CORKER/ALEXANDER "FISCAL SUSTAINABILITY ACT" BILL SUMMARY

Proposal	Spending Reduction
Medicare Reform	$689 Billion
Social Security Reform	$62 Billion
Chained-CPI Government Wide	$216 Billion
Medicaid Reform	$50 Billion
Total	**$1.017 Trillion**

Title I Medicaid ($50 Billion/10 Years)

Comprehensive Medicaid Waivers

Expand the Secretary of HHS' waiver authority under section 1115 of the Social Security Act upon enactment. If a state chooses to apply for a waiver under this Act, the state has access to expedited approval and a share of any savings achieved.

Some savings are built into the waiver. In exchange for limited Secretarial involvement, the state accepts 99% of the funds it would have otherwise received for the five year waiver; demonstrate quality measures improvement; implement waste, fraud and abuse prevention; and cover all eligible populations. The state may include the Medicaid expansion population of childless adults up to 133% of federal poverty as allowed by PPACA at the state's discretion.

For a state to determine how much they will spend throughout the waiver, the Office of Management and Budget (OMB) and the HHS Secretary work with the states to determine an aggregate spending cap based on a per person/ per month expenditure basis. There is a protection for the state if there is high unemployment. The state receives 25% of the savings achieved through an annual payment from the HHS Secretary. Of that savings, the state must reinvest 80% on health care related services, activities or operations. States that do not achieve savings cannot be paid more than the amount they were projected to spend over the life of the waiver at the time of application.

To help expedite the waiver process, the HHS Secretary in consultation with OMB, will devise a template for states to use as they prepare their waiver application. The Secretary and OMB must act upon the waiver request within 90 days of the state's application. In the case of a denial, the state has options to appeal administratively and judicially.

The HHS Secretary will conduct outreach and education to the states on how to employ this waiver and if states choose to apply, they will conduct outreach and education of their plans to their citizens.
Two years after the first waiver is approved and then every three years thereafter, the HHS Secretary will report to the Congressional committees of jurisdiction on the waivers. The report must include an evaluation of the quality of care and cost effectiveness of the state's waiver program. The state will be required to supply information as requested by the HHS Secretary.

Phased in Elimination of Allowable Provider Taxes under Medicaid ($50 Billion/10 Years)

Upon enactment, allowable provider taxes under Medicaid will be phased down by 0.6 percentage points a year until they reach 0% in 2024 and will then remain 0%.

Title II Medicare ($689 Billion/10 Years)

Medicare Fee-For-Service Program Reforms ($150 Billion/10 Years)

Beginning in 2015, Medicare Part A and B will have a unified deductible of $550. There will be a uniform 20% coinsurance on everything up to $5,500 out of pocket and then 5% coinsurance until $7,500 out of pocket. Total out of pocket spending is capped at $7,500. In addition, Medigap will no longer be allowed to offer first dollar coverage. In 2018, there will be no new entrants into Medigap plans, but current enrollees may renew.

Medicare Total Health Program ($290 Billion/10 Years)

This plan ensures that fee-for-service Medicare will exist permanently with no cap on funding, while providing beneficiaries an additional option. Medicare Advantage is phased out and replaced with Medicare Total Health. All Medicare beneficiaries are eligible for a Total Health plan beginning in 2017 or traditional Medicare. There is no artificial cap on spending growth. Instead we rely on competition to reduce spending by setting up a competitive bidding system for plans. To ensure plenty of plan options, the bids weighted averages are divided into quintiles. The subsidy for the beneficiary is set to the 2nd lowest quintile. Both traditional Medicare and the new Medicare Total Health have to bid in all regions.

Plans bid in regions based on Health Service Areas which follow the MSAs and rural health service patterns within a state as recommended by MedPAC.

Premiums are subsidized at 85% of the 2nd lowest quintile. CMS will adjust payments to plans to risk adjust for health status and provide for a geographic adjustment. We expect the original fee for service Medicare to be in the 2nd lowest quintile across about 80% of the country.

Medicare Total Health Plans must offer a basic benefit plan that is equivalent to traditional Medicare. The basic benefits under a Medicare Total Health plan must include the same benefits and cost sharing structure as under original Medicare fee-for-service. Medicare Total Health plans can also offer plans that are actuarially equivalent to traditional Medicare. However the benchmark will be set to the basic plan.

