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MEDICARE REFORM

Issues Associated With General Revenue Financing

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Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the use of general fund revenues as part of Social Security and Medicare reform. As you requested, I will focus my remarks specifically on general revenue financing of the Medicare program. Despite some very positive, short-term developments regarding our economy, the federal surplus, and Medicare spending, the bigger picture remains virtually unchanged. Long-term cost pressures facing the program are considerable. Even before adding a prescription drug benefit, for example, projected program spending threatens to absorb unsustainable shares of the nation's budgetary and economic resources. The Office of the Actuary at the Health Care Financing Administration has estimated the actuarial imbalance for the Hospital Insurance (HI) portion of Medicare at $2.9 trillion through 2074–this is the present value of the amount by which future payments exceed projected revenues for the program. In testimony before this and other congressional committees, the Comptroller General has expressed concern about the expanded use of general revenues in program financing and the need for comprehensive reform that will address the program's long-term sustainability.[1] My statement today will underscore these concerns.

It is tempting to push aside this gloomy forecast in light of recent surplus projections. However, the recent good news on the budget does not mean that difficult budget choices are a thing of the past. First, it is important to recognize that, by their very nature, projections are uncertain. This is especially true today because, as the Congressional Budget Office (CBO) notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution.

Moreover, while the size of future surpluses could exceed or fall short of projections, demographic and cost trends will, in the absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to

[1]See *Medicare: Program Reform and Modernization Are Needed But Entail Considerable Challenges* (GAO/T-HEHS/AIMD-00-77, Feb. 8, 2000); *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS/AIMD-00-103, Feb. 24, 2000); *Medicare Reform: Observations on the President's July 1999 Proposal* (T-AIMD/HEHS-99-236, July 22, 1999).

view this period of projected prosperity as an opportunity to begin addressing the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and possible solutions much more difficult and painful.

As the foregoing suggests, the stakes associated with Medicare reform are high not only for the program but also for the rest of the federal budget, both now and for future generations. Without meaningful reform, the long-term financial outlook for the Medicare program is bleak. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) by reducing public debt to increase national saving and investment, (2) by reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) by establishing a more sustainable Medicare program that delivers effective and affordable health care to our nation's seniors.

Leading reform proposals that address comprehensive reform such as those of the President and Breaux-Frist include the use of general funds as part of their financing mechanisms. While some precedent exists for the use of general funds in federal trust funds, we need to ask how such general fund infusions can be structured so as to facilitate, not impede, needed reform and fiscal discipline.

In this context, I would like to make a few summary points before delving into the specifics of Medicare's financial health and issues raised by increased reliance on general revenue financing.

- To qualify as meaningful reform, any proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability—the most critical issue facing Medicare. Reform efforts ought not to be piecemeal. Financial reforms such as general revenue financing should not be considered alone but as part of a broader reform package. Recent history with Medicare reform shows that benefit expansions are compelling while fiscal controls and constraints are difficult to enact and sustain.

- General fund infusions may well be a necessary part of program reform, but caution is warranted in considering the commitment of additional general revenues. General revenue financing can extend the solvency of the program but does not alone do anything to make the program more sustainable in the long term. In fact, without underlying reforms, general revenue financing could very well serve to reduce the sense of urgency to

make needed program changes that impending trust fund bankruptcy provides to policymakers.

- In addition, some consideration should be given to a process to guard against the risk that growing program financial needs will routinely be met with additional general fund infusions, thereby further mortgaging the future and crowding out other national needs. Accordingly, any additional general revenue infusions should be coupled with mechanisms to monitor costs over time and to alert policymakers of the need to take timely action when total projected costs exceed thresholds or triggers related to some indicator of sustainability.

Health care costs compete with other legitimate priorities in the federal budget, and their projected growth threatens to crowd out future generations' flexibility to decide which competing priorities will be met .In making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of providing for other important national needs and economic growth. Given the size of Medicare's projected funding needs, it is realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. The time to begin the difficult but necessary steps to reclaim our fiscal future is now, when we have budget surpluses and a demographic "holiday" with retirees a far smaller proportion of the population than they will be in the future.

Federal Trust Funds

Before I turn to a more detailed description of Medicare's financial structure including the Hospital Insurance (HI) trust fund, it is helpful first to look more generally at what the term "trust fund" means in the context of the federal budget.

The federal budget consists of several fund types: the general fund, special funds, public enterprise funds, intragovernmental funds, and trust funds.[2] All of these except trust funds are considered to be "federal funds." All unified budget transactions fall within either of two fund groups: (1) federal funds and (2) trust funds.

[2]There are both revolving and nonrevolving trust funds, but that difference is not relevant to this analysis.

Although some budget summary tables show only about a dozen major trust funds, in fiscal year 1998 there were 112 trust funds.[3] These covered a wide range of purposes: from social insurance (Social Security and Medicare), employee compensation (pensions and health benefits), insurance, natural resources and environmental cleanup to transportation. Social Security is by far the largest trust fund, followed by federal employee retirement funds (civilian and military) and the Medicare trust funds.

