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EYE ON WASHINGTON

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on fiscal wake-up tours and toothless tigers

In what seems to have become an annual exercise in fiscal futility, the Medicare trustees dutifully released their annual report in late March indicating impending fiscal disaster for Medicare.

And once again, the report was met with scarcely a ripple in the press and hardly more than a yawn from the public.

Oh, to be sure, many of the "usual suspects" bemoaned the future fiscal stresses of the program. The fiscal "wake-up" tour—involving David Walker, former director of the Government Accountability Office; Stuart Butler, vice president of the Heritage Foundation; and Alice Rivlin, the first director of the Congressional Budget Office (CBO) and long-time senior fellow at the Brookings Institution—has been traveling around the country, pressing people to pay attention to what the growth in entitlement spending will mean for our future. And in what has become another annual tradition, the American Enterprise Institute for Public Policy Research (AEI) held a panel in late March in which Rick Foster, Centers for Medicare and Medicaid Services (CMS) actuary, reviewed the predictions of the trustees and Robert Bixby from the Concord Coalition, Joe Antos from AEI, and I dutifully reviewed the enormity of the fiscal chasm between what Medicare is projected to spend and Medicare revenues under current law.

The Problem

For the second year, the Medicare trustees' report indicates that if current trends continue, Part A of the trust fund—the portion that funds inpatient hospital care, nursing home care, and the first 100 days of home care—will be depleted of funds early in 2019. Although 2019 seems a long way off (at least in the political world, where it represents more than six election cycles for the House of Representatives and three election cycles for the White House), already this year more funds will flow out of Part A than will come in from the portion of the wage tax devoted to Medicare and interest on Part A funds. We have clearly embarked on a path to fully depleting Part A funds.

Even more alarming is what will be happening to the general revenue portion of Medicare funding that finances most of the spending on Part B—physicians, outpatient hospital, and lab spending—and Part D, the outpatient prescription drug program of Medicare. Since these funds come from the Treasury as needed, they cannot be depleted, but the level of spending on Parts B and D can put enormous stress on what else the government can fund. As a result, Congress put a "trigger" in place in the Medicare Modernization Act (MMA) that requires the president to propose legislation whenever the general revenue share of total Medicare spending is projected to exceed 45 percent of total Medicare spending two years in a row. This trigger has been "pulled" twice now. But since the MMA requires only a proposal by the White House and a review—but no action by Congress—it's more of a toothless tiger than a trigger.

The basic problem is that Medicare spending, like the rest of healthcare spending, has been growing on average at 2 to 2.5 percentage points faster than the rest of the economy in "real terms" (i.e., adjusted for inflation). The aging of the population just adds to the problem, accounting for perhaps 10 percent to 15 percent of future spending growth. But that's not the main problem. It's the "excess spend" that's the main problem.

How Big of a Problem?

The numbers quickly get beyond the ability of mere mortals to imagine. How big this problem is also depends on whether it is assumed that eventually Medicare spending will slow down to a 1-percentage-point growth faster than the rest of the economy, as the CMS actuary and the Medicare trustees assume it will—or whether it will continue at the higher rate of growth observed, as the CBO assumes. The trustees project that Medicare spending as a share of gross domestic product (GDP) would increase from 3.4 percent in 2010 to 11.3 percent in 2080, while the CBO projects Medicare spending will constitute about 17 percent of GDP in 2080. Given that the entire federal budget currently runs around 18 percent of GDP, these are staggering percentages.

In another context, Medicare would require $36 trillion (measured in current dollars) in general taxes to be transferred if it were to pay all of its bills over the next 75 years. These numbers make the current concern regarding about $1 trillion in unfunded liabilities in the subprime mortgage market look kind of puny in comparison. In fact, the increase in Medicare's shortfall over the past year was more than $10 trillion!

What Next?

Realistically, there is no way that an issue as politically sensitive as Medicare reform is going to receive serious consideration during an election year. The more troubling fact is that much of this year's discussion on healthcare reform has focused on how to expand insurance coverage, which, while important both for the 15 percent of U.S. residents without coverage and for the country as a whole, is much easier to solve than the problem of how to moderate spending and improve quality and clinical appropriateness. The latter two affect not only the 15 percent of us without coverage, but also the 85 percent of us with coverage. Becoming more focused on strategies to slow down spending and improve quality will make it easier to expand coverage to those without, and also to begin to reclaim our fiscal future.

The kinds of changes that need to occur are both substantive and process in nature.

In terms of process, fiscal advocates on both the right and left are arguing for a change in the budgetary treatment of entitlements. The changes need to include periodic reviews of entitlements, with Congress being forced to vote on a process for the long term with triggers that require explicit decisions, unlike the trigger for Medicare general revenue spending.

In terms of substance, there need to be a series of changes. First and foremost, the reimbursement system needs to be fundamentally changed so that financial incentives between and across providers are realigned, rewarding efficiently produced, high-quality care—or, as Secretary Leavitt recently phrased it, "rewarding value, not volume." Increasing the role of competition is also important. The substantially lower-than-predicted spending on Part D shows that competition can help slow down spending, although a lot of effort needs to be made so that senior citizens can understand the choices that are being offered, as Part D also has shown.

There are a variety of ways that increased competition can be introduced into Medicare, but my favorite remains the adoption of a premium support program—one modeled after the Federal Employees Health Benefit plan, where private plans and the traditional Medicare program would compete on a financially and regulatory level playing field. Increasing the age of full eligibility for those without health-related disabilities and making the level of Medicare benefits be determined more by income level also make sense.

Some may disagree with both the process and substantive changes I've outlined. But few can disagree with the need to make Medicare more fiscally viable. ●

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