

The Global Budget Race

The Great Recession drove home a reality Americans have long avoided. An aging nation with mounting health and retirement bills must make hard choices or be outrun by its competitors—some of whom have been quicker to face facts.

BY DOUGLAS J. BESHAROV AND DOUGLAS M. CALL

NEWS STORIES REGULARLY REMIND US THAT most national governments in the developed world are essentially insolvent. The United States has one of the worst balance sheets, with a projected debt in 2050 of \$123 trillion. Of course, what can't happen won't happen, as economist Herbert Stein taught us. Long before that point, most countries will get their finances in order—either after a careful analysis of the alternatives or because they will be unable to borrow money and will be forced to take corrective action. How capably they respond will determine their future economic competitiveness and their standard of living.

Those countries that do a better job of bringing revenues and spending into balance—in a way that fosters a healthy and productive citizenry—will have a competitive advantage in the global economy, and they may be able to avoid economic decline.

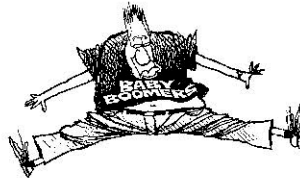
Whether they know it or not, the developed (and emerging) nations of the world are in a race—not, one hopes, a race

to the bottom, but rather a race to develop more economically efficient tax and social welfare policies while maintaining an effective social safety net. As in any race, learning from your competitors can be crucial to doing well. Around the world, countries are trying different approaches to solving the same long-term budgetary problems.

The accruing national debts are truly staggering. In a report earlier this year that reflected the catastrophic impact of the recent recession on national balance sheets, the Congressional Budget Office (CBO) estimated that in 2050 the U.S. gross debt will reach about 344 percent of the nation's gross domestic product (GDP). That's up from an already alarming estimate of 292 percent before the recession. (State and local liabilities, in the form of unfunded pension and health costs, would add trillions of dollars more.) As of late last year, in 2050 France's debt was projected to reach 337 percent of GDP, Germany's 221 percent, and Britain's 560 percent.

The root of the problem is the same in most countries: With populations aging, the intergenerational transfer system that has paid for pensions and health care is breaking down. Low birthrates and longer life spans are changing the

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Only five years from now, as the number of retirees grows, Social Security will start paying out more in benefits than it takes in from taxes.

balance between workers and retirees so that current levels of taxation cannot support the promised benefits. Across the developed and, increasingly, developing worlds, worker-to-recipient ratios are declining. By 2050, the U.S. Census Bureau estimates, there will be only 2.7 American workers for each retiree, down from 4.7 in 2008. The European Union nations will have only 1.8 workers per retiree, and Japan 1.3. China faces the biggest adjustment, dropping from about 7.7 workers per retiree to 2.1.

As a result of these demographic changes, many government pension and health care systems for the elderly worldwide are now little more than Ponzi schemes that are running short of new “investors.” Aggravating the budget situation is the rapid rise in health care costs caused by the development of new—and expensive—medical technologies, drugs, and treatment procedures.

The math is simple: Projected tax revenues are not nearly sufficient to cover future obligations—with the imbalance growing over time as larger shares of the populations in these countries begin to receive benefits. The U.S. Social Security and Medicare trust funds are giant and growing IOUs from the federal government to future recipients. Last

year, the government “owed” the trust funds about \$4.3 trillion. (These IOUs are dutifully printed at the Bureau of the Public Debt in Parkersburg, West Virginia, and placed in a filing cabinet. Not exactly Al Gore’s lock box.)

Years ago, budget watchers warned that the so-called wealthy countries of the developed world had erected unsustainable social welfare systems. The predicted crisis, however, was decades in the future, so neither politicians nor voters were prepared to make tough choices. Then came the recent recession. Sharply reduced tax revenues combined with massive stimulus spending raised budget deficits in developed countries to levels unprecedented in peacetime and added vastly more debt on top of the existing long-term social welfare debt. In the United States, the federal deficit jumped from about 1.2 percent of GDP to about 9.9 percent between 2007 and 2009, reaching \$1.4 trillion. According to *The Washington Post*, the federal government will “borrow 41 cents of every dollar it spends” this year.