In the federal budget, the term "trust fund" neither means what it does for a private trust fund nor indicates unique characteristics within the federal budget.[4] The manager of a private trust has a fiduciary obligation to the beneficiary and must manage the trust's assets on behalf of that beneficiary according to the stipulations of the trust. The manager cannot unilaterally alter the terms of that trust. In contrast, the federal government both owns the assets of most trust funds and can, through legislation, raise or lower the fund's collections or payments, or alter the purposes of the trust fund.

Unlike a private trust fund, which can set aside money for the future by increasing its assets, federal trust funds are not vehicles to park "real" savings for the future. They are simply budget accounting mechanisms used to record receipts and expenditures earmarked for specific purposes. This is unlike state governments, which can "park" surplus resources in "real" pension funds and other trust funds that are routinely invested in "assets" (e.g., readily marketable securities) outside the government. Under current law, when a federal trust fund like the HI trust fund runs a surplus of payroll tax revenues over benefit payments, that surplus must be invested in Treasury securities and used to meet current cash needs of the government. These securities are an asset to the trust fund, but they are a claim on the Treasury. When a trust fund runs a cash deficit, as the HI trust fund did between 1992 and 1998, it redeems these securities to pay benefit costs exceeding current payroll tax receipts. Medicare will be able to do this until 2015 under current law when the HI trust fund securities are projected to be exhausted. However, in order to redeem these securities, the government as a whole must come up with cash by

[3]Based on GAO analysis. This count represents trust funds and trust fund groupings for similar purposes.

[4]Within the federal budget, there is no substantive difference between a trust fund and a special fund. Both are internal accounting devices used to track the collection and use of funds earmarked for specific purposes. The only difference between a "special" fund and a "trust" fund is the word "trust" in the legislation establishing the account. In fiscal year 1998 there were 102 special funds.

increasing taxes, reducing spending, reducing projected surpluses, or borrowing more from the public if projected surpluses are not realized.

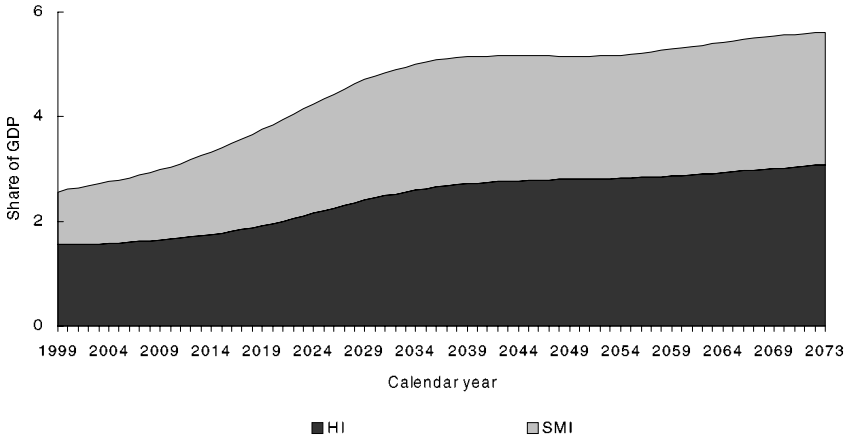
Since the trust fund's securities constitute a legal claim against the Treasury, increasing the balances of Treasury securities held by the HI trust fund would extend its solvency and increase the formal claim that HI has on future general revenues. However, increasing the HI trust fund balances alone, without underlying reform, does nothing to make the program more sustainable. From a macro perspective, the critical question is not how much a trust fund has in assets, but whether the government as a whole has the economic capacity to finance the trust fund's claims to pay benefits now and in the future and at what cost for other competing claims for scarce resources. From a micro perspective, trust funds can provide a vital signaling function for policymakers about underlying fiscal imbalances in covered programs. However, extending a trust fund's solvency without reforms to make the underlying program more sustainable can obscure the warning signals that trust fund balances provide, thereby creating a false sense of security and delaying needed reform.

Medicare's Financial Condition

Medicare Is Fiscally Unsustainable in the Long Term

Without meaningful reform, the long-term financial outlook for the Medicare program is bleak. Under the Trustees' 1999 intermediate projections, HI and Supplementary Medical Insurance (SMI) expenditures taken together are expected to increase dramatically, rising from about 12 percent in 1999 to about a quarter of all federal revenues by mid-century, even without adding to the benefit package. Over the same time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown in figure 1.

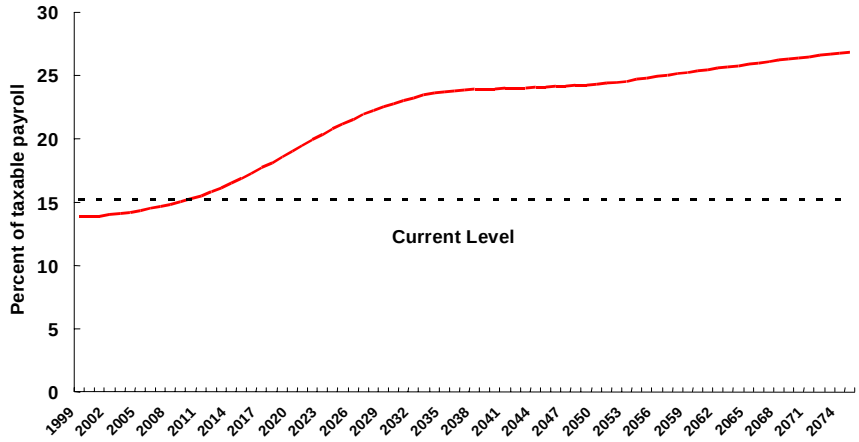
Figure 1: Medicare Spending as a Percentage of Gross Domestic Product (GDP) 1999 to 2073



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

Absent reform, the financial burden of Medicare and Social Security on future taxpayers becomes unsustainable. As figure 2 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers.

