



October 12, 2011

The Honorable Patty Murray
Co-Chair
Joint Select Committee on Deficit Reduction
448 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Jeb Hensarling
Co-Chair
Joint Select Committee on Deficit Reduction
129 Cannon House Office Building
Washington, D.C. 20515

Dear Co-Chairs and Members:

As the Joint Select Committee on Deficit Reduction considers proposals to achieve \$1.2 trillion in deficit reduction, we ask you to avoid making decisions that would have negative impacts on our nation's 40 million senior citizens and their families. At a time when one in four older Americans has lost all retirement savings, Social Security, Medicare, and Medicaid are more important than ever. This is true not only for the 3 million seniors living below the \$11,000 federal poverty level, but for those struggling to remain in the middle-class.

As Co-Chairs of the Congressional Task Force on Seniors, we ask that you consider the following principles as you continue your important work.

First, at least 50% of the total package required under the Budget Control Act should come from revenues. Median senior household income is less than \$22,000 and only 1% have incomes over \$250,000. It is wrong to ask seniors and other lower-income and middle-income families to sacrifice without requiring millionaires and billionaires, oil companies and corporate outsourcers to pay their fair share.

Second, while we need to address health care spending, it is critical to recognize this as an overall health system problem, not a failure of Medicare and Medicaid. Despite serving an older, more disabled, and more chronically ill population, the Medicare per capita spending rate grew less than the increase in the private insurance sector: 4.6% compared to 6.7% between 2002-2009.

Third, reductions in Medicare and Medicaid spending should come from efficiencies – not cost-shifting to families, businesses, providers, or state and local governments. The Affordable Care Act incorporates many proposals to improve health care delivery and lower costs. We should build on those policies to achieve health savings in any deficit reduction package.

Fourth, savings should be used primarily to provide the adequate provider payments needed to ensure access. The Joint Committee should act to provide a permanent solution to the Sustainable Growth Rate problem that, if left unresolved, would result in a 30% cut to physicians next January. States should use Medicaid efficiency savings to improve provider payments that block access to needed health and long-term care services.

Finally, at a time when 29 million Americans are looking for full-time work, we need to avoid cuts that will negatively impact job creation and growth in our country.

We believe that there are ways to reduce federal health care spending by improving efficiencies and without harming patients and providers, or job creation. Again, however, those cuts need to be part of a balanced package that includes revenue increases and strategic cuts in other non-health care-related discretionary spending, and does not attempt to balance the budget on the backs of the health care sector, or older Americans.

The Committee should also look for ways to reduce the burgeoning defense budget. Though we believe a strong and robust military is needed to defend American citizens and interests, and those of our allies, we strongly feel that key, strategic spending reductions can be made at the Department of Defense. The largest defense savings that could be achieved would be by ending military operations, and redeploying our brave men and women in uniform serving in Iraq and Afghanistan. This could save \$1.8 trillion.

There have been a number of proposals that could help reduce the burden of deficit reduction on older Americans, and in some instances work to improve the programs on which they depend. For example, the Select Committee could examine ways to reduce prescription drug costs by extending Medicaid prescription drug rebates to qualified low-income Medicare beneficiaries which could yield upwards of \$135 billion in savings; or allow CMS to negotiate Medicare Part D prescription drug prices directly with pharmaceutical manufacturers, which could save \$156 billion. In order to achieve further savings on drug costs, the Committee could examine prohibiting so-called "pay for delay" practices, in which brand name biologic manufacturers enter into agreements with generic manufacturers to delay production of generic products. It is estimated that this could net \$2.7 billion in savings.

The Committee could also look at ways to further combat Medicare fraud and abuse. By granting the Centers for Medicare and Medicaid Services greater authority and resources to aggressively target those who would defraud the system, Medicare could save upwards of \$9 billion according to the President's National Commission on Fiscal Responsibility and Reform. This option not only provides much needed savings, but also ensures a more efficient and higher functioning Medicare system.

