Inquiring Minds topic – 28 June 2013

Moderator: Maurice Ernst

Entitlements in America

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Dear Mr President:

Please take a moment to gloat. All through your first term you were accused of presiding over America's fiscal ruin. In your first year in office the deficit hit a peacetime record of 10.1% of GDP, and went past $1 trillion for four years.

Suddenly the critics have fallen silent. The idiotic comparisons to Greece have stopped. The reason: deficit projections are falling fast. The Congressional Budget Office (CBO) now says it will shrink to 4% of GDP in this fiscal year and 2.1% by 2015. No wonder Republicans would rather talk about the Internal Revenue Service and Benghazi than the budget.

Yet your fiscal mission is far from over. The deficit is falling thanks to the cyclical recovery of the economy, the expiry of your stimulus programmes, a fortuitous but partly temporary slowdown in health-care costs, and three deficit-reduction packages worth 1% of GDP over the next decade.

This isn't good enough. Don't take it from us; almost every impartial observer, including the CBO and the IMF, says the same. The federal debt is too high, at 73% of GDP last year (gross debt is 103%). On current policies, it will hit 90% by 2035. You have, to your credit, proposed a budget which (if, by some miracle, it becomes law) puts debt on a downward course over the next decade, but it would probably not fall for much longer.

The hard truth is that an ageing population and rising health costs are inexorably pushing up the cost of Social Security (pensions), Medicare (health care for the elderly), Medicaid (health care for the poor) and the subsidies in Obamacare (see chart 1). The total cost of these entitlements will rise from 9.8% of GDP this year to 11.6% by 2023 and 13.6% in 2035, which would push the deficit sharply higher.

You declared from your first days in office that Social Security and Medicare have to be fixed. We must not, you said, leave American children a "debt they cannot pay". But how? You got the rich to pay more taxes, and you rightly want them to pay a bit more. But you have never asked for tax rises on a scale that would finance this sort of growth in entitlements, and for good reason: neither Congress nor the voters would tolerate them for a minute.

You need a credible, long-term plan that will stabilise entitlement spending over the next two decades.

A few first principles for such a plan:

• *No steep cuts in the next five years*. The recovery is fragile enough as it is. And you can't spring big changes on people who are about to retire.

• *Any reforms should boost the economy's supply side*. Millions of working-age Americans have left the labour force, sapping the country's economic potential. Most have quit because they cannot find jobs; but too many entitlements give them an incentive to leave.

• *The rich should bear the lion's share of the adjustment,* simply because their incomes have grown so much faster than the average in recent decades.

• *Don't be deterred by the political difficulty*. Democrats don't want to touch benefits, and the only thing Republicans hate more than higher taxes is Obamacare. But action is necessary.

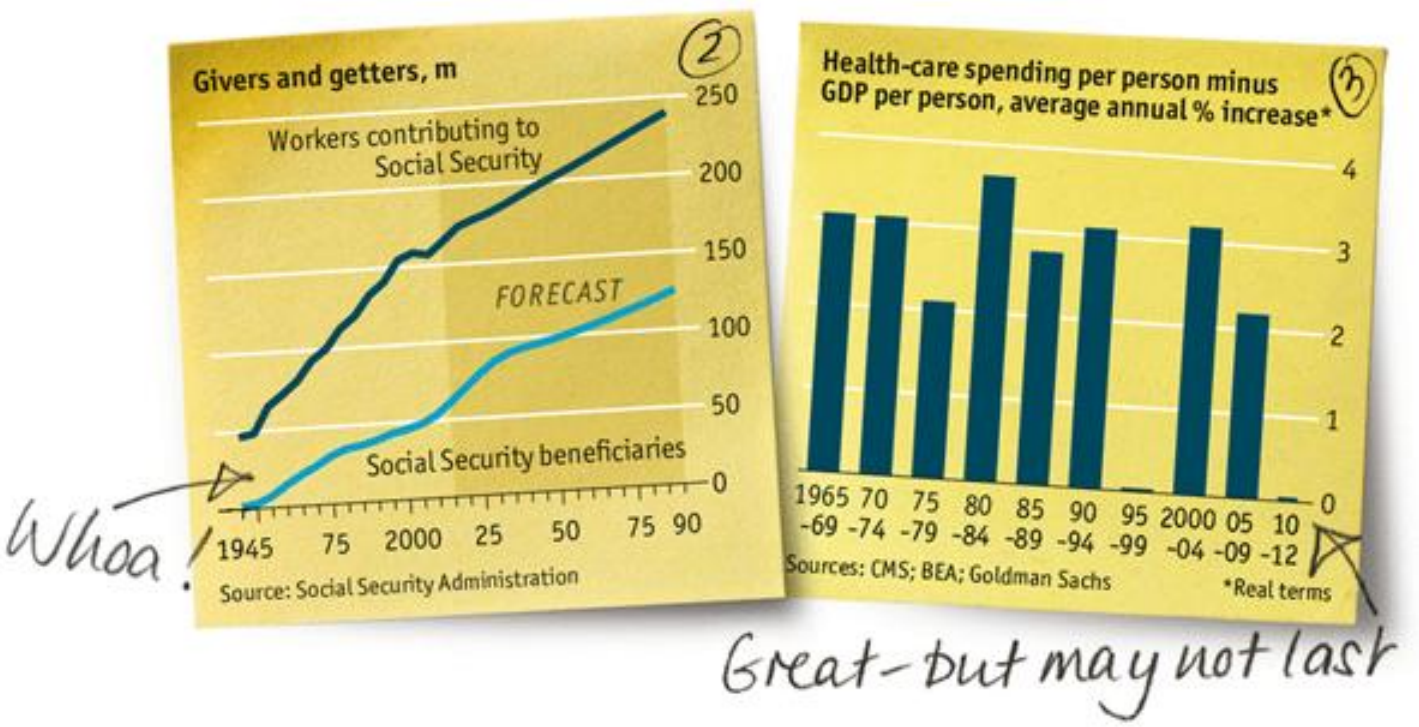
Everyone is sick of the words "grand bargain". But only a bipartisan effort can forge a solution that lasts.