Figure 2: Social Security and Medicare HI Costs as a Percentage of Taxable Payroll, 1999 to 2074



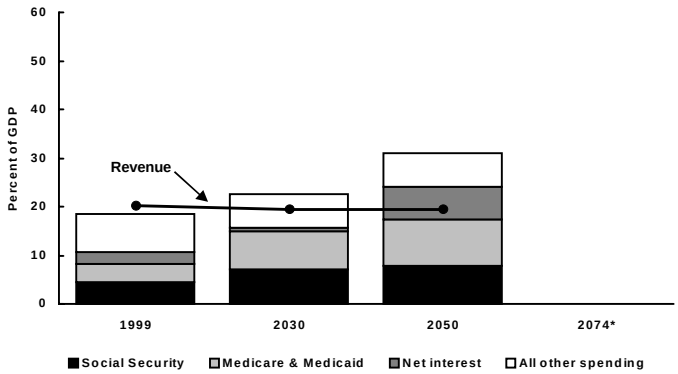
Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund, and *1999 Annual Report*, Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To bring Social Security into actuarial balance today would require raising the payroll tax by 2.07 percentage points–a 17-percent increase–whereas the HI payroll tax would have to be raised by 1.46 percentage points–a 50-percent increase–to restore actuarial balance to the HI trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare and Social Security spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming, for example, that the Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would require more than three-quarters of total federal revenue. (See fig. 3.) Budgetary flexibility would be drastically constrained and

little room would be left for other federal spending priorities such as national defense, the young, infrastructure, and law enforcement.

Figure 3: Composition of Spending as a Share of GDP Under the "Eliminate Non-Social Security Surpluses" Simulation



*The "Eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.

Notes:

1. Revenue during the simulation period is lower as a share of GDP than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.

2. Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure.

Source: GAO's January 2000 analysis.

The levels of public saving assumed in the simulation exceed both U.S. historical levels and those sustained by most other countries we have studied. Essentially, saving just the Social Security surplus would eliminate debt held by the public—an outcome with benefits for both the budget and the economy. But it would require sustained fiscal sacrifice unlike any seen in our modern experience. Under this simulation, debt held by the public would not only be eliminated; the U.S. would be investing federal surpluses in nongovernmental assets for several years. Moreover, the levels of public saving assumed in the simulation will not by themselves be enough in the long term to promote the kind of economic growth to which we have become accustomed. Even assuming these significant and unprecedented levels of fiscal restraint over many years, entitlement spending will still encumber an unsustainable share of federal resources in the future.

As with Social Security, the progressive absorption of a greater share of the nation's resources for health care is in part a reflection of the increasing growth in the elderly population, but Medicare cost growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

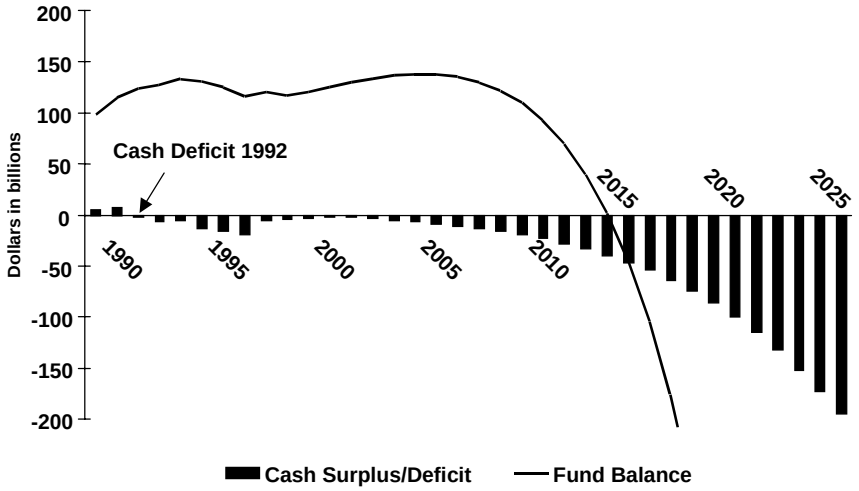
Medicare's Current Program and Financing Structure

Under the current Medicare structure, the program consists of two parts. Medicare's HI Trust Fund, also known as part A, is financed primarily by payroll taxes paid by workers and employers.[5] SMI, also known as part B, is financed largely through general revenues. Currently, the financial health of Medicare is often gauged by the solvency of the HI trust fund. This measure, however, presents an incomplete picture of total program solvency. In addition, because of the nature of federal trust funds, the HI trust fund balances do not provide meaningful information about program sustainability—that is, the government's fiscal capacity to pay benefits when the program's cash inflows fall below benefit expenses.

