TESTIMONY BEFORE THE

SENATE BUDGET COMMITTEE

ON

A HEARING ON S. 2063, THE BIPARTISAN TASK FORCE FOR RESPONSIBLE FISCAL ACTION ACT OF 2007

October 31, 2007

WASHINGTON, D.C.

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AARP appreciates the opportunity to present its views regarding S. 2063, which would create a bipartisan task force for responsible fiscal action. We commend the Chairman and Ranking Member for their commitment to addressing our nation's long-term deficit in a balanced and bipartisan manner. Our nation's fiscal health has a direct impact on our economy, our people, and our international standing. Solving the fiscal problems that confront us is a daunting and, in many ways, thankless task that will require enormous effort and cooperation. The choices we make matter not only to the budget, but more importantly, to the long-term health and economic security of the American people. Program and revenue changes are more than just budget savings -- they have a direct impact on the lives of every American now and in the future.

People need to be able to count on affordable, quality health and financial security for a lifetime – for themselves, their families and future generations. The long-term challenge is to make sure that current and future generations have health and financial security by maintaining the integrity of Social Security and Medicare in a fair and fiscally responsible manner.

AARP applauds efforts such as this that can also help educate the American people about the dangers of large and continuing federal deficits. We welcome this and other opportunities to reframe the national debate on health and financial security to include the concerns of everyday Americans. AARP members understand that deficit reduction is vital for the future of our children and grandchildren. The solution must be fair and involve everyone: government, business, and individuals. AARP shares the view that we must address the long-term budget deficit in a bipartisan and balanced way, and dealing with it sooner will avoid more dire consequences later. Prompt action means the options

will be more moderate and will provide for greater opportunity for people to prepare for changes over time.

A necessary first step, proposed in this legislation, is a review of the causes of the deficit – both in the long and short terms. AARP believes it is critical to focus on the real drivers in the budget. We strongly urge all policy makers, not just this task force, to reject the misperception that often-blamed "entitlements" are the chief cause of the federal budget deficit. We do not have an entitlements crisis in this country – we have a health care crisis. Blaming all entitlement spending ignores the reality that only health care spending is growing faster than the economy. As a result, it is the health care costs that are the big drivers of our long-term budget outlook. Yet, reducing the rate of growth of health care costs must be accomplished on a system-wide basis, and cannot be achieved by focusing only on Medicare and Medicaid because they merely reflect the rapid growth of health costs throughout the economy. Failure to take a broad look at our health care system will simply result in cost shifting to individuals, businesses and other parts of government and will further destabilize our already fragile health care system with enormous consequences for health security.

We applaud the bill's sponsors for recognizing that deficit reduction cannot be accomplished solely through spending changes; we must also have adequate revenue to finance our nation's priorities. In addition to exploring the traditional revenue base, AARP would recommend particular focus on tax expenditures, that – similar to spending entitlements - confer direct benefits automatically, require no advance appropriation under the law, and have a large impact on the federal budget.

We also urge policymakers to acknowledge the importance of other policies, such as measures to increase personal and national savings and to encourage extending working lives, that would improve our economy and our fiscal health and make the transition to an aging society more manageable.

I. An Aging Population is not the Problem

The fact that America is an aging population is well established, although the consequences are often exaggerated. AARP believes that as a nation we can balance the advancements of longer life spans with the pressures the aging of the boomers and increased longevity place on our government and our society. While demographics play a role, the real budget culprit is a fragmented and disorganized health care delivery system. We hope this task force can help put to rest the notion that our country's fiscal problems are caused primarily by the aging of its citizens. The Congressional Budget Office (CBO) has repeatedly pointed out that the aging of the population is not the primary factor affecting the growth of entitlement programs. If this myth continues to dominate policy decision-making, we run the risk of developing ineffective solutions.

The old refrain is to cut back on entitlement spending, particularly for Medicare and Social Security, because they will consume a large share of our available resources as the boomers start retiring. This refrain reflects two fundamental flaws: it lumps all entitlement spending together, and it overemphasizes the budget impact in dollar-and-cents terms, rather than by the impact they have on people's lives.

