

November 3, 2003

**ADMINISTRATION PROPOSAL TO COMBINE THE ACCOUNTING OF MEDICARE
PART A, MEDICARE PART B, AND PRESCRIPTION DRUGS IS UNSOUND**

By Richard Kogan and Edwin Park

The *Wall Street Journal* reported last week that “In a Monday meeting with Medicare negotiators, administration officials proposed limiting the amount of the general fund that could be spent on physician services and the new drug benefit in future years...”¹ This proposal has been variously described as merging Parts A and B of Medicare, or as capping the general-fund financing of Medicare Part B and the new prescription drug benefit. While differing descriptions have been provided for the Administration’s precise proposal, the Administration is reported to have proposed changes in the Medicare financing structure that would result in the overall insolvency of *all* parts of Medicare, apparently by 2026. Currently, only Medicare Part A will eventually become insolvent, with its insolvency projected for 2026.

The proposed change in the Medicare financing structure thus would eventually precipitate a much larger Medicare crisis. It would likely lead to a steady alarmist drumbeat that the entire Medicare system will collapse unless radical changes are made in it, and could lead to proposals for radical changes to all aspects of Medicare, which Congress might then consider in a crisis atmosphere.

There is no question that the rising cost of Medicare will place pressure on the budget in coming decades. But, as explained below, the Administration’s proposal is both ill conceived and inequitable. If a Medicare trigger of some sort is desired, it would be better to develop a mechanism that triggers Congressional consideration when Medicare cost growth per beneficiary exceeds some benchmark or when total Medicare costs exceed some level of the Gross Domestic Product.

Moreover, the growing cost of Medicare is an issue because the federal budget *as a whole* is on an unsustainable path. The long-term budget path is unsustainable not only because of projected increases in health care and retirement costs as the population ages but also because of the erosion of the nation’s revenue base. Last year, federal revenues fell to their lowest level as a share of the economy since 1959. If a budget enforcement mechanism is to be enacted, it would be far better to impose a mechanism that applies *budget-wide* and covers revenues as well as expenditures — such as reinstatement of the Pay-As-You-Go rule that worked successfully for most of the 1990s — rather than to single out Medicare while allowing further tax cuts or other program expansions to be enacted without limit.

Background

The Medicare program, which provides publicly financed medical care for almost all persons age 65 or older and for persons who receive Social Security disability payments, currently operates as two separate budget accounts.

¹ Sarah Lueck, “Lawmakers Near Generic-Drug Deal,” *Wall Street Journal*, October 29, 2003, page A2.

- Medicare Part A (the Hospital Insurance trust fund) is financed by payroll taxes and interest earnings on the balances in the trust fund.² Part A is estimated to run short of resources by 2026 because the elderly population will grow more rapidly when the baby boomers retire and because per-person health care costs are rising faster than wages.
- Medicare Part B pays for physician and other outpatient services. It is financed by premiums paid by enrollees (25 percent) and by general revenues (75 percent), primarily the individual and corporate income tax. The new prescription drug benefit will be financed similarly, through enrollment premiums and general revenues. Because general revenues are made available in the amounts needed, Part B and the new prescription drug benefit do not have issues of “trust fund insolvency.” They are more like regular general fund entitlements such as Veterans Compensation and Medicaid or other parts of the budget financed from general funds, such as defense and education. The concept of insolvency does not apply to them.

The Administration apparently wants conferees to place a legal limit on the amount of general revenues that can be devoted to Part B and the prescription drug benefit, thereby provoking insolvency for these parts of Medicare. If the Administration succeeds, physicians’ services and prescription drugs will be faced with the same “insolvency” issues as Medicare Part A. Reportedly, the Administration wants the date of insolvency for Medicare Part B and the prescription drug benefit to be 2026, the same as the year in which Medicare Part A is projected to become insolvent. It would make no difference whether the Administration’s goal were achieved through a “combined Medicare trust fund” with a cap on general fund resources or through *separate* trust funds with an overall cap on general fund resources.

