



THE MEDICARE TRIGGER:

*What rising program costs
could mean for surgery*

by

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In relative quiet and with little fanfare, on April 23, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds submitted their 2007 annual report to Congress. Although neither this date nor this event may find its way into the yet-to-be-written historical accounts of 2007, it is entirely possible that they could mark a significant moment in health care policy and the delivery of health care services in the U.S.

The warning trigger

This annual report was significant among federal health care policymakers because in it the Medicare Trustees, as they are more commonly known, project that general funds from the federal Treasury will begin to cover more than 45 percent of all Medicare spending in 2013. These are the same general funds that pay for all “discretionary” federal spending, including defense, roads, agriculture, and education.¹ Under its current structure, most of Medicare’s funding comes from payroll taxes, premiums, and payments from the states specifically allocated for

Medicare services. Medicare also is funded in part through general Treasury dollars, and this portion of Medicare’s funding has been growing in recent years.

This projection is important because the Medicare Modernization Act of 2003 (MMA), best known for creating Medicare’s prescription drug benefit, included a provision requiring the President to submit a proposal to Congress to contain Medicare costs and preserve Medicare’s solvency when, in two consecutive reports, the Trustees project that general revenues will exceed 45 percent of Medicare spending within the next seven years. Because in 2006 the Trustees had predicted the 45 percent threshold would be reached in 2012, the President must submit a proposal to contain Medicare spending to Congress in early 2008. Congress is then required, under the MMA, to vote and either approve or reject the President’s proposal. If Congress does not take steps to address the 45 percent threshold, the process will start over again in 2009.

There is disagreement in Congress and among health policy experts about the importance of

this funding warning, often referred to as the 45 percent “trigger.” Some stakeholders contend that the trigger is an ideologically driven and arbitrary measure of Medicare’s fiscal health.² Although policymakers and professionals who support the concept of the warning trigger may agree that there is “nothing particularly magical about the 45 percent figure,”³ they do believe that it serves to signal a warning for Congress to shore up Medicare’s finances. Regardless of the significance of the 45 percent figure itself, in testimony before a U.S. Senate subcommittee in May 2006, David Walker, Comptroller General and head of the U.S. Government Accountability Office, addressed the topic of budget triggers: “By identifying significant increases in the spending path of a mandatory program relatively early and acting to constrain it, Congress may avert much larger and potentially disruptive financial challenges and program changes in the future.”⁴

Later in his testimony, Mr. Walker also pointed out that the task of constraining spending growth is complicated by a “tension between the idea of triggers and the nature of entitlement [programs]” because programs like Medicare were designed to provide certain benefits based on eligibility formulas and not based on Congress’ annual spending decisions.⁴ Although most Medicare benefits are not directly affected by annual congressional decisions, it is becoming an increasing possibility that the care that Medicare patients receive will be affected by the decisions that Congress makes each year. The most notable example of this scenario is in the area of Medicare physician reimbursement levels, which have been subject to the prospect of cuts every year since 2002. As Fellows and others in the physician community have come to know all too well, Medicare’s flawed sustainable growth rate methodology for calculating reimbursement levels and its required cuts of 5 percent or more per year mean that physicians’ ability to treat Medicare patients is becoming increasingly dependent on annual congressional decisions.*

*After Medicare payments were cut by 5.4 percent in 2002, Congress has acted over the past five years to prevent further cuts from going into effect. While congressional action stopped cuts between 2003 and 2007, physicians and patients are again faced with uncertainty as Congress must act to stop a 9.9 percent cut from taking effect in 2008.

Beyond the trigger

In spite of disagreements about the nature of the Medicare trigger, health policy experts and other policy leaders from across the ideological spectrum largely agree that Medicare’s financial future needs to be addressed, or serious fiscal and economic consequences will result.^{2,3} This widespread concern about Medicare and other entitlement programs, such as Medicaid and Social Security, has led some of the most respected fiscal and economic policy leaders from the Concord Coalition, the Brookings Institution, and the Heritage Foundation to come together to raise the country’s awareness of the significant fiscal challenges posed by obligations to fund these programs in an initiative called the Fiscal Wake-Up Tour.⁵ Groups such as the Committee for a Responsible Budget, the Committee for Economic Development, the Association of Government Accountants, and AARP have participated in events organized by the Fiscal Wake-Up Tour.⁶ Mr. Walker serves as an advisor to the Tour and has been a regular participant in its public events.⁵

