Executive Summary
Backgrounder
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Entitlement Reform Is Necessary for Long-Term Fiscal Stability

Douglas Holtz-Eakin and Gordon Gray

Attention has focused recently on the explosion of federal borrowing to meet the demands of economic "stimulus," housing market stabilization, and the financial sector crisis. However, even if the United States had been fortunate enough to avoid these crises, the federal government would still face an unsustainable fiscal course.

The most current long-term projections of growth in Social Security, Medicaid, and Medicare (often referred to as entitlements) paint a bleak fiscal picture, which emphasizes the need for reform. Left unchecked, entitlement spending is projected to exceed 20 percent of gross domestic product (GDP) by 2060. Viewed in isolation and from the distance of 50 years, this may not seem altogether daunting—distressing perhaps, but hardly alarming. However, the federal budget would also need to expand to include discretionary spending and the other mandatory outlays. Even more important, mandatory outlays would include spending a crushing 22 percent of GDP to service the debt accumulated from five decades of debt-financed federal spending. The projections beyond 2060 reflect the snowball effect of compounding debt and dwarf the nearer-term estimates. Regardless of the time horizon, addressing U.S. fiscal straits will require increasingly drastic measures.

The projections demonstrate the futility of attempting to finance entitlements with debt. On its present course, this debt and the accompanying interest will swamp the U.S. economy, harm U.S. standing in world capital markets, damage capital formation and productivity growth in the United States, and reduce future standards of living.

The problem needs to be addressed soon, but some proposed solutions will not work. Raising taxes to match the growth in the spending would dramatically harm economic growth and competitiveness. Similarly, it is unrealistic to expect sustained GDP growth sufficient to afford this spending. Instead, addressing the long-term fiscal challenges confronting the United States will require fundamentally reforming entitlement spending.

This paper suggests some possible approaches that Congress should consider when it reforms entitlements to rein in spending and makes broader reforms to the health care and health insurance markets.

Reforming Social Security. Social Security should be reformed by reducing the growth of future benefits to higher-earning workers to balance the cash flow so that revenue from Social Security payroll taxes equals Social Security retirement benefits. Achieving a cash-flow balance would immunize Social Security from the larger vagaries of the federal budget.

This paper, in its entirety, can be found at:
www.heritage.org/Research/SocialSecurity/bg2291.cfm

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Reforming Medicare and Medicaid. In Medicare and Medicaid reform, an important first step is to think separately about the markets for health care and health insurance.

The Health Care Market. In reforming the health care market, the first step is to employ the bully pulpit as loudly and frequently as possible to encourage people to take care of themselves and prevent chronic diseases when possible, but this would not be enough by itself. Next, the reforms should focus on promoting competition throughout the health care system among providers and among alternative treatments. Medicare payment policy needs to be reoriented away from paying for all treatments used on a patient and toward paying for cost-effective, coordinated care that yields high-quality outcomes.

These "supply-side" approaches to changing the use of medical services could be complemented by needed legal reforms to eliminate frivolous lawsuits and excessive damage awards and to provide a safe harbor for doctors that follow clinical guidelines and adhere to patient safety protocols.

The Health Insurance Market. The first pillar of reforming the health insurance market is to change the tax treatment of health insurance to level the playing field between employer-provided insurance and other types of insurance.

The second pillar is to improve the variety and affordability of these alternatives. As with markets for providers, health insurance markets should be national in scope and support vigorous competition. Highly competitive, deep national insurance markets will avoid the potential for large insurers to "capture" state regulators, limit monopoly power, provide out-of-state alternatives for consumers saddled with unreasonably costly insurance mandates, and reduce the potential for wasteful overhead and excessive compensation that survives in the absence of competition.

The third pillar of better insurance markets is to "risk-adjust" the tax credit so that higher-cost individuals receive greater resources, thereby transforming the nature of insurance company competition.

Conclusion. The U.S. faces a fundamental budgetary challenge that will have severe economic implications over the long term. However, the scale of these challenges and the severity of an attendant economic collapse demand a near-term approach to bring the U.S. fiscal situation back into balance.

Entitlement spending seriously threatens U.S. fiscal solvency. Left unchecked, it will contribute to a crippling national debt burden, which will stifle economic growth and force later and unluckier generations to bear the cost of these imbalances through severe federal cuts or draconian tax increases.

The U.S. still has a window, however indeterminate, during which it could implement sensible reforms to return Social Security to solvency without incurring massive future deficits and to rein in the health care costs that are driving the increasing Medicare and Medicaid spending. Properly implemented, reforms along the lines suggested in this paper would return federal spending to a sustainable path and ensure a foundation for prosperity throughout the coming decades.

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The projections demonstrate the futility of attempting to finance entitlements with debt. On its present course, this debt and the accompanying interest will swamp the U.S. economy, harm U.S. standing in

Talking Points

- Left unchecked, entitlement spending is projected to exceed 20 percent of GDP by 2060. Furthermore, by 2060, the U.S. will be spending a crushing 22 percent of GDP to service the debt accumulated from five decades of debt-financed federal spending.
- This debt and the accompanying interest will swamp the U.S. economy, harm U.S. standing in world capital markets, damage capital formation and productivity growth, and reduce future standards of living.
- While Medicare and Medicaid spending is influenced principally by rising health care costs and poses a greater fiscal threat, Social Security offers a relatively smaller challenge that can be addressed within the parameters of the program itself.
- Reforms of the health care and health insurance markets should focus on promoting nationwide competition throughout the health care system among providers and among alternative treatments.

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This paper suggests some possible approaches that Congress should consider when it reforms entitlements to rein in spending and makes broader reforms to the health care and health insurance markets.