The 1999 Trustees' annual report showed that Medicare's HI component was, on a cash basis, in the red from 1992 to 1998; in fiscal year 1998, earmarked payroll taxes covered only 89 percent of HI spending. Although the Office of Management and Budget has recently reported a $12 billion cash surplus for the HI program in fiscal year 1999 due to lower than expected program outlays, the Trustees' report issued in March 1999 projected continued cash deficits for the HI trust fund. (See fig. 4.)

[5]Old-Age and Survivors Insurance and Disability Insurance (OASDI) beneficiaries whose adjusted gross income exceeds certain threshold amounts must pay income taxes on up to 85 percent of their annual benefits. The Omnibus Budget Reconciliation Act of 1993 increased the maximum amount of Social Security benefits subject to income tax from 50 to 85 percent and provided that the additional revenues would be credited to the HI trust fund. Revenue from this source totaled $5.1 billion in fiscal year 1998.

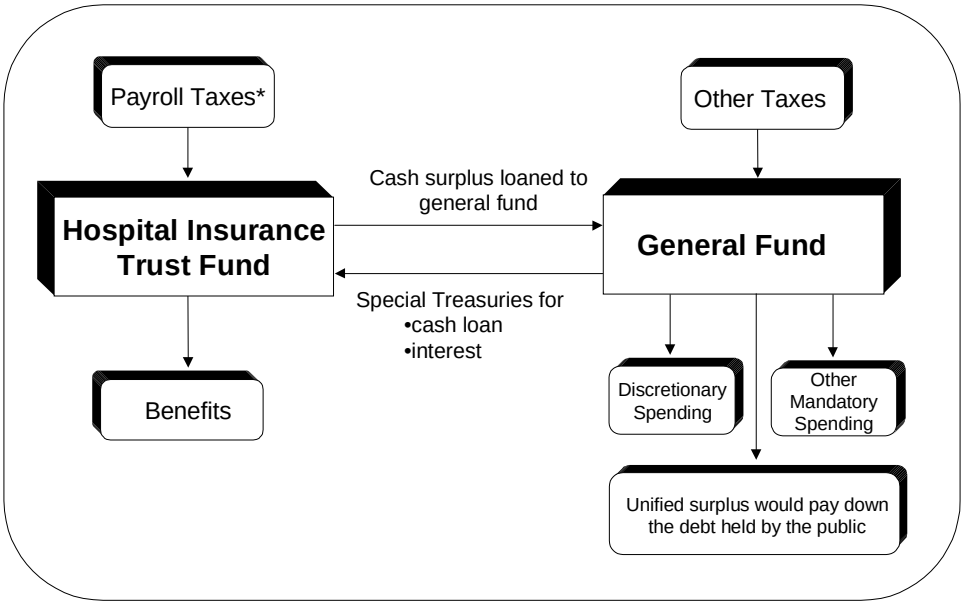
Figure 4: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025



Source: GAO analysis of data from the Office of the Actuary, Health Care Financing Administration.

Much of the public debate focuses on trust fund balances—and the 1999 Trustees' report estimates that the HI trust fund will remain solvent through 2015. However, the more important measure is the net cash impact of the trust fund on the government as a whole. From this perspective, when the HI trust fund has an annual cash deficit, as it did from 1992 through 1998, Medicare is a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. To finance these cash deficits, Medicare drew on its special issue Treasury securities acquired during the years when the program generated a cash surplus. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce projected surpluses. Figure 5 depicts the relationship of the HI trust fund to the unified budget and the general fund under current law when the trust fund has a cash surplus.

Figure 5: Hospital Insurance Trust Fund Flows Under Current Law



*Since 1994, the HI trust fund has also received a share of income taxes paid on Social Security benefits.

Note: If the trust fund has a cash surplus, debt held by the fund increases because special Treasuries are issued to the fund. If the fund is in deficit, the flow is reversed with the fund redeeming special Treasuries and receiving cash from the general fund to make benefit payments.

Source: GAO analysis.

In contrast to HI, SMI, also known as part B, is financed through general revenues and beneficiary premiums. The history of SMI financing illustrates the difficulties of maintaining fiscal discipline. Originally the part B premium was set at a level to finance 50 percent of SMI program costs. However, less than 10 years later, the method for setting the SMI premium was tied to changes in the cost of living, resulting in premiums dropping below 25 percent of program costs. Under current law, the premium is now set at 25 percent of program costs, with general revenues paying the remaining 75 percent.

Currently, the financial health of the entire Medicare program is generally gauged by the solvency of the HI trust fund–not the imbalance between total program revenue and total program spending (both HI and SMI). Clearly HI trust fund solvency is an incomplete measure, and since SMI is projected to grow faster than HI in the coming decades, the HI trust fund

risks becoming an increasingly inadequate signal of future fiscal imbalances. This measure could in fact become misleading if additional general revenue were used in program financing.

When outlays outstrip revenues in the HI fund, it is tempting to shift some expenditures to SMI. Such cost shifting extends the solvency of the HI Trust Fund but does nothing to address the fundamental financial health of the program. Worse, it masks the problem and may cause fiscal imbalances to go unnoticed. For example, in 1997 the Balanced Budget Act modified the home health benefit, which resulted in shifting a portion of home health spending from the HI trust fund to SMI. Although this shift extended HI trust fund solvency, it increased the draw on general revenues in SMI while generating little net savings. Ultimately, the critical question is not how much a trust fund has in assets, but whether the government as a whole can afford the promised benefits now and in the future and at what cost to other claims on scarce resources.