In addition to the funding warning, the Medicare Trustees’ report included other projections about Medicare’s fiscal future. Specifically, the Trustees predicted that payroll tax revenues, which fund Medicare’s Hospital Insurance (HI) trust fund, will be exceeded by payments for these covered services in 2007.¹ In addition to hospital care, the HI fund—also referred to as Medicare Part A—covers skilled nursing, hospice, and some home health services as well.¹ In previous years, when payroll tax revenue exceeded payments from the HI fund, those excess funds were exchanged for interest-bearing securities issued by the U.S. Treasury. In years when those securities need to be redeemed to pay benefits, the Medicare program effectively cashes them through the U.S. Treasury, which redeems these securities with funds paid out of the Treasury.² Whether those securities should be counted as general fund dollars is a point of dispute.² Because payroll tax revenue is anticipated to cover 99 percent of Part A payments in 2007, the additional 1 percent of funding will have to come from the cashing of HI trust fund securities.¹ Regardless of whether payments made from these securities are counted as general fund expenditures, the Trustees project

that the HI trust fund will be exhausted by 2019, at which point current law will prohibit Medicare from paying for any HI-covered care beyond that which payroll taxes cover.¹

In contrast to the HI fund, the Supplementary Medical Insurance (SMI) fund—from which Medicare pays for physician services (Part B), outpatient hospital services (Part B), and prescription drugs (Part D)—will continue to receive the funding needed to meet its financial obligations.¹ The SMI trust fund is able to meet its obligations because current law provides that a certain amount of the care is paid by beneficiaries and that the remaining amount is covered by funds paid out of the general Treasury; the latest Trustees' report estimated that the federal Treasury covers 79 percent of SMI program costs.¹

Meaning for surgery

Given the Trustees' announcement that the SMI trust fund has the funding needed to pay for its covered services under Medicare Parts B and D into the future, some may question why Fellows and others reimbursed through SMI funds should be concerned regarding the solvency of the HI trust fund or the 45 percent trigger. Not surprisingly, the answer lies in the rising cost of health care. In 2005, \$2 trillion, or 16 percent, of the gross domestic product (GDP) was spent on health care in the U.S., and since 1970, health care costs have grown an average of 2.5 percent more per year than the GDP.⁷ Following this trend, the Medicare Trustees found that Medicare outlays, which composed approximately 3.1 percent of the GDP in 2006, are expected to consume more than 11 percent of the GDP in the next 75 years.⁷ Given that approximately 75 percent of the funds for physician services in Medicare are paid out of general Treasury dollars, it becomes understandable that policymakers will have to look at a wide range of options to address the continued growth in Medicare spending. The Medicare Payment Advisory Commission (MedPAC) and others who advise Congress and the Administration about health care issues generally highlight three possible solutions to containing the rising costs of the Medicare program:

- Changing the benefit structure
- Raising taxes to improve Medicare's finances

“ Given the political difficulty associated with attempting to either cut benefits or raise taxes, it follows that policymakers, particularly in Congress, have spent considerable time in recent years on the third option of payment policy: to obtain better value. ”

- Using payment policy to obtain better value⁸

Given the political difficulty associated with attempting to either cut benefits or raise taxes, it follows that policymakers, particularly in Congress, have spent considerable time in recent years on the third option of payment policy: to obtain better value. In fact, a case could be made that this drive to use payment policy to obtain better value has served as the foundation for most, if not all, of the efforts by Congress and the Centers for Medicare and Medicaid Services (CMS) on Medicare physician reimbursement since 2005. Even though surgery would be affected by changes to Medicare's benefit structure or by increased taxes, it is this effort to use payment policy to obtain better value—however that may be defined and ultimately applied in the decisions of policymakers—that has the greatest potential to impact the practice of surgery.

Paying for quality

When considering the issue of value, policymakers have often quickly turned their attention to the quality of care patients receive. In the

past two-and-a-half years, whether it has been called pay for performance (P4P), value-based purchasing, or any another name, the effort to link Medicare reimbursement to certain quality incentives has gained considerable momentum. Significant catalysts for early quality improvement (QI) efforts were findings issued by the Institute of Medicine (IOM) in reports such as *To Err Is Human: Building a Safer Health System*,⁹ *Crossing the Quality Chasm: A New Health System for the 21st Century*,¹⁰ and *Leadership by Example: Coordinating Government Roles in Improving Healthcare Quality*¹¹; these reports raised public awareness of the gaps in patient safety and quality and highlighted the need for a new approach to protect patients and to improve the quality of patient outcomes. Following up on such research, in its March 2004 report, MedPAC raised the issue of linking payments to quality in the context of Medicare payment policy,¹² and in its March 2005 report issued recommendations that Congress should establish quality incentive payment policies for physicians and others who provide care to Medicare patients.¹³