For a while, it seemed that the developed countries might be able to borrow their way out of immediate trouble. But with Greece’s brush with insolvency this past year, and fears that Spain, Italy, and Portugal would soon face similar prob-

lems, the day of reckoning suddenly, very suddenly, seemed at hand.

Many European countries responded by adopting multibillion-dollar austerity packages including elements such as higher taxes, cuts or freezes in government spending, salary freezes for government employees, and, most important, rollbacks in social welfare benefits. Some of the packages were modest, but many involved major tightening, notably in Britain, where the new Tory–Liberal Democratic coalition government is cutting most government departments by 25 percent over five years (though health care, notably, is largely exempt) and raising taxes.

As politically controversial as they have been, these austerity measures aren't anywhere close to correcting the immense long-term imbalances these countries face. And, of course, the United States has yet to start the process of retrenchment because the Obama administration, with the support of many economists, has decided that the economy should recover first—a strategy that is easier to pursue because America's bond rating is not yet under pressure.

Nevertheless, the immediacy of today's budget problems—and the looming threat of a failed debt refinancing—makes the conditions for long-term reform in the United States ripe. Most international finance economists agree that the bond market will eventually insist on a solution and that the sooner the needed corrections are made, the less jarring they will be. They also agree the fix will be a combination of big tax hikes and deep spending cuts.

Whatever one's view on the proper size of government, one thing is undeniable: Contemporary American politics have given us a government that seems incapable of living within its means. Even though our relatively high birthrate gives us a demographic advantage over most other developed countries in paying for retirement benefits, our lower tax rates and costlier health care system mean that our projected debt is higher.

Despite vociferous opposition from many quarters (not just the Tea Partiers), any realistic solution will require that *all* Americans pay considerably higher taxes. The budgetary imbalance is so large that fixing it with spending cuts alone would eviscerate important parts of the federal government. Americans are now taxed substantially less than citizens in most European countries. In 2007, taxes (federal, state, and local) amounted to 28.3 percent of GDP in the United States

and 39.7 percent in the European Union. At least for now, however, we are at a political impasse about raising tax rates, especially on the voting middle class.

Around three-quarters of our projected debt in 2050, according to the CBO, will be caused by three factors and their effect on interest rates and payments on the national debt: (1) the continuing impact of the George W. Bush administration's tax cuts of 2001 and 2003, about 80 percent of which went to the middle class; (2) the continued indexation of the alternative minimum tax to inflation, which keeps taxes on the middle class lower; and (3) Congress's regular suspension (in every year since 1997) of the rule that is supposed to limit increases in Medicare and Medicaid reimbursements to the rate of GDP growth, which would hurt doctors, nurses, and other health care providers.

Fix all three, and the U.S. debt 40 years from now falls to about 90 percent of GDP. That is still too high in the opinion of many economists, but it probably would be manageable and, bearing in mind the imponderables of estimating a federal budget 40 years from now, a reasonable goal. But a different mix of solutions will have to be found.

As the three key sources of our problems suggest, it won't be just the rich who will have to pay higher taxes. President Barack Obama has repeatedly promised not to raise taxes "even one single dime" on families earning less than \$250,000 and single people earning less than \$200,000. Unfortunately, increasing taxes only on upper-income people will not yield nearly enough money to fill the revenue gap. Reinstating pre-Bush tax rates on people in the top two tax brackets (who now pay rates of 33 and 35 percent) would yield only \$55 billion of the \$250 billion in revenues cut by Bush. Hence, Obama is widely expected to find some way to reverse his promise not to raise middle-class taxes (and many have noted the president has already done that in the health care bill). The report of his National Commission on Fiscal Responsibility and Reform, which is expected to recommend a broad-based tax increase, could give him an excuse to do just that. The report will be delivered after the November elections.

Here is the menu of unappetizing tax choices Obama and Congress face:

Increase Social Security and Medicare payroll taxes. Payroll taxes now fund all of Social Security and about 42 percent of Medicare. If immediate action were taken to fill the long-term Social Security funding gap, the payroll tax would need to increase from its current 12.4 percent of wages to 14.2

percent. (Half the tax is paid by employers, half by employees.) Filling the gap by cutting spending would require an immediate 12 percent cut in benefits. The longer decisions are delayed, the more the cost will go up.

