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SENATE BUDGET PROCESS LEGISLATION EMBRACES MISGUIDED "45-PERCENT TRIGGER"

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Executive Summary

Major budget-process legislation approved by the Senate Budget Committee on June 20 seeks to limit the share of Medicare expenditures that are financed by general revenues. The legislation (S. 3521), crafted by Senate Budget Committee Chairman Judd Gregg (R-NH), would establish a new Senate prohibition against legislation that would increase expenditures for *any* entitlement program (not just Medicare) without offsetting the costs, if the share of Medicare expenditures financed by general revenues is projected to exceed 45 percent within the next six years.[1]

The Gregg bill also would establish a commission to propose measures to restore "solvency" to Social Security, Medicare, and Medicaid, and would redefine Medicare "solvency." It would classify Medicare as "insolvent" in any year in which general revenues would fund more than 45 percent of the program's costs.[2]

These provisions build upon a provision of the 2003 Medicare prescription drug law (added in conference behind closed doors), under which the President is required to propose legislation to reduce the portion of Medicare funding coming from general revenues to no more than 45 percent if projections indicate the portion will rise above that level within the next six years.

These provisions of the Gregg bill would represent a fundamental change in policy. They would alter the definition of solvency that has applied to Medicare since its inception in 1965. Instead of using the test that the Medicare Trustees apply in determining the solvency of the program — whether the Medicare Hospital Insurance Trust Fund will have adequate assets to cover expected Medicare Hospital Insurance costs — the commission that the Gregg bill would establish would be required to say that Medicare solvency is achieved *only* if the share of funding for Medicare that comes from general revenues is held to no more than 45 percent. While it is appropriate to require

[1] A similar provision was included in the Congressional budget resolution adopted by the Senate on March 9 (a motion to strike the provision failed on a 50-50 vote). That provision has not gone into effect because the Senate and House have been unable to agree on a final version of the budget resolution.

[2] The Bush Administration also is pushing the 45-percent Medicare standard. Its budget for fiscal year 2007 calls for Medicare to be subject to *automatic cuts* in any year in which more than 45 percent of Medicare expenditures are financed by general revenues.

any effort to deal with the long-term problems of Medicare to go beyond achieving solvency (as traditionally measured) in the Medicare Hospital Insurance Trust Fund and to ensure a sustainable long-term balance between total Medicare costs and the resources (from whatever source) available to fund the program, it is not appropriate to arbitrarily redefine solvency in an ideological way that diverts attention from the real financing problems that Medicare faces.

The new definition of solvency that the Gregg bill would establish has no actuarial basis. Nor does it bear any relationship to how Medicare actually is financed. The new definition seems clearly designed to achieve an ideological goal — to ensure that increases in the income tax (such as increases from scaling back a portion of the Bush tax cuts for high-income households) *cannot* be used to address even a fraction of Medicare's long-term financing problems as part of a larger Medicare reform effort. The Gregg bill would redefine Medicare "solvency" in a way that limits the steps that can be taken to make Medicare "solvent" to those that the bill's sponsors find more ideologically acceptable. In essence, the new definition of "solvency" appears designed to give an aura of respectability to an effort to alter the program in ways that would make Medicare funding less progressive over time than it otherwise will be — i.e., funded less by progressive income taxes and more by regressive payroll taxes and beneficiary premiums and copayments.

These provisions of the Gregg bill rest upon the misguided notion that an increase in the percentage of Medicare funding that comes from *general* revenues, rather than *dedicated* revenues, itself represents a problem and that reducing this percentage would represent an important improvement in the outlook for Medicare and the federal budget. As explained below, both notions are mistaken.

The Gregg bill provision that would erect a barrier to Senate consideration of legislation that would increase the costs of any mandatory program (once Medicare is projected to exceed the 45-percent standard within the next six years[3]) has another basic flaw as well — it is one-sided. While imposing strict fiscal discipline on legislation to strengthen any entitlement program — including programs that serve the neediest Americans or war veterans — it would impose *no* discipline on the passage of new deficit-increasing tax cuts, including tax cuts for the nation's wealthiest individuals and largest corporations. The restoration of Pay-As-You-Go rules that apply to *both* entitlement increases and tax cuts would be more equitable and more effective.