Use of General Funds in Medicare Reform Raises Design Issues

A consensus appears to be emerging that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. The current Medicare program, without improvements, is ill-suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other, the program is outmoded in that it has not been able to adopt modern, market-based management tools, and its benefit package contains gaps in desired coverage. Thus, while financial questions loom, pressure is mounting to update Medicare's outdated benefit design. However, doing so carries with it the potential to exacerbate Medicare's spending trajectory.

Given the aging of our society and the increasing cost of modern medical technology, it is inevitable that the demands on the Medicare program will grow. The National Bipartisan Commission on the Future of Medicare noted that the program will require additional resources as the percent of the population eligible for benefits increases. One major uncertainty in Medicare's future financing needs, the Commission noted, is the inability to predict the evolution of the health care delivery system or the impact that technology will have on health care costs. At the same time the Commission emphasized the urgent need for reforms that will slow the growth in Medicare spending.

Consider the case of prescription drug coverage. In 1965, when the Medicare program was first established, outpatient prescription drugs were not nearly as important a component of health care as they are now. Used appropriately, pharmaceuticals can cure diseases, improve quality of life, and substitute for more expensive services in some cases. Most private insurance options recognize these advantages by including pharmaceutical coverage in their benefit packages. Many seek to similarly modernize Medicare's benefits. However, this desired expansion comes at a time when prescription drug spending is increasing rapidly. From 1993 to 1998, prescription drug spending grew at an average annual rate of 12.4 percent compared with 5 percent average annual growth in health care expenditures overall. A recent study has suggested that expanding Medicare's benefit package to include prescription drugs could add between 7.2 and 10 percent annually to total program costs,[6] and CBO estimates the cost of the President's proposed prescription drug benefit at $149 billion in additional federal spending between 2003 and 2010.[7] Although the case for adding a prescription drug benefit to Medicare is appealing, any benefit expansion needs to be targeted, include appropriate cost controls, and other program reforms that will begin to close the gap between existing promised and funded benefits.

Given the size of Medicare's projected funding needs, it is realistic to expect that reforms to bring down future costs will have to proceed in an incremental and iterative fashion. Comprehensive Medicare reform cannot, once implemented, be put on automatic pilot. Recent experience implementing changes shows that reform is a dynamic process requiring vigilance and flexibility.

Last year, when the Comptroller General testified before the Congress on the financing of the HI trust fund, he said that additional general revenues may very well be necessary, but such a change would represent a marked departure from payroll tax financing with implications that warrant explicit and serious debate.[8] Leading reform proposals that address comprehensive reform such as those of the President and Breaux-Frist include the use of general funds as part of their financing mechanisms. While some precedent exists for the use of general funds in federal trust

[6]M.E. Gluck, *National Academy of Social Insurance Medicare Brief: A Medicare Prescription Drug Benefit* (April 1999), p. 8. *http://www.nasi.org/Medicare/medbr1.htm*

[7]CBO, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001: A Preliminary Report* (March 9, 2000), p. 4.

[8] *Medicare and Budget Surpluses: GAO's Perspective on the President's Proposal and the Need for Reform* (GAO/T-AIMD/HEHS-99-113, March 10, 1999).

funds, we need to ask how such general fund infusions can be structured so as to facilitate, not impede, needed reform and fiscal discipline.

The proposed changes to Medicare financing raise some important issues that are not unique to the Medicare program but arise whenever general revenues are commingled with other types of revenues such as payroll taxes and beneficiary premiums in a federal trust fund. Whatever the financing structure of Medicare, a continuing need will exist for a signal of future fiscal imbalances to alert policymakers of the need to take timely and prudent action. In addition, some consideration should be given to a process that could guard against the risk that growing program financial needs will routinely be met with additional general fund infusions, thereby further mortgaging the future and crowding out other national needs. Such a process could also be used to periodically re-assess the mix of differing sources of program financing.

In the remainder of this testimony I would like to examine design issues raised by leading reform proposals' expanded use of general revenue, focusing on the implications for program fiscal discipline and consequences for the unified budget.