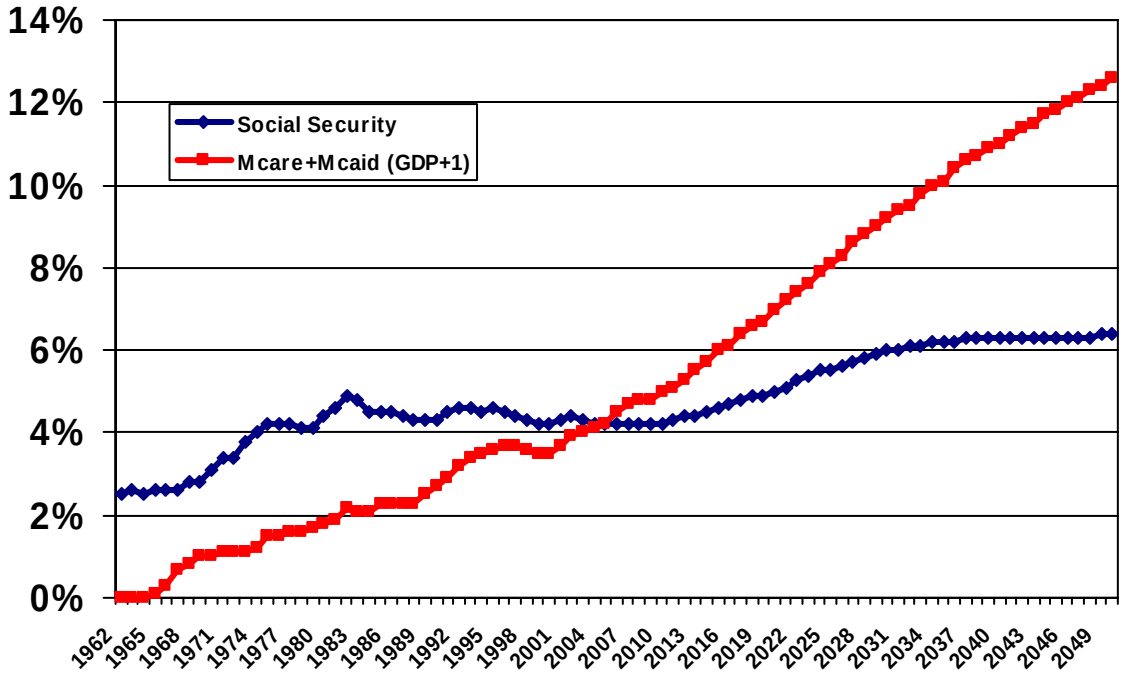
Demographic aging, while significant, is not a sufficient explanation for either current or projected future growth in entitlement spending. Chart 1 shows spending for Social

Security compared to spending for the two largest health programs, Medicare and Medicaid, as a percentage of GDP from 1962 to the present and projected out to 2050.[1] If demographic aging were the problem, we would see similarities in the growth of Social Security and Medicare.[2] Instead, we see a very striking difference in the past and future growth patterns of Social Security and Medicare. A fairly steep increase in overall entitlement spending as a share of GDP between 1962 and 1982 was followed by a 25-year window of stability; with entitlements fluctuating between 10 and 12 percent of GDP. Those differences confirm that demography as an explanation misses much of the story. Social Security's growth "bump" from 2010 to 2035 is due almost entirely to the retirement of the boomer cohort, while the steep health spending trajectory is largely due to non-demographic factors.

[1] CBO projects spending for Social Security, Medicare, and Medicaid through 2050 based on growth in beneficiary populations as well as other programmatic assumptions. Other entitlements are simply assumed to grow at the same rate as GDP.

[2] Both programs do have a substantial share of beneficiaries who are under 65.

Chart 1: Spending for Three Largest Entitlements as Percent of GDP, 1962-2050 (assumes health spending grows at rate of per capita GDP +1%)



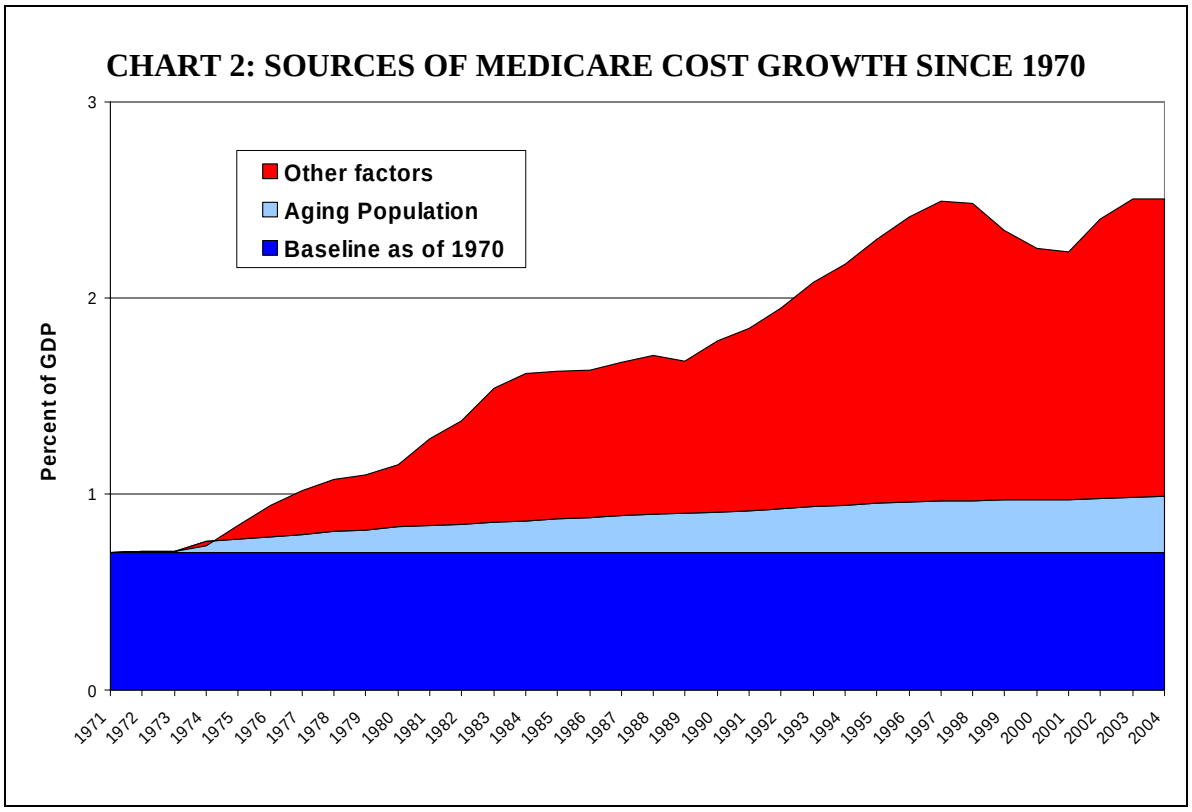
Source: Congressional Budget Office, The Long-Term Budget Outlook, December, 2005

II. Skyrocketing Health Care Costs

While the numbers point to Medicare and Medicaid, the underlying problem is not really with those programs themselves; rather, the problem lies with the overall growth in costs in the health care system. Those rising costs dominate the policy agenda for consumers, employers and unions, state governments, and, with Medicare and Medicaid, the federal government.