Why the 45-Percent Trigger is Misguided

Medicare faces serious long-term financial problems. Last year, the Social Security and Medicare trustees projected that the Medicare Hospital Insurance program (Medicare Part A) will become insolvent in 2019. In addition, Medicare expenditures are projected to rise rapidly in coming decades as the baby-boom generation retires and health care costs continue to rise. A trigger that would prompt Presidential and Congressional review of measures to extend the solvency of the

[3] Under the Gregg bill, this barrier would go in to effect once the Chairman of the Budget Committee has notified the Senate for two consecutive years that he "projects that within 7 years, General Fund of the Treasury contributions to Medicare funding, expressed as a percentage of total Medicare outlays, will exceed 45 percent." Although the proposed rule does not require it, we assume the Chairman will rely on the report of the Medicare Trustees in making his determination. The 7-year period the Trustees are required to look at includes the year in which the report is issued. Thus, for the 2006 Trustees' Report, the relevant period ends in 2012, six years from now.

Medicare Hospital Insurance program and to address the larger budgetary issues raised by the rising costs of health care — and hence of Medicare — could be useful.

The 45-percent standard, however, is not designed to address these challenges. To the contrary, the 45-percent threshold is an arbitrary benchmark laden with ideological overtones. It is inconsistent with Medicare's basic financing structure.

By law, Medicare physicians' coverage (Medicare Part B) and the new Medicare drug benefit (Medicare Part D) are *supposed to be* financed by general revenues (as well as beneficiary premiums), rather than by payroll taxes. That a particular share of overall Medicare costs are financed by progressive income taxes rather than by regressive payroll taxes is not itself a problem, just as it is not inherently problematic that defense, education, veterans' health care, or space exploration are financed by general revenues. That the 45-percent level will be reached soon (the trustees project that it will be reached in 2012) also is of little significance. The 45-percent threshold will be reached in a relatively few years even if Medicare costs rise *much more slowly* than is currently projected.

Of particular concern, *complying with the 45-percent threshold would rule out certain approaches to strengthening Medicare's finances rather than allow all approaches to be on the table*. By and large, the only approaches that could be considered would be those favored by individuals on the right of the political spectrum. As this analysis explains, the 45-percent trigger seems designed more to rule out scaling back any part of the 2001 and 2003 tax cuts and using some or all of the proceeds to help address even a fraction of Medicare's financing needs as part of a larger Medicare reform package than to address Medicare's solvency problems forthrightly.

Marilyn Moon, a former Social Security and Medicare trustee who is widely regarded as one of the nation's leading Medicare experts, observed in 2004 that the 45-percent standard "is a measure that actually makes very little sense the more you look into it" and is "a measure that not only is indicating a warning but it essentially limits the options that you have to finding a solution." Moon commented that establishing a trigger that would be pulled when Medicare expenditures reach a certain share of the U.S. economy would represent a much sounder policy.[4]

Moon also noted that Medicare's financing problems are sufficiently large that long-term solutions almost certainly will need to include changes in health care generally, reforms in the Medicare program, *and* additional general revenues. If revenues are not a part of the solution, Moon observed, Medicare cuts will have to be severe. "[The] solution is not going to be an easy one to come up with, and it probably cannot be done and keep a viable Medicare program without tax increases at some point in the future," she said. As noted, however, the 45-percent threshold is designed largely to take general revenue increases off the table, thereby intensifying pressure for cuts in Medicare that ultimately would have to be very deep.

The Gregg bill would exacerbate these problems by seeking to enshrine more fully in law the misguided notion that increases in the general-revenue share of Medicare financing are inherently problematic and must be avoided — and that it is more important to keep the general-revenue share of Medicare funding below 45 percent than to focus on the share of the budget or the U.S. economy

[4] Citations of statements by Marilyn Moon come from presentations and comments by Moon in two audio-conferences sponsored by the Center on Budget and Policy Priorities on March 23, 2004. Transcripts are available from the Center.

that Medicare costs constitute. This misguided approach could deflect attention from Medicare's real problems. It also could make it harder to reach agreement on appropriate ways to deal with those problems, since it would effectively rule out balanced Medicare packages that include some increased general-revenue funding alongside changes in Medicare and in the overall U.S. health care system.

The-45-Percent Threshold and the Gregg Bill

As a result of a provision added behind closed doors in the conference on the Medicare drug legislation in 2003, the Medicare trustees now are required to include in each of their annual reports on the program's finances an estimate of the year in which general revenues will finance at least 45 percent of overall Medicare expenditures. By law, Medicare Hospital Insurance is financed primarily by payroll taxes, while Medicare physician's coverage and the new Medicare drug benefit are financed primarily by a combination of general revenues and beneficiary premiums.[5]

Once the trustees estimate in two successive reports that the 45-percent level will be reached by the sixth year after the year in which the report is issued, the President is required to include a proposal in his next budget — and to submit legislation within 15 days of the budget's release — that is supposed to alter Medicare so the 45-percent threshold will not be exceeded.[6] Congressional committees with jurisdiction over Medicare must then report the President's proposal or other Medicare legislation by June 30.