In addition to patient safety and quality concerns, another catalyst in the QI effort has been the rising cost of care. In its March 2007 report, MedPAC reiterated its support for QI payment incentives in the context of larger Medicare policy and highlighted its possible role in obtaining a better value of care.⁸ Drawing the link between the QI effort and rising health care costs, Frank G. Opelka, MD, FACS, and Cynthia A. Brown, Director of the Division of Advocacy and Health Policy, in a September 2005 *Bulletin* article, chronicled the challenges of public and private payors to contain costs and the shift away from a system that limits care by restricting costs and moves toward a P4P model that rewards high-quality care.¹⁴ They highlighted the College's role as one of the partners in the Surgical Care Improvement Project (SCIP), which has led policymakers to see promise in QI efforts that have the potential to not only save lives but to save precious health care dollars as well. (For example, SCIP has successfully led to reductions in complications such as postoperative pneumonia, which has an associated mortality rate of between of 30 and 46 percent and a financial cost of between \$22,000 and \$28,000 per patient per admission.¹⁴)

Congress' interest in moving some form of P4P efforts in Medicare followed soon after MedPAC's recommendations in 2005. In the U.S. Senate, Sens. Charles Grassley (R-IA) and Max Baucus (D-MT)—then the Chair and Ranking Member of the Finance Committee, respectively—introduced the Medicare Value Purchasing Act of 2005 (S. 1356),¹⁵ and in the House of Representatives, former Rep. Nancy Johnson (R-CT), then Chair of the Ways and Means Committee's Subcommittee on Health, introduced the Medicare Value-Based Purchasing for Physicians' Services Act of 2005 (H.R. 3617).¹⁶ Although the bills differed in many ways, both envisioned a consultative quality measurement development process between Medicare and physician stakeholders, such as the College. By introducing these bills, these leaders on Medicare policy were not only establishing the paradigm for the QI effort going forward but they were reframing how Medicare physician reimbursement would be addressed in coming years as well.

While Congress was discussing value-based purchasing and QI efforts in 2005 and 2006, the College was actively working with CMS, the surgical specialties, and other physician organizations to develop appropriate surgical measures for CMS' voluntary nationwide QI demonstration project, the Physician Voluntary Reporting Program (PVRP). Although the PVRP was entirely voluntary and not linked to payment, the College was actively engaged in the measurement development process. Despite challenges along the way, the College continues to be actively engaged with policymakers to ensure that any measures promulgated by CMS recognize the unique nature of surgery. The College also continues to work to educate policymakers about its many successful QI efforts, such as the ACS National Surgical Quality Improvement Program (NSQIP) and SCIP.

Although neither S. 1356 nor H.R. 3617 became law, legislative provisions linking Medicare physician payment to basic measures were included in the Tax Relief and Health Care Act of 2007 (H.R. 6111),¹⁷ which did become law in December 2006. H.R. 6111 built on the PVRP effort and established the voluntary Physician Quality Reporting Initiative (PQRI), which allows physicians who report on measures relevant

to their specialty to receive a bonus of up to 1.5 percent for allowed charges under the Medicare Physician Fee Schedule between July 1 and December 31, 2007.

Paying for efficiency

While additional IOM reports—such as *Performance Measurement: Accelerating Improvement*¹⁸ and *Rewarding Provider Performance: Aligning Incentives in Medicare*¹⁹—have kept attention focused on the issue of how Medicare can better align incentives to promote high-quality care, the concept of P4P has always envisioned paying for quality processes and outcomes as well as efficiency. Even though efficiency measures were included in the previously discussed legislation, the bills and the discussion over the past two-plus years have focused largely on enhancing quality measurement. Although developing quality metrics has been a daunting task, much of the challenge has been in determining how to best use data and knowledge that already exist and apply it to measures of the process involved in the physician's delivery of care. When it comes to measuring efficiency, the challenge is at least as daunting as measuring quality—if not more so. Yet, in spite of the challenges, the effort to examine, study, and better understand individual physicians' efficiency, specifically their use of resources, has increasingly become a regular part of the value-based payment discussion.