This proposal would have profound implications. Eliminating the guaranteed general-fund financing of Part B and prescription drugs could:

- provoke an artificial insolvency crisis for Medicare Part B and the prescription drug benefit and more than double the actuaries’ estimate of the sum of Medicare’s “unfunded liabilities,” leading to demagogic charges that all of Medicare is going bankrupt and needs radical overhaul;
- strengthen arguments to cap Medicare benefits artificially and probably lead to a substantially larger share of costs being borne by elderly and disabled beneficiaries; and
- increase the likelihood that the financing of Medicare will be significantly shifted from progressive income taxes to regressive payroll taxes, which in turn would shift the cost of public benefits from the well-off to the middle class and the working poor.

² In addition, about 7 percent of Part A’s income is derived from other sources. For instance, a portion of Social Security benefits for better-off retirees is considered ordinary income for purposes of the federal income tax. Some of the income taxes collected on these Social Security benefits are transferred from the Treasury to the Social Security trust funds and the rest to the Medicare Part A trust fund.

Possible Ramifications of the Administration's Proposal

Limiting the amount of general revenues that can be used to finance Medicare Part B (or Part B and the new prescription drug benefit, or the entirety of Medicare) is an inherently arbitrary constraint and has the following ramifications.

- **It creates a much larger “crisis.”** Instead of only Medicare Part A becoming insolvent by 2026, as it is estimated to do under the current financing structure, the entire Medicare system — including prescription drugs — would become insolvent by 2026. The actuaries would say so in each future annual report and would show extremely alarming multi-trillion dollar estimates of Medicare’s “75-year unfunded liability.” These reports almost certainly would be used to scare seniors into believing that Medicare will soon collapse and to call for much more radical changes to Medicare, probably labeled “reforms.”

One approach to the impending insolvency of the entire Medicare program could be the elimination of selected Medicare benefits. A more radical approach might be the imposition of a global cap on total Medicare reimbursements to health care providers. (The hard-charging Congress elected in 1994 on the basis of the Contract with America adopted such an approach in 1995, but President Clinton vetoed it.) Under such a cap or under any other system that substantially reduces Medicare reimbursements, either providers will stop seeing Medicare patients or, more likely, the law will be changed to allow them to make up for lost federal reimbursements by billing Medicare patients substantially more.

An alternative approach would be to repeal Medicare’s direct payments to hospitals and physicians and instead have Medicare pay subsidies to health insurance plans; in effect, Medicare would ultimately provide a capped voucher to each beneficiary to help purchase private-sector health insurance. The value of the vouchers would be reduced to the point necessary to keep the new, combined trust fund solvent, and beneficiaries would have to supplement the vouchers with out-of-pocket payments of whatever amount was needed to pay their premiums to their health insurance plans. (It should be noted that using private sector health insurance plans is not necessarily an effective method of containing costs. The experience under “Medicare + Choice” is that Medicare costs are somewhat *higher* for enrollees who chose private managed care plans than the costs would have been if the same enrollees had remained in regular fee-for-service Medicare. Vouchers will likely save money only if their value is capped so that they cover a lower share of medical costs than Medicare currently covers.³)

Under either a global cap or a capped voucher system, Medicare would pay less because of the “insolvency crisis,” and beneficiaries would either pay more out of

³ Medicare + Choice, also known as Medicare Part C, is a Medicare option under which some Medicare beneficiaries choose to enroll in private managed care plans such as health maintenance organizations. On their behalf, Medicare pays a monthly amount that the plans accept as the beneficiaries’ enrollment premiums. Some of that amount is paid by Part A and some by Part B.

pocket or go without health insurance. In addition, older and sicker beneficiaries and the severely disabled could face problems finding adequate, affordable insurance in the individual market.

- **It favors higher premiums, co-payments, and deductibles.** A statutory cap on general fund financing for Medicare could lead to increases in the share of medical costs paid by enrollees, because the cap would eventually preclude higher costs being paid by general revenues. An increase in premiums, co-payments, or deductibles would shift costs onto enrollees and away from the income tax. Since many Medicare enrollees live in poverty or only modestly above the poverty line, such an outcome would be quite regressive.

As a share of income, the extra out-of-pocket costs would be smallest for the well-to-do and largest for beneficiaries of modest incomes. Note that beneficiaries already spend an average of \$1,500 per year out of pocket for current Medicare premiums, deductibles, and co-payments.