The Problem

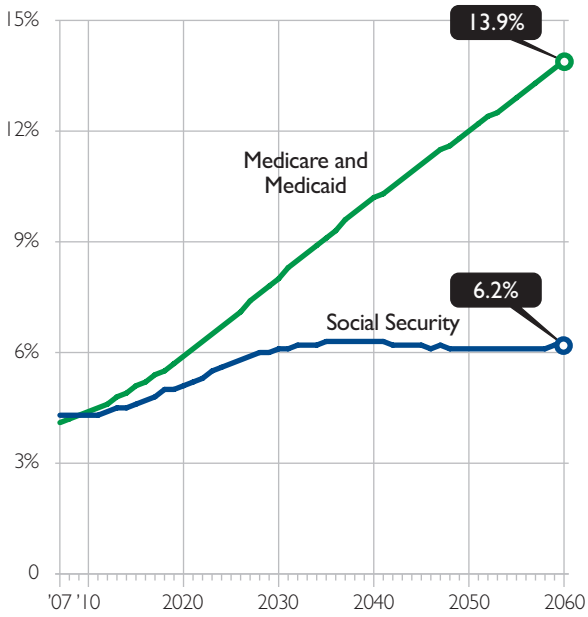
Irrespective of the latest binge of federal spending, the U.S. was already on a long-term unsustainable budgetary path. This year's $1.85 trillion deficit will only exacerbate the preexisting problem.

At present, the U.S. spends more than 8 percent of GDP on entitlements, but by 2018 that figure will have grown to more than 13 percent of GDP—a much larger slice of a larger pie. By 2028, entitlement spending is projected to be 30 percent higher than in 2018 and 60 percent higher than today. Chart 1 illustrates how entitlement spending is projected to grow rapidly in only a few years. Measured in terms of Administrations or congressional terms, the rapid growth is not far in the future.

Without major reform, these expenditures will require debt financing. Accordingly, public debt projections mirror the rapid escalation of federal obligations, which are driven largely by entitlement spending. In the current scenario, public debt in 2008 was about 40 percent of GDP, close to the historical average of 36 percent. However, under current assumptions, this number appreciates quickly, increasing by one-third in 10 years and nearly tripling by 2028. Chart 2, which ignores the debt associated with the economic stimulus and financial bailout, portrays an alarmingly rapid debt escalation well beyond historical precedent.

Projected Spending for Social Security, Medicare, and Medicaid

As a Percentage of Gross Domestic Product (GDP)



Source: Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

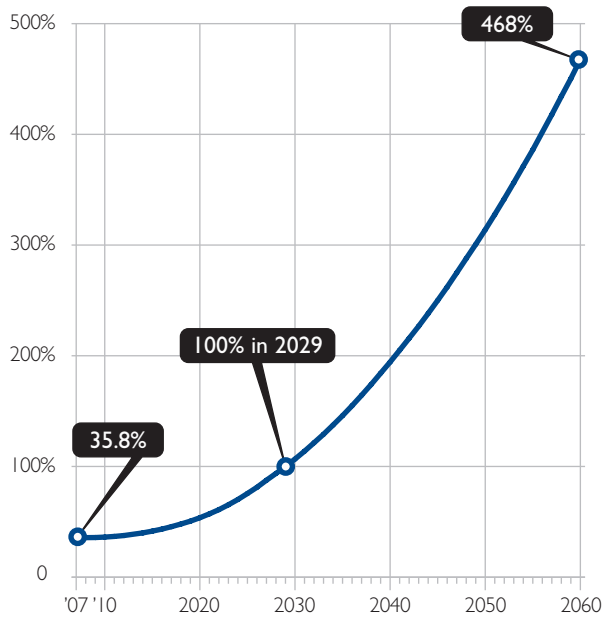
Chart 1 • B 2291 heritage.org

The prospect of mounting public debt carries with it the specter of burdensome interest payments to service the nation's growing liabilities. This increased debt service, paired with unrestrained entitlement growth, darkens the U.S. fiscal picture. Chart 3 illustrates the trajectory of estimated interest cost on the public debt to 2060. With interest payments on the public debt equaling one-fourth of economic output by 2060, these projections underscore the imperative to begin addressing challenges sooner rather than later.

1. Long-term budgetary data in this paper were principally taken from Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/ftpdocs/88xx/doc8877/12-13-LTBO.pdf* (April 30, 2009).

Projected Debt Held by the Public

As a Percentage of Gross Domestic Product (GDP)

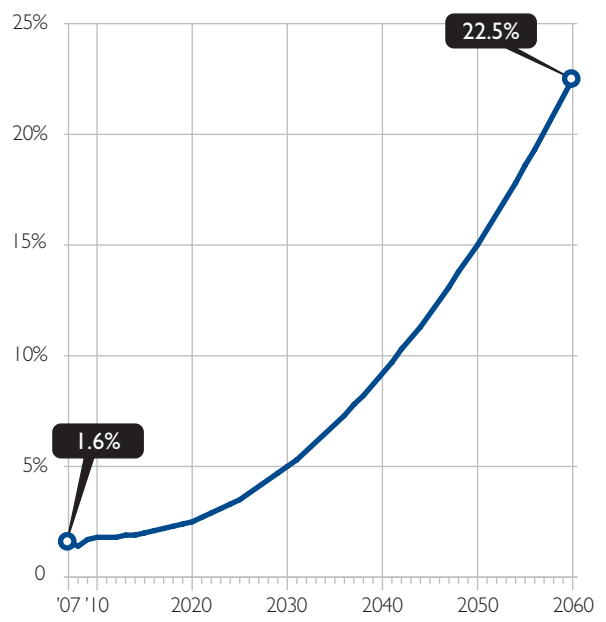


Source: Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

Chart 2 • B 2291 heritage.org

Projected Interest on Debt

As a Percentage of Gross Domestic Product (GDP)



Source: Author's calculations based on data from the Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

Chart 3 • B 2291 heritage.org

These data necessarily beg an honest assessment of U.S. fiscal wherewithal, and some analysts have reached unpleasant conclusions. Laurence Kotlikoff posed the question: "Is the United States Bankrupt?"[2] and concluded that indeed, "the United States is going broke." Among the measures he examined was the U.S. fiscal gap, which measures the present value difference between all future obligations and any offsetting revenue. In their 2005 paper, Jagadeesh Gokhale and Kent Smetters determined that this gap would stand at $76.6 trillion as of 2009.[3] The prevailing indicators of U.S. fiscal health would seem to indicate a long-term unsoundness.