In 2007, Social Security accounted for about 4.2 percent of GDP, and Medicare and Medicaid together accounted for only slightly more - about 4.6 percent of GDP. The Congressional Budget Office projects that Social Security spending will increase to about 6.4 percent of GDP by 2050. Medicare and Medicaid, in contrast, are projected to surpass Social Security and grow to more than 12 percent of GDP – primarily because

spending is driven less by aging and more by underlying health care costs increasing faster than the rest of the economy. Health care costs are the key fiscal challenge, not just for the federal budget but for patients and their families, business labor, and state and local governments.

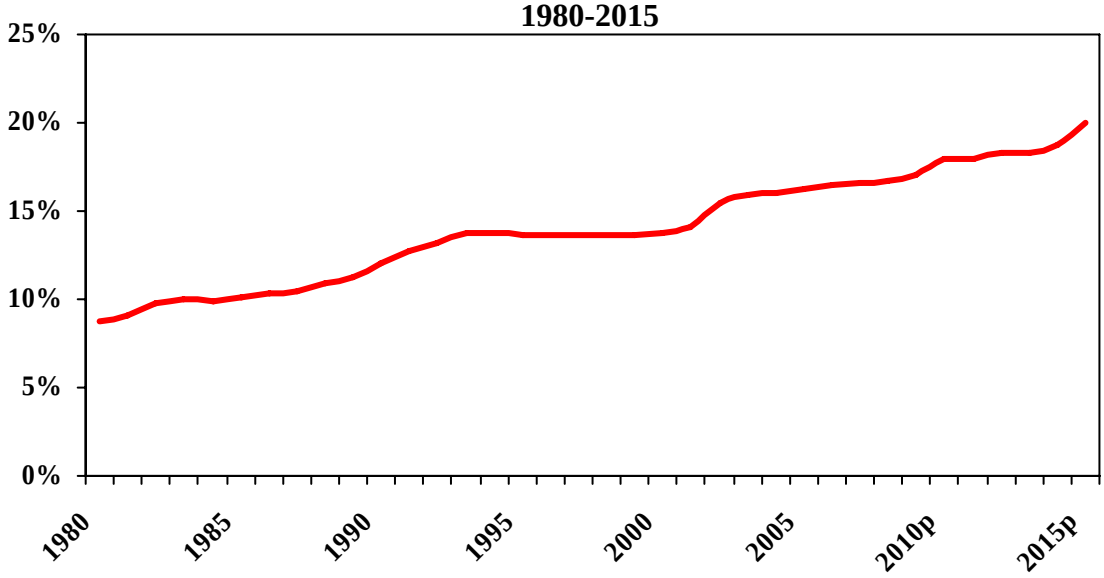


Source: Congressional Budget Office, The Long-Term Budget Outlook, December, 2005, Supplemental Data (Intermediate projections)

The facts are well known, but they remain compelling:

- Health care costs in the United States, which accounted for 12 percent of GDP in 1990, reached 16 percent in 2005. Health costs are projected to reach 20 percent of GDP by 2015.

CHART 3: NATIONAL HEALTH SPENDING AS A PERCENT OF THE GDP, 1980-2015

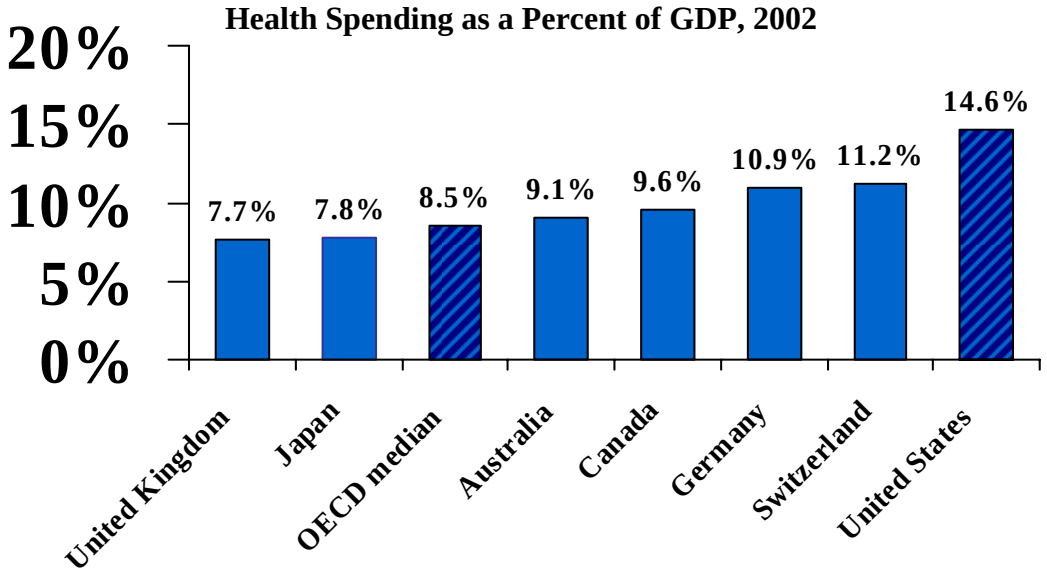


CMS National Health Expenditures: "Health Spending Projections Through 2015: Changes on the Horizon," Health Affairs, February 22, 2006 and "National Health Spending In 2004," Health Affairs January/February 2006.