Medicare Total Health plans must also include prescription drug coverage and will be reimbursed for providing that coverage in the same way Medicare Advantage plans that offer prescription drug coverage are reimbursed for prescription drug coverage under current law. Beneficiaries enrolled in the original Medicare fee-for-service program option may elect a prescription drug plan under Medicare Part D in the same manner as under current law.

Plans may also offer supplemental benefits so long as the beneficiary pays any additional costs resulting from the addition of those benefits to the plan.

Increase in the Medicare Eligibility Age ($125 Billion/10 Years)

Raise the age incrementally to 67 by 2027.

Income Related Part B and D Premiums ($50 Billion/10 Years)

Require income related premiums for seniors with incomes starting at $50,000/year and increase the share of premiums incrementally through $250,000/year.

Direct and Indirect Graduate Medical Education ($50 Billion/ 10 Years)

This provision would limit direct graduate medical education to 120% of the national average salary paid and is annually updated by chained CPI.

The IME adjustment bump in Medicare reimbursement of their inpatient rates is decreased from 5.5% to 2.2%.

Eliminate Bad Debt ($15 Billion/10 Years)

Phase out bad debt payments by FY 2019 except for dual-eligibles.

Home Health ($9 Billion/10 Years)

Accelerate Medicare home health productivity adjustments and there basing of Medicare home health payments by 1 year. Both of these were included in PPACA.

Title III Social Security

Adjustments to the Bend Points

Modifies the current retirement benefit formula to make it more progressive by adding a new bracket (*i.e.* bend point) transitioning the replacement rates from 90/32/15 to 90/30/15/5.

Changes to Benefit Computation

Phases in an increase in the number of work years used for benefit computation from 35 years to 38 years.

Minimum Social Security Benefit

Creates a new minimum benefit to ensure that full career workers (i.e. those with 30 years in the workforce) receive at least 125% of the Federal Poverty Line from their Social Security benefits. This benefit is aimed primarily at minimum wage workers and would phase down proportionally for workers that have less than 30 years but more than 10 years of earnings.

Longevity Benefit

Adds a new 20 year benefit increase, equal to 5 percent of the average benefit, to protect Social Security recipients who may have outlived their personal retirement resources. The benefit is proportionally phased in over a five year period.

Adjustment to the Normal and Early Retirement Age

Starting from 2027 (the year in which the Normal Retirement Age hits 67), both the Normal Retirement Age and the Early Eligibility Retirement Age are indexed to life expectancy. This will have the effect of raising the Normal Retirement Age to 68 and the Early Eligibility Retirement Age to 63 by 2050. The goal is to maintain the constant ratio of years in retirement to years in adulthood.

Hardship Exemption

Allows beneficiaries to collect half of their benefits as early as age 62 and the other half at a later age.

Coverage for Newly Hired State and Local Workers

After 2020, all newly hired state and local workers shall be covered under Social Security. All state and local pension plans must share their data with Social Security. Currently, Social Security covers around 90 percent of all workers, but there is a share of states and localities that exclude their employees from Social Security and put them in their own separate retirement systems, which is allowed under current law.

SSDI Reforms

Converts SSDI beneficiaries (i.e. those on disability insurance) to retired status upon attainment of the early eligibility age. This reform is phased in over an 18 year period, and in conjunction with the other reforms to the early eligibility age. Medicare eligibility for those who are still medically disabled would continue.

Information Campaign

Directs the Social Security Administration to better inform future beneficiaries on the financial implications of early retirement and promote greater retirement savings.

Enhanced Social Security and Medicare Statements:

The Social Security statement sent to beneficiaries will be required to show the present value of payroll taxes paid and expected benefits for the both the Medicare and Social Security programs. The statement will also show the present value of the portion of benefits a beneficiary will receive from both programs that is not covered by premiums or payroll taxes (i.e., the portion that is deficit financed).

Title IV Miscellaneous Federal Government Programs

Chained CPI ($216 Billion Spending Reduction/$124 Billion Revenue/10 Years)

The Government would move to chained CPI for all programs that have colas or cost increases automatically set each year. This would also include Social Security.