Without significant reforms to change the expenditure or revenue picture, the federal government would increasingly find itself forced to debt-finance its obligations. In the near term, the U.S. could expect foreign countries to continue to purchase U.S. treasuries and not see serious consequences. However, as deficits mounted, federal borrowing would diminish capital stock and investment, harming growth, productivity, and wages. Interest rates would also rise. At some point, these pressures would likely shake the world markets' confidence in the value of U.S. securities, which would further increase the cost of servicing the growing debt. This cycle could precipitate a

2. Laurence J. Kotlikoff, "Is the United States Bankrupt?" *Federal Reserve Bank of St. Louis Review*, Vol. 88, No. 4 (July/August 2006), pp. 235–249, at *http://research.stlouisfed.org/publications/review/06/07/Kotlikoff.pdf* (April 30, 2009).
3. Jagadeesh Gokhale and Kent Smetters, "Measuring Social Security's Financial Problems," National Bureau of Economic Research *Working Paper* No. 11060, January 2005.

reinforcing negative feedback loop that would drag down the entire U.S. economy.

The Congressional Budget Office (CBO) has estimated the growth implications of several scenarios over the long term. A current policy baseline projects that federal debt will rise sufficiently by 2040 to reduce capital stock by 25 percent compared to what it would have been if the deficit had been held steady at its 2007 share of GDP. This would translate into a 13 percent relative loss to real GNP. Losses would become more dramatic thereafter. Indeed, the CBO notes, "Beyond 2062, projected deficits become so large and unsustainable that CBO's textbook growth model cannot calculate their effects."[4]

However, the approach embodied in this model may understate the impact. It explicitly does not incorporate or allow future expectations of debt and, therefore, minimizes the impact of U.S. debt becoming an increasingly risky investment. Rather, if the U.S. finds itself in a sufficiently precarious fiscal situation that forward-looking markets no longer value U.S. treasuries and thereafter all securities generally, the U.S. would confront a far more rapid and dramatic economic challenge than the model would otherwise predict.[5]

An oft-cited quote by Laurence Ball and Gregory Mankiw summarizes the state of the literature on this potential phenomenon:

> We can only guess what level of debt will trigger a shift in investor confidence, and about the nature and severity of the effects. Despite the vagueness of fears about hard landings, these fears may be the most important reason for seeking to reduce budget deficits.[6]

With a manifest unsustainable budget path and a prevailing view that unchecked mounting debt could precipitate an unpredictable economic collapse, it seems curious that many foreign governments continue to regard the dollar as their reserve currency of choice and continue to buy U.S. debt. For example, as of January of this year, China held $740 billion in U.S. treasuries, up more than $200 billion from the previous year.[7] The only apparent explanation is that the market assumes that the U.S. will eventually put its fiscal house in order. With world markets waiting, albeit quietly, for the U.S. to rein in its future obligations, the imperative for the U.S. is to do it efficiently.

Bad Solutions

The prospective debt facing the U.S. is a function of expenditures and revenues. Thus, the approach to a sustainable policy could be viewed as either broadly reducing expenditures to match revenues or increasing revenues to match expenditures. A third option is to blithely assume that sufficiently robust economic growth will generate enough revenue to meet the U.S. spending requirements.

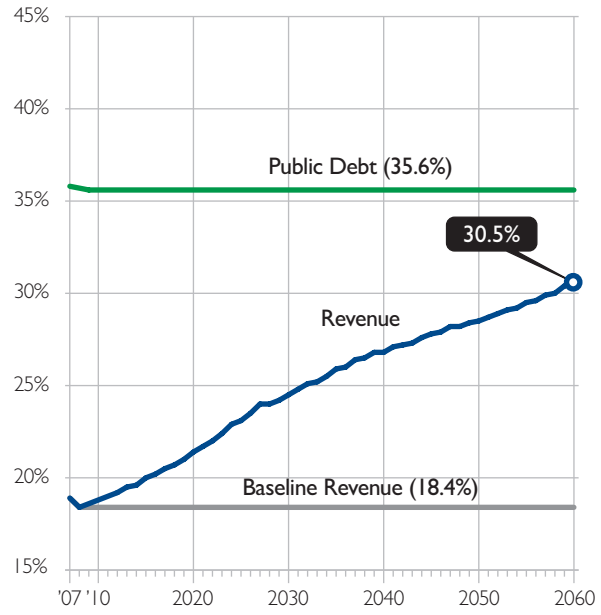
Absent major programmatic reform, it is worthwhile to examine what revenue and expenditure measures would need to be employed to stabilize the U.S. public debt over the long term and when they should be employed. The first approach is to examine the extent to which revenue would need to increase to match spending without any spending controls. Chart 4 illustrates the steady increase in revenue as a share of GDP required to sustain the growth in federal expenditures and thereby stabilize the public debt. By 2019, revenues would need to reach 21 percent of GDP to keep pace with expenditures, higher than any share in the past 40 years, and would need to continue increasing thereafter.

However, this scenario assumes that taxes are increased and allowed to increase beginning in 2010.

4. Congressional Budget Office, "The Long-Term Budget Outlook," p. 14.
5. Peter Orszag, Robert E. Rubin, and Allen Sinai, "Sustained Budget Deficits: Longer-Run U.S. Economic Performance and the Risk of Financial and Fiscal Disarray," Brookings Institution, January 4, 2004, at *http://www.brookings.edu/papers/2004/0105budgetdeficit_orszag.aspx* (April 30, 2009).
6. Laurence Ball and N. Gregory Mankiw, "What Do Budget Deficits Do?" in Federal Reserve Bank of Kansas City, *Budget Deficits and Debt: Issues and Options*, symposium in Jackson Hole, Wyoming, August 31–September 2, 1995, pp. 95–119, at *http://www.kc.frb.org/publicat/sympos/1995/pdf/s95manki.pdf* (April 30, 2009).
7. U.S. Department of the Treasury and Federal Reserve Board, "Major Foreign Holders of Treasury Securities," March 16, 2009.

