Achieving deficit reductions of $1.5 trillion over the next ten years is the task given the Joint Select Committee by the Budget Control Act. Unfortunately, this is not enough to set the federal government’s finances in order, and the short time frame may not lead to meaningful reforms to the main drivers of federal spending growth: Medicare and Social Security. These two entitlement programs account for 37 percent of federal spending today and are expected to increase to more than 50 percent by 2021.

The Joint Select Committee comprised of six senators and six congressmen, split evenly along party lines, must vote on a proposal by November 23. If a proposal is recommended by a majority of the committee, then a majority vote on the proposal will take place in both houses of Congress by December 23. However, in the event that a proposal does not achieve committee approval or if it does not reduce the deficit by at least $1.2 trillion over the next ten years, the Budget Control Act specifies certain automatic reductions in federal spending.

Interestingly, Social Security is essentially excluded from the automatic reductions, and the maximum reductions in Medicare payments to health care providers cannot exceed 2 percent per year. Thus, by not agreeing, the committee can take a pass on addressing the political hot button issues of Medicare and Social Security.

Avoiding entitlement reform has a long history. The last major Social Security reform occurred in 1983, almost 30 years ago. That reform produced annual surpluses from 1984 to 2009 by increasing both the payroll tax rate and the maximum taxable income and by taxing benefits. These surpluses funded contemporaneous government programs while simultaneously being credited to the Social Security Trust Fund, thereby committing current and future taxpayers to funding the system’s expenses when the projected deficits occurred. The 1983 reforms also reduced future benefit payments by increasing the full retirement age, but those increases came into effect twenty years after the legislation was passed.

Given that current and near-term retirees have counted on Social Security in their retirement planning, it is difficult to reduce expenditures within the Select Committee’s ten-year window. However, the short time constraint may make Social Security tax increases, like raising the taxable maximum, a tempting policy option. Some will argue that raising the taxable maximum is a “win-win-win” option — it raises current revenues in excess of current costs and thereby counts towards the goal of reducing the deficits over the next ten years, it extends the life of the trust fund, and it enhances the progressivity of the program. In fact, such a change is a lose-lose proposition since any surpluses would be spent on other programs, and the increase in the Trust Fund commits future taxpayers to higher taxes. Thus, it is a tax on citizens now and again in the future. Also, such a change increases the size of the program in the long run and kicks the problem down the road.

Meaningful long-term reforms of Social Security will include a variety of expenditure reductions phased in over time. These will likely include reducing benefits for higher income workers and tying the length of retirement to gains in longevity. Ideally, the reformed program would include a prepayment component as well.

While the Select Committee’s ten-year deficit reduction window may preclude fundamental Social Security reform, reforms to Medicare remain in the conversation. Further reductions in payments to health care providers, beyond the reductions included in current law, continue to be
For some, the appeal of a single payer system is the payer’s ability to exercise monopsony market power and pay lower prices. Medicare is thought of as a single payer for much of the health care consumed by retirees and eligible disabled workers. However, Medicare has established payment rates that, according to the program’s chief actuary, are currently 80 percent of private insurers’ payment rates. Furthermore, under the Affordable Care Act’s additional spending constraints, they will continue to decline; within ten years they will be lower than the rates paid by Medicaid. Such payment rate reductions, should they occur, will undoubtedly lead to severe access to care issues. The payment rate reductions are embodied in the often-overridden Sustainable Growth Rate (SGR), the strictures expected from the Affordable Care Act’s Independent Payment Advisory Board (IPAB) and the Act’s productivity goals. Further payment reductions would only exacerbate the access problems seniors currently face.

Proponents of a single payer system argue that a single buyer of health care (think Medicare) will exercise its market power and reduce payments to providers (doctors, hospitals, nurses). Those providers will have no recourse and will be forced to accept the lower payments. But will doctors, hospitals, and nurses work for lower pay?

To answer this we must think about the supply of health care providers, say nurses. At low wages the number of individuals willing to enter the nursing field is limited, but as wages rise the number of individuals willing to train as nurses rises. This positive relationship between nurses’ wages and the number who are willing to enter the field defines the supply curve of nurses. The higher wages are enough to induce some workers to forgo other training and enter nursing. The same holds true for doctors, other health care professionals, as well as the supply of hospitals.

