that assist vulnerable families while providing a greater degree of transparency and accountability.

Recommendations

The JSC should consider collapsing the Social Services Block Grant (SSBG), the Child Care and Development Fund (CCDF) and the Temporary Assistance for Needy Families (TANF) into one funding stream for states, the Social Services Fund (SSF) and establish time-defined goals.

A potential timeline to increase transparency and accountability could be as follows:

- Within 2 years after date of enactment, states may no longer simply describe welfare funding uses as "Other" or "Authorized under Prior Law." States must report the percentage of SSF funds used to support:

    - Foster Care Maintenance Payments
    - Family Support, including activities designed to keep families together or reunify
    - Child care
    - Cash welfare payments
    - Adult protective services
    - Work supports including education and training
    - Domestic violence counseling
    - Substance Abuse treatment
    - Child welfare
    - Child Only TANF cases

- Juvenile Justice

- Within three years after date of enactment, a state must implement policies to ensure that ALL benefits derived from an Electronic Benefit Transfer (EBT) card are not being cashed in casinos, liquor stores or strip clubs.

- Within four years after the day of enactment, states must report on how individuals administering the SSF are integrating these services with services in the jurisdiction of the child welfare agency, the Juvenile Justice Agencies, law enforcement and the courts.

Finally, after 5 years, any funds not accounted for or that are not being used in a coordinated delivery system will be returned to the Treasury in the form of a reduction in the states' next year's allocation. A state may apply for additional flexibility to fold other social services programs such as Food Stamps, Child Support Enforcement and WIC into the SSF.

Other Proposals

Tort Reform

Frivolous malpractice litigation remains a significant contribution to rising national health care spending by incentivizing billions of dollars in unnecessary defensive medicine. This impacts America's health care system by increasing costs and limiting access to care.

Medical malpractice litigation is a problem threatening to cripple the American medical community. For years, health care providers have faced difficulty obtaining affordable medical liability coverage. The problem is now so great that patients are being deprived access to crucial medical care as hospitals and physicians find it increasingly difficult to continue offering certain services.

Almost 68 percent of medical liability cases are dropped or dismissed. In those cases, the plaintiff receives no award because no harm is found. But legal fees associated with these frivolous lawsuits average $25,000 per case, and these costs increase the cost of medical liability insurance. These in turn translate into higher premiums for American families.

President Obama has committed to working on this issue, and the JSC has a unique opportunity to work together to resolve this issue on a bipartisan basis. According to CBO, comprehensive tort reform could slash medical malpractice premiums by 10 percent, reduce total national health spending by 0.5 percent and save the federal government more than $54 billion over the next 10 years.

With national health expenditures continuing to rise and health insurance premiums sky-rocketing, meaningful tort reform would not only reduce the deficit by billions of dollars, but reform our health care system to ensure that patient care is driven by quality and efficiency.

Conclusion

The above represents a series of options for reining in the rate of growth for Medicare and Medicaid spending. JSC should seriously consider those options that are most appropriate at this time. These recommendations by no means are the final answer, but they do promote responsible steps in the right direction. These proposals represent a sensible approach that puts our federal health care spending on a more sustainable path, while promoting greater beneficiary choice in services and providers.

International Trade

Trade Adjustment Assistance (TAA)

The cost of the Trade Adjustment Assistance program should be carefully constrained by actions such as: reforming the eligibility criteria to ensure that only those dislocated workers whose job loss is directly related to international trade are eligible for benefits; that benefits under the program be narrowly defined; and that additional funding through TAA be directed only to those programs that directly benefit dislocated workers.

Social Security

Findings

- The Old-Age, Survivors, and Disability Insurance (OASDI) program, known as Social Security, provides basic levels of monthly income upon attainment of retirement eligibility age, death, or disability by insured workers. The program consists of Old-Age and Survivors Insurance (OASI), which provides monthly benefits to retired insured workers and their families and to survivors of deceased workers, and disability Insurance (DI) which provides monthly benefits to disabled insured workers and their families.

- Over 55 million Americans receive Social Security retirement, disability, or survivors benefits. The program is an important part of the social safety net, but faces financial challenges in light of changing demographics in the U.S. population. Both the OASI and the DI components of Social Security system need reform.