2010 Revenue-Side Debt Stabilization

As a Percentage of Gross Domestic Product (GDP)

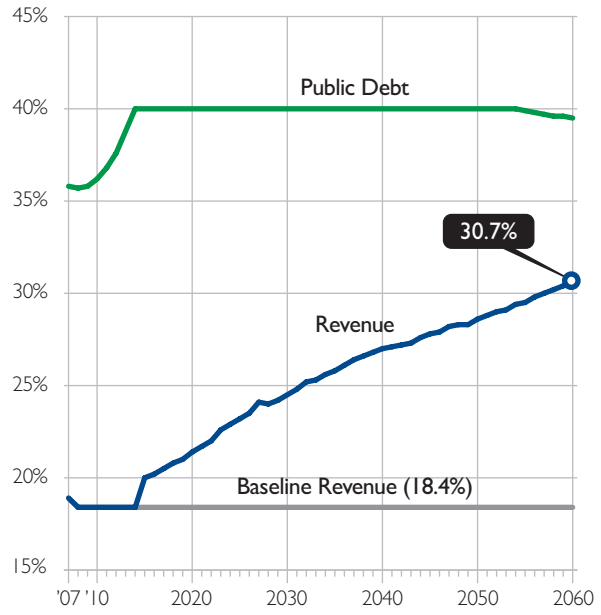


Source: Author's calculations based on data from the Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

Chart 4 • B 2291 heritage.org

2015 Revenue-Side Debt Stabilization

As a Percentage of Gross Domestic Product (GDP)



Source: Author's calculations based on data from the Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

Chart 5 • B 2291 heritage.org

If policymakers delay a revenue-side approach to debt stabilization until 2015, the outlook becomes even darker. As shown in Chart 5, delaying the tax approach would necessitate a more aggressive increase in tax revenue in the first year, presumably through steeper tax increases, while leaving the debt stabilized at a higher share of GDP than under the 2010 scenario. As a matter of economic policy and political reality, Congress could not plausibly enact such a dramatic tax increase nor would the economy be resilient enough to weather its impact. This underscores the immediacy and far-reaching implications of current fiscal policy.

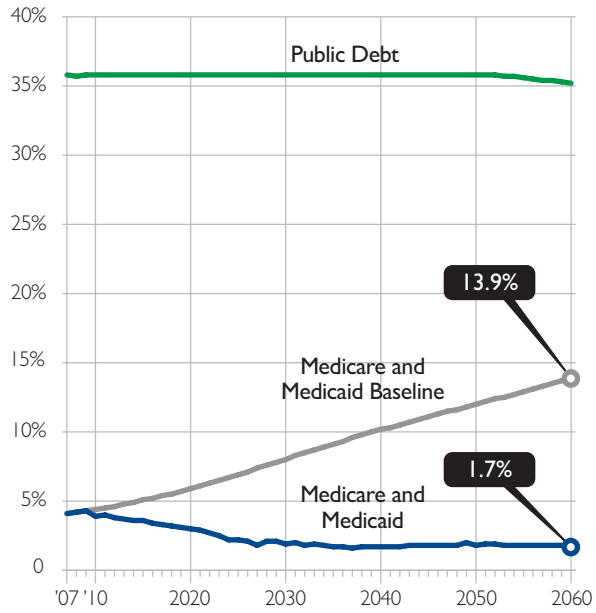
Another approach would be to simply cut spending—perhaps across the board or per recipient—as a crude approach to stabilizing the public debt. As shown in Chart 1, Medicare and Medicaid are the driving factors, even greater than Social Security, behind the projected growth in federal expenditures. Hence, examining controls on expenditures through those programs to keep the debt in check is appropriate. However, as Chart 6 demonstrates, stabilizing the debt level would require draconian and untenable reductions in Medicare and Medicaid expenditures. If the reductions begin in 2010, by 2060 they would shrink expenditures in both programs to levels not seen since 1979, even as the U.S. demography shifts to a more aged population.

As with delaying action on the revenue side, delaying an expenditure debt-stabilization approach leads to a less desirable outcome than would be achieved by implementing the same measures earlier. Chart 7 illustrates that delaying reductions in the share of Medicare and Medicaid requires a steeper initial reduction, while allowing a higher stable debt as a share of GDP.

A final, dubious approach would be to "grow our way out of it." That is, policymakers might mistakenly leave the problem untouched and simply

2010 Medicare/Medicaid Reduction Debt Stabilization

As a Percentage of Gross Domestic Product (GDP)

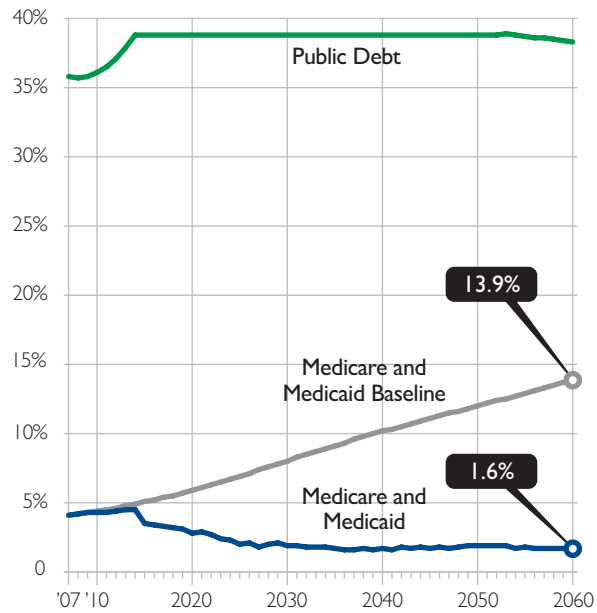


Source: Author's calculations based on data from the Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

Chart 6 • B 2291 heritage.org

2015 Medicare/Medicaid Reduction Debt Stabilization

As a Percentage of Gross Domestic Product (GDP)



Source: Author's calculations based on data from the Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

Chart 7 • B 2291 heritage.org

assume that the U.S. economy can grow fast enough to fund these expenditures without needing to raise tax rates. Chart 8 shows the GDP growth rate that the U.S. would need to sustain over the long term to follow that fiscal course. The needed growth is well in excess of baseline estimates and wholly unrealistic. There is no substitute for real reform.