So, when the health care profession is presented with lower payments from Medicare, the number of doctors, hospitals, and nurses willing to accept the lower payment declines. Now this may not happen immediately, and some health care providers will accept the lower payment in the short run, but as time goes on, hospitals will reduce staffing, doctors will reduce the time spent with patients and fewer individuals will train to be doctors and nurses; and Medicare patients will be treated differently and receive less than they would otherwise. Access will be limited, waiting lines will be longer, and quality will be lower. By exercising its market power, the single payer essentially constricts the amount it demands and pays less for it.

With Medicare buying less care and paying less for it, don’t taxpayers benefit? The answer is yes. Basically, at the initial higher price and quantity, what was once a surplus to the providers who were willing to accept less, has been transferred to the taxpayer in the form of lower taxes. But the fact that a price ceiling is in place creates another loss to society. Economists refer to this loss as a deadweight loss. Less health care is consumed and less is supplied than in the case without the ceiling, leaving demand unsatisfied at the lower price and quantity.

We see that there are three groups whose welfare is affected when a price ceiling is in place: Medicare patients, health care providers, and taxpayers. Taxpayers benefit at a cost to providers and with reduced access for Medicare patients. Let’s assume for now that further Medicare cuts remain on the Select Committee’s menu of policy options and that the cuts are in addition to current law that already includes SGR, and the Affordable Care Act’s IPAB and productivity goals. The adverse effects of these various forms of price ceilings can be avoided by adopting alternative ways to achieve lower taxpayer spending.

Rather than reforming Medicare by restricting supply, let’s explore some demand-
side options. Demand-side reforms include raising copays and deductibles, premium support, higher premiums, means testing benefits, and allowing beneficiaries to supplement Medicare’s reimbursements.

A starting point on the demand side is restricting Medigap insurance. Medigap is on the chopping block for many reformers because these plans basically convert Medicare to first dollar coverage insurance and drive up Medicare spending. Medigap thus thwarts Medicare’s cost sharing, but does close beneficiaries’ exposure to potential catastrophic losses. The extra costs imposed on Medicare could be collected as a tax on the sale of the Medigap policy and turned over to Medicare. Alternatively, the catastrophic exposure of Medicare’s insurance coverage could be closed in tandem with other structural reforms to make Medigap unnecessary.

Of the demand-side reforms on the table, premium support combined with means-tested health accounts is preferable to the other reforms. Suppose the premium support amount is tailored to the individual’s health status and is equal to the price the individual would pay for a major medical health insurance policy. In this way, all beneficiaries are still covered for catastrophic events. The dollar amount at which the major medical spending kicks in and/or maximum out-of-pocket spending could be means-tested. It would be required that the premium support each beneficiary receives be spent on insurance that includes catastrophic coverage, but the premium support could be combined with one’s own funds to buy other types of insurance as well.

The health spending account would be means-adjusted in the following way. Each year, health care coupons are deposited in beneficiaries’ accounts and the value of the coupons in buying health care would vary by income. To illustrate the idea, consider the case of a low-income beneficiary who has a premium support payment sufficient to buy a $5,000 deductible policy. Suppose also that 500 health care coupons are deposited in the beneficiary’s spending account. The coupons have a face value of $500 and any unspent amount can be redeemed for cash at the end of the year. However, if the beneficiary spends the coupons on health care they are worth $10 each for a total value in the health care market of $5,000. Thus, this low income beneficiary is fully covered. Higher income retirees would receive fewer coupons and face higher cost sharing because the premium support amounts are means-tested and adjusted for health status.

Such demand side changes allow the market to determine the prices of health care services and still ensure that beneficiaries have sufficient means to access the market. Of course the distribution and variety of health care services consumed by each beneficiary will change as incentives change. But in terms of Medicare’s relative transfers to individuals with different lifetime earnings, means-tested premium support and means-tested health spending accounts will increase the program’s progressivity.

Political reality suggests that another path is more likely – a gradual transition to a fully means-tested Medicare program that retains characteristics of the current program. In such a program, lower-income retirees would have essentially the same coverage as they have today through Medicare and Medicaid. It appears that there is agreement that Medigap should be scaled back, so middle-income retirees would see their cost of participating in the program rise through higher premiums and higher copays. Finally, higher-income retirees would likely pay the full actuarial cost of the insurance should they choose to participate. While this path is more likely than the pure demand-side reforms we outlined, it will still require Medicare to set prices for years to come.

The Select Committee has a great opportunity before it. Though its faces a short-term window it can affect the long-term by introducing demand-side changes today; any dramatic change in the short run is highly unlikely. No politician wants to be the victim of a Mediscare attack, derided for trying to dismantle Medicare when they are actually ensuring its integrity for the vulnerable seniors of the future.