Statement to the House Committee on Oversight and Government Reform, Subcommittee on Health Care, District of Columbia, Census, and National Archives

Triggering a Policy Response to the Medicare Funding Warning

Joseph R. Antos, Ph.D.
Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

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Thank you, Chairman Gowdy, Ranking Member Davis, and members of the Subcommittee for the opportunity to speak today on Medicare's financial status and the need for a policy response to the funding warning issued by Medicare's Trustees in their most recent report.

I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), a non-profit, non-partisan public policy research organization based in Washington, D.C. I am also a member of the panel of health advisers for the Congressional Budget Office (CBO), and I was formerly the Assistant Director for Health and Human Resources at CBO. My comments today are my own and do not necessarily reflect the views of AEI, CBO, or other organizations with which I am affiliated.

Because of Medicare's complicated structure, it can be difficult to ascertain fully the program's financial status. The date at which the Hospital Insurance (HI, or Part A) trust fund is exhausted is one easily-understood indicator but it focuses on only a portion of Medicare that accounts for less than half of program spending. Congress established a trigger mechanism known as the Medicare funding warning that reflects the combined financial condition of all parts of the program. It was intended to call attention to imbalances between Medicare spending and revenue specifically dedicated to fund the program. In the event of a funding warning, the President is required to present legislative proposals to Congress that would reduce program spending or increase program revenue (or both).

A Medicare funding warning has been declared by the Trustees every year since 2007. President George W. Bush responded by sending a proposal to Congress on February 15, 2008, but Congress failed to act on it.[1] In each of his first three years in office, President Barak Obama has failed to respond to the funding warning.

It is essential that the president heed the clear evidence presented by his board of Trustees that Medicare's ability to finance the promises made to America's seniors is in jeopardy. It is equally essential that Congress act to shore up Medicare's finances, whether or not the president presents his own plan.

Measuring Medicare's Fiscal Status

There is no single number that adequately describes Medicare's fiscal status, and every measure presented in the annual Trustees report depends critically on assumptions about the health system's response over 75 years to federal policy and other changes in the program's environment. The most-widely cited indicator is the insolvency date for the HI trust fund, but that reflects only a part of Medicare's operations.

The HI trust fund can become insolvent because it is financed mainly through payroll tax contributions which are projected to grow more slowly than HI outlays. The Supplementary Medical Insurance (SMI) trust fund, which accounts for financial transactions under Part B for outpatient services and under Part D for prescription drugs, was deliberately designed so that it can never run out of money. Beneficiary premiums account for approximately 25 percent of

SMI revenues. The remainder is paid from general revenue—essentially income taxes. By law the SMI trust fund may draw as much general revenue as it needs to cover its costs.

The SMI trust fund is always in balance, but that tells us nothing of interest. The Trustees project that federal spending under Part B and Part D will continue to grow rapidly, gobbling up more resources and exerting increasing pressure on the economy.

To measure the combined fiscal impact of HI and SMI, the Trustees account for the flow of general revenue into Medicare (including money that could be infused into HI after its insolvency date). The rationale is that greater inflows of general revenue into Medicare leave that much less to finance other federal programs and priorities.

The 2011 Trustees report indicates that $24.4 trillion in general revenue must be transferred to the Medicare trust funds if the program is to pay all of its bills over the next 75 years.[2] About $38.4 trillion is required to fully finance Medicare indefinitely.

These estimates show that Medicare will not be able to fulfill its promises to future generations of seniors without significant changes in policy. However, long-term estimates such as these do not provide a sense of when the fiscal crisis is likely to occur and do not provide a clear impetus for action.

How the Funding Warning Works

The Medicare Modernization Act of 2003 attempted to provide a measure of the program's fiscal status that would trigger legislative action to correct an imbalance in the program's financing. It created a cost containment mechanism based on the amount of general revenue that funds the program.[3] The Trustees declare that general revenue funding is "excessive" when it funds more than 45 percent of total Medicare outlays within a seven-year time frame. Two successive findings of "excessive general revenue Medicare funding" trigger a "Medicare funding warning." The law requires the president to respond by submitting legislation within 15 days of his annual budget request in the year following the Trustees' warning. The first finding of excessive general revenue funding was made in 2006 and the first Medicare funding warning was issued in 2007.