In his testimony before the House Ways and Means Health Subcommittee in May 2007, MedPAC Chairman Glenn Hackbarth raised the issue of resource use as one means toward improving Medicare's payments to physicians and pointed out that higher use of health care services does not necessarily lead to better patient outcomes.²⁰ It was not the first time that MedPAC has raised the issue. In its March 2005 report, MedPAC recommended that Congress direct the Secretary of the U.S. Department of Health and Human Services (HHS) to use Medicare claims data to confidentially educate physicians about their resource use,^{13,20} and the June 2006 report studied how episode groupers—a disease-based, risk-adjusted methodology that compares resource use and costs incurred in treating similar patients for an entire illness episode—might be used to assess physician resource use.²¹ Because

“When it comes to measuring efficiency, the challenge is at least as daunting as measuring quality—if not more so.”

Medicare is the single largest purchaser of health care services, Hackbarth argued that by sharing information with physicians regarding their resource use, Medicare has the potential to affect physicians' practice patterns with greater success than private payors.²⁰ Although MedPAC has found that most episodes of care can be attributed to a particular physician,²⁰ it remains to be seen how such a model might incorporate surgery—especially since the global payment structure for surgical services already includes an inherent incentive for efficient care. Regardless of these uncertainties, the College will continue to work with policymakers to ensure that any efficiency measurement recognizes the unique nature of surgical care.

What's next?

With the Democrats' victories in the November 2006 elections, the outlook for the Medicare trigger and P4P have changed. With respect to the 45 percent trigger, health care policy leaders among the new Democratic majority in the House of Representatives have called for its repeal. In fact, a provision to repeal the trigger altogether was included in the Children's Health and Medicare Protection (CHAMP) Act of 2007 (H.R. 3162),²² which was passed by the House in July. Unlike H.R. 3162, the Senate version of the children's health care legislation, the Children's Health Insurance Program Reauthorization Act of 2007 (S. 1893),²³ did not include any Medicare provisions. At press time, it remained uncertain as to what course the House and Senate might take on the possible inclusion of any Medicare

provisions in a final version of the legislation. It also remains to be seen if President George W. Bush would sign a bill into law that included provisions to repeal the Medicare funding trigger, but he has issued veto threats for both H.R. 3162 and S. 1893.

With respect to P4P, some House Democratic leaders, such as Reps. John Dingell (D-MI) and Pete Stark (D-CA), have expressed skepticism about P4P efforts in the past, whereas Sen. Max Baucus (D-MT), the Senate Finance Committee Chairman, has long supported value-based purchasing and was integral in the effort to include the PQRI along with provisions to prevent a cut in Medicare payments to physicians in 2007. In spite of the skepticism among House leaders about P4P, it would be incorrect to say that Medicare's costs or that improving value will not continue to be important issues for the Congress, but it does remain to be seen how exactly those issues may be addressed by the new majority.

An idea about how the value issue will be addressed was seen in the CHAMP Act, which included provisions to repeal the Physician Assistance and Quality Initiative Fund (PAQI), which CMS has planned to use to continue the PQRI in 2008, to free funds to pay for other Medicare benefits, including increases in Medicare physician payments in 2008 and 2009. In spite of those provisions, H.R. 3162 does not end the value-based discussion; rather, the bill actually furthers the value-based effort with measures that would implement some of MedPAC's recommendations on efficiency. Specifically, the bill included provisions that would require the HHS Secretary to develop a mechanism that enables physicians to receive confidential feedback about their resource use and how they relate to their peers both locally and nationally.²² In addition, the bill calls for the establishment a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to study the comparative clinical effectiveness of the full range of medical services, including surgical procedures.²²

Regardless of whether the trigger is ultimately repealed, "pay as you go," or PAYGO, budgetary requirements passed by the new Democratic majority will likely mean that these issues of quality and efficiency will continue to present

themselves in one form or another for years to come. These PAYGO requirements mean that any spending increases included in legislation must be offset by either savings or increased revenues elsewhere. As a result, PAYGO will mean that policymakers will continue to face the challenge of saving health care dollars. This task becomes particularly formidable when combined with policymakers' effort to avert a 9.9 percent cut in Medicare physician reimbursement in 2008 and further cuts of 5 percent per year through at least 2016.

Medicare's rising costs will continue to pose significant challenges for policymakers. Although it is hard to say what it will all mean for surgery, one of the expressed goals is to improve the value of care that patients receive in Medicare. In this effort, policymakers will continue to look to MedPAC and others in the effort to improve the Medicare's quality, efficiency, and value for beneficiaries. As it has done in the quality improvement effort, the College will continue to work with policymakers and offer the lessons learned through its many endeavors in quality improvement. In so doing, the College's commitment is to ensure that this value-based effort is ultimately not about dollars but about ensuring that patients receive the highest quality surgical care in a timely fashion. It is a commitment we cannot afford not to make. Ω

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