As for Medicare, if the payroll tax increase were immediate, the rate would need to go from its current 2.9 percent of wages to either 3.6 or 4.8 percent, depending on how effective one assumes the cost-cutting measures in the new health care law would be. (As with Social Security, the cost of Medicare is shared by employers and employees.) Again, delays raise the cost. Combined, these new U.S. payroll tax rates would reach a level approaching the European norm of about 22 percent of workers' paychecks.

The advantage of using a payroll tax increase is that it would maintain the connection (however tenuous) between "taxes" and "benefits" in Social Security and Medicare, which advocates on both sides of the debate see as important. Liberals fear that breaking the connection—by using general revenues to cover the shortfall—would highlight that neither program is really a form of insurance, thereby reducing voter support for the programs. Conservatives fear that drawing on sources other than a payroll tax would open the door to even bigger increases in benefits, as voters not subject to the relevant taxes would be more inclined to push for higher benefits.

There are, however, at least two major disadvantages to raising the payroll tax rate. First, many consider such taxes regressive: Because the rate is the same for all payers, it hits low-income taxpayers hardest. One way to compensate would be to increase the size of the Earned Income Tax Credit, which is available to lower-income people, but that would create problems of its own. Another would be to raise or remove the cap on earnings subject to the tax, currently \$106,800. (There is no cap on the Medicare payroll tax.) But the sharp disparity between what the many millions of affected people would pay in taxes and receive in benefits would also dramatize the politically uncomfortable fact that Social Security is not an insurance system.

A second disadvantage to raising these taxes is that payroll levies are a tax on labor. They make it more costly for employers to take on new employees, and they diminish the potential take-home pay of people who may be looking for

jobs, which reduces their incentive to work. At least at the margin, payroll taxes can hurt employment, productivity, and international competitiveness. That is one reason why so many other nations have turned to consumption taxes.

Impose consumption taxes. Consumption taxes, such as a value-added tax (VAT) or an energy or carbon tax, are

BIG TAX HIKES and deep spending cuts are inevitable.

used to apparently good effect around the world to raise large amounts of money, encourage saving, conserve energy, and minimize negative impacts on productivity and international competitiveness. Although both kinds of taxes have been decisively rejected in the United States, this time could be different—if they were part of a grand social welfare budget compromise in which both political parties admitted that, one way or another, middle-class taxes needed to increase and, at the same time, agreed on a major fix to the benefit structure.

More than 140 countries have a VAT, including every country in Europe, the vast majority of Asian and South American countries, and most of those in Africa. A VAT is essentially a sales tax that is levied on the value added to a product at each stage of its manufacture and distribution. Set at European levels (around 20 percent), a VAT could raise almost \$1 trillion a year, or about 70 percent of the value of today's deficit. That's enough to make it extremely attractive to both deficit hawks and defenders of government spending. A VAT has the added benefit of reducing consumption, thereby increasing saving. The VAT does not apply to exports, and because it is a flat-rate tax, some U.S. proposals include measures to offset the regressive effects.

Some sort of additional tax on energy may also be on the table. The cap-and-trade bill that died in the Senate earlier this year would have brought in some \$750 billion over 10 years. There are now bills in Congress to create a carbon tax that would generate revenues of between about \$70 billion and \$125 billion annually. Besides raising money, energy taxes would push consumption down, thus reducing U.S. dependence on oil imports. As with a VAT, the burden of an energy tax would fall most

heavily on those with low incomes, so it too might be accompanied by some form of targeted tax relief.

Using consumption taxes to help fund Social Security and Medicare would, indeed, break the direct link between taxpayer “contributions” and benefits. One way to avoid the perils that both liberals and conservatives see in such a course is to change the way benefits are calculated so it is based upon an explicit and transparent set of objective criteria. That could give the system an aura of fairness the current one does not enjoy, and, if the experience in other countries is a guide, help voters and politicians to internalize budget discipline.

