United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

January 24, 2013

Dear Colleague,

Our Nation is at a crossroads. With four straight years of trillion dollar deficits and a national debt above $16 trillion, the time to address Washington's spending addiction is now. Failure to act is an abdication of our responsibility not only to our constituents today but also to future generations. Congress will likely have several opportunities to act to curb runaway spending and unsustainable entitlements this year, and we need to be ready with bipartisan ideas that will require our collective courage.

According to the Director of the nonpartisan Congressional Budget Office (CBO), health care entitlement spending represents our "fundamental fiscal challenge." Over the next decade alone, Medicare and Medicaid will spend more than $12 trillion. To put this in perspective – this is bigger than the combined gross domestic product (GDP) of France, Germany, Italy, Spain, and the United Kingdom. At their current rates of growth, Medicare and Medicaid will devour almost 10 percent of our economy by 2035.

Entitlement reform is not a Republican or a Democratic issue – it's an American challenge. To help address that challenge, I have enclosed five structural entitlement reform proposals, each of which has bipartisan origins. These proposals range from the Bowles-Simpson Commission recommendations to President Clinton's entitlement reform ideas. I hope that we will use them as a starting place to start a serious conversation to address the urgent fiscal challenges our country faces.

I look forward to working with each one of you. We have faced other steep challenges in our history, and we as Americans have, time and time again, answered the call with courage and determination. We can – and we must – do so again.

Sincerely,

Orrin G. Hatch
Ranking Member

Why We Need Entitlement Reform?

Over the next decade alone, the federal government will spend more than $12 trillion on Medicare and Medicaid. To put this in perspective, this amount is bigger than the entire combined economies of France, Germany, Italy, Spain, and the United Kingdom. At their current rates of growth, Medicare and Medicaid will devour almost 10 percent of our economy by 2035.

Medicare

- In 2012, Medicare spent $478 billion — and over the next 10 years it will spend more than $7 trillion.
- While 10,000 new seniors join the program EVERY DAY, the number of workers (per beneficiary) paying into the program has declined by 18 percent over the last decade.
- Over the long term, Medicare has $38.6 trillion – or $328,404 per American household – in unfunded liabilities. To put this in perspective, an average American household can give up their income for an entire year and sell their house and still not have enough to pay off their obligation.
- In just 7 years, Medicare spending will eclipse the entire national defense budget.
- According to the Medicare Trustees, Medicare is projected to grow much faster than the economy, government revenues, or the population for decades to come.
- In fact, for a single-earner couple, the program spends six dollars in benefits for every dollar it collected in payroll taxes.

Medicaid

- Federal Medicaid spending as a share of the economy is set to grow by 37 percent over the next 10 years (OMB) with total federal spending alone during that time reaching $4.4 trillion.
- The federal government spent $261 billion on Medicaid in 2012 and the states spent $196 billion. The combined total Medicaid budget was $457 billion.
- According to the National Governors Association, "Medicaid represents the single largest portion of total state spending, estimated to account for 23.6 percent of total spending in 2011"

- While Medicaid was originally designed as a safety net, serving just 4 million people in 1966, by 2020 there will be 85 million Americans - or almost 1 in 4 Americans - in this government program.

- Medicaid consumes the largest health-related share of FEDERAL revenues. "For the Federal government, Medicaid is the largest source of general revenue-based spending on health services. Notably, Medicaid is a larger source of such Federal expenditures than Medicare."

A BIPARTISAN PATH TO ENTITLEMENT REFORM

I. STRENGHTEN MEDICARE'S FINANCIAL STANDING
Raise the Eligibility Age

POLICY

Raise the Medicare eligibility age for seniors gradually from 65 years of age to 67 years. The eligibility age would increase each year by two months until it reaches the new eligibility age of 67 years within a decade.

