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MEDICARE AND BUDGET SURPLUSES

GAO's Perspective on the President's Proposal and the Need for Reform

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Mr. Chairman and Members of the Committee:

It is a pleasure to be here today to discuss the President's recent proposal for addressing Medicare and use of the projected budget surpluses over the next 15 years. As you know, I testified last month on the implications of the President's surplus proposals for Social Security. Today, I will briefly reprise our views on the overall fiscal consequences of the proposal, discuss what it does and does not do for the Medicare program, and examine the importance of and difficulty in making fundamental changes to this complex program.

Regarding the President's proposal:

- It would significantly reduce debt held by the public from current levels, thereby also reducing net interest costs, raising national savings, and contributing to future economic growth. This element of the President's proposal would have positive short- and long-term effects on the economy.
- It provides a grant (or in the President's word, a gift) of a new set of Treasury securities for the Medicare Hospital Insurance (HI) program which would extend the life of the HI trust fund from 2008 to 2020. It is important to note, however, that these new Treasury securities would constitute a new unearned claim on general funds for the HI program--a marked break with the payroll tax-based financing structure of the program. This would be a significant change that could serve to undermine the remaining fiscal discipline associated with the self-financing trust fund concept.
- It has no effect on the current and projected cash-flow deficits that have faced the HI program since 1992–deficits that taxpayers will continue to finance through higher taxes, lower spending elsewhere or lower paydowns of publicly held debt than the baseline. Importantly, the President's proposal would not provide any new cash to pay for medical services.
- It does not include any meaningful program reform that would slow spending growth in the HI program. In fact, the transfer of these new Treasury securities to the HI program could very well serve to reduce a sense of urgency for reform. At the same time, it could strengthen pressure to expand Medicare benefits in a program that is fundamentally unsustainable in its present form.

The current Medicare program is both economically and fiscally unsustainable. This is not a new message--the Medicare Trustees noted in

the early 1990s that the program is unsustainable in its present form. They also noted the need for dramatic and fundamental reform of the program to assure its solvency. With regard to Medicare:

- The program's continued growth threatens to crowd out other spending and economic activity of value to our society. Even if we save the entire surplus, Medicare is projected to more than double its share of the economy by 2050.
- Meaningful reform of this program is urgently needed and such reform will require hard choices. The program changes enacted in 1997 illustrate how difficult even incremental reform is to adopt. Major change requires reshaping the nation's perspective on health care consumption and drawing distinctions between what the nation needs, wants, and can afford both at the national and individual level.
- To be effective and sustainable, reforms must begin soon and be comprehensive in nature. However, the history of entitlement reforms tell us that, to be enduring, such reforms must be introduced gradually after widespread public education in order to garner sufficient support from the system's multiple stakeholders.

Context: Long-term Outlook Is Important

It is important to look at the President's proposal in the context of the fiscal situation in which we find ourselves. After nearly 30 years of unified budget deficits, we look ahead to projections for "surpluses as far as the eye can see." At the same time, we know that we face a demographic tsunami in the future that poses significant challenges for Social Security, Medicare, and our economy as a whole. In this context, it is noteworthy that the President has proposed a longer term framework for resource allocation than has been customary in federal budgeting.

Although all projections are uncertain—and they get more uncertain the farther out they go—we have long held that a long-term perspective is important in formulating fiscal policy for the nation. Each generation is in part the custodian for the economy it hands the next and the nation's long-term economic future depends in large part on today's budget decisions. This perspective is particularly important because our model and that of the Congressional Budget Office (CBO) continue to show that absent a change in policy, the changing demographics to which I referred above will lead to renewed deficits. This longer term problem provides the critical backdrop for making decisions about today's temporary budget surpluses.

Surpluses are the result of a good economy and difficult policy decisions. They also provide a unique opportunity to put our country on a more sustainable path for the long term, both for the nation's fiscal policy and selected entitlement programs. Current decisions can help in several important respects: (1) current fiscal policy decisions can help expand the future capacity of our economy by increasing national savings and investment, (2) engaging in substantive reforms of retirement and health programs can reduce future claims, (3) by acting now, we have the opportunity of phasing in changes to Social Security and Medicare programs over a sufficient period of time to enable our citizens to adjust, and (4) failure to achieve needed reforms in the Social Security and Medicare programs will drive future spending to levels that will eventually "squeeze out" most or all discretionary spending, including national defense spending. If we let the achievement of a temporary budget surplus lull us into complacency about the budget, then in the middle of the 21st century we could face daunting demographic challenges without having built the economic capacity or program and policy reforms to handle them.

The Proposal

Before turning to Medicare specifically, it is important to describe the President's overall proposal for using the surpluses over the next 15 years. The proposal's effects on Medicare are part of a broader initiative to save a major share of the surplus to reduce the debt held by the public and thereby enhance future economic capacity for the nation.

The President proposes to use a significant portion of the total projected unified budget surpluses over the next 15 years to reduce debt held by the public. He also proposes to take some related steps to address the financing problems facing both the Medicare and Social Security programs. His approach to this, however, is extremely complex and confusing.

Specifically, the President proposes to allocate about two-thirds of the projected surplus over the next 15 years to reduce publicly held debt. This portion of his proposal would increase our future economic capacity. At the same time, the President proposes to transfer a like amount to the Social Security and Medicare trust funds in the form of nonmarketable Treasury securities. In effect, the President's proposal would trade debt held by the public for debt held by the Social Security and Medicare trust funds. The administration has defended this approach as a way of assuring both a reduction in debt held by the public and as securing a "first claim" for both Social Security and Medicare on what they call the "debt-reduction dividend" to pay future benefits for those two programs. The HI program

would receive nearly $700 billion in additional Treasury securities – representing nearly 15 percent of total surpluses over the 15 years.[1] This transfer is projected to extend the life of the HI trust fund from 2008 to 2020.

The President's proposal has raised important questions about how the federal government can promote long-term economic security by using today's surplus resources to "save for the future." In the federal unified budget, the only way to save for the future is to run a unified budget surplus or purchase a financial asset. When there is a cash surplus it is used to reduce debt held by the public. Therefore, to the extent that there is an actual cash surplus, debt held by the public falls. This is exactly what happened in fiscal year 1998 when the debt held by the public was reduced by $51 billion.

In the federal budget, trust funds are not vehicles to park "real" savings for the future. They are simply budget accounts used to record receipts and expenditures earmarked for specific purposes. A private trust fund can set aside money for the future by increasing its assets. State governments similarly 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. However, under current law, when a trust fund like HI ran a surplus of payroll tax revenues over benefit payments, the excess was 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, like HI has been doing since 1992, it redeems these securities to pay benefit costs exceeding current payroll tax receipts.[2] Medicare will be able to do this until 2008 under current law when its trust fund securities will be exhausted. However, in order to redeem these securities, the government as a whole must come up with the cash by either increasing taxes, reducing spending, or raising borrowing from the public above the baseline.

Increasing the balances of Treasury securities owned by HI trust funds alone would increase the formal claim that the trust funds have on future general revenues since the trust fund's securities constitute a legal claim

[1]With the additional interest these new securities would earn, total assets held by the HI trust fund would go up by over $1 trillion.

[2]This may mean either using interest or the principal itself to cover the difference.

against the Treasury. 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 funds claims to pay benefits now and in the future. 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 paper solvency without reforms to make the underlying program more sustainable can, in effect, obscure the warning signals that trust fund balances provide.