Voter hostility to higher taxes will be the major check on the size and shape of any tax hike. Concerns about taxation’s effects on the economy and international competitiveness are another limit. Even those economists most skeptical of the Laffer curve recognize that tax increases eventually produce diminishing returns. Higher taxes can raise the price of a nation’s goods in the global marketplace, deter investment, and invite increased tax avoidance, while taxing specific activities or groups can lead to harmful distortions of incentives. That’s why, in the past few decades, European countries have been hesitant to raise their taxes much, and why their recent austerity packages rely so heavily on spending cuts.

People who have not been paying close attention to government spending might wonder why the cuts need to be in Social Security, Medicare, and Medicaid and not elsewhere, such as the military. The quick answer is the same one Willie Sutton gave when asked why he robbed banks: That’s where the money is.

Cuts in military spending are surely coming, especially as American troops leave Iraq and Afghanistan. Some of the resulting savings, however, will have to be used to replenish badly depleted stocks of weapons and equipment. Moreover, there just won’t be that much to cut from—even if military readiness is reduced. The cuts Secretary of Defense Robert Gates proposed in August, though controversial, came to only \$100 billion over five years, or about a week of each year’s Social Security and Medicare expenditures.

Military spending has not amounted to more than 25 percent of the federal budget since 1989 and the end of the Cold War. Last year, even as the United States was fighting two costly wars, the Pentagon accounted for only about 19 percent of all federal spending (or about \$660 billion). The

big three of social programs collectively accounted for a much bigger share of spending: Social Security (about 19 percent), Medicare (about 12 percent), and Medicaid (about seven percent).

What about the proverbial waste, fraud, and abuse in government that so many critics decry? Even President Obama has felt the need to promise a new crackdown. The projected savings? About \$300 million a year. Not a small amount of money, at least outside Washington, but only a rounding error in the health care budget.

This year, for the first time, Social Security payments to retirees will exceed tax revenues, thanks to the recession. The imbalance is then expected to right itself, but only temporarily. Beginning in 2015, as the number of baby-boomer retirees increases, a more fundamental, demographically driven shift will occur. From then on, funds will be “drawn” from the Social Security Trust Fund to maintain benefit levels until the trust is exhausted in about 2037. After that, Social Security payroll taxes will be able to pay for only about 78 percent of expected benefits.

In 1983, the last time a major correction to Social Security was made (as a result of the Greenspan Commission’s recommendations), the payroll tax was raised from 5.4 percent to 6.2 percent, the retirement age was increased from 65 to 67, and a tax was imposed on the benefits of individuals with incomes over a specified threshold (with the revenues to go to the Social Security Trust Fund). The conventional wisdom is that it will be relatively easy to repair the system with similar “small” adjustments to the age of retirement and benefit levels. Don’t count on it. Up close, the adjustments most frequently suggested don’t seem as small as advertised—and raise serious questions of fairness and viability.

In 2008, a third of all Social Security recipients relied on their monthly check for about 90 percent of their retirement income, and almost two-thirds of all recipients depended on it for about half or more of their income. Even if benefit cuts are phased in slowly enough so that current workers have time to adjust, perhaps by increasing their savings, they may not want or be able to do so. There will be plenty of politicians eager to take up their cause.

The major reform options include:

Raise the retirement age. A popular proposal, at least among Washington analysts, is to raise the Social Security retirement age, on the ground that life expectancy has

increased dramatically. When Social Security was launched in 1935, a 65-year-old retiree could expect to live another 12 years. Now that number is 19.