How to repair the third rail

Start with Social Security: by far the single biggest obligation of the federal government, costing $809 billion this year, or 5% of GDP—and long known as the "third rail", because it would electrocute any politician who touched it. The number of beneficiaries will grow by 1.5m per year for the next two decades, sending the cost of benefits to 5.9% in 2031. As the ratio of retired people to workers grows (see chart 2), the cost of benefits will outstrip the payroll taxes earmarked to finance them. By around 2035, the gap will reach 1.5% of GDP (though your proposal to index benefits to a different inflation measure would trim that). Three ways to eliminate that gap:

• *Raise the retirement age*. In 1983 Ronald Reagan and a split Congress agreed to raise the full retirement age from 65 in 2002 to 67 in 2022. (Workers can still retire as early as 62 with reduced benefits; on average, they retire at 64.) This not only extended the life of the programme; as a result, the labour-force participation of workers over 60 has been rising since the late 1990s, even as participation falls for younger workers for other reasons.

Today's 65-year-olds can expect to live 19.2 more years, up from 16.4 in 1980. So the full retirement age can be gradually extended another three years, to 70, and the early retirement age can be raised to 64. Both should then be indexed to life expectancy. This would not only save big sums, but also—the CBO thinks—boost GDP by 1%, as more of the elderly kept working.



• *Try progressive price indexing*. Right now, each new pensioner receives a benefit based on wage inflation over his working life. That should remain true for the poor; but the formula should adjust as the retired person's income rises until at the top it is based on price inflation, which is usually lower than wage inflation.

• *Put up payroll taxes*. Employers and employees currently pay a combined 12.4% tax on wages up to $113,700. That limit rises each year in line with average wages. But average wages have grown more slowly than total income as the rich and highly skilled have pulled ahead, so a smaller portion of total income each year is subject to the payroll tax: it has fallen from 91% in 1983 to 83% in 2009. The limit should be allowed to rise faster than wages until it once more covers 90% of wage income. Lastly, the programme should include a formula, similar to Sweden's, that adjusts the benefit rate and payroll tax if the system becomes insolvent.

• *Reform Social Security's disability-insurance programme*. Enrolment has swelled from 1.3% of the working-age population in 1970 to almost 5% now—because the workforce is older, because more women are working, and because a loosening of eligibility criteria makes it easier to qualify for conditions such as mental illness or back pain.

Many jobless workers apply for disability when their unemployment benefits expire. Once on the rolls, fewer than 5% leave.

Two obvious reforms are, first, earlier intervention to steer applicants to other forms of work: employers should pay lower premiums when they keep workers off the disability rolls. Second, beneficiaries should be regularly assessed to see what work they can do, and benefits should be contingent on looking for, and taking, such work. Denmark, for example, now grants a benefit only if the ability to work is permanently reduced and flexible work is impossible. This won't save huge sums soon; but, over time, the economic benefit of reinserting millions into the workforce would be immense.