After flattening at around 14% of GDP from 1995 – 2001, health spending is again increasing as a percent of GDP. It reached 16% of GDP in 2004, and is projected to reach 20% by 2015.

- U.S. health care spending is substantially higher than that of any other developed nation, despite the fact that we are the only nation that doesn't assure coverage for its citizens. In 2002, for example, health care spending was just under 15 percent of GDP in the U.S. That was about one-third higher than spending in the next highest country, Switzerland, where health care spending reached just over 11 percent of its GDP. The median developed nation spent just 8.5 percent of its GDP on health care.

CHART 4: U.S. HEALTH CARE SPENDING MUCH HIGHER THAN OTHER COUNTRIES



"U.S. Health Spending Habits Grab International Attention," Health Affairs July/August 2005 Note: Most recent data show that NHE as percent of GDP in the U.S. in 2002 were 15.4% not the 14.6% given in the graph.

High and increasing health care costs have dramatic implications for projected future spending for Medicare and Medicaid. The underlying growth in health care costs is the key variable for projected federal spending. CBO sets out three scenarios:

- Low cost: if we could slow health care cost growth to the growth in the GDP, Medicare and Medicaid would reach just 7 percent of GDP by 2050.
- Intermediate cost: if health costs increase just 1 percentage point faster than GDP, Medicare and Medicaid would account for about 12.6 percent of GDP by 2050.
- High cost: if health costs increase by 2.5 percentage points faster than GDP, Medicare and Medicaid would account for nearly 22 percent of GDP by 2050.

As these scenarios make clear, the overarching issue in the debate over projected federal spending generally, and entitlements specifically, is the underlying growth in health care costs.

The cost issue must be viewed in the context of the systemic quality problems in our health care system. The Institute of Medicine of the National Academy of Sciences has issued a path-breaking series of reports, notably "To Err is Human" and "Crossing the Quality Chasm." They document tens of thousands of annual deaths due to medical errors and the need to completely transform health care to achieve the aims of a high quality system in the U.S.

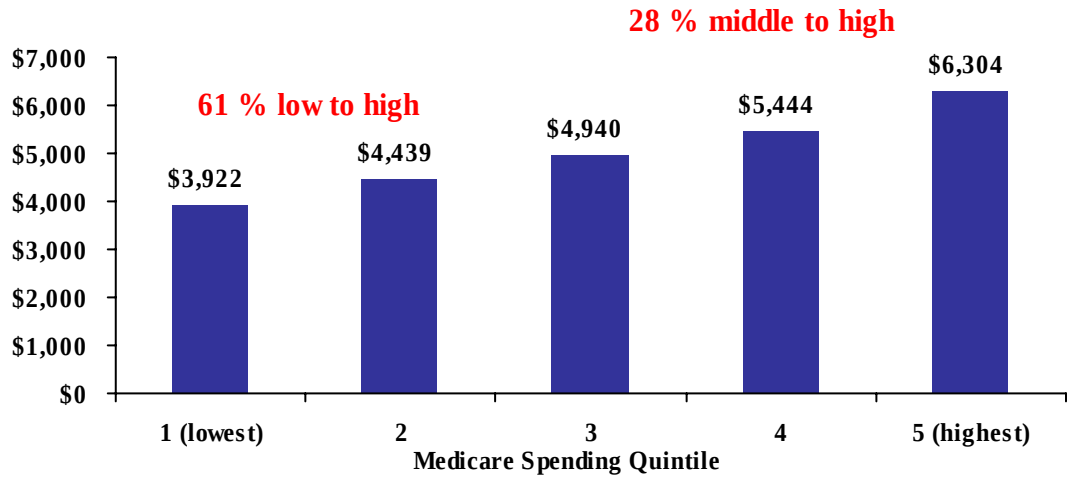
Of most compelling interest for the long-term Medicare spending debate is the link between higher costs and quality concerns. The key finding is that we have reached a level of overall health care spending in this country at which incrementally higher aggregate Medicare spending does not appear to be associated with higher quality.

The most prominent research is from the health care studies group at Dartmouth Medical School, publishers of the Dartmouth Atlas of Health Care. That team has for years conducted careful research using the Medicare data base. They find substantial cost differences in Medicare among different geographic regions around the country, even after adjusting for all of the relevant demographic factors.

For example, after all of the adjustments, Medicare spending still varies by about 61 percent from the regions in the lowest spending quintile (lowest spending 20 percent) to those in the highest spending quintile in the country. And the higher spending regions

(and states) are NOT associated with higher quality. In fact, they achieve lower quality/service scores.