The 2006 trustees' report, like the previous year's report, projected that the 45-percent level will be reached in 2012. If this projection remains unchanged in subsequent trustees' reports, the trigger date (i.e., the date on which two consecutive reports project that the 45-percent level will be reached within the coming six years) will come a year from now (in March 2007) when the trustees issue

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[5] Beneficiary copayments cover part of the costs of services provided by all three parts of Medicare.

[6] In directing the trustees to calculate the percentage of Medicare expenditures financed by general revenues, the Medicare drug law requires the percentage be determined in the following manner. The trustees calculate the percentage that total Medicare expenditures minus dedicated revenues (i.e., revenues *other than* general revenues) make up of total Medicare expenditures. Because "total Medicare expenditures minus dedicated revenues" is very similar, but not strictly identical, to "general revenues supporting Medicare," the 45-percent threshold is not strictly based on general revenues. We and others refer to the 45-percent threshold as applying to general revenues for ease of discussion.

Dedicated revenues are defined in the Medicare drug law as Medicare Part A payroll taxes, the portion of income taxes on Social Security benefits that is dedicated by law to the Medicare Part A trust fund, Medicare beneficiary premiums, and "clawback" payments from state Medicaid programs, which finance a portion of the cost of the Medicare drug benefit for low-income beneficiaries who are enrolled in Medicaid.

Some observers mistakenly believe that the "general-revenue share" of Medicare financing will increase when the parts of Medicare that are funded by general revenues (physician services and prescriptions drugs) grow faster than the part of Medicare that is funded by payroll taxes (hospital services). As defined in the 2003 prescription drug legislation, however, the "general-revenue share" of Medicare funding increases whenever total Medicare expenditures grow faster than dedicated revenues. Under this definition, the "general-revenue share" of Medicare actually increases *more rapidly* if Medicare expenditures for hospital services grow faster than expenditures for physician services and prescription drugs. That is because increases in Medicare costs for drugs and physicians services lead to increases in beneficiary premiums, which are counted as dedicated revenues, while increases in Medicare hospital insurance costs do not, because Medicare hospital insurance does not charge premiums. (Under the 2003 legislation, an increase in dedicated revenues reduces the amount of "general-revenue funding," because "general-revenue funding" is defined as total Medicare expenditures minus dedicated revenues.)

their 2007 report. The President would then be required to include in his budget for fiscal year 2009 (the budget that he will submit in February 2008) a proposal to reduce the general-revenue share of Medicare funding to no more than 45 percent.

Two provisions in Chairman Gregg's budget process bill are tied to the 45-percent threshold. One provision would establish a new prohibition in the Senate against consideration of legislation that would increase entitlement costs (for any entitlement program, not just for Medicare) unless the increased costs are paid for in the same bill through reductions in other entitlement programs or increases in revenues. This prohibition would take effect once the Budget Committee Chairman has determined for two years in a row that the general-revenue share of Medicare funding will exceed 45-percent within the next six years. Based on current projections, the chairman would make this determination in March 2007. The Chairman would presumably rely on the findings of the Social Security and Medicare Trustees in making his determination.

This new Senate rule could make it harder to enact legislation that would increase the costs of any entitlement program (since it would take 60 votes on the Senate floor to override the new prohibition), although legislation increasing entitlement costs already is prohibited in the Senate unless the increases are paid for or the annual Congressional budget resolution assumes the increase in expenditures. The new rule is flawed in two fundamental respects.

- It represents an endorsement of the importance of the 45-percent threshold as a key measure of Medicare's financial soundness and as a way to keep Medicare from placing too much pressure on the rest of the budget, despite the fact that the 45-percent threshold is seriously deficient in both respects.

- It uses the 45-percent threshold to further tighten the budget constraints on legislation to improve any entitlement program (including programs for people who are poor, veterans, or have severe disabilities) while imposing no constraints on new tax cuts, including new tax breaks for the well-off and powerful corporations that engage high-paid lobbyists.