REASONING

The total number of seniors enrolled in Medicare will increase from 47 million in 2010 to 81 million in 2030. We are currently adding 10,000 seniors per day to the program while the number of workers paying into the program per beneficiary has declined by 18 percent in the last decade. When Medicare was created in 1965, the average life expectancy was 70 years. In 2009, it stood at 78 years. Currently, 41 percent of Medicare beneficiaries are 75 years and older and account for 50 percent of total spending in the program. This common-sense proposal would reflect increases in longevity and simply align the Medicare eligibly with Social Security eligibly at 67 years of age over time.

BIPARTISAN SUPPORT

- This policy was supported by the bipartisan Simpson-Bowles National Commission on Fiscal Responsibility and Reform.
- It was also included in the bipartisan Biden-Cantor deficit reduction negotiations and the bipartisan Obama-Boehner negotiations.
- Prominent Democrats, such as former Senate Budget Committee Chairman Kent Conrad and House Budget Committee Ranking Member Chris Van Hollen, have suggested that this policy should be part of the discussion to reform entitlements.
- It was also included in the bipartisan Coburn-Lieberman Medicare proposal last Congress. The nonpartisan Congressional Budget Office (CBO) has provided this as an entitlement reform option.

II. PROMOTE SMARTER CHOICES FOR SENIORS
Reform the Medigap Program

POLICY

Encourage seniors to make better healthcare choices — and reduce costs for Medicare that stem from over-utilization of services — by limiting Medigap plans from providing first-dollar coverage for cost-sharing.

REASONING

In 2010, Medicare paid $9,765 per beneficiary on average. The average cost-sharing per beneficiary was $1,679. Nearly 90 percent of all Medicare beneficiaries have some supplemental insurance coverage to offset their cost-sharing costs. Almost 30 percent of them have Medigap policies that provide first-dollar coverage. Multiple studies have found the Medigap policyholders use about 25 percent more services than Medicare enrollees who have no supplemental coverage, and about 10 percent more services than enrollees who have employer-sponsored retiree coverage. This over-utilization of services directly contributes to higher costs for all seniors in Medicare. Limiting first-dollar coverage will ensure that seniors make the right choices to ensure the highest-quality outcome while keeping costs low for the entire Medicare population.

***BIPARTISAN SUPPORT*:**

- This policy was supported by the bipartisan Simpson-Bowles National Commission on Fiscal Responsibility and Reform.
- It was also included in the bipartisan Biden-Cantor deficit reduction negotiations.
- The House Democratic Ways and Means Committee included this as part of broader cost-sharing reform options in 2011.
- The President's own deficit reduction proposal in September 2011 included a policy to achieve a similar result by applying a 15 percent surcharge on Part B premiums for those seniors who purchase Medigap plans with low cost-sharing.

III. PROTECT SENIORS FROM CATASTROPHIC HEALTH COSTS
Simplify Beneficiary Cost-Sharing and Establish a Catastrophic Limit

POLICY

Streamline the complicated Medicare cost-sharing into a single combined annual deductible for both Part A and B services, and establish a uniform coinsurance rate for amounts above the deductible. Also institute an annual catastrophic cap to financially protect seniors in cases of serious heath events.

REASONING

Under the current system in Medicare, cost-sharing such as co-pays and deductibles vary significantly depending on the type of service provided. Currently, Medicare has a deductible for inpatient care under Part A ($1,132 in 2011) and a separate deductible is charged for physician and other outpatient services under Part B ($162 in 2011). Cost-sharing requirements also vary by type of service. However, the biggest concern is that there is no limit on out-of-pocket spending, which is a serious threat to the financial well-being of any senior who faces a serious illness.

This benefit structure has long been criticized for being too complex, and for promoting overutilization of care which, in turn, translates into higher costs for seniors. Streamlining the cost-sharing will make it easier for seniors to navigate Medicare more efficiently while reducing costs related to overutilization. Most importantly, the catastrophic cap will provide seniors with much needed financial security.