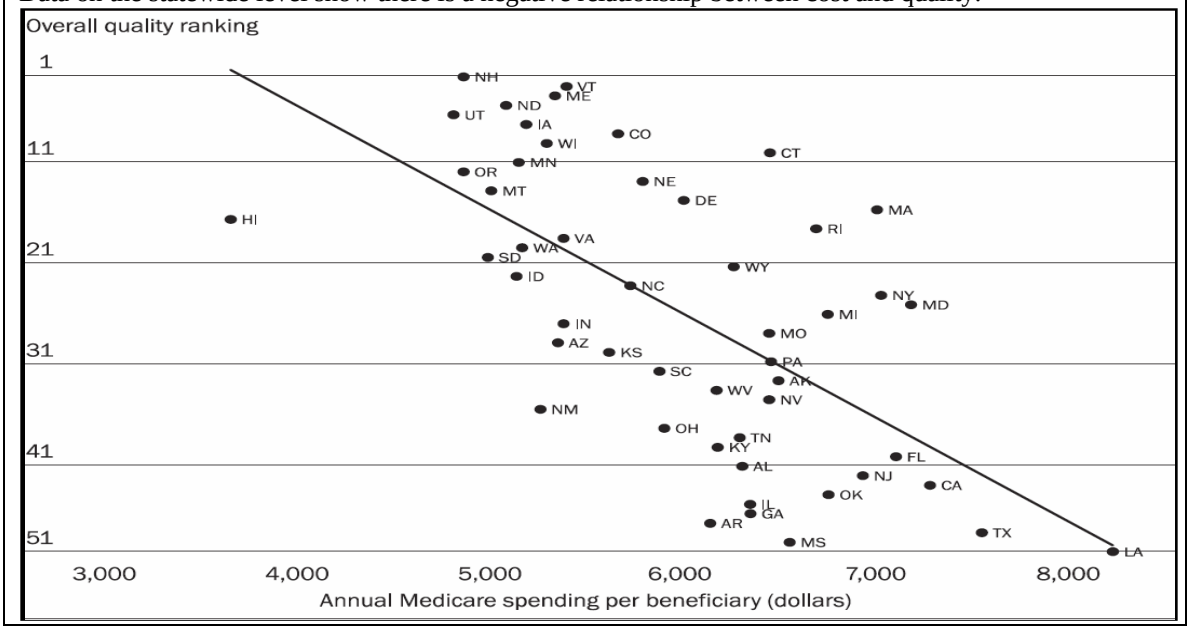
CHART 5: MEDICARE SPENDING PER CAPITA VARIES SIGNIFICANTLY AMONG HOSPITAL REGIONS



Fisher, et al., "The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care." Annals of Internal Medicine, 2003:138(4)

CHART 6: HIGHER SPENDING NOT ASSOCIATED WITH BETTER QUALITY – STATEWIDE

Data on the statewide level show there is a negative relationship between cost and quality.



Baicker and Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality Of Care," Health Affairs Web Exclusive, April 7, 2004

What accounts for the differences? A key driver, accounting for more than 40 percent of the difference in spending among regions of the country, is the structure of the underlying health care delivery system. The researchers find that the higher cost/lower quality areas have more hospital beds per capita, more specialists per capita, and fewer primary care physicians per capita. That leads to higher costs and lower quality because it appears that providers in those communities provide more "supply sensitive" care.

The good news is that there are areas of the country, and states, in which beneficiaries get better quality and service outcomes, at lower cost to Medicare, and lower total coinsurance for patients. We can accomplish that in Medicare in this country under the right conditions – and in particular, if payment incentives are better aligned. The bad news is that beneficiaries in the other areas get worse quality at higher costs. And all beneficiaries and all taxpayers pay more for premiums, cost-sharing, and taxes to pay for the high cost inefficiencies.

But even in the good areas there is substantial room for improvement because efforts to coordinate care and provide the most effective treatments are hampered by a lack of data. There is no comprehensive national health information technology system in place to ensure that physicians and other caregivers have all the relevant information about each patient they are treating. And there is little reliable scientific evidence on which drug or procedure is the most effective option for a given patient in a specific circumstance.

Moreover, according to the U.S. Centers for Disease Control and Prevention, the problem of chronic diseases – such as cardiovascular disease, cancer, and diabetes – must be addressed if we are to tackle escalating health care costs. Chronic diseases account for

more than 75 percent of the approximately $2 trillion Americans spend each year on health care.

It is critical to view Medicare and Medicaid in two ways:

- as participants in that health care system, subject to the dynamics of the underlying health care system in which it purchases care; and
- as leaders and a source of leverage for change in that system. Medicare has a long history of leadership and innovation, especially in payment policy. Innovations have included prospective payment, first for hospitals and now for a full range of providers, as well as the resource-based relative value scale for physicians.

Implications for policy

It is critical to balance Medicare's participant and leadership roles in addressing the cost and quality issues.

- The long-term imperative is to shape and support a more effective health care delivery system for all, including the Medicare population: a system designed to provide high quality and affordable health care for all patients.
- At the same time, it is important to recognize the reality of the need for short-term changes in Medicare where necessary – and for Medicare to help lead toward longer-term structural solutions.