Government Financing

The President's proposals would enhance the nation's future economic capacity by significantly reducing debt held by the public from the current level of 44 percent of gross domestic product (GDP) to 7 percent over the 15-year period. The President notes that this would be the lowest level since 1917. Nearly two-thirds of the projected unified budget surplus would be used to reduce debt held by the public. Because the surplus is also to be used for other governmental activities, the amount of debt reduction achieved would be less than the baseline (i.e., a situation in which none of the surplus was used), but nonetheless the outcome would confer significant short- and long-term benefits on the budget and the economy.

Our previous work on the long-term effects of federal fiscal policy has shown the substantial benefits of debt reduction.[3] One of these is lowering the burden of interest payments in the budget. Today, net interest represents the third-largest "program" in the budget, after Social Security and Defense. Interest payments, of course, are a function of both the amount of debt on which interest is charged and the interest rate. At any given interest rate, reducing publicly held debt reduces net interest payments within the budget. For example, CBO estimates that the difference between spending the surplus and saving the surplus is $123 billion in annual interest payments for debt held by the public by 2009--or almost $500 billion cumulatively between now and then. Compared to spending the entire surplus, the President's proposal would also substantially reduce projected interest payments. Lower interest payments lead to larger surpluses; these in turn lead to lower debt which

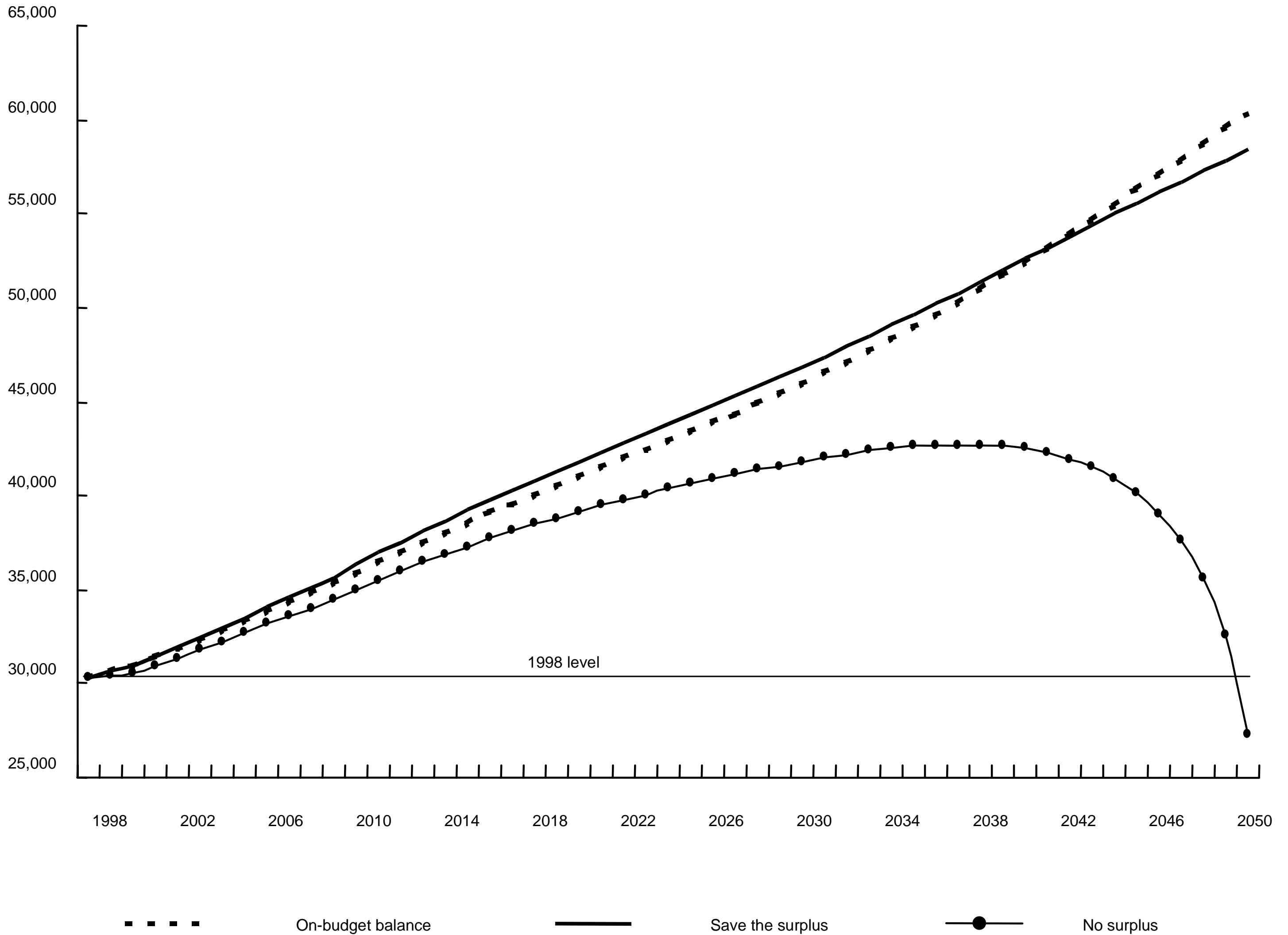
[3]Budget Issues: Analysis of Long-Term Fiscal Outlook (GAO/AIMD/OCE-98-19, October 22, 1997).

leads to lower interest payments and so on: The miracle of compound interest produces a "virtuous circle." The result would be to provide increased budgetary flexibility for future decisionmakers who will be faced with enormous and growing spending pressures from the aging population.

For the economy, lowering debt levels increases national saving and frees up resources for private investment. This in turn leads to increased productivity and stronger economic growth over the long term. Over the last several years, we and CBO have both simulated the long-term economic results from various fiscal policy paths. These projections consistently show that reducing debt held by the public increases national income over the next 50 years, thereby making it easier for the nation to meet future needs and commitments. Our latest simulations done for the Senate Budget Committee, as shown in figure 1, illustrate that any path saving all or a significant share of the surplus in the near term would produce demonstrable gains in per capita GDP over the long run.[4] This higher GDP in turn would increase the nation's economic capacity to handle all its commitments in the future.

[4]The "on-budget balance" path assumes that any surplus in the non-Social Security part of the budget is "spent" on either a tax cut or spending increases or some combination but assumes the current law path for the Social Security trust fund (SSTF). Thus, the surplus in the Social Security trust fund remains untouched until it disappears in 2013 after which the unified budget runs a deficit equal to the SSTF deficit. The "save the surplus" path assumes no changes in current policies and that budget surpluses through 2024 are used to reduce debt held by the public. The "no surplus" path assumes that permanent increases in discretionary spending and tax cuts deplete the surpluses but keep the budget in balance through 2009. Thereafter, deficits reemerge as spending pressures grow.

Figure 1: GDP Per Capita Under Alternate Fiscal Policy Simulations



Source: GAO Analysis.

While reducing debt held by the public appears to be a centerpiece of the President's proposal—and has significant benefits—as I noted above, the transfer of a portion of the unified surpluses to the HI trust fund is a separate issue. The transfer is not technically necessary: Whenever revenue exceeds outlays and the cash needs of the Treasury, debt held by the public falls.

The President's proposal appears to be premised on the belief that the only the way to sustain surpluses is to tie them to Social Security and Medicare. He has merged two separate questions: (1) How much of the surplus should be devoted to reducing debt held by the public? and (2) How should the nation finance these two programs in the future? The President has proposed to save the surplus by, in effect, hiding it in the Social Security and HI trust funds. The additional nonmarketable Treasury securities transferred to the Social Security and Medicare trust funds are recorded as a subtraction from the unified budget surplus–a new budgetary concept. Accordingly, the surplus disappears under this novel scoring approach since these transfers approximate the surplus the President is proposing to save by reducing publicly held debt.[5]

Let me turn now to the question of how the President's proposal would affect Medicare financing.