There are two major problems with this Medicare trigger mechanism. First, there is no actuarial basis for choosing 45 percent as the point at which general revenue funding is excessive. The 45 percent mark could just as well have been higher or lower, but that does not invalidate its use.

High levels of general revenue funding in Medicare signal a program whose costs are higher than its revenue from payroll taxes and premiums, but that has been true since Medicare's inception. According to the 1970 Trustees report, general revenue accounted for about 24 percent of total program spending.[4] Medicare has never been fully self-financed, and such an objective may be unrealistic in an aging society.

How much should workers be expected to pay for benefits for seniors? The 45 percent mark provides one answer to the question, but that is a judgment call over which reasonable people could differ. Nonetheless, this is a question that we as a society must answer.

This has profound significance, not only for how we finance Medicare but also for the way we allocate scarce resources among competing priorities. Debates over Medicare policy too often ignore the trade-off between Medicare spending and the money available for education, housing, the environment, and other policy areas. The funding warning trigger could be a tool for ensuring that we maintain a balance in financing not just Medicare but also programs intended to meet the needs of young and old alike.

Second, the Medicare funding warning does not have any teeth. This is a particular problem when the purpose of the warning is to prod reluctant policymakers into taking difficult but necessary actions. Although the law requires the president to send a proposal to Congress, both the Bush and Obama administrations have argued that the Constitution protects him from that obligation.[5] Congress also did not bind its hands with the funding warning, requiring only expedited consideration rather than actual legislation. Although it may have raised attention to the issue, the funding warning has been ineffective in controlling Medicare spending.[6]

Medicare's Fiscal Condition Remains Critical

Despite White House claims that the new health reform law keeps Medicare strong and solvent, the Patient Protection and Affordable Care Act (PPACA) only modestly improved the program's fiscal outlook.[7] According to the Trustees, spending from the HI trust fund has exceeded revenue since 2008 and trust fund assets will be exhausted in 2024. SMI spending is projected to moderate somewhat from past trends, but the drain on the Treasury remains extremely high.

In fact, the estimates the Trustees used to determine whether to issue the funding warning are optimistic. They incorporate net Medicare savings from PPACA of $575 billion through 2019, primarily through reductions in payments to providers, that Medicare's actuary considers unrealistic.[8] The estimates also assume that Medicare payments to physicians will be cut an unprecedented 30 percent in January 2012.

Neither assumption is plausible. Even the Trustees state that "the actual future costs for Medicare are likely to exceed those shown by the current-law projections" contained in their report.

Congress will almost certainly intervene to prevent the worst consequences of arbitrary payment cuts. Unless the law is changed, increasing numbers of providers will drop out of the program as payment rates drop every year without relief.[9] About 15 percent of hospitals and other institutional providers will face negative profit margins by 2019, with that number rising to 25 percent by 2030. The loss of that capacity would compound the challenge of ensuring adequate access to health services that Medicare faces with the influx of baby boomers into the program.

The physician payment reductions scheduled under the sustainable growth rate (SGR) are equally unlikely to take effect. Congress has acted multiple times since 2003 to overturn even modest reductions in Medicare's payment update.[10]

The actuary estimates much higher levels of Medicare spending assuming that Congress rescinds those cuts.[11] According to that analysis, total Medicare spending will be 8 percent higher than the official estimate in 2020 and 14 percent higher in 2030, with spending growth continuing to accelerate beyond that point. That translates into trillions of dollars of additional general tax revenue that will be needed by Medicare unless responsible policies are adopted to reduce program costs.

Triggering a Policy Response

As we have seen, the president can ignore a Medicare funding warning with impunity. Even when a proposal is advanced (as President Bush did in 2008), there is no requirement that it address the fundamental cost drivers in Medicare. There are no immediate consequences if Congress fails to enact the legislation, and there may even be a voter backlash if Congress does take action.

This is a trifecta of inadequate legislative process, but toughening the process will not automatically solve the problem. Even a weak trigger could promote useful political debate leading to legislation, but all sides must rise above politics and take the fiscal problem seriously. This will only happen if the public makes it clear that business as usual in Washington is no longer acceptable.

The president and Congress do not need a Medicare funding warning to become aware of the program's financial circumstances. The Trustees have been warning us for many years that Medicare faces unprecedented fiscal pressures as the baby boom generation leaves the work force and enters the program. Over the course of the next two decades, some 70 million people will move from paying into Medicare to drawing benefits.