That calls for a clear policy framework to assure that the short-term changes are supportive of long-term directions – or at least are not detrimental to those directions. There are a number of key cost and quality policies to pursue, including:

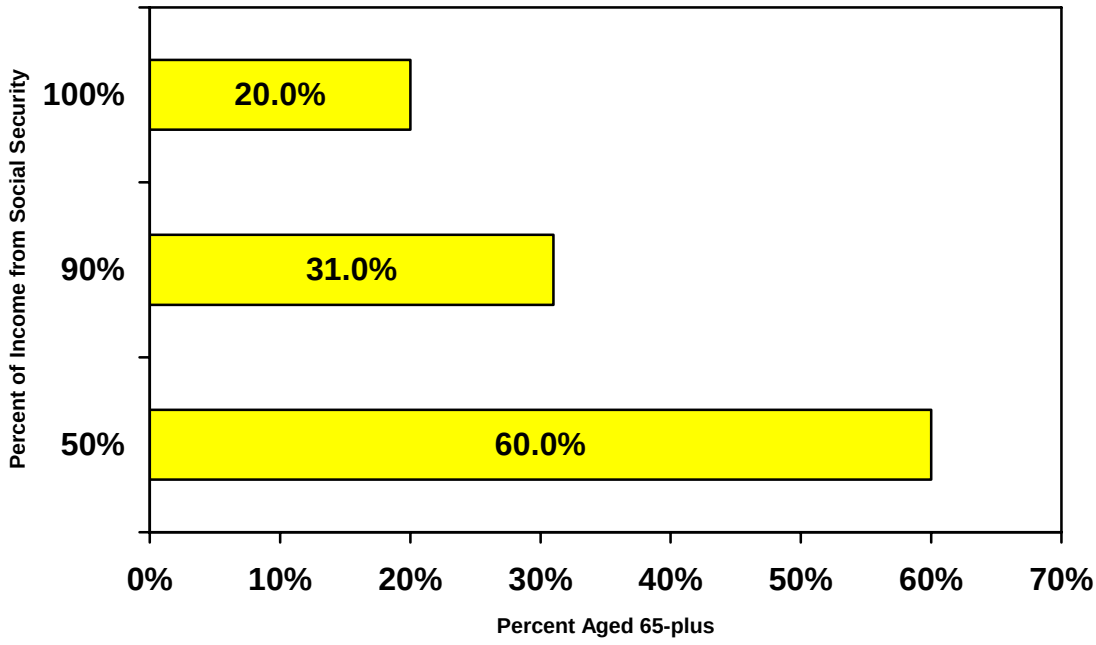
- A much stronger infrastructure of information technology to support the clinical and cost decisions made by health care providers and their patients.
- A much more robust national program of comparative effectiveness research.
- Improving the efficiency of health care delivery by increasing the use of primary care services and encouraging coordination of care. Coordination of care is important for individuals with multiple chronic conditions and especially as individuals move across care settings.
- Providing much better and clearer information about the cost and quality of care for providers, patients, families, and communities. Quality and service issues should be as transparent as possible, as that will stimulate the improvement that both clinicians and patients' desire.
- Avoiding the types of automatic and arbitrary, across the board cuts, driven by the annual budget process or the general revenue "trigger," that have no grounding in policy. With an issue as complicated and critical as health care, this is no time to put health care policy on a budget-driven automatic pilot.
- Reshaping payment incentives across Medicare: provider payments in the traditional program, and health plan payments and competition in Medicare Advantage. All parts of Medicare must work in parallel to provide incentives to restructure care to better serve beneficiaries, and the public at large.

III. Social Security

Social Security is one of our nation's most popular programs among people of all ages. By providing a guaranteed standard of living, Social Security is the hallmark of responsible society. It is financed through workers' contributions that establish eligibility for retirement and disability benefits for workers and eligible family members, and survivor benefits for the loved ones that workers of any age and retirees leave behind upon their death. Social Security has reduced poverty among beneficiaries more effectively than any explicitly anti-poverty program, and it gives countless millions of Americans the freedom to live the lives they choose. We must continue to ensure that the defined benefit promise is preserved and made secure, and that benefits remain adequate.

Most Americans would not have a viable retirement without Social Security, and given our nation's low savings rate and diminished pension system, it will continue to be a critical pillar of retirement income in the future. Today, nearly 1 in 3 retirees count on it for at least 90% of their income and 3 out of 5 rely on it for the majority of their income. We need to make Social Security financially strong over the long-term so that our children and grandchildren can have the same rock-solid foundation on which to build a secure retirement that current beneficiaries enjoy, and so that all Americans can have greater peace of mind.

Chart 7: Relative Importance of Social Security to the Aged 65-Plus Population, 2004



Source: Social Security Administration, *Income of the Population 55 or Older, 2004, Table 6A.1.*

Social Security does not require draconian changes or a major overhaul. Unlike health care, it is not projected to drain the federal budget. In fact, Social Security spending is a smaller share of GDP today than it was in Ronald Reagan's first term. By 2016, it will still consume about the same share of the economy as it did when Reagan was first elected president. Eventually, Social Security's costs will rise, but its growth will largely reflect the eligibility of the boomer cohort, which will occur between 2008 and about 2030. When the last boomer has retired, Social Security costs will resume a gradual and manageable growth path.