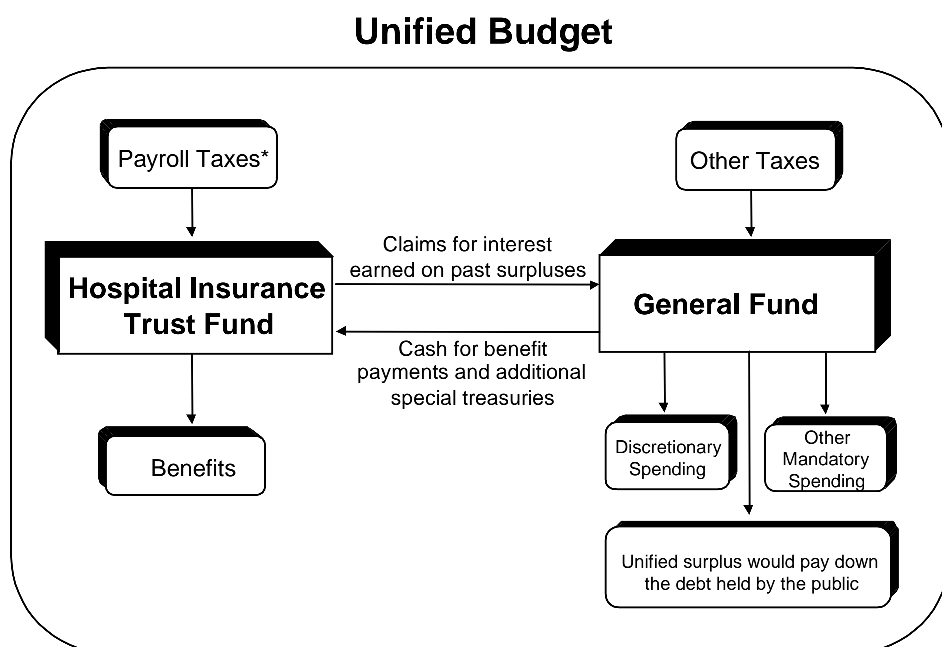
Impact on Medicare Financing

The mechanics of the proposed transfer of surpluses to the Medicare program are, like the transfers to Social Security, complex and difficult to follow. In form they are similar, but the effects on Medicare would be somewhat different. Unlike Social Security, Medicare's HI program has been experiencing a cash flow deficit since 1992–current payroll taxes and other revenues have been insufficient to cover benefit payments and program expenses. Accordingly, Medicare has been drawing on its special Treasury securities, along with interest on those accumulated balances, acquired during the years when the program generated a cash surplus. In effect, these general fund payments can be viewed as repaying the loan of cash that the trust fund provided the rest of government when the Medicare program was in surplus. In fiscal year 1999, the HI program will run a cash deficit of $8 billion. As noted earlier, in order to redeem these securities, the government must either raise taxes, cut spending, or increase borrowing from the public. In essence, Medicare has already crossed the point where it is a net claimant on the Treasury–a threshold that Social Security is not currently expected to reach until 2013. Stated differently, the bleeding of the HI trust fund has already started based on the program's annual cash flow deficits.

[5]The President also proposes to use about 13 percent of these surpluses to purchase stocks for Social Security.

The current financing flows for the HI program are depicted in figure 2 below. As the figure shows, to help pay benefits in fiscal year 1999, the HI trust fund receives an $8 billion general fund payment for interest it earned on its treasury securities from its past cash surpluses. The HI fund also receives $5 billion for a portion of the income taxes paid on Social Security benefits.

Figure 2: Medicare Flows Under Current Law



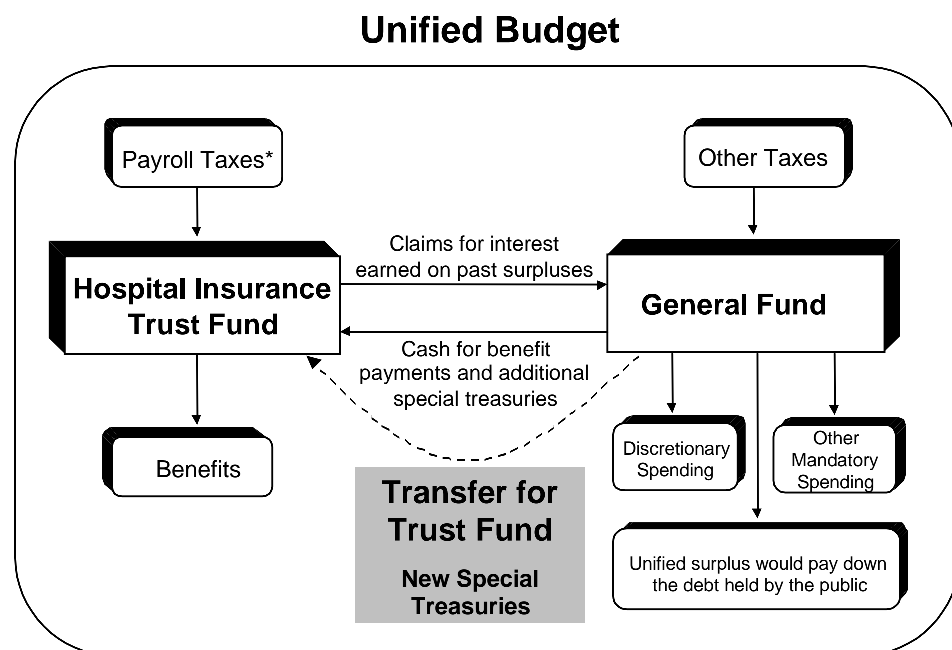
*Since 1994, the HI trust fund has also received a share of income taxes paid on Social Security Benefits.

Source: GAO Analysis.

Under the President's proposal, the above scenario would continue. However, as shown in figure 3, at the point where total tax receipts are allocated to pay for government activities, a new financing step would be added to "transfer" a portion of the projected unified budget surpluses to the Medicare HI trust fund. The Treasury would do this by issuing a new set of securities for the HI trust fund. Unlike the current securities owed the trust fund, these new securities are not supported by payroll tax surpluses in the program; rather, they represent what amounts to a grant or gift. However, it is important to remember that these new securities equal a

portion of the excess cash that would be used to reduce the debt held by the public. The administration argues that the new securities are, in effect, supported by the enhanced economic resources gained by reducing publicly held debt. Nonetheless, we should remember that under the current law baseline—i.e., with no changes in tax or spending policy—this would happen without crediting additional securities to either the Social Security or Medicare trust funds.