The President's Proposal

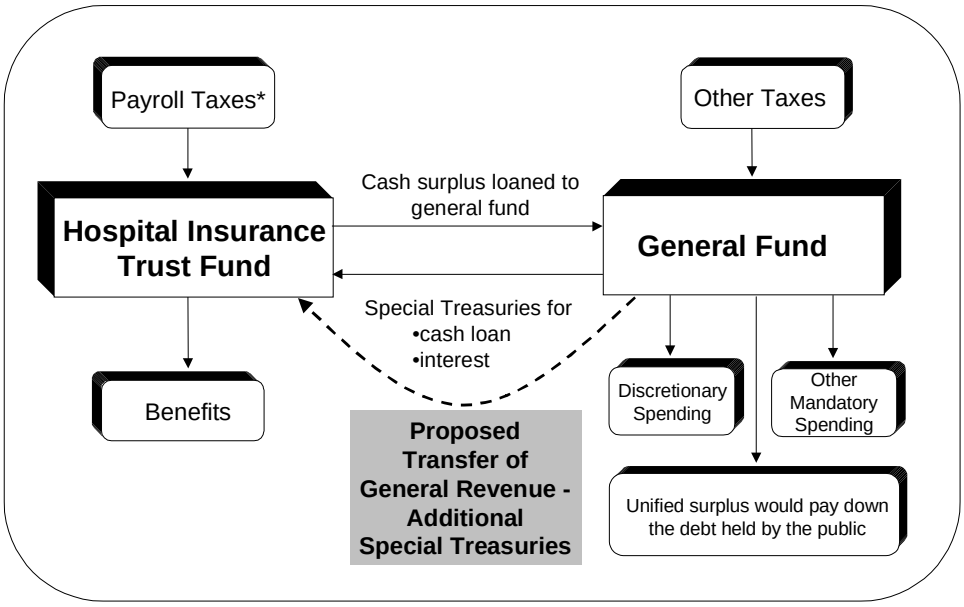
The President's proposal is intended to make Medicare more efficient, modernize the benefit package, and extend the program's long-term solvency. The proposal consists of several programmatic changes. Private health plans would set their own premiums for a standard package of benefits, competing on the basis of price and quality. Beneficiaries who joined relatively inexpensive plans would pay little or nothing. Those who joined relatively expensive plans would pay more. The system is intended to make beneficiaries more sensitive to the cost consequences of their decisions. The proposal maintains the traditional Medicare fee-for-service program and includes measures intended to improve its efficiency and strengthen future financing.[9] The proposal also includes a prescription drug benefit.

[9]For example, the plan would create a preferred provider option that would reward beneficiaries with lower cost-sharing requirements when choosing certain providers; expand use of centers of excellence, in which providers that specialize in certain procedures receive a global fee for all services provided rather than a separate fee for each service; extend certain Balanced Budget Act (BBA) provisions that reduce provider payment rate increases; impose a 20-percent copayment for clinical laboratory services; and index the part B deductible for inflation. See *Medicare Reform: Observations on the President's July 1999 Proposal* (GAO/T-AIMD/HEHS-99-236, July 22, 1999) and *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS/AIMD-00-103, Feb. 24, 2000).

In addition the proposal would earmark a portion of the projected non-Social Security surpluses for Medicare. According to the Office of Management and Budget, the proposal would use $432 billion, or 58 percent of the projected on-budget surpluses, over the next 10 years for Medicare. Of the $432 billion, $299 billion (40 percent of the on-budget surplus) would be transferred to the HI trust fund and used to reduce debt held by the public. The proposal would use $98 billion of projected on-budget surpluses to pay for the proposed prescription drug benefit. The remaining $35 billion would be used to establish a reserve fund. This fund is to be used for debt reduction or, in the event that the President and the Congress agree, for a policy that provides protections against catastrophic drug costs for Medicare beneficiaries or policies that otherwise strengthen the Medicare program.

The proposed transfer of surpluses would extend the solvency of the HI trust fund from 2015 to 2025 and preserve the divided financing structure (HI and SMI). It would not, however, address the sustainability of the Medicare program and may, in fact, serve to decrease the likelihood of needed reform. The transfer would also represent a significant departure in how HI is financed. Established as a payroll tax funded program, HI would now receive an explicit grant of funds from general revenues not supported by underlying payroll tax receipts. That is, the value of securities held by the HI trust fund would exceed that supported by earlier payroll tax surpluses, and these additional securities would constitute a new claim on the general fund for the future. Figure 6 depicts the flow of funds for the HI program under the President's proposal.

Figure 6: Hospital Insurance Trust Fund Flows Under the President's Proposal



*Since 1994, the HI trust fund has also received a share of income taxes paid on Social Security benefits.

Note: If the trust fund has a cash surplus, debt held by the fund increases because special Treasuries are issued to the fund. If the fund is in deficit, the flow is reversed with the fund redeeming special Treasuries and receiving cash from the general fund to make benefit payments.

Source: GAO analysis.

According to the Administration, the underlying rationale for the transfers is that Medicare should be guaranteed a share of the benefits resulting from the fiscal improvement that debt reduction and lower interest costs would bring about.

With regard to its more general budgetary significance, the President's proposal is part of a broader initiative that would save a major share of the surplus, including all of the Social Security surplus, to reduce debt held by the public. According to the Administration's projections, this initiative will reduce interest payments from $230 billion in 1999 to nearly zero in 2013 when publicly held debt would be virtually eliminated. The reduction

in publicly held debt proposed by the President would confer significant short- and long-term benefits to the budget and the economy. Our work on long-term budget outlooks illustrates the benefits of maintaining surpluses for debt reduction. Today, interest on the debt represents the third largest expenditure in the federal budget. Reducing the publicly held debt reduces these costs, freeing up budgetary resources for other programmatic priorities. For the economy, lowering debt increases national saving and frees up resources for private investment. This in turn leads to stronger economic growth and higher incomes over the long term.

The size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional financing from general revenues. However, the mechanism the President has proposed entails significant risks if considered on its own without being coupled to reforms. Indeed, I would note that the President has also included certain reforms as part of his proposal. Without underlying reform, increasing the HI trust fund balances would do nothing to make the program—HI or SMI—more sustainable. In fact, the transfer would interfere with the signaling function that trust fund mechanisms can serve for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that the proposed transfer will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program through 2025—well into the peak of the baby boomers' retirement. Furthermore, the SMI portion of Medicare, projected to grow even faster than HI, is unaffected by this transfer.