The other provision in Chairman Gregg's budget process plan that embraces the 45-percent threshold is part of the section of the bill that would establish a commission to recommend changes in Social Security, Medicare, and Medicaid. The commission would be directed to make recommendations (and propose legislation) that would "ensure the long-term solvency of Social Security, Medicare, and Medicaid…." However, instead of allowing the commission members to recommend ways to ensure both that Medicare remains solvent, as solvency is currently understood and defined,[7] and that there is a sustainable long-term balance between *overall* Medicare costs (including the costs of Medicare Parts B and D) and the total resources available to fund the program, the Gregg proposal requires that the commission focus solely on ways to achieve a new and very different definition of solvency — that the general revenue share of total Medicare funding be no more than 45 percent.

As explained below, the goal that the commission is directed to work toward has less to do with the financial health and adequacy of Medicare than with a particular ideological view of how Medicare should operate and be funded. Calling the commission a "commission to make Medicare

[7] The longstanding definition of Medicare solvency is that the assets of the Medicare Hospital Insurance Trust Fund be adequate to cover the expected costs of the Medicare Hospital Insurance program, which is known as Medicare Part A.

financing more regressive" would not be politically wise. Yet that is essentially what the commission's charge would be with respect to Medicare. The official name the commission would have — the "National Commission on Entitlement Solvency" — is more politically appealing, but it is not be an accurate description of what the commission would be asked to do with respect to either Medicare or Medicaid.[8]

The 45-Percent Threshold is Misguided and Misleading

Both the existing statutory requirement relating to the 45-percent trigger and Chairman Gregg's new proposals may create an impression that the 45-percent benchmark is an important measure of Medicare's overall financial health and that 2012 is a critical date, after which Medicare's finances will be in substantial danger. That is not the case.

The 45-percent level is an artificial threshold with little substantive merit. By law, Medicare is supposed to be financed in substantial part by general revenues rather than payroll tax revenues.

- Under Medicare's financing structure, the Medicare Hospital Insurance program (Medicare Part A) covers hospital costs and is financed through payroll taxes. The remainder of Medicare — Part B, which covers physician and other outpatient services, and Part D, which provides the new drug benefit — is designed to be financed with premiums paid by beneficiaries and general revenues, rather than regressive payroll tax revenues. That these parts of Medicare are financed with general revenues is no more problematic than that defense, education, veterans' health care, Medicaid, the war on terrorism, or most other parts of the budget are financed by general revenues.

  In addition, nothing in Medicare law bars the general fund from paying Part B and Part D benefits if general-fund financing reaches 45 percent of total Medicare costs. The federal government is required by law to use general revenues to the extent needed to pay Part B and Part D costs that are not covered by beneficiary premiums.

- The 45-percent threshold is certain to be reached in coming years for two reasons. First, Congress and the President specifically elected to fund the new drug benefit with general revenues (and beneficiary premiums), rather than payroll taxes. This decision increased the share of Medicare costs that is financed with general revenues.

- The second reason that the 45-percent threshold is certain to be reached — and that the share of Medicare costs financed by general revenues is projected to continue rising in future years — is that total Medicare expenditures are projected to rise more rapidly than dedicated revenues. The payroll tax — the main source of dedicated revenues — generally grows *more slowly than the*

[8] The Gregg bill also would create a new definition of *Medicaid* "solvency" that has nothing to do with the generally understood meaning of solvency. (It is hard to think how the term solvency could be applied in a meaningful way to Medicaid, since the program is funded entirely by general revenues rather than revenues dedicated to a trust fund.) To meet the bill's new Medicaid "solvency" standard, the Medicaid program would have to be cut massively in coming decades. See Robert Greenstein, James Horney, and Richard Kogan, "Gregg Bill Would Make Far-Reaching Changes In Budget Rules: Bill Would Aim Budget Knife at Domestic Programs While Shielding Tax Cuts from Fiscal Discipline," Center on Budget and Policy Priorities, June 19, 2006.

economy because an increasing portion of income is received in forms not subject to the payroll tax, such as untaxed fringe benefits, capital gains, and dividends. In contrast, Medicare expenditures — whether for hospitalization, outpatient care, or prescription drugs — are projected to grow faster than the economy for the indefinite future.[9] This will cause the share of Medicare costs that is financed by general revenues to rise toward 45 percent and ultimately past it, even if Medicare expenditures grow more slowly than expected in coming years.