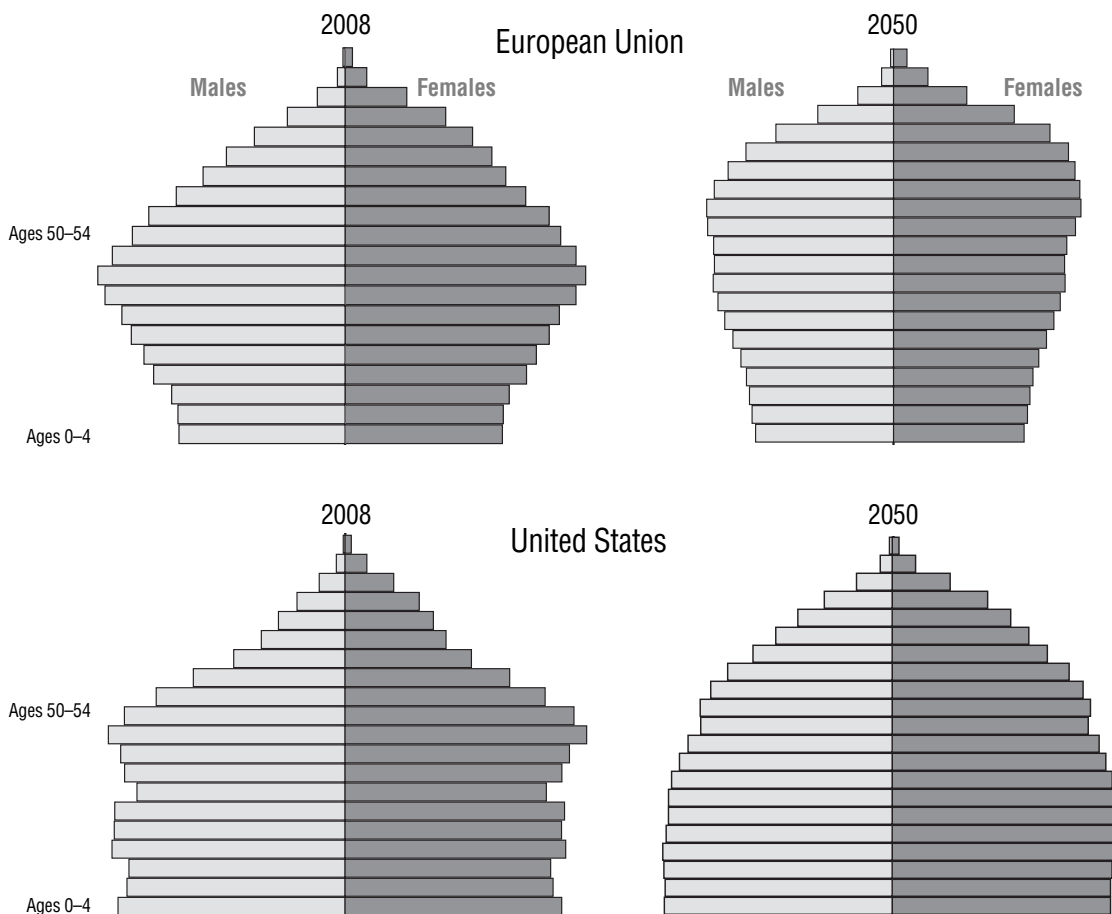
Currently, retirees born between 1943 and 1954 cannot receive full benefits until they reach age 66. (Retiring at 62 reduces benefits by 25 percent, with the penalty lessening the later one retires.) Between now and 2022, the age of eligibility will gradually increase until it reaches 67. (The penalty for early retirement will increase to 30 percent.) Some have suggested a further incremental increase, perhaps to age 70 over a 20-year period. Others have proposed “objective” formulas that would have roughly the same effect, for example, by changing the retirement age to keep post-retirement life expectancy constant at 12 years. But as Brookings Institution

health care specialist Henry Aaron points out, raising the retirement age is “simply an across-the-board benefit cut.” An increase to age 70 would amount to a 20 percent cut.

Later retirement might be fine for lawyers and university professors, but what about people who make a living lifting heavy things, or waiting on tables, or standing behind a counter? Right now, their practical choice is to retire at age 62 and accept a reduced benefit. To raise the retirement age to 70 would mean increasing the penalty for early retirement, exacerbating class differences.

Replace a smaller share of workers’ pre-retirement income. Most Americans probably don’t realize that the formula for determining their Social Security payment is set at an arbitrary percentage of their past wages. This is called the

The Demographic Future



Source: U.S. Census Bureau

America’s population will age considerably in the next 40 years, but not as much as Europe’s. Yet if its current policies on health care, Social Security, and taxation remain unchanged, the United States is expected to amass an even larger national debt than some European countries.

“replacement rate,” and some proposals would, over the long term, reduce it drastically.