This is a major change in the underlying theoretical design of the HI program. Whether you believe it is a major change in reality depends on what you assume about the likely future use of general revenues under the current circumstances. For example, current projections are that the HI trust fund will exhaust its securities to pay the full promised benefits in 2015. If you believe that this shortfall would be made up with general funds when the time came, then the shift embedded in the President's proposal merely makes that explicit. If, however, you believe that there would be changes in the benefit or tax structure of the fund instead, then the President's proposal represents a very big change. In this case, less of the long-term shortfall would be addressed through future changes in the HI program itself and more would be financed through higher taxes or spending cuts elsewhere in the federal budget as a whole. Again, we have recognized that the President has now coupled his financing proposal with substantive Medicare reforms. It is critical that these two elements not be severed.

Another issue the proposal raises is whether the transfers would be made regardless of whether the expected budget surpluses are actually realized. The amounts to be transferred apparently would be written into law as a fixed dollar amount rather than as a percent of the actual on-budget surplus in any given year. These transfers would have a claim on future general revenues even if the actual on-budget surplus fell below the amount specified for the transfers. It is important to emphasize that any proposal to allocate surpluses is vulnerable to the risk that those projected surpluses may not materialize. Proposals making permanent changes to use the surplus over a long period are especially vulnerable to this risk.

The Breaux-Frist Proposal

Like the President's, the Breaux-Frist proposal (S. 1895) would effect both structural and substantive change to Medicare financing. Breaux-Frist addresses the principal elements of reform using a competitive premium approach to contain costs and modernize program benefits.[10] The proposal would also eliminate the HI trust fund by merging it with SMI to create a single unified Medicare trust fund. This change would eliminate the potential for cost shifting between the two programs as well as the use of the HI trust fund as a measure of program solvency. Instead, the proposal would establish a new concept for measuring "programmatic insolvency" as the point at which general fund contributions exceed 40 percent of total program expenditures. Under Breaux-Frist, the Trustees would be required to report annually on the percentage of total expenditures financed by general fund contributions and identify the first fiscal year (if any) in which the program was projected to become "programmatically insolvent." Congressional approval would then be required to authorize any additional contributions to the Medicare trust fund.

In these and certain other respects, the Breaux-Frist proposal incorporated recommendations made by the National Bipartisan Commission on the Future of Medicare. The Commission called attention

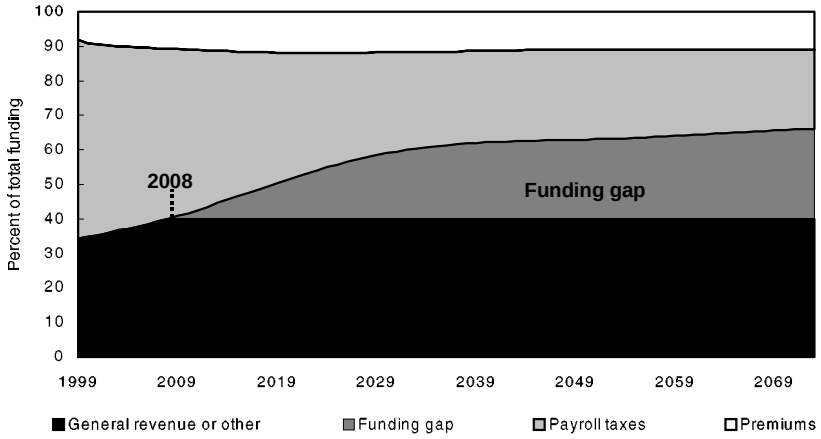
[10]Under Breaux-Frist, each participating health plan (including traditional fee-for-service Medicare, which would be administered by the Health Care Financing Administration) would determine its own premium for a benefit package that must cover all benefits offered by traditional Medicare. The percentage of the premium paid by the beneficiary would be set through a formula that compares a plan's premium with a national average of all plan premiums. Beneficiaries who joined relatively inexpensive plans would pay little or nothing. Those who joined relatively expensive plans would pay more. The system is intended to make beneficiaries more sensitive to the cost consequences of their decisions. Because plans would compete for market share, they would have an incentive to operate efficiently and attract beneficiaries by setting premiums that reflect that efficiency. The proposal includes provisions to ensure low-income beneficiaries access at little or no cost. Breaux-Frist would require plans to offer high option coverage that would modernize Medicare's benefit package by providing outpatient prescription drug and stop-loss benefits. The incremental cost of high option coverage would be subsidized for low-income beneficiaries while other beneficiaries would pay such costs themselves. An independent Medicare board would be established to administer the program as a whole.

to the inadequacy of the HI trust fund as a measure of total program solvency, noting that the portion of Medicare expenditures paid by general funds has increased over time relative to the share paid by payroll taxes and beneficiary premiums. According to the Commission, a new measure of solvency was needed that would couple the uncertainty inherent in the task of gauging program financing in light of the difficulty in predicting future health care technology with the real need for the public to evaluate the cost of Medicare and how we should choose to fund this program over time.