A report issued by Trust for America's Health indicated that a modest investment in preventative medicine could yield significant savings for Medicare and Medicaid. The report predicted that investing as little as \$10 per person annually in community-based programs focused on healthier living could bring in as much as \$5 billion in Medicare savings and \$1.9 billion in Medicaid savings. Though we recognize that CBO will not score "prevention" savings, we can all agree

that if one promotes healthier living such as smoking cessation, regular exercise, and eating right, one has a far less likely chance of developing long-term, chronic conditions such as diabetes. In fact, according to the National Prevention Strategy, those who increase physical activity combined with healthy weight loss reduce their risk of the onset of type 2 diabetes by 58 percent. It is worth noting that one of every five health care dollars spent in the United States is spent on the treatment of diabetes.

Lastly, as the Congressional Budget Office has indicated, providing a public option for the health insurance exchanges could save the federal government \$88 billion over 10 years. This would provide greater choice for consumers and increase competition within the insurance marketplace, while preserving private market choices. This is a real, viable, and most importantly scored option available to the Super Committee in lieu of cutting benefits to Medicare, Medicaid, or Social Security. Similarly, a Medicare-administered Part D drug plan would reduce costs.

We implore the Committee to reject proposals that would reduce benefits to programs that older Americans have been promised, paid into, and, as such, deserve. Cutting into Medicare, Medicaid, and Social Security would put the fiscal and physical health of senior citizens needlessly at risk, especially at a time of economic hardship.

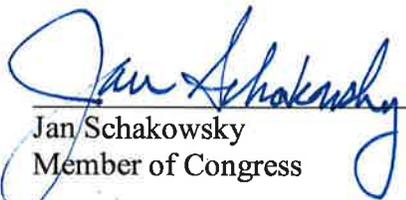
We strongly believe that the Committee should *reject* the following proposals:

- **Reduce Social Security benefits:** Social Security retiree benefits are modest – averaging \$14,000 a year (\$12,000 for women) – but represent the majority of income for 64% of retirees and 90% or more of income for one in three. Half of seniors have less than \$2,100 of retirement savings and 60 percent lack a pension. Since Social Security does not contribute to the deficit and since its 75-year solvency gap can be addressed with modest changes such as raising the wage cap, there is no justification for reducing benefits. Proposals to reduce initial benefits or substitute the chained CPI – which would harm current as well as future recipients – should be rejected. An average earner retiring in 2011 would lose over \$6,000 in benefits over 15 years with the chained CPI.
- **Raise the age of eligibility for Social Security or Medicare.** It is not true that all Americans are living longer. For example, a recent report found that, in 737 counties across the United States, life expectancies for women fell between 1997 and 2007. It is true, though, that raising the age of retirement for full Social Security benefits from 67 to 69 would be a 13% benefit cut. Raising the age of eligibility for Medicare would shift \$11.4 billion in costs to individuals, employers, state and localities.
- **Increase Medicare cost-sharing burdens.** Premiums, deductibles and cost-sharing under Medicare are already high and there is no limit on annual out-of-pocket costs – as a result seniors pay three times the amount of out-of-pocket costs as the non-elderly. Higher cost-sharing will result in seniors foregoing necessary care and will drive up costs to Medicaid and employers who provide retiree benefits.

- **Means testing Medicare.** Medicare already charges higher premiums – up to \$370 a month more for Part B premiums and up to \$70 a month for Part D premiums to higher-income seniors (\$85,000 for an individual, \$170,000 for a couple). There aren't a lot of millionaire seniors -- only 5% of seniors have incomes above the threshold and only 3% have incomes above \$100,000. Seeking more reductions by expanding means-testing would result in seniors with incomes as low as \$45,000 paying significantly higher costs.
- **Reduce federal Medicaid payments.** Medicaid provides assistance to 6 million low-income seniors and pays for 62% of long-term care services. Federal cuts would threaten those services and leave seniors and their families with the financial burden of paying for care. A cut of 15% in federal funding could cost over 753,000 jobs.

We respectfully ask that you carefully weigh these options, as well as all proposals to reduce the federal deficit. Yours is a difficult task, but we are confident that you will make the right decisions that will set our country's fiscal house in order, while maintaining a viable social and health safety net for American families.

Sincerely,


Jan Schakowsky
Member of Congress


Doris O. Matsui
Member of Congress

CC: Sen. Max Baucus
Rep. Xavier Becerra
Rep. Dave Camp
Rep. James Clyburn
Sen. John Kerry
Sen. Jon Kyl
Sen. Rob Portman
Sen. Pat Toomey
Rep. Fred Upton
Rep. Chris Van Hollen