- Adding to these problems with the 45-percent measure, the calculation that the Medicare drug law requires the Medicare trustees to make in determining when the 45- percent level will be reached is itself seriously flawed. The trustees are required to treat the interest that the Medicare Hospital Insurance trust fund earns on the Treasury securities it holds as though this interest income were a subsidy from the general fund. It is not, as the box on page 8 explains. This unjustifiable aspect of the 45-percent measure accelerates the date when the 45-percent threshold will be reached by *as much as eight years* and ultimately will necessitate deeper cuts in Medicare if the 45-percent threshold actually is complied with.

These are among the reasons that the 45-percent general-revenue financing threshold built into the Medicare drug law is unsound. As Marilyn Moon has stated, "general revenue contributions have been in this program since 1965 when it was first passed and are an intended and not a problematic part of the program." It makes no more sense to say that the reliance of Medicare Parts B and D (the parts providing physicians' services and the new drug benefit) on general revenues is inherently problematic than to say that the reliance of the Pentagon, education, or veterans benefits on general revenues is a problem.

To help illustrate the shortcomings with the measure, let us suppose that overall Medicare costs grew at the same rate as overall revenues. In that event, the Medicare program would place no additional pressure on the budget as the years passed. There would be no special need to cut future Medicare benefits or increase future taxes. Yet if Medicare costs grew at the same rate as overall revenues, the program's costs would likely be growing more rapidly than payroll tax revenues and more slowly than general revenues. As a result, the 45-percent threshold would be breached, since overall Medicare costs would be increasing at a faster pace than dedicated revenues.

As another example, suppose Congress enacted increases in premiums for the Medicare physician and prescription drug programs (Medicare Parts B and D) in response to the 45-percent threshold. That would increase the amount of dedicated financing for Medicare and could bring the program into compliance with the 45-percent threshold. But for every additional dollar of premiums Medicare received, the program would receive one fewer dollar of general revenues. (This is how the financing of Medicare Parts B and D is structured.) Total Medicare financing would be unchanged, and the Medicare Hospital Insurance trust fund would gain no additional years of solvency. In other words, nothing would have been accomplished for Medicare. Dedicated revenues would simply be substituted for general revenues, with the result that more of the revenue

[9] The growth of Medicare spending is driven both by the growth in the beneficiary population and by increases in the cost of health care per beneficiary. CBO's intermediate assumption is that Medicare spending *per beneficiary* will grow 1 percentage point faster than per capita GDP in coming decades. This is consistent with the Medicare trustees' assumptions but is slower than the average growth of 2.9 percentage points faster than GDP that Medicare has experienced since 1970 or the 1.9 percentage points faster-than-GDP average observed since 1990. Congressional Budget Office, *The Long-Term Budget Outlook*, December 2005, page 31.

Law Requires Flawed Calculation of When 45-Percent Level is Reached

Adding to the problems that the 45-percent threshold provision poses, the calculation that the Medicare drug law requires the trustees to make in determining when the 45 percent threshold will be reached is flawed. In making this calculation, the law requires the trustees to treat the interest earnings that the Medicare Part A trust fund earns on its trust fund balances as though these savings were a general fund subsidy. Yet these earnings are not a subsidy from the general fund.

The Part A trust fund balances currently total about $275 billion, and the Office of Management and Budget projects that these reserves will grow to $365 billion by 2010. These balances are invested in Treasury securities and earn interest. The interest earnings are essential; interest is the way in which $1 in payroll taxes that is collected today but intended for future benefits can hold its value until it is eventually needed.

These interest earnings essentially represent dedicated trust fund revenues rather than a subsidy from the general fund. It is easy to see why. Suppose the Medicare Part A trust fund invested its balances in private financial markets rather than in Treasury securities. Those balances would still accrue earnings. Yet the general fund would not be involved; it would not be making interest payments to the Medicare Part A Trust Fund. The balances are invested in Treasury securities rather than in private financial markets because that is what federal law requires. That does not make the interest earnings a subsidy from the rest of the government to the trust fund.

Moreover, the general fund would have to pay the same amount of interest even if no trust fund balances were invested in Treasury securities. If the general fund of the Treasury did not borrow from the Medicare Part A trust fund to help finance general fund deficits, it would have to borrow the same amount from the public instead and pay interest on it. Borrowing from the Medicare Part A trust fund and paying interest on the borrowed funds does not increase total general fund spending or total general fund interest payments.