Figure 3: Medicare Flows Under President's Proposal



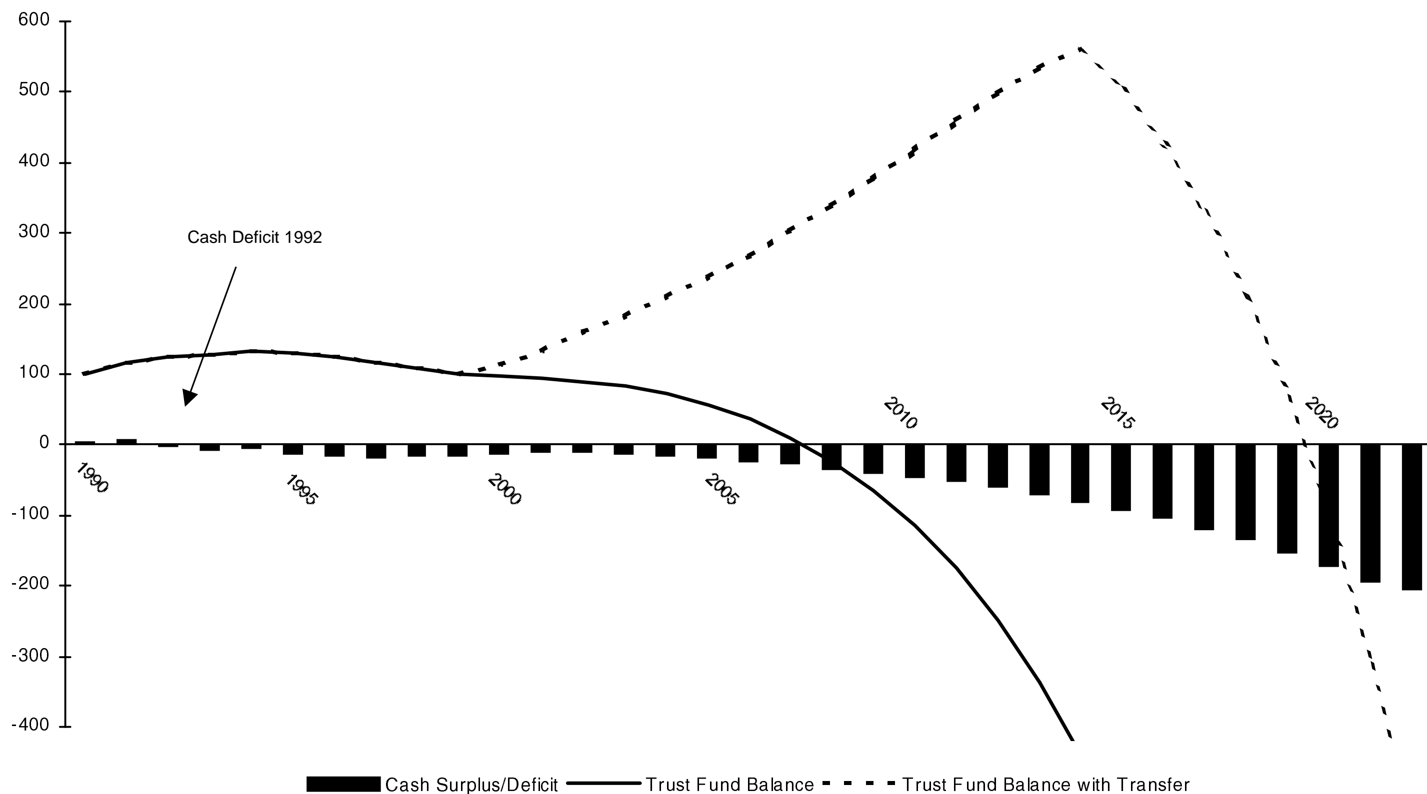
*Since 1994, the HI trust fund has also received a share of income taxes paid on Social Security Benefits.

Source: GAO Analysis.

The financial consequences of this transfer are depicted in figure 4 below. This graph first shows that by providing the additional Treasury securities, the solvency of the Hospital Insurance trust fund would be extended from 2008 to 2020. However, the figure also shows that the President's proposal does nothing to alter the imbalance between the program's tax receipts and benefit payments. It has been in cash deficit since 1992 and remains in a cash deficit even with the new Treasury securities. Thus, the President

proposes to provide additional claims on the Treasury, not additional cash to pay benefits.

Figure 4: Medicare Hospital Insurance Trust Fund Financial Outlook Under President's Proposal



Source: GAO Analysis.

Notwithstanding the fact that no real cash is exchanged, the transfer of additional securities to Medicare is a discretionary act with major economic consequences for the future financing of the HI program. As with Social Security, this proposal represents a fundamental shift in the way the HI program is financed. It moves it away from payroll financing toward a formal commitment of future general fund resources for the program for the future. The general fund obligation would begin far earlier than for Social Security. Specifically, the HI trust fund would begin drawing on the general fund to redeem these new securities in 2008–well before the full reduction in publicly held debt and associated benefits to the general fund will have been realized under the President's plan. In addition,

this is 24 years before the Social Security Trust Fund would begin drawing on the additional Treasury securities that the President is proposing to grant to that program.

The transfer would constitute an explicit general fund subsidy for the HI program–a subsidy whose magnitude is unprecedented for this program. This is true because the newly transferred securities would be in addition to any buildup of historical payroll tax surpluses. Securities held by the trust fund have always represented the value of the loan of its surpluses to the Treasury--annual cash flows in excess of benefits and expenses, plus interest. Under the President's proposal, the value of securities held by the HI trust fund would exceed that supported by earlier payroll tax surpluses and constitute a new and unearned claim on the general fund for the future. In effect, the proposal would shift the financing of the HI Trust Fund to look more like that for the Part B Supplemental Medical Insurance (SMI) Trust Fund. The SMI portion of Medicare obtains 75 percent of its revenues from a general fund subsidy, with the remainder supported by beneficiaries' premiums.

This is a major change in the underlying theoretical design of the HI program. Whether you believe it is a major change actually 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 Fund will exhaust its securities to pay the full promised benefits in 2008. If you believe that this shortfall would—when the time came—be made up with general fund moneys, 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 financed through higher taxes or spending cuts elsewhere in the federal budget as a whole. Thus, the question of bringing significant general revenues into the financing of the HI program is a question that deserves full and open debate. The debate should not be overshadowed by the accounting complexity and budgetary confusion of the President's proposal.

In our view, the proposal carries some significant risks that should be carefully considered by the Congress. One risk is that the transfers to both the Medicare and Social Security trust funds 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 either a fixed

dollar amount or as a percent of taxable payroll rather than as a percent of the actual unified surplus in any given year. These transfers would have a claim on the general fund even if the actual surplus fell below the amount specified for the transfers. However, 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 history of budget forecasts should remind us not to be complacent about the certainty of these large projected surpluses. In its most recent outlook book, CBO compared the actual deficits or surpluses for 1988-1998 with the first projection it produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says its errors averaged about 13 percent of actual outlays. Such a shift in 2004 would mean a surplus $250 billion higher or lower; in 2009, the swing would be about $300 billion. Accordingly, we should consider carefully any permanent commitments that depend on the realization of a long-term forecast.