Currently, replacement rates are set to be “progressive,” so that lower-wage workers get monthly Social Security checks that represent a bigger share of their pre-retirement earnings than others do. The rates are calculated using a formula based on an arbitrarily selected percentage of a retiree’s previous earnings, which also are arbitrarily measured: The recipient’s highest 35 years of earnings are indexed to the increase in wages in order to derive “average indexed monthly

SOME PROMISE SOCIAL Security will be saved with a few small adjustments. Don’t count on it.

earnings” (AIME). That number is then multiplied by politically determined replacement rates to arrive at the recipient’s monthly Social Security benefit.

For AIME up to \$761, the replacement rate is 90 percent. For the amount of AIME income between \$761 and \$4,586, it is 32 percent. And for AIME income above that level, it is 15 percent. (However, remember that during earners’ working years, some of the income in this category was above the Social Security tax cap and so was not subject to the payroll tax.) According to Andrew Biggs of the American Enterprise Institute and Glenn Springstead of the Social Security Administration, in 2005 the average middle-income retiree received about 64 percent of his or her last year of pre-retirement earnings in Social Security benefits.

In keeping with Social Security’s progressive framework, however, workers with slightly higher incomes do not do nearly as well. In 2005, the Social Security Administration’s chief actuary estimated the “internal real rate of return” on the amount people paid in Social Security taxes—their return on investment. For a hypothetical two-earner couple who retired in 2008 with “high” average career earnings (about \$50,000), the average annual rate of return was about 1.64 percent. For a single woman with “very low” earnings (about \$8,000), it was about 4.42 percent, and for a one-earner couple with similar earnings, it was about 6.59 percent.

Some current proposals would make the return to

middle-income workers even worse by indexing past earnings to the increase in prices rather than wages. That would reduce benefits by about 39 percent by 2050, enough to erase the funding problem. In order to soften the blow for the less well-off, some analysts would add yet another arbitrary twist to Social Security’s formulas by indexing these workers’ earnings differently.

Reduce the inflation adjustment. Social Security payments are adjusted for inflation using a version of the Consumer Price Index (CPI). Many economists believe that the

index overstates inflation, with surprising results over time. In 2008, the liberal Center on Budget and Policy Priorities recommended using a different version of the CPI, which would reduce annual increases by about three-tenths of a percentage point. According to one esti-

mate, that change alone would shrink Social Security’s long-range funding gap by about 30 percent. Although this is a widely supported option, it is not pain-free. Over those 75 years, it would reduce benefits by roughly 20 percent.

Increase taxes on Social Security benefits. Retirees whose income rises above a certain threshold (\$44,000 for married couples) must pay income tax on 85 percent of their Social Security benefits, with the revenues funneled back into Social Security. If all benefits were subject to taxation, regardless of the recipient’s income, the proceeds would reduce the 75-year gap between Social Security outlays and revenues by about 28 percent.

The threshold is another indirect way that Social Security is means tested, and thus made more progressive. It is also a disincentive to work for retirees whose paychecks might push them over the threshold. Some analysts recommend eliminating the threshold on grounds of equity, arguing that current beneficiaries should not be exempt from helping alleviate the system’s future deficits. And why, they ask, should Social Security income be treated differently from income from traditional pensions, which is already fully taxable? Others, however, argue that taxing benefits discourages work and saving among the elderly, an ever more significant share of the population.

The reform of Social Security presents an unattractive set of options: push the retirement age to what, for many work-

ers, would be an unfairly high level; reduce benefits by adjusting the payment formulas; or increase taxes, either on all or only on higher-income workers, thereby lowering the return on their lifetime payments. No matter which of these options is adopted, it will mean the continuation of a program that shortchanges middle- and higher-income workers while failing to encourage people to save.

Faced with the difficulties of traditional social security systems, many countries have decided that “defined-contribution plans” are a fiscally and politically superior approach to providing for citizens’ retirement.

Under these plans, a portion of a worker’s pretax earnings is paid into or credited to an account. In some countries, there is a real account in the individual’s name; in others the account is “notional,” more like a bookkeeping entry. When there is an actual private account, the worker decides how the money is invested and, therefore, bears the investment risk (and upside potential). Workers with notional accounts have no choices about investments or only very limited ones, and the interest rate is set (and guaranteed) by the government. But in both cases, the direct link between payments and subsequent benefits provides a defensible rationale for keeping benefits in check when workers retire rather than bumping them up for political purposes. Another virtue of defined-contribution systems is that they encourage work and saving: The more a person earns, the larger that person’s contribution and ultimate payout. At the same time, most countries in the developed world that have such plans complement them with a second retirement benefit, funded by general revenues, to ensure that low-wage workers receive adequate pensions.