- **It favors regressive taxation.** Currently, only the long-term shortfalls in the Part A trust fund can be addressed by higher payroll taxes. By contrast, under the Administration's proposal, payroll taxes could be raised to meet not only Part A shortfalls but also shortfalls in Part B and in prescription drugs. The Administration's plan thus could have the effect of placing the financing burden of growing health care costs much more heavily on payroll taxes, while relieving to some extent the burden on income taxes. Since payroll taxes are regressive while income taxes are progressive, the plan could well lead over time to a less progressive tax code. The Administration's proposal thus could ultimately prove to be especially burdensome for the middle class and the working poor.
- **It constitutes inappropriate health care policy.** Over time, medical practice has gradually shifted from acute care in hospitals to preventive or other types of care in non-hospital settings, including outpatient care, physicians' care, and home health care. Overall, this shift seems to have resulted in healthier patients and cheaper costs — it has somewhat restrained the growth rate of Medicare expenditures. This shift is also the main reason that costs for Medicare Part B (which covers physician services) have risen faster than costs for Part A (which covers hospitalizations). The effect of this evolution in health care has been to put less pressure on payroll taxes and more on general revenues. Because the trend has been good for health care and good for cost containment, it is especially inappropriate to limit the general fund financing of Part B and prescription drugs in such a way that the evolution to better, cheaper care could be slowed.

Conclusion

Ironically, the reason that general-fund financing of Medicare has been growing more rapidly than payroll-tax financing is that medical care outside of hospitals is now better and relatively cheaper than the older, hospital-based acute-care system. The Administration appears to be defining a positive trend in medical care as a problem. Its proposal to place a statutory cap on general fund financing of Medicare, and in effect or in reality to merge the Medicare Part A

trust fund (which is financed almost exclusively from payroll taxes) and Medicare Part B (which is financed from the general fund), would likely result in a public perception of a much larger crisis in Medicare as a whole. Arguably, that crisis would be resolvable only by major cuts in Medicare benefits and significant increases in out-of-pocket payments for medical care by beneficiaries, or by upward pressure on regressive payroll taxes rather than the current upward pressure on progressive income taxes.

There is no doubt that the rising cost of Medicare will be a large source of pressure on the federal budget in coming decades. But the Administration's proposal is poorly designed to trigger congressional action on the issue. If a Medicare trigger of some sort is desired, it might be better to require a Presidential recommendation of legislative changes if the per-person cost growth of total Medicare benefits exceeds some benchmark over time, or when the total level of Medicare benefits and administrative costs exceeds some percentage of the Gross Domestic Product. Neither of those alternatives would punish good medical practice or good cost-containment practices. Nor would either of the alternatives favor regressive taxation over progressive taxation or favor well-off taxpayers over the bulk of Medicare beneficiaries with modest incomes.

Moreover, it should be noted that the growing cost of Medicare is a major issue because the federal budget as a whole is on a path that ultimately is not sustainable. On top of expected growth in Medicare and Social Security, deep tax cuts have eroded the revenue base to the point that it cannot support the public programs the federal government operates, even in a completely healthy economy. Federal revenues, as a share of the economy, fell in 2003 to their lowest level since 1959, and *income-tax* revenues fell to their lowest level as a share of the economy since 1942. While revenues are expected to rise somewhat as the economy improves, revenues are expected to remain below their average levels for the 1970s, 1980s, and 1990s even after full recovery has occurred (if the tax cuts of recent years are extended). In short, the long-term issue is not Medicare in isolation, but the relationship between the costs of all federal programs including Medicare and the revenues to support them.

Consequently, if a budget enforcement mechanism is to be enacted, it would be much sounder to have a mechanism that applies budget-wide and covers revenues as well as expenditures, rather than to single out Medicare while allowing further tax cuts (or other entitlement expansions) to be enacted without limit and thereby continuing to dig the long-term deficit hole still deeper. As we, the Committee for Economic Development (a distinguished group of business and education leaders) and the Concord Coalition (a fiscal watchdog group) recently recommended jointly, the Pay-As-You-Go law that worked quite effectively through much of the 1990s — under which both tax cuts and entitlement expansions must be “paid for” — should be reinstituted forthwith. Such a step would be far more important for long-term fiscal discipline than an arbitrary mechanism focused solely on Medicare.