Good Solutions

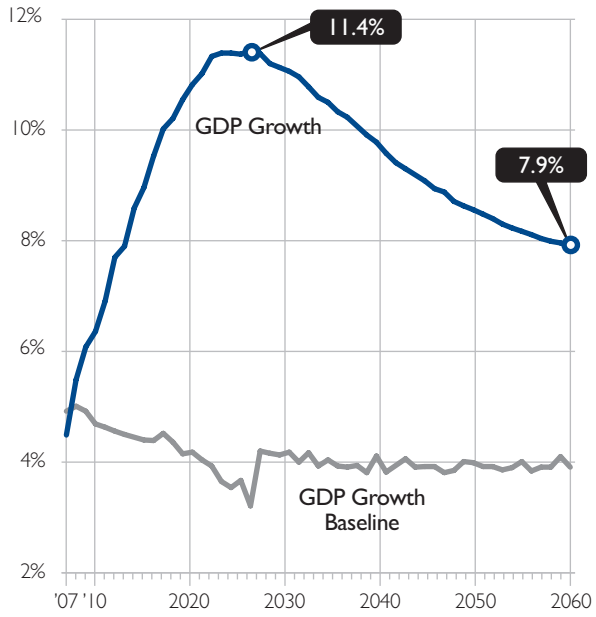
Until this point, Medicare, Medicaid, and Social Security have been treated as budgetary equivalents, rather than as unique challenges meriting unique reforms. In terms of the implications for budgetary pressures, this is reasonable. However, in examining worthwhile reforms, disentangling them makes sense because the politics and the dynamics of each program differ.

While Medicare and Medicaid spending is influenced principally by rising health care costs and poses a greater fiscal threat, Social Security offers a relatively smaller challenge that can be addressed within the parameters of the program itself. As such, it would be sensible to address Social Security separately from Medicare and Medicaid, which require fundamental health care reform to place them on a sound footing.

Social Security. Social Security should be reformed by reducing the growth of future benefits to higher-earning workers to balance the cash flow so that revenue from Social Security payroll taxes equals Social Security retirement benefits. Several aspects of this strategy merit discussion.

First, this reform strategy does not place primary emphasis on private equity investments or other "personal account" features that have dominated recent reform proposals. Shifting the system, at least in part, to such vehicles would change the system from a

Requisite Growth of GDP for Sustainability



Source: Author's calculations based on data from the Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *http://www.cbo.gov/doc.cfm?index=8877&type=2* (June 18, 2009).

Chart 8 • B 2291 heritage.org

pay-as-you-go social insurance toward a private retirement savings model. In the latter, the retirement benefit is determined in part by the fortunes of the individual in the labor market, which determines resources for contributions to accounts, and the individual's skills as an investor. In contrast, the social insurance model decouples the retirement benefit from these factors by using the government's power. In light of the decline in private-sector defined-benefit pensions and the labor market implications of globalization, it seems desirable to retain in the U.S. retirement savings system a component that has the risk characteristics of the current system.

That said, there is every reason to expand the system of household and pension savings to restore Social Security to its appropriate role as a safety net for retirement income and not the bulwark of the savings system. Focusing on the traditional system reflects the political reality that the United States has completed a vigorous and contentious debate over using Social Security payroll taxes for investment accounts, with the result that this approach was not adopted. Moreover, the recent financial crisis has only further weakened support for this proposal. Revisiting this debate would likely lead reform to fail, so reform efforts are best focused elsewhere.

In addition, putting the existing system on a sound financial footing is sensible even if one favors adding personal accounts. Furthermore, the reform posed herein could be viewed as the first stage of a two-step reform process.

Second, even without investment accounts, this approach will contribute to higher national savings. At present, the expectation of receiving future benefits lowers the incentives for households to save for retirement. At the same time, there is no offsetting savings in the private sector. Instead, taxes are used to pay for the retirement benefits of current retirees. Reducing the growth of benefits, especially benefits of those best situated to save more, will raise national savings.

Third, the proposed reform focuses on cash-flow balance. This contrasts with the typical approach of focusing on the program's "actuarial balance," which is the present value different between payroll tax revenues and spending on benefits, often expressed as a fraction of the taxable wage base. However, bringing Social Security into actuarial balance falls far short of desired reform.

After decades of running a cash-flow surplus, Social Security will begin running a deficit in the next decade. Bringing the system into actuarial balance means that up-front surpluses are counted more heavily than the future deficits because future years are discounted. Therefore, bringing the system into actuarial balance does not rule out future deficits. For that reason, actuarial reforms are not necessarily sufficient to make Social Security sustainable and do not rule out Social Security contributing to the U.S. fiscal problem in the future. Cash-flow reforms ensure sustainability and eliminate further contribution to the fiscal problem.

In addition, the logic of actuarially counting surpluses against future deficits assumes that Social Security surpluses are "invested" in interest-bearing securities. This underpins the logic that $1 in 2007

will be worth more than $1 in the future and vice versa. Regrettably, Social Security surpluses are "invested" in the sterling investment vehicle known as the unified federal budget deficit, hardly a blue-chip investment. In recent years, policymakers have vigorously debated the feasibility of a "lock box" that would effectively keep surpluses invested in securities and unavailable to the remainder of the federal budget. The failure to identify a working proposal in this area highlights the misleading nature of actuarial-based fixes.