While Social Security faces no immediate crisis, it does face a serious, though manageable, long-term financing problem. Viewed from the perspective of the Social Security Administration actuaries, even with no changes, Social Security can pay full

benefits through 2040; after that date, Social Security can pay almost three quarters of promised benefits for decades thereafter.[3]

Of course, delay is neither desirable nor likely. Social Security's long-term solvency can be resolved by relatively modest adjustments if we make them sooner rather than later. The first priority of Social Security reform must be to strengthen the long-term solvency of this guaranteed, defined-benefit program. As in 1983, the path to successful reform of Social Security is likely to combine additional revenues with changes to the benefit structure in a way that maintains the integrity and adequacy of the program but also ensures its long-term viability. Solutions must also be evaluated in the broader context of retirement security so that tomorrow's retirees are not put at greater risk.

IV. **Revenue**

Any meaningful examination of deficit reduction should include a look at both traditional revenue sources and tax expenditures. While taxes are visible to all of us, tax expenditures – often called tax entitlements - are not.

The federal revenue base has eroded over the past seven years. Federal revenues dropped by nearly 5 percent of GDP in only four years (between 2000 and 2004) and spending increased by 1.5 percent of GDP[4] sending the budget from a surplus of 2.4 percent of GDP in 2000 to a deficit of 3.6 percent of GDP in 2004. Although revenues recovered

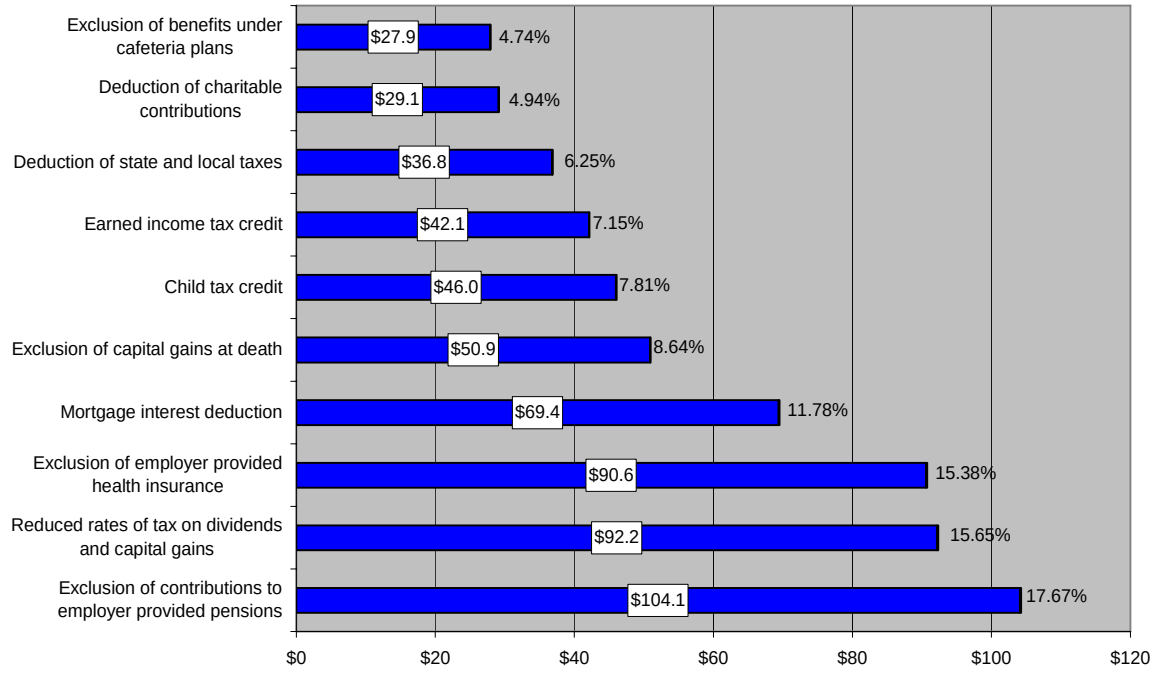
[3] OASDI Board of Trustees, 2007.
[4] Five percent of GDP in 2006 is about $650 billion, more than twice the budget deficit for FY2006. This decline was from an all-time high of revenues as a percentage of GDP, which reached 20.9 percent of GDP in 2001.

somewhat in 2005 and in 2006, they are still well below their peak of 2000, and below levels needed to finance our increasing domestic and global commitments.

The tax code contains a multitude of tax provisions that automatically convey benefits, similar to spending entitlements, but they have very different distributional effects. Chart 8 shows the top 10 tax entitlements.

These "tax entitlements" entail significant amounts of foregone revenue and thus have a deficit impact similar to spending entitlement programs. The benefits of tax entitlements are generally skewed toward more affluent workers. Unlike programs like Social Security and Medicare, which spread their benefits broadly, tax entitlements are highly skewed to the most affluent 20 percent of the U. S. population.

Chart 8: Ten Largest Tax Entitlements in Billions of 2006 Dollars and as Percent of Total Top Ten Tax Entitlements, 2006



Source: U. S. Congress, Joint Committee on Taxation, Estimates of Federal Tax Expenditures for Fiscal Years 2006-2010.

V. Other Considerations

A number of policy and behavioral changes might mitigate adverse long-term budgetary trends. The promotion of longer worklives would have many benefits, both personal and social, including increased ability to save for retirement, reduced number of retirement years to finance, and increased revenues to finance federal programs. The promotion of greater individual saving would improve workers' and families' retirement prospects, particularly as traditional pensions become scarcer.