Despite this, the provision of the Medicare drug law that established the 45-percent measure requires that the interest the Part A trust fund earns on its balances be counted as part of the general fund financing that is subject to the 45-percent threshold. Medicare faces serious fiscal challenges in future decades. But this dubious accounting of the trust fund's interest income will make Medicare's financing problems look worse than they are. This misleading accounting maneuver will cause the 45-percent threshold to be hit as much as eight years earlier than it otherwise would be reached. This maneuver also will necessitate more drastic changes in Medicare if the 45-percent threshold is adhered to.

supporting the program would be raised through regressive measures, and potential pressures to scale back the 2001 and 2003 cuts in the progressive income tax to help ease Medicare's long-term financing problems would be lessened.[10]

If Congress' goal is to establish a measure to trigger review by policymakers when Medicare costs threaten to reach too high a level, a much sounder measure could be designed under which a review would be triggered whenever Medicare costs were projected to reach a certain share of the economy or of the federal budget. Such a measure, which would be far more rational, was suggested in 2003, but the designers of the Medicare drug law rejected it.

[10] To be sure, an increase in beneficiary premiums would reduce the federal budget deficit, if the resulting reductions in the amount of general revenues needed to fund Medicare are not used as an excuse to cut taxes.

Staying Within 45-Percent Level Would Limit Options Available to Policymakers

As Marilyn Moon has pointed out, adhering to a goal of holding general-revenue financing below 45 percent of Medicare expenditures would limit the options available to policymakers. To remain below the 45-percent level would entail cutting Medicare services, raising beneficiary premiums and/or other co-payments, cutting provider payments, and/or shifting more of the burden of financing Medicare from progressive income taxes to regressive payroll taxes (and hence from affluent taxpayers to those with more modest incomes).

- As Medicare expenditures rise over time with the aging of the population and increases in the cost of health care in the United States, the amount of revenues needed to finance Medicare will increase. The 45-percent measure is designed to limit sharply any increases in general revenues. If general revenues cannot exceed 45 percent of total Medicare costs, Medicare will face artificially induced financing crises that become deeper with each passing year.

- The primary revenue-raising measure that could be used to help meet the 45-percent threshold would be to shift more of the financing for Medicare from general revenues — i.e., from the income tax — to increased payroll taxes. Such a change would be regressive, shifting tax burdens from upper-income individuals to middle-class families and the working poor.

- The only ways that the 45-percent threshold could be met *other than* through the regressive step of increasing Medicare payroll taxes would be through increases in beneficiary premiums and co-payments that grow much larger over time or through ever-deeper cuts over time in Medicare eligibility, the medical services that the program covers, and/or payments to Medicare providers. To stay within the 45-percent threshold, such cuts or beneficiary payment increases eventually would have to reach stunning proportions.

In short, the 45-percent threshold threatens to skew the Medicare debate by ensuring that progressive income taxes are not among the mix of options under consideration to help pay for rising Medicare costs, and thus by placing the burden of future increases in Medicare costs (other than increases averted through cuts in Medicare eligibility, benefits, or payments to providers) squarely on increases in premiums, deductibles, and co-payments, or on increases in payroll taxes. The revenue-raising options that would be allowed generally have one common element: they largely shield the most affluent Americans and place more of the burden on people on the low and middle rungs of the income ladder. (An exception to this would be increases in Medicare premiums that apply only or primarily to Medicare beneficiaries with higher incomes.)

The 45-percent provision is essentially an ideological cousin to fiscal policy proposals to establish Pay-As-You-Go rules that apply to expenditures for federal entitlement programs but exempt tax cuts from fiscal discipline. Like those budget proposals, the 45-percent provision appears designed in part to protect the tax cuts enacted in 2001 and 2003, which provide very generous tax-cut benefits to the nation's most affluent individuals, from being scaled back even modestly as one element of a larger package to address Medicare's looming deficits as the population ages and medical practice continues to advance.

Conclusion

It is important for policymakers to begin addressing Medicare's long-term financing problems. The trustees project that the Medicare Hospital Insurance program will become insolvent in 2018 and Medicare expenditures are projected to increase rapidly in coming decades as health care costs continue to rise and the baby-boom generation retires. But the 45-percent threshold for general-fund financing of Medicare that the Gregg bill seeks to enforce in various ways does not address these problems in a straightforward or ideologically neutral manner. The 45-percent measure is an arbitrary measure that defines the problem in simplistic and ideological terms. It also poses the risk of leading policymakers and the public to a mistaken belief that Medicare will face a significant financing crisis at the point when the 45-percent level is reached and that holding general-fund financing below 45 percent of Medicare costs is necessary to restore Medicare to long-term financial health and maintain stability for the budget as a whole.