A related point is that the interaction of actuarial measure and the timing of surpluses and deficits leads to misguided policy proposals. For example, proposals that would raise the maximum amount of taxable wages for Social Security would immediately raise cash-flow surpluses and relieve the actuarial imbalance. However, to the extent that historical practice prevails, these surpluses would be unavailable in the future when even greater benefits would be owed.

Next, the fundamental logic of actuarial accounting is to eliminate timing by collapsing present surpluses and future deficits into a single number. Yet timing is the essence of the problem. The baby boomers are beginning to retire and Social Security's transformation from a cash cow for the federal budget to a cash drain is apace. Politicians need to address the year-by-year problem—it is here and now—and not some average of present and future problems.

Finally, reforms that achieve cash-flow balance would immunize Social Security from the larger vagaries of the federal budget. Given the stresses emanating from other sources, this represents an appropriate objective for reforms.

Social Security reforms that fit this model include two changes that would better measure the lifetime labor-market earnings of individuals and their ability to save for retirement outside Social Security. In this model, beginning in 2009:

- The number of years included in the computation of Average Indexed Monthly Earnings would be increased to 40 years, and
- The measurement of inflation during retirement and the associated cost of living adjustments would be improved by reducing the cost-of-living allowance (COLA) by 0.4 percentage point.

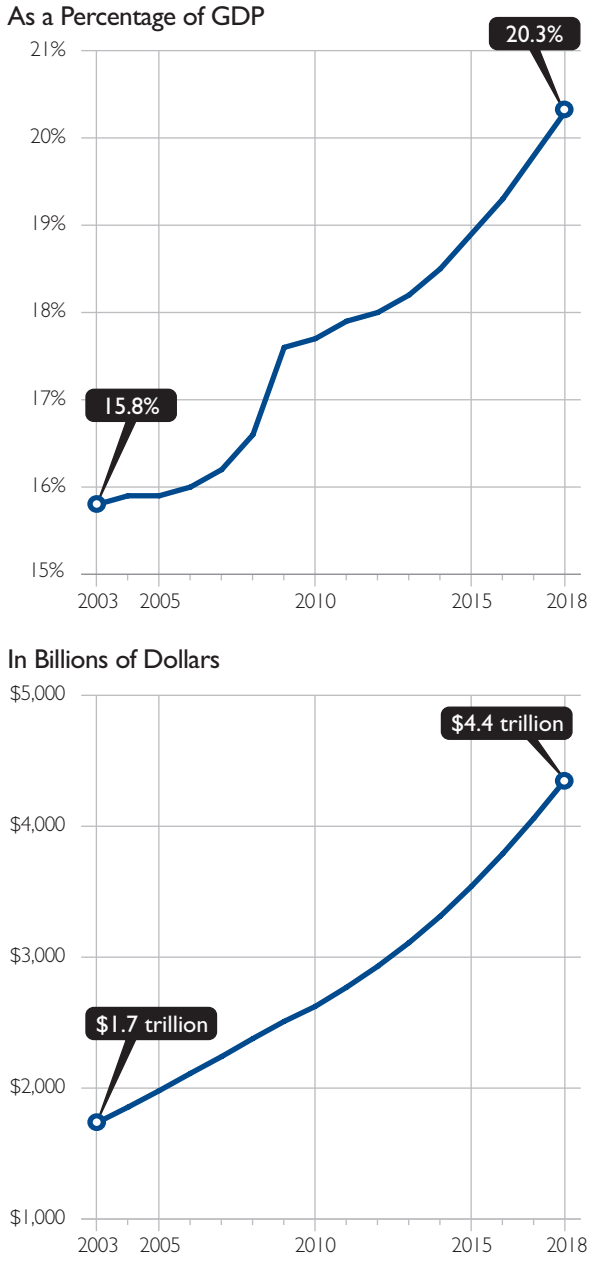
Policymakers could bring the system into balance by pairing these two reforms with two proactive policy changes:

- Reducing the future growth of Social Security benefits of higher-earning workers. This would slow benefit growth in a progressive fashion.
- Embracing longer longevity by increasing the normal retirement age to 68 years, while retaining the option of retiring early and collecting benefits at age 62. This could be accomplished by lowering the top two Primary Insurance Amount (PIA) factors from 15 percent to 10 percent and from 32 percent to 20 percent over the period 2012–2031 and by continuing to raise the normal retirement age at the current pace without a hiatus until it reaches 68.

Medicare and Medicaid. Health care spending is the leading U.S. economic and social policy challenge, and the future growth of federal health spending is the preeminent budgetary threat. However, this threat is not solely the result of Medicare and Medicaid and their design. Instead, a broader focus is appropriate to understand the rising national spending on health care. In 1970, national health expenditures totaled $1,300 per person and consumed 7 cents out of every national dollar (7 percent of GDP). Over the past three decades, per capita spending has grown 2.5 percent faster per year than per capita income has grown. As a result, national health spending per capita reached $7,421 in 2007, and national health spending constituted more than 16 percent of GDP. Chart 9 depicts how these figures will continue to increase significantly, even over the near term.[8]

8. Centers for Medicare and Medicaid Services, "Historical National Health Expenditure Data: NHE Web Tables," Table 1, at *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf* (April 30, 2009), and Centers for Medicare and Medicaid Services, "National Health Expenditure Projections 2008–2018," Table 1, at *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf* (April 30, 2009).

Projected Growth in National Health Expenditures



Sources: Centers for Medicare and Medicaid Services, "Historical National Health Expenditure Data: NHE Web Tables," Table 1, at *http://www.cms.hhs.gov/NationalHealthExpendData/ downloads/tables.pdf* (April 30, 2009), and "National Health Expenditure Projections 2008–2018," Table 1, at *http://www.cms.hhs.gov/ NationalHealthExpendData/ downloads/proj2008.pdf* (April 30, 2009).