- With fewer and fewer workers supporting more and more retirees, the system already faces unsustainable imbalances between receipts and benefits.
    - The number of workers paying into Social Security per beneficiary was 5.1 in 1960; 3 in 2009; and is projected to fall to 2 by around 2060.
    - The 2011 annual report of the Board of Trustees of the OASDI Trust Funds identifies that payments now exceed tax receipts, and the combined assets of the Trust Funds will become exhausted in 2036. After 2036, Social Security beneficiaries could face across-the-board reductions in benefits of 23 percent, rising to reductions of 26 percent by 2084.
        - The Disability Insurance part of Social Security by itself is projected to run out of assets as early as 2018 (or 2016, under high cost assumptions). Before that time, legislation will be required to salvage the Disability Insurance program's financial position.
    - According to the Trustees' 2011 annual report, looking out over the next 75 years: "The open group unfunded obligation for OASDI over the 75-year period is $6.5 trillion in present value…" Looking further, according to the report: "Over the infinite horizon, the shortfall (unfunded obligation) amounts to $17.9 trillion in present value."

- Undertaking Social Security reform now sends a positive signal to financial markets that America is taking concrete steps today to solve long-term financial imbalances in the face of the known near-term increases in the number of eligible beneficiaries.
    - Indeed, Standard & Poor's (S&P) August 5, 2011 report on its downgrade of the long-term sovereign credit rating of the U.S. from AAA to AA+ referred to an "inflection point on the U.S. population's demographics and other age-related spending drivers." Officials at the rating company cite entitlement reform as key

to restoration of the AAA rating, as projected growth in entitlement spending represents the biggest component of projected future growth in Federal government spending.
    - Ratings downgrades threaten to increase the cost of credit to American families and businesses and to Federal, State, and local governments. Increases in the cost of credit to the government will amplify our fiscal challenges.

- Reform of the Social Security program to ensure sustainable solvency and protection against poverty will:
    - Restore the long-term viability of the Social Security program upon which seniors, disabled workers, and dependents depend;
    - Provide younger workers with clear signals and ample time to adjust their lifetime savings plans;
    - Protect general government finances from irreversible deterioration and further future stresses;
    - Help restore our AAA credit rating;
    - Help guard against future ratings downgrades; and
    - Send useful signals to financial markets of serious action on unsustainable entitlement promises.

- As the President's Fiscal Commission identified in its December 2010 "*The Moment of Truth*" findings: "The do-nothing plan would lead to an immediate 22 percent across-the-board benefit cut for all current and future beneficiaries in 2037."
    - Since that time, the benefit cuts necessary given Social Security's deteriorating financial position has been brought forward one year to 2036 and the necessary cuts to benefits would be 23 percent.

- Social Security reform, aimed at solvency and integrity of the program, and not for near-term deficit reduction, needs to occur as soon as possible and should not be delayed.

- As the 2011 Social Security Trustees' report makes clear:

> "The projected trust fund shortfalls should be addressed in a timely way so that necessary changes can be phased in gradually and workers and beneficiaries can be given time to adjust to them. Implementing changes sooner would allow the needed revenue increases or benefit reductions to be spread over more generations. Social Security will play a critical role in the lives of 56 million beneficiaries and 158 million covered workers and their families in 2011. With informed discussion, creative thinking, and timely legislative action, Social Security can continue to protect future generations."

Principles of Reform

- The objectives of Social Security reform should be to ensure lasting solvency of the program over the infinite horizon and to maintain Social Security as a safety net program that protects against poverty in old age or when a worker becomes disabled.

- The objectives of reform should be sustainable solvency and integrity of the program for its own sake, and not for deficit reduction.

- Any changes in promised benefits considered by JSC should apply primarily to younger workers who will be given time to adapt their lifetime savings and spending plans to changes in Social Security benefits. The real value of benefits to current retirees or those close to retirement who cannot quickly alter their savings and spending plans should not be affected.

- Any changes entertained by the JSC to formulae used to calculate benefits should conform to the principle of ensuring protection against poverty for workers with low lifetime earnings and disabilities.

- If consideration is given to changes to the formulae used to calculate benefits that alter income redistribution within the Social Security program, the JSC should maintain, as best possible, the fundamental value that there is a relationship between what you put into the system and what you get out.

- Increasing payroll taxes or lifting the taxable wage cap means higher taxes on labor and small businesses, which will slow growth in jobs and the economy. Moreover, higher payroll taxes levied on employers are ultimately borne primarily by workers in the form of lower wages and other benefits. The JSC should be mindful of those negative economic effects in any deliberations over payroll taxes.

- Comprehensive reform of the Disability Insurance component of the Social Security system, funded by Trust Fund assets that will be depleted as early as 2016, must be a part of any overall Social Security reform effort.