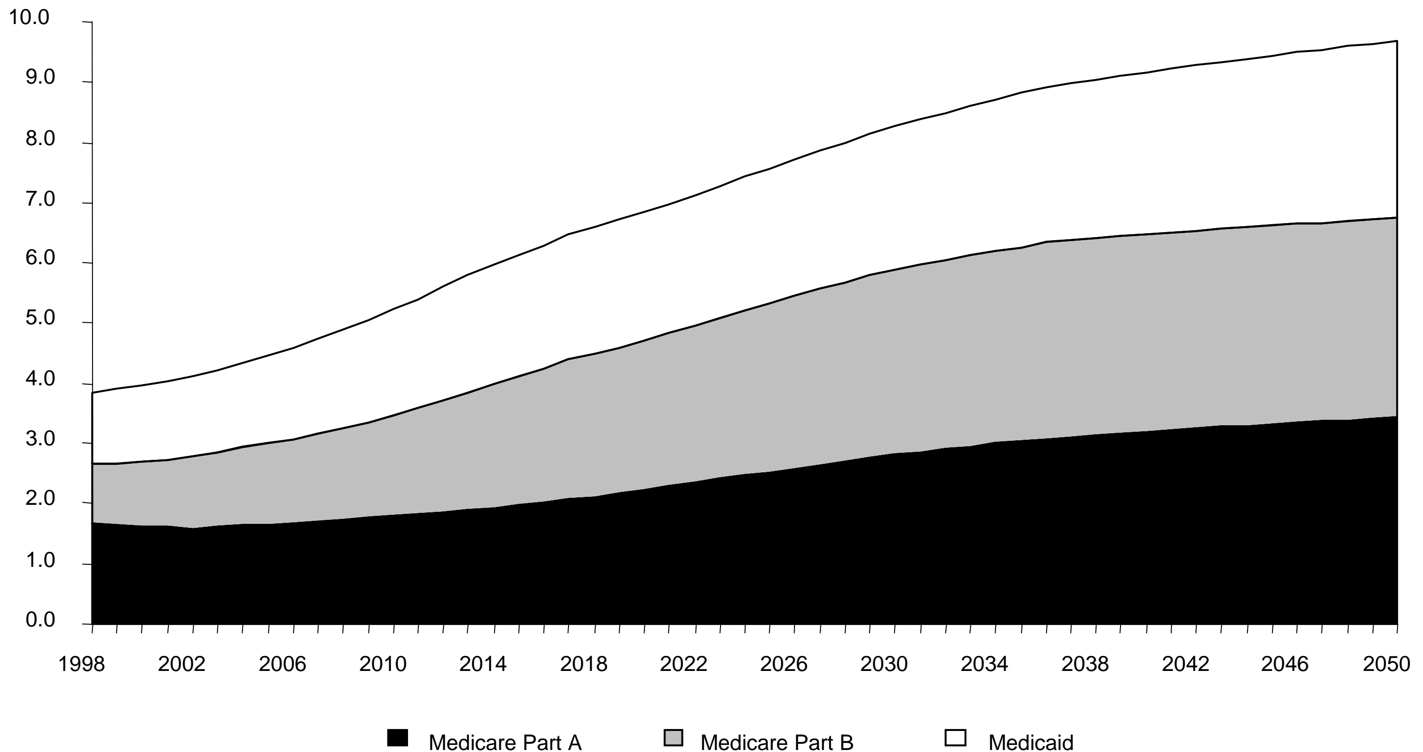
The Compelling Need for Fundamental Program Reform

A more significant risk of the President's proposal is that by appearing to extend financial stability for Medicare, it could very well undercut the incentives to engage in meaningful and fundamental reform of the HI program—reform that is vital to making the HI program sustainable over the long term. Unlike Social Security, the HI program is already in a negative cash flow position—payroll taxes support 89 percent of spending now and will cover less than one half 75 years from now. Even in the short term, the HI program's annual outlays grow by several times the rate of general inflation. Although its growth has slowed in recent years, it remains one of the most volatile and uncontrollable programs in the federal budget. According to CBO, the growth of Medicare—both HI and SMI-- will increase its share of the economy by nearly a full percentage point over the next 10 years, from 2.5 percent to 3.3 percent of GDP in 2009. By contrast, the share devoted to Social Security is projected to remain relatively flat during this period rising from 4.4 percent of GDP in 1999 to 4.7 percent in 2009.

Over the long term, the program's growth rates are more daunting. Absent any changes, the combined Medicare program (i.e., HI and SMI) is projected to more than double its share of the economy by 2050–from 2.7 percent now to 6.8 percent based on the Medicare Trustees' most recent best estimated assumptions. When coupled with Medicaid, federal health

care costs will grow to nearly 10 percent of GDP by 2050, as depicted in figure 5. The progressive absorption of a greater share of the nation's resources for health is, like Social Security, a reflection of the rising share of elderly in the population. However, health care growth rates also reflect the escalating cost growth of health care at rates well exceeding general rates of inflation. Increases in the number and quality of health services fueled by the explosive growth of medical technology has spurred much of this extraordinary cost growth in health care. Consequently, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

Figure 5: Medicare and Medicaid as a Share of GDP



Source: GAO's "save the surplus" long-term simulation based on HCFA's 1998 intermediate projections for Medicare spending and CBO's May 1998 projections for Medicaid spending.

The President's proposal to strengthen the HI program is more perceived than real. Specifically, while the HI trust fund will appear to have more

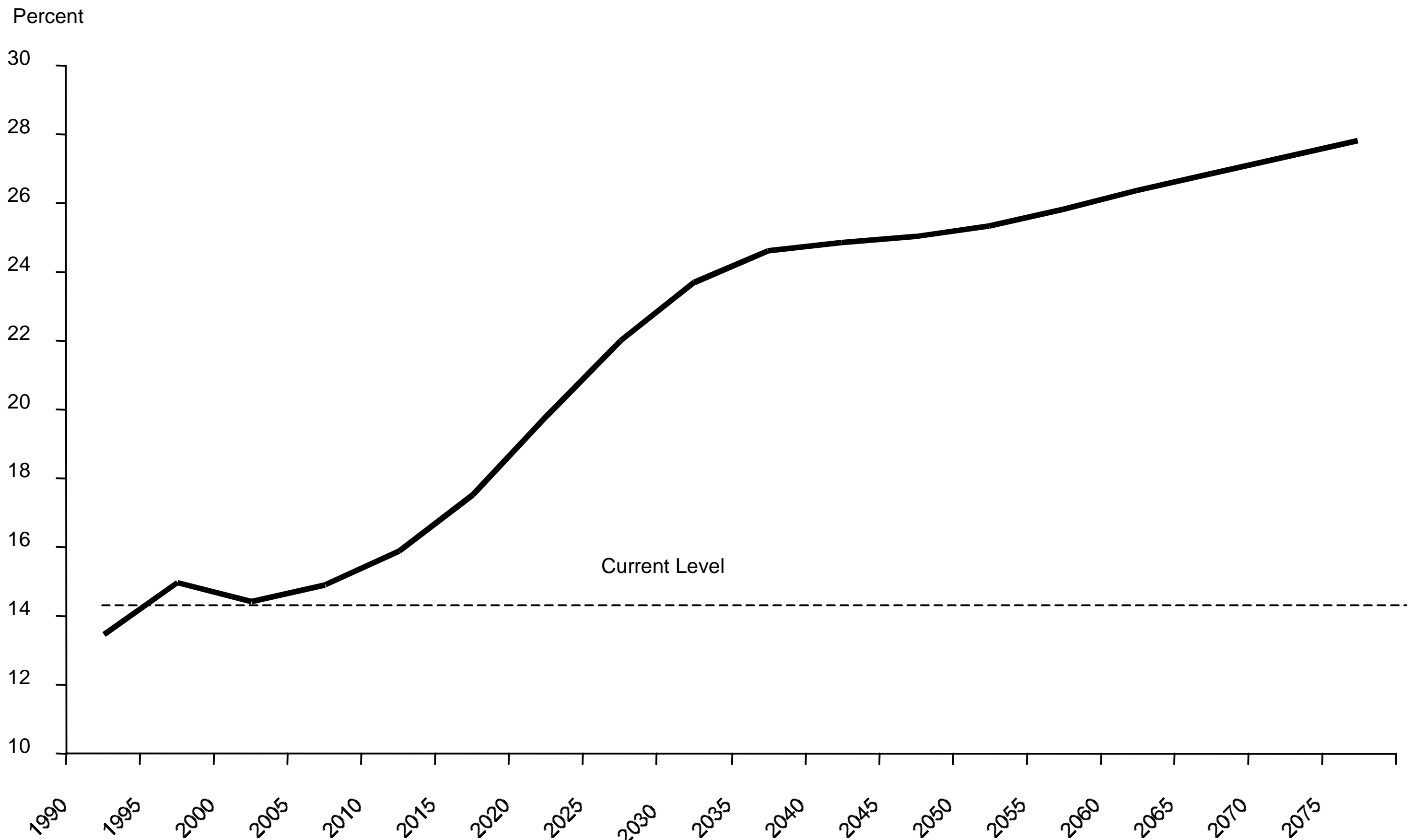
resources as a result of the President's proposal, in reality nothing about the program has really changed. The proposal does not represent program reform but rather a supplemental means to finance the current program. Stated differently, the reform proposed has more form than substance.