A. Encouraging Older Workers to Remain in the Workforce

The experience of younger retirees, those about-to-retire, and future retirees will be markedly different than it is for older Americans today. Boomers view retirement as a transition of lifestyles rather than the abrupt end of a job, a new opportunity rather than the conclusion of a career. Nor do boomers necessarily view any particular age as the end of an active life, including work. Indeed, nearly 70 percent of boomers report that they expect to continue working in their retirement years. [5]

According to Bureau of Labor Statistics (BLS) data, a growing number of workers age 65 and over are remaining in the workforce. Earnings from a full-time or a part-time job have become increasingly important for retirement security for many older workers who work out of necessity.

A concerted effort to encourage workers to voluntarily remain in the workforce longer would have significant benefits for our society. If workers age 50 and over remain in the workforce longer, the government's fiscal picture would improve because of added

[5] AARP, Staying Ahead of the Curve: The AARP Work and Career Study, Washington, DC: AAPR, 2003

income tax and payroll tax. Encouraging 50+ workers to voluntarily stay in the workforce would help employers avert potential labor shortages projected as a result of the retirement of the Boomers. Workers age 50+ have years of experience, have valuable skills, and a strong work ethic – their continued work can improve productivity and benefit both the employer and the employee. By working longer, individuals will also have an opportunity to accumulate additional retirement income and stay physically and mentally engaged in society.

B. Increasing Retirement Assets

Roughly half of all working Americans age 50 and older have current pension coverage, a percentage that has not changed in over three decades. We must find ways to raise the national savings rate – particularly for those without access to employer-paid plans – in order to improve individuals' financial security. Particularly promising are automatic enrollment for 401(k) plans and providing workers who currently lack employer provided retirement plans with an opportunity to save in the workplace through automatic payroll deductions.

An increasing number of employers are offering automatic enrollment and employee participation has risen as a result. About half the American workforce -- approximately 75 million workers -- do not have access to workplace saving plans of any kind. For some of these individuals, one option is the saver's credit, which provides tax credits to low and moderate-income individuals and couples who put money into retirement accounts. The credit should be expanded to cover more moderate-income savers. Another promising approach is to provide a payroll deduction mechanism, such as an Automatic Individual Retirement Account, or Auto IRA, for those whose employers do

not provide them with a pension plan or an opportunity to save for their retirement in the workplace.

VI. The Bipartisan Task Force on Fiscal Responsibility

Over the years, the growing federal deficit, long-term financial problems in specific spending programs, such as Medicare and Social Security, and the need for tax reform have resulted in the creation of specific commissions and many more calls for them. The key to success for any policy process, whether a Congressional debate, a task force, or a commission, is to properly define the fundamental nature of the problem and to propose solutions that can garner political and popular support.

Successful ones, such as the 1983 Greenspan Commission, have a specific charge, are bipartisan, take sufficient time to deliberate, and allow our elected officials the opportunity to make changes. The ultimate success of the 1983 commission's recommendations depended on the willingness of key Administration officials and Congressional leaders to come together and finish the job the commission started.

Another successful commission was used for base closings and serves as a model for this task force. The base closing commission, however, had a limited mission, and its recommendations affected a smaller group than this proposal. The importance and scope of spending and revenue changes do not lend themselves to the procedures that were used for closing military bases or other more narrowly focused objectives. While the bipartisan nature of the task force is a plus, the accelerated timetable for non-amendable consideration of the task force recommendations does not allow for an in-depth consideration of the issues or an adequate opportunity for public comment.

Commissions are not a substitute for the willingness of our nation's leaders to come together and solve these problems. Finding solutions will also require the engagement of the American people-- raising their awareness, getting their input, and winning their support. The fast-track process suggested in the proposed commission would largely bypass the input of the American people. Given that the issues at stake go to the heart of the health and financial security of every American, a full and open debate is not only important, but necessary. In fact, increased public engagement is the reason AARP, the Business Roundtable, and SEIU have joined together in an effort called "Divided We Fail" to urge action to secure a brighter future for everyone. Today, people remain concerned about their health and long-term financial security -- only about one-third of Americans believe the next generation will have a better quality of lives than their parents.

AARP, SEIU, and the Business Roundtable, which together represent tens of millions of Americans, are calling upon elected officials to find bipartisan, broad-based solutions to pressing problems. These solutions will involve the American people, our elected officials, and the business community. Divided We Fail is designed to help create an environment for making change happen by bringing together organizations that hold different views. A first step - one that a fast-track approach shortchanges - is to hear what everyday people have to say - about the problems we face and the suggested solutions. Ensuring that Congress and the American people work through these key issues is at the heart of our democracy.

VII. **Conclusion**

The United States is reaching a tipping point with millions of Americans concerned about their health and long-term security. As policy makers seek to deal with budgetary issues, they must do so in a way that addresses the issues of retirement and health security that most people worry about every day .

The debate over government spending, especially Medicare and Social Security, and its impact on the budget, has focused primarily on projected costs, with less attention given to the beneficial impact these programs have had on people's lives. The debate has also failed to focus on the underlying problem of system wide health care costs, which largely drives the increase in projected entitlement spending. The challenge is to improve the quality of people's lives while finding ways to keep pension, health care and other systems affordable and sustainable. These are complex issues that will require the involvement of every sector of society. Meaningful solutions are the responsibility of all of us -- governments, businesses and individuals -- all. Working together, with the right focus and framework, we can ensure affordable quality health and financial security for current and future generations.