Private investment accounts are used in more than two dozen countries, including Australia, Denmark, and Sweden. The individual manages the funds in the account, but regulations often limit choices to some degree in order to reduce risks.

“Privatization” is the mantra of those who want to radically reform Social Security by establishing private investment accounts—and the epithet of their opponents. President Obama has raised the bloody flag of privatization in advance of the 2010 elections, warning that the Republicans are pushing to make such a scheme “a key part of their legislative agenda if they win a majority in Congress this fall.” The term conjures up the private investment accounts proposed

by President George W. Bush and decisively rejected by the public—in part because they seemed to leave the size of retirement nest eggs to the vagaries of the stock market. And, yes, the returns can be negative. Even in the wake of the brutal downturn in world equity markets in 2008, however, the long-term performance of some funds has been quite good. In Australia, workers had a large share of their money in equities when the global recession began, and their realized losses between 2007 and 2008 were about 26 percent. Yet stretching our perspective to include the 10 years between 1998 and 2008 yields a brighter picture: The median account grew at a seven percent annual rate—a much higher return than most Americans can hope for from Social Security.

Almost overlooked in the political drama surrounding private investment accounts has been the development of defined-contribution plans with predetermined or formulaic—and guaranteed—rates of return. Such “provident funds,” found mostly in Asian countries, require workers to deposit a percentage of their wages via payroll deductions into an interest-bearing account in a government-administered institution. Hong Kong, India, Malaysia, and Thailand are some of the places where this strategy is used. In Singapore, for example, workers’ contributions are deposited with the nation’s sovereign wealth fund, which invests the proceeds in Singapore and abroad. The returns are tied to government bonds, with a guaranteed minimum annual return of 2.5 percent.

Notional accounts are used in Italy, Poland, and Sweden. Workers and employers are taxed at a specified rate and the proceeds credited to a virtual account, with the government setting the rate of return. At retirement, the total is invested in an annuity (which throws off regular payments) that is given to the retiree.

Countries that have existing pay-as-you-go systems, such as the United States, face huge problems in attempting the transition to certain kinds of defined-contribution plans. The Bush proposal, for example, would have required that a portion of each person’s Social Security payroll taxes be directed into one of the new accounts, which would have meant that more money would need to be raised to maintain existing Social Security benefits—\$754 billion in the first 10 years. A significant advantage of notional plans like those in Australia and Sweden is that the accounts do not need to be funded with tax dollars during the transition.

One key attribute of notional plans is that the promised rate of return can be made affordable by pegging it to a rea-

sonable standard, such as the rate of economic growth. Contrast that with the arrangement in the United States, where political factors can intrude. Last year, for example, President Obama proposed to override Social Security rules in order to give retirees an extra \$250 because there had not been enough inflation to trigger an increase. The one-year cost? \$13 billion. The Senate narrowly defeated the measure.

As is the case for Social Security, Medicare's looming insolvency is widely recognized among policy experts. But Medicare's day of reckoning will come earlier, and its impact will be much larger. Outlays exceeded income in the Medicare Hospital Insurance Trust Fund for the first time in 2009, a landmark slightly hastened by the recession. Funds are now being drawn from the trust, which the Medicare trustees estimate will be exhausted by 2029.

Last year, Medicare and Medicaid made up almost 22 percent of the federal budget, about \$500 billion and \$250 billion, respectively. By 2050, together with the additional costs of the new health care law, they will expand to 48 percent of the budget (excluding interest payments on the national debt). At about \$4.8 trillion (in today's dollars), that sum will dwarf that year's projected spending on Social Security by a factor of more than two, even though the retirement program, at \$680 billion, is currently much larger.

Not even its strongest proponents claim that the new health care law, the Patient Protection and Affordable Care Act, will solve our long-term health care spending problems. Even if all its provisions work as predicted, the CBO estimates that over the next 20 years, it will reduce health care expenditures by "only" \$1.1 trillion. That's a truly massive sum, of course, but in 2030, it is expected to amount to only a half-percentage-point reduction in total health care expenditures as a share of GDP, not enough to produce a substantial change in the long-term financial prognosis.

