

Testimony Presented to the Subcommittee on Health Care, District of Columbia, and
National Archives of the House Committee on Oversight and Government Reform:

“The Medicare Trigger”

James C. Capretta
Fellow, Ethics and Public Policy Center

July 12, 2011

Mr. Chairman, Mr. Davis, and members of the Subcommittee, thank you for the opportunity to participate in this very important hearing on the statutory Medicare trigger.

In the short time available, I would like to focus my comments on the reasons the trigger was proposed and adopted by Congress in the Medicare Modernization Act of 2003 (MMA), and why a credible reform of the Medicare is so important for sustaining the program for future generations of seniors and for bringing about improvements in the broader health system.

The Nature of Medicare Financing Under Current Law

The Medicare program is financed in ways that are not often well understood. Part of the program -- for hospital insurance, or HI -- is financed much like the Social Security program, with a payroll tax that is dedicated to a trust fund from which hospital insurance claims are paid. When payroll taxes run short of paying for full hospital insurance benefits, then the program faces a funding shortfall and corrective steps must be taken to either increase HI revenue or decrease spending to keep the trust fund solvent

and paying full benefits. Currently, the Trustees for the Medicare program expect the HI trust fund to run out of reserves in 2024.

The other parts of Medicare -- for physician and outpatient services, and for coverage of prescription drugs -- are financed differently. Enrollees pay premiums for the coverage they get, but the premiums cover only a small portion of the total cost. In the case of part B (for physician and other non-institutional services), the beneficiary premiums have covered roughly 25 percent of total program costs (at enactment in 1965, the expectation was that beneficiary premiums would cover half of total part B program costs). The other 75 percent comes from the general fund of the Treasury. Similarly, for part D, beneficiary premiums and payments made by states to the federal government cover about 25 percent of the prescription drug program's total costs. The balance comes from the general fund of the Treasury.

These general fund payments to Medicare are not trivial. As shown in Chart 1, the present value of these payments, as estimated by the Medicare Trustees, is expected to exceed \$21 trillion over the long-range projection period.

Chart 1:
General Fund Contributions to Part B and D of Medicare

Present Value of General Fund Contributions to Medicare Parts B and D*	
<u>\$ Trillions</u>	
Part B	13.9
Part D	7.5
Total	21.4

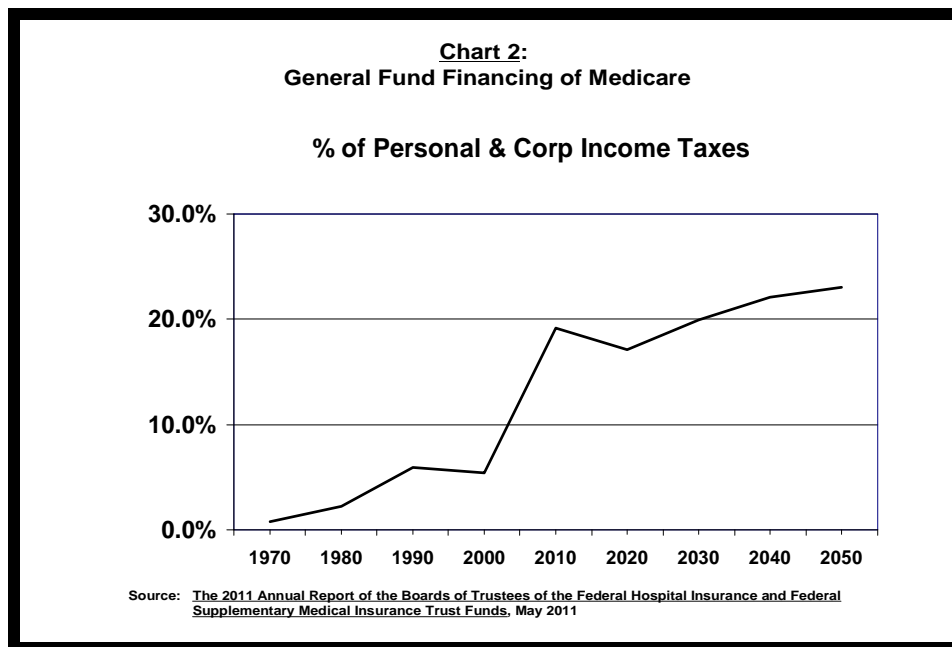
*Covering the long-range (75-year) projection period

Source: The 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 2011

Financing part B and part D in this manner can be deceptive in terms of the burden on taxpayers. Officially, these parts of Medicare are “solvent.” The trust fund that pays these benefits is not expected to ever be depleted because it is, by definition, always solvent. No matter the total cost, enough is drawn every year from the general fund to ensure part B and part D benefits are paid in full.