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The rise in spending comes from several sources. The first is rising incomes and increased health insurance coverage. Rising incomes increase the ability to purchase health care, and increased health insurance coverage strengthens incentives to purchase more health care. At the same time, the tort system has likely contributed to excessive testing and other forms of defensive medicine, although the exact scale is far from clear. Finally, especially going forward, as the population ages a larger fraction of the population will be in high-spending stages of the life cycle.

However, a dominant characteristic of health care in the United States is its fragmentation and focus on acute care episodes. This system feeds the growth in spending per capita above what is due to the factors outlined above. Medicare itself illustrates this. It has a program for hospitals (Part A), a program for doctors (Part B), a program for insurance companies (Part C), and a program for drug companies (Part D). These compartmentalized programs are dedicated to ensuring that various providers receive their payments in a fee-for-service system. Doctors and hospitals are literally paid for every treatment used on a patient and are paid more the more they treat.

This system focuses on payments to providers, not the health of families or quality of care. It gives scant regard to coordinating the decisions of the various medical providers and does not reward preventive care.

It is, therefore, not surprising that a medical system focused on paying for episodes of care has spawned rewards for the innovation, adoption, diffusion, and utilization of new technologies for these episodes. Because the system is not oriented around quality outcomes—particularly paying for quality outcomes—a key feature of rising health spending is that it has not generated improved outcomes. The U.S. spends a greater fraction of its income on health care, but does not enjoy comparably superior longevity or health quality. The trends are most pronounced in Medicare, but the same broad characteristics prevail for the private system serving those younger than 65. Furthermore, in Medicaid and, especially, Medicare, large regional differences in

spending do not lead to apparent differences in the quality of outcomes.

A Better Solution. Clearly, there is an opportunity to achieve the same outcomes at lower cost. However, aiming strictly at cost runs the risk of forfeiting opportunities to take advantage of the advances in medical science in which the U.S. is the global leader. A bit of reflection suggests that these issues do not arise in well-functioning markets. In effective market settings, high value—the correct combination of quality and cost—is rewarded. Thus, the key to addressing health care costs in the U.S. is to rely on market forces and to focus those market forces on higher quality and lower costs.

In such reforms, an important first step is to think separately about the markets for health care and health insurance. The rising cost of health care is the fundamental challenge. Health care reform should focus on obtaining the highest quality outcome at the lowest possible cost. Health insurance serves to shift the financial cost of the nation's health care bill to ensure that family finances survive the economic consequences of episodes of bad health. However, insurance *per se* does not change the total bill. The primary focus should be on reforming the health care system.

Reforming the Health Care Market. The first step is to employ the bully pulpit as loudly and frequently as possible to encourage people to take care of themselves and prevent chronic diseases when possible. Childhood obesity, diabetes, and high blood pressure are all increasing in their prevalence and severity. Teaching children about health, nutrition, and exercise is important. This is a financially inexpensive, but potentially valuable, effort.

Next, the reforms should focus on promoting competition throughout the health care system among providers and among alternative treatments. At present, health markets are balkanized by state-by-state licensing and rigidities in who delivers care and where. National provider markets would permit direct state-to-state trade in medical services through telemedicine and would remove impediments to the natural flow of lower-cost providers and medical practices to high-cost areas.[9] Policies should support innovative delivery systems, such as clinics in retail outlets and other ways that provide greater market flexibility in permitting appropriate roles for nurse practitioners, nurses, and doctors. The flexibility of the U.S. economy is widely perceived to be a source of its superior productivity performance and ability to weather shocks. This same flexibility must be infused into health care markets.

These supply-side deregulatory efforts should have dramatic impacts similar to those achieved by the deregulation of telecommunications, transportation, and the financial sector in earlier eras. At the same time, the federal government has a powerful lever to reform the practice of medicine in the United States: Medicare payment policies. Medicare and Medicaid are paying a large portion of the nation's medical bills that is rapidly approaching 40 percent. As noted above, the Medicare payment mechanism supports—indeed produces—the flaws of fee-for-service medicine in the United States.

Medicare payment policy needs to be reoriented away from paying for all treatments used on a patient and toward paying for cost-effective, coordinated care that yields high-quality outcomes.[10] The first step in this regard is to not pay for bad care. Already, the federal government has taken steps to not pay for events that should "never" happen, but a more aggressive approach would include not paying for treatment if readmission occurs too soon—for example, within a month—for the same problem.[11]

9. This should also extend to Medicaid. The least-advantaged should be able to take advantage of crossing state lines. Tom Miller notes that competition could extend past nationwide markets to opening the possibility of international medical tourism. Providing Medicare reimbursement to out-of-country providers would provide a major competitive impetus. Clearly, quality control and licensing issues merit attention, but increasing international competition should not be dismissed out of hand.
10. Simplifying the payment issue to paying for good care versus bad care is a useful rhetorical device. In practice, efforts should aim to foster a more nuanced approach that pays more for better care and less for worse care with as many gradations as feasible.

Next, payment policy should explicitly incentivize the use of low-cost care and coordination of care among providers, which will lead Medicare to become a more accountable health care system that rewards efficiency and good clinical outcomes. Medicare reimbursement now rewards institutions and clinicians who do more and provide services that are more complex. There is a need to change fundamentally how physicians are paid and to focus more on chronic disease and managing its treatment because this is where the money will be used for an aging population.

In the short term, Medicare can start paying physicians on an annual basis for treating patients with chronic disease or multiple chronic diseases rather than on a per service basis.[12] Medicare could also make a single payment for all the care of the most complex types of cases. As reporting of quality information continues, these measures also need to become part of the payment process.

These "supply-side" approaches to changing the use of medical services could be complemented by needed legal reforms to eliminate frivolous lawsuits and excessive damage awards and to provide a safe harbor for doctors that follow clinical guidelines and adhere to patient safety protocols. Focusing on the patient provides a business model for much needed improvements in electronic medical records and 21st-century information systems. Until all providers have financial incentives to coordinate, to lower the cost of care through coordination, and to produce quality outcomes, there will be no natural incentive to use health information technology to enhance productivity.