What is most alarming is that the President's proposal could induce a sense of false complacency about the financial health of the HI program. The impending insolvency of the HI program sends important signals to policymakers that the program needs to be made more affordable through benefit changes, revenue increases, or both. The 2008 date has become an important cue to policymakers that could provide the impetus needed to make the hard choices necessary to promote the solvency and sustainability of the HI program for the long term. Extending the life of the HI trust fund without substantive program reform could be a recipe for delay and denial that could increase the ultimate fiscal and social cost of HI program reform. At a minimum, the President's proposal is likely to create a public misperception that something meaningful is being done to reform the Medicare program.

Changes to the HI program should be made sooner rather than later. The longer meaningful action is delayed, the more severe such actions will have to be in the future. Since Medicare is the fastest growing sector of the federal budget, early action to reduce its costs will have compounding fiscal benefits. Even if the rate of growth is not changed, reducing the base level of spending can produce outyear dividends for the program's finances. Moreover, acting now would allow changes to benefits and health care delivery systems to be phased in gradually so that stakeholders and participants can adjust their saving or retirement goals accordingly.

When viewed together with Social Security, the programs' financial burden on the future economy takes on daunting proportions. As figure 6 shows, the cost of these two programs 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, even without including the financing challenges of the SMI program.

Figure 6: Social Security and Medicare's HI Program as a Percentage of Taxable Payroll



Note: Taxable payrolls of the two trust funds are different. For analytic purposes, they have been combined by the Social Security Trustees.

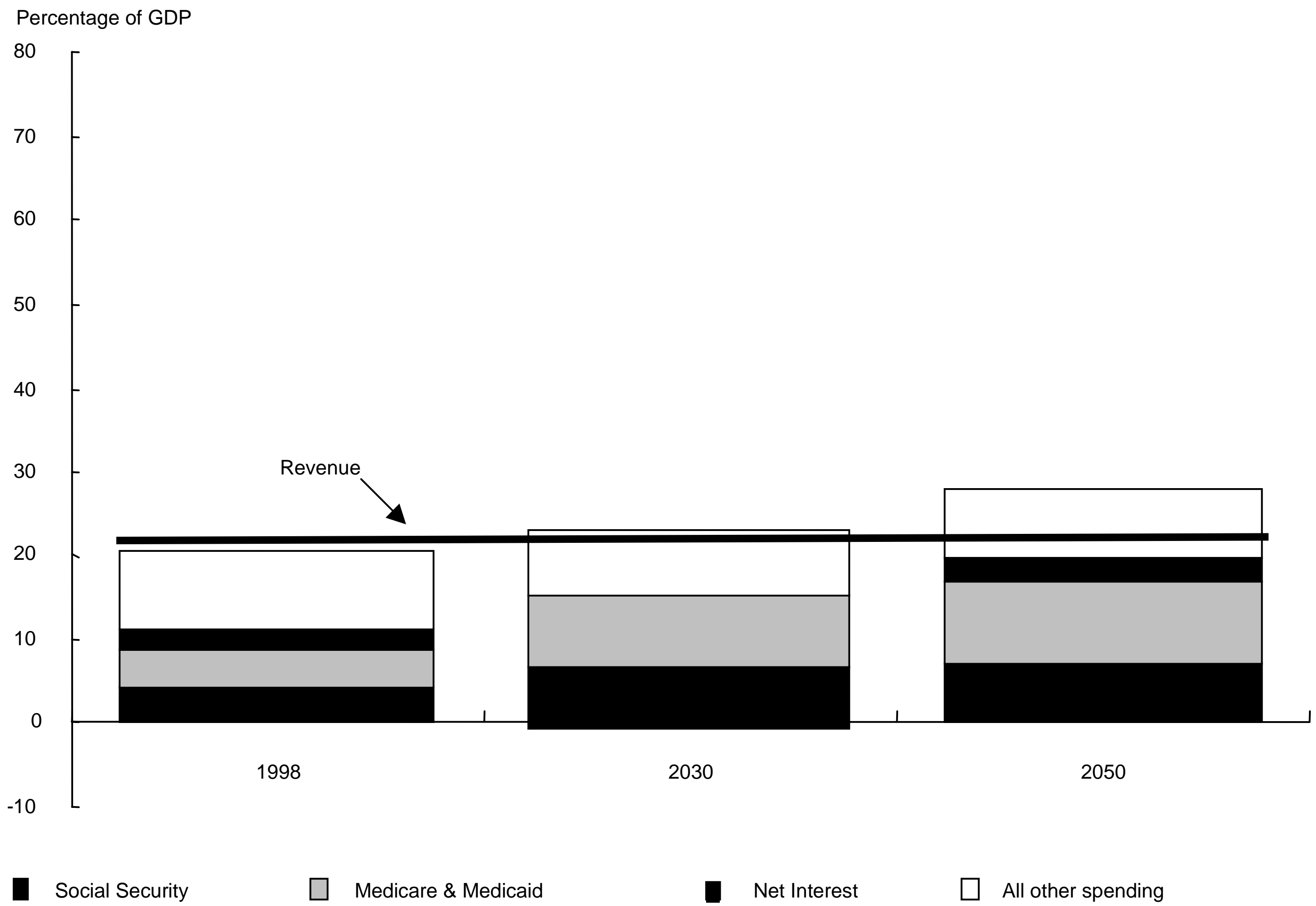
Source: 1998 Social Security Trustees' Report.

There is another reason to take early action to reform both Social Security and Medicare costs. Reducing the future costs of these programs is vital to reclaiming our nation's future capacity to address other important needs in the public sector. To move into the future without changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming no financing or benefit changes, our long-term model (and that of CBO) shows a world in 2050 in which Social Security, Medicare, and Medicaid absorb a much greater share of the federal budget. (See figure 7.) Budgetary flexibility declines drastically and there is increasingly less room for programs for national defense, the

young, infrastructure, and law enforcement—i.e., essentially no discretionary programs at all. Eventually, again assuming no program or financing changes, Social Security, health and interest consume nearly all the revenue the federal government takes in by 2050. This is true ***even*** if we assume that the entire unified budget surplus is saved and these continued surpluses reduce interest from current levels. As shown in figure 8, the picture is even more dramatic if we assume the entire unified budget surplus is used.[6] In that scenario, lower GDP and higher interest payments lead to a world in which revenues cover only Social Security, health, and interest in 2030. And in 2050 revenues do not cover Social Security and federal health expenditures alone! Although views about the role of government differ, it seems unlikely that many would advocate a government devoted solely to sending Social Security checks and health care reimbursements to the elderly.