But just because the trust funds look to be “solvent” on paper does not mean that there is no cost to this open-ended tap on the Treasury. The money must come from somewhere. When part B and part D costs rise, and the general fund is tapped for more funding, it just means that the total federal budget goes deeper into deficit, thus forcing more borrowing and debt.

One way to look at the burden that general fund financing of Medicare places on the rest of the budget is to look at the amount of this financing relative to the total of personal and corporate income taxes, which are the main source of government revenue for programs without a dedicated funding source. As shown in Chart 2, as recently as 1990, the general fund contribution to Medicare part B took up only 5.9 percent of total personal and corporate income tax collections. By 2010 (with part D now also part of the overall program), the percentage had risen to 19.2 percent. By 2050, the Trustees expect the percentage to reach 23 percent.

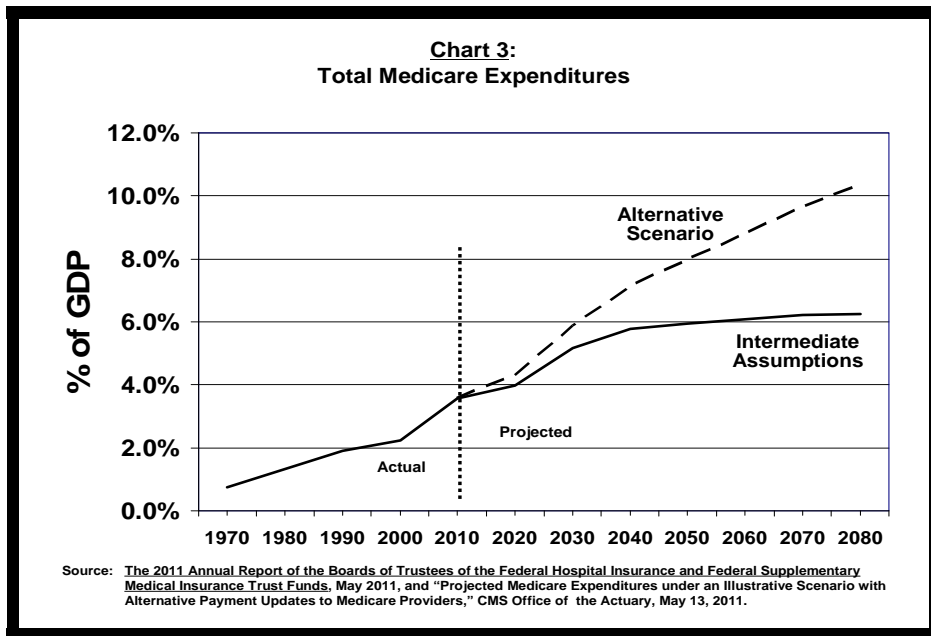


And this is a very optimistic scenario. The Medicare Trustees' official projections (using what are known as intermediate assumptions) presume that the current law payment rates for physician services will continue indefinitely into the future. This is highly unlikely to occur, as there is strong bipartisan opposition to the scheduled, deep

cuts in physician fees that are to take place beginning in 2012 under current law. Those cuts have been reversed by Congress repeatedly over the past decade, and the actuarial office for the Medicare program expects them to be reversed in the future as well.

Moreover, the health law enacted in 2010 imposed other reductions in the Medicare program to partially finance the entitlement expansions contained in that legislation. Those cuts hit other providers of services, some of whom are paid by the part B account. The actuaries at the Medicare program believe it is very likely that these cuts will be reversed as well because, if they are allowed to stand, they will force many hospitals and other providers to limit their participation in Medicare to limit their losses.

To help gauge what Medicare's finances will look like if these cuts are reversed, the actuaries have produced an "Alternative Scenario" for Medicare's finances that differs from the official projections in the 2011 Trustees' report. As shown in Chart 3, this alternative scenario reveals that Medicare's long-term spending trajectory is likely to be far worse than the official projections, with total Medicare spending exceeding 10 percent of GDP by the end of the projection period, compared to just over 6 percent in the official projections. Under this alternative scenario, the draw on the general fund for parts B and D of Medicare would be substantially higher than under the official projections as well.



The Role of the Trigger

The “Medicare Trigger” was enacted to bring into the policy debate a broader view of Medicare’s finances, beyond the misleading picture of permanent solvency for parts B and D.