Reforming the Health Insurance Market. Reforms that control the growth of health care costs are the most important insurance reform. Employers still provide the bulk of insurance, and these employers largely self-insure. Thus, the growth in the cost of care translates directly into insurance costs. Controlling cost growth will reduce pressure on employers to reduce or eliminate coverage and on employees to forgo this part of their compensation.

The first pillar of reforming the health insurance market is to change the tax treatment of health insurance to level the playing field between employer-provided insurance and other types of insurance.

The second pillar is to improve the variety and affordability of these alternatives. As with markets for providers, health insurance markets should be national in scope and support vigorous competition. Highly competitive, deep national insurance markets will avoid the potential for large insurers to "capture" state regulators,[13] limit monopoly power, provide out-of-state alternatives for consumers saddled with unreasonably costly insurance mandates, and reduce the potential for wasteful overhead and excessive compensation that survives in the absence of national markets. At the same time, the ability to purchase insurance across state lines would place all policies on an even playing field with those offered by large, multistate employers.

The third pillar of better insurance markets is to "risk-adjust" the tax credit so that higher-cost individuals receive greater resources, thereby transforming the nature of insurance company competition. Instead of making money by excluding such individuals, insurance companies will compete for their additional dollars and seek to find providers who can provide quality outcomes at low costs, reinforcing the basic care reforms.

In a reformed insurance market in which success does not rely on excluding individuals, insurers will be more willing to accept pools of policies provided by nontraditional sources. This will permit individuals to obtain insurance through any organization or association (for example, employers, churches, and professional associations) that chooses to spon-

11. A more refined policy would preclude paying for readmissions above an empirically based threshold to allow for the inherent problem of adequately adjusting payment for treating the sickest patients.
12. Specifically, the payment would cover care of chronic conditions with additional resources for covering unrelated conditions.
13. Arguably, "capturing" a national regulator is possible, and the damage of such capture would be even greater than at the state level. This is a judgment call, but my argument is that national scrutiny in a more transparent system will control this possibility.

sor plans. These policies will be available to small businesses and the self-employed, portable across all jobs, and automatically bridge the time between retirement and Medicare eligibility. In short, innovation in health care insurance will mimic the development of products in other areas of the financial services industry.

These reforms meet the test of political durability from several perspectives. First, they do not solve the federal government's budget stresses by merely shifting costs to the private sector. Instead, they address the underlying growth of national health spending.

Next, the focus is not on simply controlling spending. Instead, the goal is to ensure that health spending is "worth it," in that it satisfies the consumer test of being a valuable use of economic resources. While these approaches should bring overall federal spending into alignment with receipts, the larger lesson is that even greater spending would be acceptable to the ultimate judges: the taxpayers.

Finally, these reforms will be durable because they address the delivery and use of medical care itself. An alternative approach would be to focus on universal coverage and insurance issues, but any success would be short-lived because the overall bill would continue to rise and the misalignment of benefits and costs would continue.

The central remaining issue is the extent to which these reforms will affect future federal spending for Medicare and Medicaid. First, it is useful to recognize that national markets for care providers and insurance, tort reforms, improved supply-side incentives to reduce treatment costs for chronic conditions, and increased care coordination will change the level of spending needed to maintain the existing quality of outcomes.

For example, eliminating regional differences in spending could save nearly 10 percent. Using data for 2003, Medicare spending per beneficiary in each state ranged from roughly $4,800 to $8,600. If health care reforms reduce high-spending states to the median value of $6,500, overall spending would fall by 10 percent. This very conservative estimate assumes that the median itself would remain unchanged instead of falling because of the improved market incentives. Erring even further on the side of conservative estimates, it also assumes that the full 10 percent reduction occurs over 20 years—a modest pace for diffusion of better market outcomes.[14]

In chronic care, the Milken Institute estimates the potential savings from better care of chronic conditions at $277 billion,[15] nearly 14 percent of total national health spending. Again, to be conservative, this assumes that the ultimate impact of better preventive care, case management, and disease management amounts to only an efficiency gain of 7 percent phased in over 15 years.

Finally, the net impact of all of these reforms would transform U.S. health care into a system that pays more on the basis of outcomes than for service inputs. It would reward cost efficiencies in achieving those outcomes and shift to a system in which better quality is the necessary condition for higher prices. In short, it would become more similar to other sectors of the U.S. economy in which productivity advances are the norm. At the same time, supply-side reforms would generate the flexibility needed to undertake productivity advances. To capture this dynamic, national health care spending is assumed to slow due to productivity growth that peaks at 1.0 percent per annum (about half of labor productivity growth elsewhere) and that this productivity growth emerges slowly over 15 years.

Conclusion

The U.S. faces a fundamental budgetary challenge that will have severe economic implications over the long term. However, the scale of these chal-

14. Joe Antos points out that a 20-year period may not be conservative enough given that John Wennberg first researched this problem more than 20 years ago and the differences remain.

15. Ross DeVol and Armen Bedroussian, "An Unhealthy America: The Economic Burden of Chronic Disease: Charting a New Course to Save Lives and Increase Productivity and Economic Growth," Milken Institute, October 2007, at *http://www.milkeninstitute.org/pdf/ES_ResearchFindings.pdf* (May 8, 2009)

lenges and the severity of an attendant economic collapse demand a near-term approach to bring the U.S. fiscal situation back into balance.

Entitlement spending seriously threatens U.S. fiscal solvency. Left unchecked, it will contribute to a crippling national debt burden, which will stifle economic growth and force later and thus, less fortunate, generations to bear the cost of these imbalances through severe federal cuts or draconian tax increases.

The U.S. still has a window, however indeterminate, during which it could implement sensible reforms to return Social Security to solvency without incurring massive future deficits and to rein in the health care costs that are driving the increasing Medicare and Medicaid spending. Properly implemented, reforms along the lines suggested in this paper would return federal spending to a sustainable path and ensure a foundation for prosperity throughout the coming decades.

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