Taming the dragon: tackling health inflation

Now for the really hard part. The principal source of rising entitlement spending is "excess-cost growth": the tendency of health spending per head to grow faster than per capita GDP because of ageing, the continuous introduction of costly treatments, the industry's perverse incentives (which reward doctors for providing more, rather than better, procedures), and labour intensity, which makes it hard to raise productivity.

For the most of the past five decades health spending has grown by three percentage points above GDP per person every year, but since 2010 the gap has fallen close to zero, according to Goldman Sachs (see chart 3). Both private and public costs have slowed. Medicaid spending grew by 9% a year from 2001 to 2009, but has been flat since. Medicare spending also grew by 9% a year in that period, but has risen by only 3% a year since. In 2010 the CBO said the two would cost $1.5 trillion, or 6.4% of GDP, in 2020. This year it lowered that total to $1.3 trillion, or 5.8% of GDP.

Why is this happening? Michael Chernew of Harvard University estimates that changes to insurance design, such as requiring consumers to pay cash for a greater share of care, account for about 20% of the slowdown from 2009 to 2011. And something else may be at work: Obamacare and insurers are testing contracts to spur doctors to provide better, cheaper services.

Still, much of this is transitory. Workers have lost their jobs and often their insurance. That has reduced the consumption of health care. An improved economy means that private spending will pick up. Public spending will surge, too, because of an ageing population, new insurance subsidies and a huge expansion of Medicaid (see next page). So you need to do more.

Certain reforms for the private market would benefit taxpayers, too. If private health costs rise, more people will be pushed into public programmes. Start by helping patients act like sensible consumers:

• *Replace the tax deduction for health insurance*, which costs some $200 billion a year in forgone taxes, with a less generous tax credit that insulates lower-paid workers, while discouraging the rest from buying overgenerous plans. Or simply cap it at a lower level than you already have.

• *Require hospitals and doctors to disclose and post their prices*, including those negotiated with insurers. At present it is almost impossible for prospective patients to know how much their care will cost.

Such reforms will make the broader health market more efficient. But public-health programmes, for your purposes, remain the biggest worry.

Keep Medicaid on a tight leash

Medicaid is a good place to begin. The programme's costs are usually shared by the states and Washington, with states administering the programme within federal rules. But spending is about to soar as Obamacare expands eligibility to more poor adults, with Washington footing most of the bill. The Supreme Court made the Medicaid expansion optional, but even Republican governors seem keen to take Obamacare's cash.

Once that expansion is in place, how do you keep Medicaid's costs under control? Paul Ryan, the Republican chairman of the House Budget Committee, wants to scrap Washington's open-ended promise to match state Medicaid spending. Instead, the federal government would pay block grants indexed to population and inflation. This would cap Washington's obligation and encourage states to contain rather than expand coverage.

You are right to view this plan with scepticism. States already have reason to limit costs. During the recession they cut payment rates to hospitals and slashed benefits, such as dental and eye care. Most states are also busy expanding managed care for their Medicaid beneficiaries, paying companies to manage their health care—but now rewarding those companies for keeping patients well, rather than paying hospitals for giving as much care as possible.

Your health department has allowed such reforms to progress. It has also given states grants to test new models. One obvious option is to put the poor elderly, who receive both Medicaid and Medicare, into Medicaid managed care. Your deficit commission reckoned that this would save $1 billion in 2015 and $12 billion to the end of 2020. But, in general, you should give states more freedom to experiment and make it easier for them to get waivers from programme rules.

A recent study of Medicaid patients in Oregon found that insurance improved their financial security, but not their health. This suggests it might be better to give less generous health insurance and spend the money fighting poverty.

Be bold enough to cut back Medicare

Now for Medicare, the hardest part of the budget. Voters adore it. Both parties sow Medicare scares to win elections. Even so, both sides agree that its costs must be contained.

You've already cut growth in Medicare fees to hospitals and private insurance plans. Experiments are afoot, under Obamacare, to improve efficiency. But these are not enough. Here are four reforms to set Medicare on a firmer path:

• *Raise the eligibility age*, as already agreed for Social Security, from 65 to 67. This will encourage Americans to work longer, which boosts GDP and thus America's capacity to pay for entitlements. Even if Medicaid and Obamacare subsidies have to rise to cover these older workers, a higher retirement age for both Social Security and Medicare would shrink the federal deficit (the CBO reckons) by 1.75% of GDP by 2060.