The president and Congress do not need an additional legislative vehicle to advance responsible policy proposals. The president's annual budget proposal should contain provisions that set Medicare on a sustainable fiscal path, and he should focus his energies on finding common ground with Congress to make Medicare reform a reality. Congress does not have to wait for the president to advance its own ideas for stabilizing Medicare's financing and improving its value to patients.

The importance of this issue cannot be overstated. Decisions about Medicare financing, whether by conscious policy or by default, will determine the fate of a program that millions of seniors depend on. Those decisions will also shape the limits on federal support for society's other priorities. Rapid growth in Medicare spending is a major contributor to the nation's debt crisis. Failure to adopt structural reforms to promote greater efficiency in delivering health care services and higher value for our Medicare dollar has impacts well beyond current beneficiaries of the program. The Medicare trigger could be a tool for ensuring that we provide for the needs

of seniors without neglecting other spending priorities (such as education, housing, and employment) that affect everyone's welfare.

The president and Congress may not need the trigger to take necessary policy actions, but past legislation has only tinkered around the edges of the current program rather than advancing more fundamental changes in the incentives that drive Medicare. Until the legislative process takes into account the long-term consequences of short-term policy actions (and inactions), we have no assurance that Medicare can be saved.

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[1] Hinda Chaikind, Jim Hahn, Jennifer O'Sullivan, and Henry Cohen, *The President's Proposed Legislative Response to the Medicare Funding Warning*, Congressional Research Service, Report RL34407 (April 3, 2008), available at http://stuff.mit.edu/afs/sipb/contrib/wikileaks-crs/wikileaks-crs-reports/RL34407.pdf.

[2] Calculated as the sum of HI (Part A) unfunded obligations plus general revenue contributions for Parts B and D from Tables III.B10, III.C15, and III.C23 in Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (May 13, 2011), available at https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf. All figures are present values as of January 1, 2011.

[3] See Title VIII, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-17, available at http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf.

[4] Author's calculation based on Table 5b of the 1970 Trustees report for the Federal Hospital Insurance Trust Fund and Table 7 of the 1970 Trustees report for the Federal Supplementary Medical Insurance Trust Funds, available at http://www.ssa.gov/history/reports/trust/1970/1970hos.pdf and http://www.ssa.gov/history/reports/trust/1970/1970sup.pdf.

[5] Julian Pecquet, "Rep. Ryan knocks Obama for not shoring up Medicare funding," Healthwatch (March 1, 2011), available at http://thehill.com/blogs/healthwatch/medicare/146821-republicans-say-obama-administration-ignoring-medicare-solvency-warning.

[6] There are also technical problems that could bias the selection of policy proposals if the Medicare funding warning ever resulted in legislation. Increases in dedicated revenue (such as raising the Part B premium) have a greater impact on reducing ratio of general revenue to outlays than an equivalent reduction in program spending. In addition, increasing dedicated revenue by raising payroll taxes would have no impact on Medicare spending. Consequently, spending could continue to rise unabated as long as taxes were raised in tandem. See Hinda Chaikind and Christopher M. Davis, *Medicare Trigger*, Congressional Research Service, Report RS22796 (January 15, 2009), available at http://stuff.mit.edu/afs/sipb/contrib/wikileaks-crs/wikileaks-crs-reports/RS22796.pdf.

[7] "Affordable Care Act Update: Implementing Medicare Cost Savings," Centers for Medicare and Medicaid Services, Memorandum (undated), available at http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf. See also Mike Lillis, "White House touts health reform's Medicare savings, defends math," Healthwatch (August 2, 2010), available at http://thehill.com/blogs/healthwatch/health-reform-implementation/112205-white-house-touts-health-reforms-medicare-savings-defends-math.

[8] Richard S. Foster, "Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended," Centers for Medicare and Medicaid Services, Memorandum (April 22, 2010), available at http://www3.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

[9] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, Memorandum (May 13, 2011), available at http://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf.

[10] Jim Hahn, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, Congressional Research Service, report R40907 (August 6, 2010), available at http://assets.opencrs.com/rpts/R40907_20100806.pdf.

[11] The alternative estimate assumes the SGR is abolished and so-called productivity adjustments that lower payment rates to other providers are phased out after 2020. See Shatto and Clemens (2011).