Don't Kill the Medicare Trigger

In their annual report in April, Medicare's Trustees pulled the so-called Medicare trigger, a provision that requires the President to submit and Congress to consider a plan to reduce spending or raise new dedicated revenue if the program's general revenue subsidy threatens to exceed 45 percent of annual expenditures. Many Congressional Democrats, with broad support from the senior lobby, have been pushing for repeal of the trigger. The push came a step closer to realization last week when language repealing it was spliced into the House bill to reauthorize SCHIP.

Repealing the trigger would be a mistake. It serves the highly salutary function of shifting Congress' attention from the actuarial status of the Hospital Insurance trust fund, a partial and misleading measure of Medicare's fiscal sustainability, to the program's overall projected burden on the federal budget. It also represents a first tentative step toward a much needed global budget for federal health-care spending, the prerequisite for effective cost control.

The critics raise many concerns about the trigger, from the way it defines general revenue to its impact on progressivity. These concerns, however, are either minor quibbles or easily addressed. The real objection is that the trigger threatens to clamp down on Medicare's open pipeline to the Treasury, and so would necessitate cost-saving reform. According to Families USA, "It will undoubtedly lead to attempts to reduce benefits, increase premiums, or cap the amount Medicare will pay per beneficiary." Indeed, it would—and that's precisely why it's needed.

A Staggering Burden

The place to start is with Medicare's long-term financial outlook. According to the latest Trustees' report, the cost of Medicare is due to soar from 3.2 percent of GDP in 2007 to 6.5 percent by 2030, 9.0 percent by 2050, and 11.3 percent by 2080, the Trustees' time horizon. Meanwhile, dedicated Medicare revenues, which consist mainly of payroll taxes and beneficiary premiums, will only grow from 1.9 to 3.1 percent of GDP. (See chart on the following page.) While Medicare's general revenue subsidy now pays for 40 percent of program expenditures, that share would have to rise to 72 percent by 2080 to cover the shortfall in dedicated revenue.

The future burden is staggering no matter how you measure it. In present value dollars, the Trustees calculate that the gap between dedicated Medicare revenues and expenditures comes to $34.2 trillion over the next 75 years. As a share of GDP, the gap will steadily widen from 1.3 percent today to 8.1 percent by 2080. Medicare's general revenue subsidy now consumes 12 percent of total federal income taxes. But closing the program's financing gap would require 73 percent of total federal income taxes by 2080, assuming that revenues remains constant as a share of GDP.

Put another way, Congress would have to jack up income tax rates by 73 percent to keep the deficit from ballooning. Either that, or it would have to gut every other function of government. As a share of GDP, Medicare's 2080 financing gap is twice what the nation now spends on national defense. Indeed, it is larger than the federal government's entire "discretionary" budget—not just defense, but everything from NASA to the national parks.

The Trigger's Importance

The trigger attempts to limit the burden of Medicare on the rest of the budget by capping its general revenue subsidy. The Medicare Modernization Act of 2003, which created the trigger, requires Medicare's Trustees to issue a "funding warning" if they determine in two consecutive annual reports that the subsidy will exceed 45 percent of program expenditures within the next seven years. When they issue this warning, as they did for the first time in April 2007, the President is required to submit a plan to Congress that would reduce spending or raise new dedicated revenues sufficiently to prevent the threshold from being breached. The President's plan is due within 15 days of the submission of his FY 2009 budget in February 2008.

To understand the trigger's importance, it's worth recalling that Medicare spending is set on autopilot—and that this in turn means that Medicare's claim on general revenue is effectively set on autopilot as well.

To be sure, spending under the Hospital Insurance or HI component of Medicare is subject to some constraint, since annual benefits by law cannot exceed dedicated tax

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revenue plus any accumulated trust-fund balance. But there is no constraint on spending under Supplementary Medical Insurance or SMI—the much faster growing component of Medicare that pays for physician services and the new drug benefit. Here dedicated revenues cover just one-quarter of costs. The balance is paid for by a general revenue subsidy that rises automatically along with expenditures, meaning that SMI is by definition perpetually "solvent." Even the constraint imposed by the HI trust fund, moreover, is more apparent than real, since there's nothing to prevent Congress from short-circuiting the trust fund by shifting spending from HI to SMI, as it did with home health benefits in the late 1990s.

The trigger, to be clear, does not actually require Congress to cut spending or raise new dedicated revenue. It merely requires the President to submit a reform plan and Congress to consider it on an expedited basis. In its FY 2008 budget, the administration proposed turning this "soft trigger" into a "hard trigger." Specifically, if Congress fails

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to take action, it would require an across-the-board 0.4 percent reduction in payments to providers in the year the threshold is breached—and an additional 0.4 percent reduction in each subsequent year that general revenues exceed the threshold. But far from considering ways to strengthen the trigger, Congress is now considering repealing it altogether.