• *Make the richer elderly pay more for their own care*. Although you have proposed some means-testing, its scope is limited by Medicare's separate plans for hospitals and doctors with different deductibles, premiums and co-payments. Merge these plans so that patients pay a single premium and deductible, rising with income. This would help solve another problem: Medicare has no cap on out-of-pocket spending, so patients buy supplementary private insurance, which masks the cost of extra care. With the different parts of Medicare combined, you could cap out-of-pocket expenses and impose penalties on extra insurance. A basic version of this plan would save $90 billion over the coming decade. With wider means-testing, it would save even more.

• *Reward hospitals and doctors for providing good care*, rather than lots of it. The traditional system pays health providers for every service, which encourages wasteful over-treatment. Your health reform tests a variety of ways to do this for Medicare. Bundled payments give hospitals and doctors a set fee for a full episode of care, such as a hip replacement. Doctors have an incentive to lower their own costs, co-operate and keep patients from developing new ailments. In your new Accountable Care Organisations (ACOs)—more than 250 of them so far—networks of doctors and nurses are responsible for the care of a given set of Medicare patients. If they keep costs for those patients below a certain benchmark, then the ACO and the federal government split the savings. It is not yet clear that these experiments save money but, if they do, you should expand them.

• *Scuttle the Independent Payment Advisory Board (IPAB)*, Obamacare's main backstop for spending. The law requires the board, from 2015, to propose cuts to keep Medicare growth below the average of general inflation and health inflation. From 2020 it must be lower still. Critics say this unelected body has too much power. We think it has too little.

IPAB may not propose changes that raise costs or reduce services for Medicare recipients. This makes hospitals the most likely target for cuts. Obamacare has already capped growth in Medicare's fees to hospitals and similar places. Medicare's trustees worry that this is not sustainable over the long term, since Medicare would end up paying far less than private insurers for the same service. Providers would either have to stop accepting Medicare, or go out of business.

Moreover, making Medicare less generous is not a bad thing. At present it pays for a range of services, some cost-effective, some not, and pays for care at both good hospitals and bad.

America has a visceral aversion to anything that smacks of rationing, but this is unusual. Britain and Germany do not shrink from considering whether treatments are cost-effective or not. The health secretary should direct patients to better, cheaper care, as private insurers have done for years.

Obamacare created a new body to study the effectiveness of different treatments. It should be allowed to consider costs, too, and recommend what treatments Medicare will cover.

(4)

	Savings in 2021, $bn	% of GDP
Social Security		
Base benefits for affluent on price instead of wage inflation	25.4	0.1
Raise early-retirement age from 62 to 64	29.4	0.1
Raise full retirement age from 67 to 70	31.4	0.1
Increase payroll tax to cover 90% of aggregate wages	60.8	0.3
Medicare		
Raise eligibility age to 67	31.8	0.1
Raise premiums to cover 35% of doctors' fees	39.8	0.2
Unify premiums & deductibles for hospitals & doctors, penalise private insurance that boosts Medicare costs	12.6	0.1
Restrict tax deductibility of employer-provided health insurance	42.1	0.2
Other		
Convert federal civil-service health benefits to vouchers	17.5	0.1

Source: CBO

Think about these!

A little bargaining won't hurt you

Republicans hate not only rationing, but also many of the potential savings on your list (see chart 4). So, as an enticement, try another idea: vouchers. Mr Ryan wants to offer the elderly vouchers to buy private insurance or traditional Medicare through an exchange. The voucher could not increase in value by more than 0.5% above nominal GDP growth. It should cover a general set of services, but insurers would be able to design products to steer patients towards cost-effective care. Beneficiaries would have to pay out of pocket for a more generous plan. Exchanges avoid the distortions of price controls and put the onus on individuals, rather than government, to decide how to ration their health care.

Start on a limited scale, by replacing civil-service health insurance with vouchers. If the scheme lowers costs with no risk to health, roll it out more broadly. There might be political benefits, too: your embrace of your fiercest critic's flagship policy idea just might persuade him to accept higher taxes and Obamacare. And that's a principle you could apply more widely: look at the ideas on the other side, see if you can give Republicans anything they want, and thus try to win them over to your own schemes.

We admit this plan is daunting. Implementation would take years, even if you manage the spirit of compromise mentioned above. But there is no quick fix, and the upside to reform is colossal. Without action, entitlements will crowd out investment in the sectors that make America grow. If you act boldly, you will leave office having kept your promise to spare today's children the crushing consequences of debt. That would be quite a legacy.