The 40-percent threshold for general fund contributions proposed by Breaux-Frist would provide a mechanism that would require policymakers to revisit Medicare reform if program financing demands continue to grow in the coming decades as the proportion of the population eligible for benefits grows. This mechanism could prompt future Congresses to periodically revisit Medicare financing issues and enact needed reforms. In concept the use of a threshold holds the potential to enhance future federal budgetary flexibility by calling attention when Medicare's share of general revenues is about to exceed specified levels. If coupled with an effective oversight process, a threshold mechanism could also prompt Congress to debate the appropriate proportions of general fund contributions, payroll taxes, and premiums for Medicare financing in the context of contemporary economic and budgetary environments.

Current spending projections show that absent reform that addresses total program cost, this limit would be reached in less than 10 years. (See fig. 7.) These data underscore the need for reform to include appropriate measures of fiscal sustainability as well as a credible process to give policymakers timely warning when fiscal targets are in danger of being overshot.

Figure 7: Projected Funding Gap Under a 40-Percent Threshold for General Revenue Contributions



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

Designing a Threshold for General Fund Contributions

As I discussed earlier, the introduction of general revenue financing to trust fund programs raises some important design issues, one of which is that such financing interferes with the signaling function that the trust fund account structure provides. Accordingly, it would be desirable to put in place some mechanism to constrain general revenue contributions or at least to signal that they are growing and ought to be addressed. Both Breaux-Frist and the President's proposals include elements designed to moderate future Medicare spending, but their approaches are untested. It would be imprudent to adopt a financing structure relying on general revenues without a mechanism to gauge spending and revenues and sound an early warning if policy course corrections are warranted.

The Breaux-Frist approach would deem the trust fund "programmatically insolvent" if the general revenue transfer needed to make payments exceeded 40 percent of total Medicare expense for the fiscal year. While this establishes a "trigger" for insolvency, it does not specify what would happen if insolvency occurs. Both a trigger and some resulting specified course of action would be necessary to ensure that imbalances between trust fund receipts and payments are addressed before they become an unending drain on general revenues.

Given that Medicare cost growth has generally been faster than growth in the rest of the budget, a trigger that permits the dollar amount of general

revenue financing to float upward as Medicare expenses increase would allow increasingly larger shares of general revenues from other government programs. To avoid this potentially unencumbered draw on general revenue a number of different indicators might be explored as possible triggers to action. For example, a trigger could be defined as when the general revenue transfer reaches some specified percent of total federal revenues. Such a trigger could limit general revenue support to a certain share of federal revenue rather than letting it grow at the same rate as Medicare expenses as in Breaux-Frist. Other possible triggers could be a specified floor in the trust fund, such as the balance falling below 1 year's worth of payments; the percentage of gross domestic product devoted to Medicare; or program spending per enrollee.

Whatever the trigger, the key question would be what happens when the trigger limits are reached. One approach in designing such a trigger would be to couple it with specified actions to occur if the trigger is reached. A "hard" trigger would include specific provisions that would automatically go into effect if the trigger is reached. Perhaps more realistically, a "softer" trigger could require the Congress or the President to take some action or to re-affirm acceptance of the Medicare cost growth and provide additional general revenues to cover it. This would at least ensure that the Congress and the President periodically review and decide how to address cost growth if it occurs.

Several alternatives might be considered for implementing such a trigger. For example, reaching a trigger could require the President to propose how to deal with the growth and the Congress to vote on the proposal, either accepting it or developing an alternative. Or the congressional budget process could be used to require the Congress to deal with Medicare cost growth by establishing a point of order against a budget resolution that includes a Medicare spending path that exceeds a specified trigger measure. Raising the point of order could require the Congress to propose changes to Medicare to bring it within the specified measure or vote to accept the cost growth. If program changes are desired, reconciliation instructions could be included in the budget resolution. The President would be brought into the process as it progressed because changes to Medicare would require enactment of a law. In fact, the current budget process contains a similar point of order against worsening the financial condition of the Social Security trust funds.

Discipline cannot be instilled by a process change alone; leaders must be committed to enforcing discipline for it to be effective. The trust fund mechanism has shown that when such processes or mechanisms are viewed as credible, they can help focus the debate and promote timely

actions. If the signaling feature of trust funds is to be weakened by general revenue injections, it is imperative that some other process discipline be developed, either as I have suggested or in some other way. We will be happy to work with your staff to further develop any of the ideas I have mentioned or others that may be proposed to inject the necessary discipline.

Concluding Observations

In determining how to reform the Medicare program, much is at stake—not only the future of Medicare itself but also assuring the nation's future fiscal flexibility to pursue other important national goals and programs. As the Comptroller General has said, the greatest risk lies in doing nothing to improve the program's long-term sustainability or, worse, in adopting changes that may aggravate the long-term financial outlook for the program and the budget.

It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Relieving them of some of the burden of today's financing commitments would help fulfill this generation's fiduciary responsibility. It would also preserve some capacity to make their own choices by strengthening both the budget and the economy they inherit. While not ignoring today's needs and demands, we should remember that surpluses can be used as an occasion to promote the transition to a more sustainable future for our children and grandchildren. While reducing debt is important, debt reduction alone will be insufficient to secure our economic future. We need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and meaningful reform less feasible.

The bottom line is that surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large. National saving pays future dividends over the long term but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. The prudent use of the

nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

Mr. Chairman and Members of the Committee, this concludes my prepared statement. I will be happy to answer any questions you may have.

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