What the Critics Say

Critics have raised a wide range of objections to the Medicare trigger, some of which have some merit. The objections, however, fail to add up to a coherent argument—or a persuasive case for repeal.

- The critics say that many government programs are entirely financed with general revenues, and that the composition of Medicare financing is therefore unimportant. This was not the understanding of Medicare's founders, nor is it the understanding of today's public, who have always believed that Medicare is a program in which participants substantially pay for their own benefits through payroll taxes and premiums, not a program that can be indefinitely expanded through general revenues.

- The critics say that the 45 percent threshold is arbitrary. The critics are right that the particular number is arbitrary, but they are wrong if they believe that the threshold caps Medicare's general revenue subsidy at an historically low level. For most of Medicare's history, general revenues were a relatively small component of its finances. Indeed, as recently as 2000 they paid for just 21 percent of program expenditures.

- The critics say that the trigger overstates Medicare's general revenue subsidy because it fails to count HI trust-fund interest and assets, which represent prior year payroll taxes, as dedicated revenue. The critics may have a point, though it's worth pointing out that the trust fund can only be redeemed by taxing the public or borrowing from it—in other words, by raising general revenue. In any case, the sums involved are trivial. The HI trust fund now totals $305 billion, enough to defray just 1.3 percent of total HI expenditures over the next 75 years. That's much less than the share that will be paid by Social Security benefit taxes credited to the HI trust fund, which *are* counted as dedicated revenue under the trigger, but (as income taxes) clearly shouldn't be. When everything is netted out, this line of argument is not to the critics' advantage.

- The critics say that the trigger would make Medicare financing more regressive by increasing its reliance on payroll taxes and beneficiary premiums. While this is a legitimate concern, it need not be a major problem. Premiums can easily be made progressive—and in fact, the President's FY 2008 budget proposes greatly expanding the means-testing of SMI premiums. In principle, even payroll taxes could be made progressive by imposing higher contribution rates on higher earners.

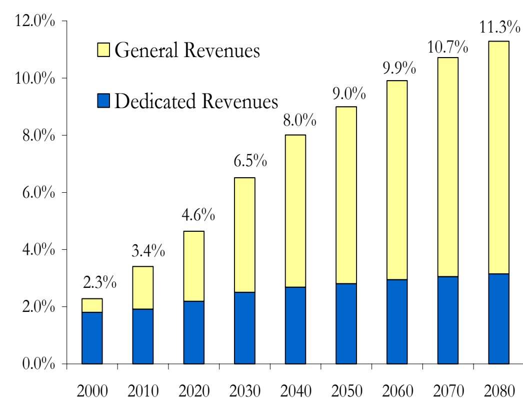
It's also important to realize that the trigger still allows for a very substantial increase in general revenue financing. Remember: 45 percent of Medicare expenditures will likely be a much larger share of GDP in 2080 than it is today, even if expenditures are reduced dramatically beneath current projections.

- The critics say that it would make more sense to base the trigger directly on some measure of total Medicare cost—for instance, total spending as a share of GDP or the rate of growth in per beneficiary spending. This approach may have merit as part of some future comprehensive cost control package. But the general revenue trigger offers a rule of thumb, grounded in the public's understanding of Medicare as contributory social insurance, that is already in place. Congress would do well to take it seriously and enforce it until it devises another. Exactly how the trigger is designed is less important than whether we have a trigger at all.

The Interests of Posterity

Underlying the critics' opposition to the trigger is the presumption that any control over federal health-care spending must await broad reform of the entire health system. It's time to lay this canard to rest. The federal government now pays directly for one-third of national health-care spending; including state spending, government's share is nearly one-half. Federal policy, moreover, indirectly affects most of the rest through extensive regulation and the open-ended tax subsidy for employer-paid health care. The underlying cost drivers must indeed be addressed. But in fact, the federal government already has plenty of leverage to begin exercising control over national health-care spending.

It's time we stopped lavishing open-ended subsidies on ourselves while mortgaging our children's future. The interests of posterity will not be served until we draw a line. We must have some cap on Medicare—and ideally, total federal health-care spending—that is capable of compelling resource trade offs. The Medicare trigger we have may not be perfect, but it's much better than no trigger at all.■



Note: Dedicated revenues include payroll taxes, premiums, benefit taxes credited to HI, and state transfers to Part D; general revenues are assumed to cover HI deficit after trust-fund bankruptcy.