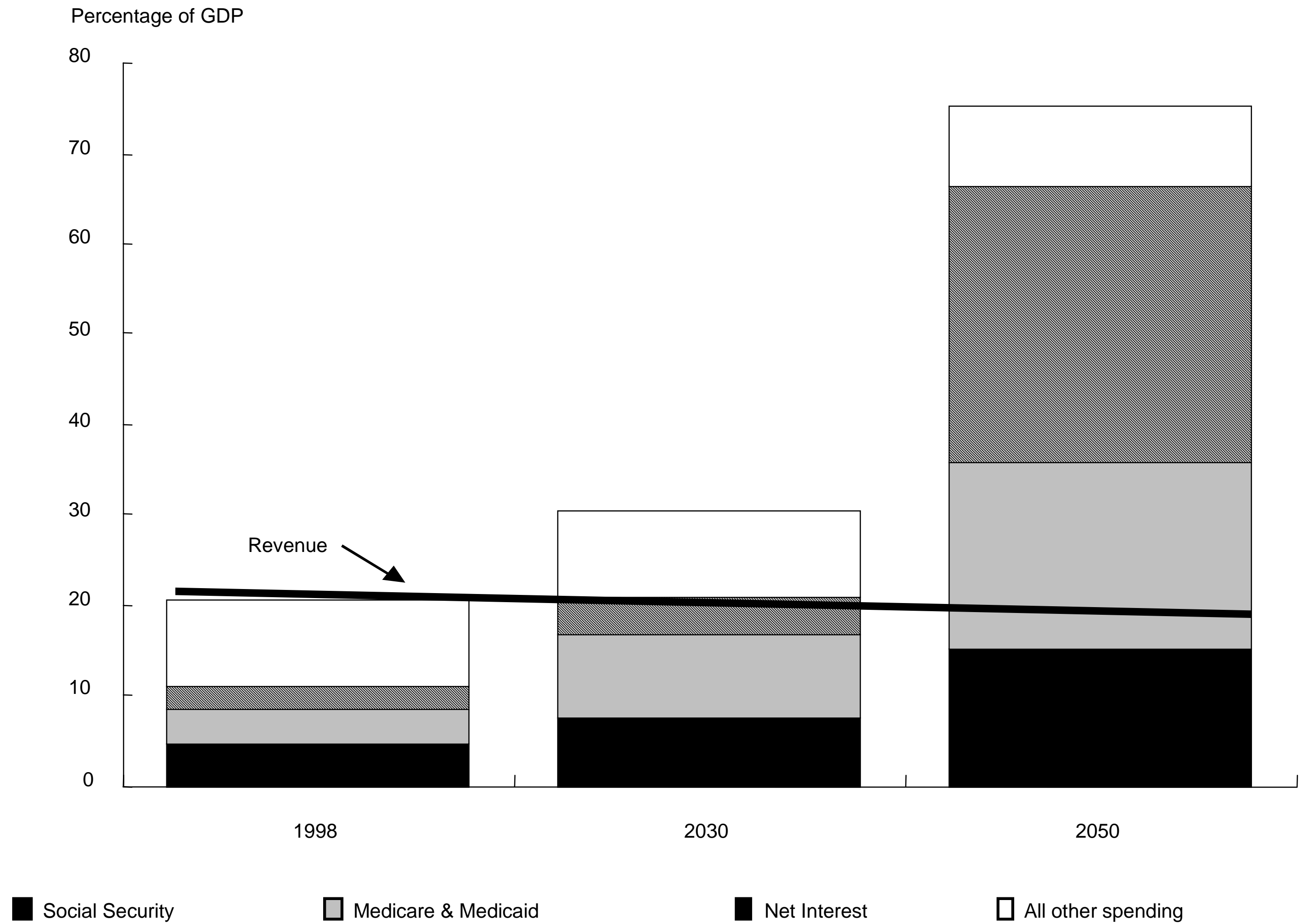
[6]Our "no surplus" simulation is not a forecast but rather an illustration of the implications of taking fiscal actions that eliminate projected surpluses and the fiscal pressures posed by the aging of the baby boom generation. This simulation shows ever-increasing deficits that result in declining investment, a diminishing capital stock, and a collapsing economy. In reality, these economic consequences would inevitably force policy changes to avert such a catastrophic outcome.

Figure 7: Composition of Spending as a Share of GDP Under "Save the Unified Surplus" Simulation



Source: GAO Analysis.

Figure 8: Composition of Spending as a Share of GDP Under "No Unified Surplus" Simulation



Source: GAO Analysis.

Mounting Pressures on Medicare Spending Pose Challenges for Long-term Program Viability

It is clear that real and substantive reform of Medicare is essential to achieving the long-term solvency and sustainability for the program itself–it is not a question of whether, but when and how. However, multiple factors complicate and magnify the challenges involved in achieving such fundamental program reform.

Substantial growth in Medicare spending will continue to be fueled by demographic and technological change. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom generation. For example, today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages. Individuals aged 85 and older make up the fastest growing group of Medicare beneficiaries. So, in addition to the increased demand for health care services due to sheer numbers, the greater prevalence of chronic health conditions associated with aging will further boost utilization.

Compounding the cost pressures of serving a larger and needier Medicare population are the costs associated with the scientific breakthroughs for treating medical conditions and functional limitations. Technological and treatment advances have resulted in more services being provided to more beneficiaries. These services can restore health, reduce pain, increase functioning, and extend lives. Medical miracles abound, such as medications that reduce the permanent damage resulting from heart attacks, hip replacements that improve the health and quality of life for many, and therapy regimens that promote recovery from what previously would have been debilitating strokes. The frequency and intensity of some high-tech services, however, may be of limited clinical value or fail to improve the quality of beneficiaries' lives.

These technological advances feed the public's expectations that more health care is better. Some expect virtually unlimited services to treat any condition. However, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of 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.

The demographic spiral will increase health care needs over the foreseeable future, while technological changes have begun expanding

health care demand. But of this demand, how much are “needs” and how much are “wants”? The distinction is blurred by the effect of scientific advances making available new treatments—which may not be universally applicable or necessarily effective—while individuals continue to be insulated from the full costs of care. At the same time, financial incentives to expand service use fail to be held in check by reasonable assessments of what society can afford.

While these 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. Consider the case of prescription drug coverage. In 1965, when the 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. Most private insurance options and Medicaid programs 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 pharmaceutical companies are increasingly marketing their products directly to consumers—raising the specter that wants will grow well beyond actual needs. Thus, the question of whether to include prescription drugs in Medicare’s benefit package illustrates the importance of affordability counterweights to moderate notions of health care wants.

BBA Reforms Overshadowed by Magnitude of the Problem

The kinds of reforms needed to put Medicare on a more sustainable footing for the future will require hard choices. Real changes in providers’ incomes and services to beneficiaries will undoubtedly be necessary. Substantive reform, not simple financing shifts among funds within the budget--which have been all too frequent in the past as a way to delay the inevitable day of reckoning–will be required to address this daunting problem.

Let’s not kid ourselves--this will not be easy. The Balanced Budget Act of 1997 (BBA) illustrates how challenging reforms can be for this program. BBA contains what are probably the most significant changes to Medicare since its inception more than 30 years ago, yet it was never intended to substitute for long-term reform. The changes will extend the HI trust fund’s solvency to 2008 before the baby boomers even begin to draw on the program. The changes will also result in an estimated $385 billion in lower program expenditures over a 10-year period through a combination of savings from constrained provider fees, increased beneficiary payments,

and structural reforms. To make even these incremental changes to Medicare required substantial effort on the part of the Congress.

Effective implementation of BBA has proved daunting to the Health Care Financing Administration (HCFA), as we have recently testified.[7] Moreover, to the extent that these changes have produced new winners and losers among health care providers, pressures to undo the related changes are growing. Examples include the following.