The trigger monitors total Medicare spending relative to the share of the program that is financed by the general fund. When the Trustees project that the share will exceed 45 percent two years in a row, the trigger goes off, and a process is set in motion to begin consideration of reforms to bring general revenue funding of Medicare below the threshold.

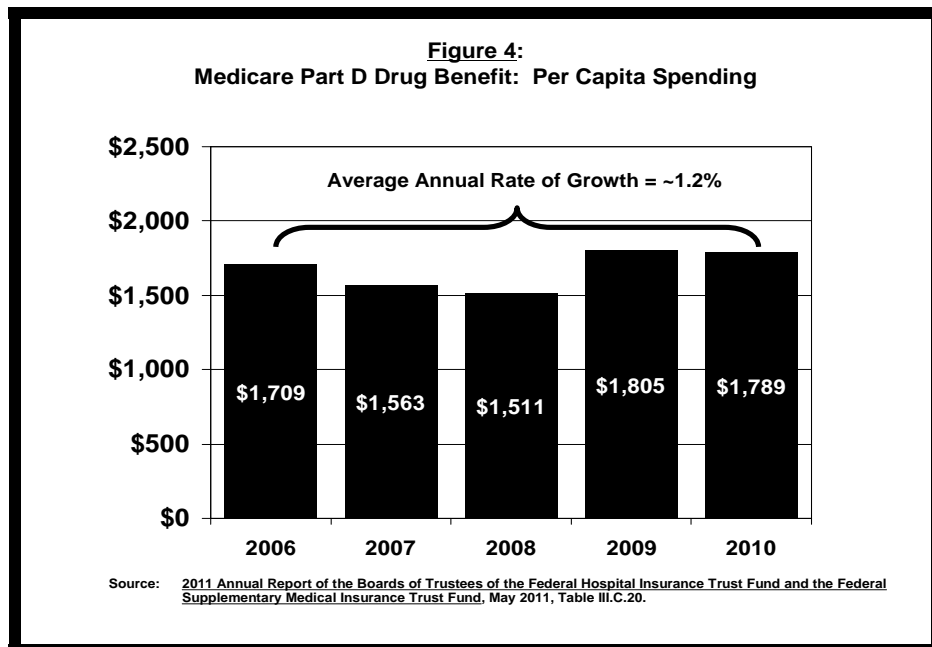
Structural Reform of Medicare Is Needed to Slow Rising Costs

There seems to be a level of bipartisan agreement on the need for fundamental reform of the Medicare program. The proponents of the 2010 health law have often said that it contains many provisions to “bend the cost curve.” Those provisions, it turns out, are mainly aimed at changing how Medicare operates today. For instance, the new law authorizes Accountable Care Organizations and other payment reforms to move away from unmanaged fee-for-service insurance. So, at some level, there is consensus that an important component of the cost challenge is to change the incentives that are now prevalent in the Medicare program.

That makes sense. Medicare is the dominant payer in most markets. The delivery system has been built up around the incentives that Medicare provides. Therefore, it will be very difficult to establish a more efficient and productive health sector if Medicare does not change.

But the question is, what direction should reform take? The new health law adopts a regulatory approach, with the bureaucracy overseeing the program trying to micromanage its way to a more efficient program. That has not worked in the past. What has happened is that the bureaucracy finds it impossible to make distinctions among providers of service based on quality. So, to hit budget targets, it imposes across-the-board payment rate reductions instead. That is very likely to occur this time as well.

I believe what is necessary is a more far-reaching reform of the program, modeled on the successful part D prescription drug program. While that program did increase the government's general fund contribution to Medicare, it also introduced into Medicare a new way of structuring the insurance benefit. The government does not micromanage part D prices but provides a fixed level of support for coverage based on weighted-average premium of the competing plans. Importantly, the government's contribution does not rise with the expense of a plan. That feature gives participants a strong incentive to find the best value they can so that the premium they must pay is kept to a minimum. This structure has worked very well to hold down annual increases in cost growth. As shown in Chart 4, the average annual per capita increase in part D costs has been about 1.2 percent over the period 2006 to 2010.



Conclusion

Medicare is a very important program for the nation's seniors. The "Medicare Trigger" was put in place to help policymakers strengthen the program so that it can be sustained over the coming decades and continue to provide insurance protection for future generations of retirees. That can be achieved with a reform that protects current recipients from unnecessary disruption even as it harnesses the power of a functioning marketplace to deliver higher value at an affordable price for future program participants.