***BIPARTISAN SUPPORT*:**

- This policy was supported by the bipartisan Simpson-Bowles National Commission on Fiscal Responsibility and Reform.
- This was also included in the bipartisan Coburn-Lieberman Medicare proposal last Congress.
- The nonpartisan Congressional Budget Office (CBO) has provided this as an option to reduce costs.

IV. ENSURE A STRONG MEDICARE PROGRAM FOR THE FUTURE
Medicare Competitive Bidding

POLICY

Competitive bidding would continue to provide seniors with a guaranteed comprehensive Medicare benefit, while reducing costs and preserving the quality of care. Under this approach, the federal government would continue to define Medicare coverage, as it does today. Each year, qualified entities, including private insurers and traditional Medicare, would submit bids to provide these guaranteed Medicare benefits. The government would then provide, on behalf of each senior, a risk-adjusted payment based on those competitive bids in their area of the country. Seniors who choose plans that cost less than the government payment would receive the difference through lower premiums or additional health benefits.

REASONING

Reforms should draw upon bipartisan, market-oriented solutions such as a competitive system of bidding including traditional Medicare and carefully-regulated private plans. Robust competition allows seniors, rather than Washington, to choose — based on transparent cost and quality information — if they prefer support for traditional Medicare or a private health plan. Sustainable Medicare reform would build on the success of Medicare Advantage by holding private health plans to a higher level of accountability through competitive bidding. Seniors already benefit from this type of structure in the Medicare prescription drug benefit (Part D), which has controlled costs and is very popular with beneficiaries.

BIPARTISAN SUPPORT

- In 1999, the bipartisan Breaux-Thomas Medicare Commission recommended a defined support model much like the system used by Members of Congress.
- The same year, President Clinton proposed a major set of Medicare reforms with his own version of premium support, which he called a "*competitive defined benefit proposal.*"
- Alice Rivlin, Director of the Office of Management and Budget for President Clinton, recently worked with former Senator Pete Domenici (R-NM) on the Protect Medicare Act, which included a defined support plan for Medicare.
- Another bipartisan team, U.S. Senator Ron Wyden (D-OR) and U.S. House Budget Committee Chairman Paul Ryan (R-WI), developed a defined support plan.

V. STRENGHTEN MEDICAID FOR PATIENTS AND STATES
Medicaid Per Capita Caps

POLICY

Similar to the 1995 proposal by President Clinton, Congress should set limits on the amount of federal dollars spent for each Medicaid beneficiary (per capita caps). Spending limits could be set by beneficiary eligibility categories and adjusted for their conditions and risks This approach would put the Medicaid program on a sustainable budget, and it would be combined with new tools for states to implement patient-centered reforms. Along with these defined funding streams, the federal government would also work with the states to set transparent goals and then monitor specific metrics on quality, access, and coverage.

REASONING

The federal share of Medicaid spending as a share of the economy is set to grow by 37 percent over the next 10 years, with total federal spending during that time reaching $4.4 trillion. According to CMS's actuary, the Medicaid program is "the largest source of general revenue-based spending on health services...a larger source of such Federal expenditures than Medicare." Meanwhile, Medicaid represents the single largest portion of state budgets (estimated at 23.6 percent in FY2011). Currently, federal taxpayers have an open-ended liability to match state Medicaid spending, which is a significant factor in Medicaid's budgetary challenges. Many states have already embraced the goals of this approach with risk-based capitation models. Bipartisan per capita cap reforms would implement desperately needed fiscal discipline in Medicaid while preserving access to care for beneficiaries.

BIPARTISAN SUPPORT

- In 1995, President Clinton proposed a Medicaid reform plan that included a provision to establish a per capita cap on federal Medicaid spending.
- All 46 Members of the Democratic Caucus of the Senate signed a letter to President Clinton expressing their "strong support for the Medicaid per capita cap structure" including several Senators currently serving and then-Senator Joe Biden.
- More recently, in October 2012, former Senate Majority Leader Tom Daschle expressed his support for Medicaid per capita caps as a way of "guaranteeing benefits of the Medicaid program."