- Introduction of prospective payment for certain Medicare services: Prospective payment systems will alter how reimbursements are made to skilled nursing facilities, home health agencies, hospital outpatient departments, and rehabilitation facilities. Rather than paying largely whatever costs providers incur, the objective is to fix rates, giving providers incentives to deliver care and services more efficiently. Our work in this area shows that weaknesses in the design and implementation details could substantially erode the expected savings. Furthermore, over the past year, the Congress has faced intense industry pressure to revisit certain BBA provisions that constrain payments to particular groups of providers.
- Creation of Medicare+Choice: BBA established this new program to encourage the expansion of managed care. It represents a first step toward the restructuring of Medicare from two perspectives. The first addresses cost growth through increased reliance on private sector expertise and resources to control costs. The Medicare+Choice provisions addressing health plan and beneficiary participation reflect in part the expectation that increased managed care enrollment will help slow Medicare spending. To date, Medicare managed care has failed to meet that promise and, owing to payment methodology flaws, has actually cost the government more than if enrolled beneficiaries had remained in traditional fee-for-service Medicare. BBA attempts to correct this problem by mandating several adjustments to Medicare's payments to managed care plans. These are adjustments that industry representatives have sought to delay and that they claim will lead to less rather than greater plan participation in Medicare+Choice.[8]

[7] HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century (GAO/T-HEHS-99-58, February 11, 1999).

[8] See Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T-HEHS-99-72, February 25, 1999).

The second perspective touches on beneficiary expectations. In principle, managed care can reshape consumer behavior. The intent of Medicare+Choice is to provide beneficiaries a greater menu of plan choices that offer additional benefits, like prescription drugs, not covered in traditional Medicare. Simultaneously, however, plans will attempt to manage care, thus resulting in beneficiaries facing limits on both traditional and additional services. In this way, Medicare+Choice would demonstrate that resources are constrained and that expanding choice must involve trade-offs.

BBA illustrates the temptation to proceed down the slippery slope of federal Treasury funding rather than sticking with the more difficult task of attempting meaningful program or financing reforms. The act calls for reallocating a portion of home health spending from the HI program to the SMI program. This is essentially an accounting exercise that moves obligations from the HI trust fund account to SMI. While this reallocation could position policymakers to develop additional structural reforms for this benefit, the movement of home health payments from HI to SMI alone generates little net savings. Similarly, 1993 legislation increased the taxable portion of Social Security benefits and, for all practical purposes, shifted this additional revenue to the HI trust fund. These two shifts illustrate a pattern of taking from Peter to pay Paul.

The lessons learned so far from the BBA experience are twofold. First, passing the legislation is a bold first step, but remaining resolute and effectively implementing the provisions constitute an equally challenging second step. Second, relative to the reforms necessary to align Medicare spending with the nation's priorities for all spending, BBA's changes may represent only a minor excision when major surgery is required to assure the HI program's solvency. BBA did result in reduced costs and cut the long-term actuarial imbalance significantly. Nonetheless, the HI and SMI programs together are still projected to grow by nearly a full percentage point of GDP over the next 10 years.

The pressures that continue to drive health care spending upward are exacerbated by the undefined boundaries between what the nation and individuals want, need, and can afford.

Conclusions

Budget surpluses provide a valuable opportunity to capture significant long-term gains to both improve the nation's capacity to address the looming fiscal challenges arising from demographic change and aid in the

transition to a more sustainable Medicare program. The President's proposal should prompt a discussion about the importance of the trust fund concept in disciplining spending for Medicare. The President's proposal is both wide-ranging and complex, and it behooves us to clarify the consequences for both our national economy and the Medicare program.

A substantial share of projected budget surpluses over the next 15 years would be used to reduce publicly held debt, providing demonstrable gains for our economic capacity to afford our future commitments. Saving a good portion of today's surpluses can help future generations of workers better afford the ballooning costs of these commitments, but we must also reform the programs themselves to make these commitments more affordable and sustainable over the long term.

The transfer of surplus resources to the HI trust fund, which the administration argues is necessary to lock in surpluses for the future, would nonetheless constitute a major shift in financing for the Medicare program. However, it would not constitute real Medicare reform because it does not modify the program's underlying commitments for the future. Moreover, the proposed transfer may very well make it more difficult for the public to understand and support the hard choices necessary for the program's future viability.

While meaningful reform is urgently needed, it will require reshaping the nation's perspective on health care consumption and draw clearer distinctions between needs, wants, and affordability. Complicating this effort is the nation's strong commitment to maintaining and even enhancing the quality of and access to services. Further, we have a history of technological development, which may in some cases make health care delivery more efficient or effective, but sometimes has driven spending up without contributing significantly to the quality or length of life.

Irrespective of whether the President's proposal is enacted or not, the Medicare program is in need of fundamental reform to assure its solvency and sustainability over the long term. There will be many proposals to modify Medicare and to implement fundamental change. I would suggest the following five criteria for evaluating these proposals.

- **Affordability:** Changes should ensure that the Medicare program consumes a reasonable share of our productive resources and that it does not unduly encroach on other necessary public programs or

private sector activities. Retaining the self-financing feature of the HI trust fund will help instill the necessary fiscal discipline that I fear could be eroded through general fund subsidies for the program. Shifting excess expenditures from one sector of the budget to another or transferring the burden to different payers or future generations should not be construed as actions that will make the trust fund solvent or future program commitments sustainable. Rather, there needs to be a fundamental rethinking of the incentives in the current program that promote increased intensity and utilization of services without sufficient consideration of their costs. Proposals that involve early action on modifications to the program to take advantage of the compounding fiscal dividends of savings that are achieved sooner should be preferred.

- **Equity:** Reforms should not impose a disproportionate burden on particular groups of beneficiaries or providers. It may be that correcting the distortions created by our current system requires substantial reductions in utilization by certain groups of beneficiaries or of certain types of services. Graduated implementation could make the burden of such shifts less onerous.
- **Adequacy:** Beneficiaries should have appropriate access to health care services, regardless of their individual ability to pay. Further, the tradition of technology development, which has contributed greatly to health and health care in this country, needs to be maintained in a manner that supports cost-effective and clinically meaningful innovations that enhance the quality and length of life.
- **Feasibility:** Reforming an entitlement defined in specified benefits rather than dollar terms must involve changing the behavior of beneficiaries and providers. A proposal must contain the correct array of incentives to achieve necessary behavioral change. It must also involve mechanisms that an entity like HCFA can implement and monitor. There must also be provisions for a safety valve to recalibrate aspects when the intermediate goals are not achieved.
- **Acceptance:** Beneficiaries, taxpayers, and providers must reach a consensus on any major changes to ensure their long-term viability. The path for getting there must begin with steps that will make program costs, which today are barely opaque, much more transparent to the public. Sufficient beneficiary and provider education to the realities of the trade-offs involved may facilitate their acceptance. Further, a phased approach could help ease any disruptions in services or incomes while garnering public approval.

Applying such criteria will require a detailed understanding of the possible outcomes and issues associated with the various elements of proposals. We will be happy to work to provide the data, information, and analysis needed to help policymakers evaluate the relative merits of various proposals and move toward agreement on much needed Medicare reforms.

The time has come for meaningful Medicare reform. Delay will only serve to make the necessary changes more painful down the road. We must be straight with the American people--achieving the goal of saving Medicare will require real options and tough decisions to increase program revenues and/or decrease program expenses. There is no "free lunch."

We have an historic opportunity to deal with the temporary surpluses available today, and how we do so could position us better to deal with the future. We also have an obligation to execute our fiduciary responsibilities regarding the nation's fiscal health. This involves demonstrating prudent management of the projected unified surpluses. At the same time, we cannot let the comfort afforded by these temporary surpluses lull us into complacency. Instead, we must capitalize on this opportunity to engage in serious entitlement reform.

We at GAO stand ready to help the Congress as you develop effective, equitable, and affordable solutions for Medicare reform. Working together, we can make a positive and lasting difference for our country and the American people.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or the Members of the Committee may have.

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