Critics think that even these predicted gains are wishful thinking. As Medicare's chief actuary, Richard Foster, explains, projections based on current law "do not represent the 'best estimate' of actual future Medicare expenditures," in part because some significant cuts called for in the law are unlikely to be implemented. Douglas Holtz-Eakin, former director of the CBO (and now a Republican policy adviser), projects that the new law will *add* about \$579 billion to health care spending between 2010 and 2019.

The hard work of cost containment has not even begun.

According to President Obama, the new law took into account "every idea out there about how to reduce or at least slow the costs of health care over time." Barring some breathtaking new developments, perhaps in prevention or low-cost technology, future belt tightening will pose even more unattractive choices.

The shortage of ideas is leading many analysts to take another look at European health care systems. The United States leads the world in health care expenditures, both in per capita terms and as a percentage of GDP. Most other developed countries spend about a third less per capita. At the same time, European countries provide medical services that seem to be at least as good as those in the United States, and by some measures better. The studies that find this, however, are the subject of much dispute. The United States has a much more diverse population with higher levels of unhealthy behavior, often provides a wider array of services, and seems to do better at handling various serious medical challenges, including organ transplants and treatment of some cancers.

Many factors help explain why European nations spend less, from lower patient expectations about how much medical care they should get (especially in the last stages of life) to tighter government control over payments to doctors and hospitals. An often-unappreciated reason is the relative wealth of our societies. According to a study by Uwe Reinhardt of Princeton, Peter Hussey of the RAND Corporation, and Gerard Anderson of Johns Hopkins, as much as 60 percent of the difference in spending between the United States and Europe could be a function of Americans' greater societal wealth. Just as wealthier people spend more on their health, so, too, do wealthier countries.

In any event, as Europe has become wealthier, its per capita health care costs have risen faster than incomes. Nevertheless, European medical spending continues to be lower than America's, and the gap between the two is increasing. Health spending in the 33 countries in the Organization for Economic Cooperation and Development rose from 7.8 percent of GDP in 2000 to 9.0 percent in 2008. In the United States, it rose from 13.6 percent to 16.0 percent.

Lower earnings for physicians. By far the biggest "savings" in the Obama health care law come from a cut in payments to private physicians, hospitals, and health care providers generally. All take a big hit under the new law—and much commentary has focused on whether political pressure

will lead Congress to reverse these reductions. The long-term trend seems clear, though: Taxpayers in the future will not pay providers as much as they do now.

The new law (which in effect continues an earlier rule that Congress has repeatedly suspended in the past) pegs Medicare reimbursement increases for providers to the rate of the nation's GDP growth, even if health care costs rise at a faster rate. This is the oft-delayed 23 percent cut in reimbursement rates scheduled to take effect in December. The new law included a further annual cut in payments to providers, saving some \$196 billion over the next 10 years.

Many observers think these reductions are not sustainable and that Congress will continue to override the cuts in the future. The new law seeks to make that more difficult by creating an Independent Payment Advisory Board. Beginning in 2014, IPAB is to propose yet more spending cuts in Medicare if the program's per capita growth rate exceeds a certain threshold. The law also makes it harder for Congress to override the cuts, by mandating a tougher version of the rules that were used to achieve military base closings: Congress must either accept the recommendations *in whole*, or find a comparable set of savings. Otherwise, 60 votes in the Senate will be needed to override the payment rates. The CBO estimates that the actions of the board will result in savings of \$15.5 billion between 2015 and 2019, with the savings growing larger each year. But will it work?

Many are dubious. Former CBO director Holtz-Eakin argues that IPAB will confront the government "with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. As a result, the cuts will be politically infeasible."

The skeptics might be right, but it is easy to envision a world in which physicians earn much less than they do today. (The many doctors now considering early retirement clearly can imagine it.) In 2004, the average American general practitioner earned \$146,000 and the average specialist \$236,000. Their European counterparts earned much less. The average French general practitioner, for example, was paid \$84,000 and the average specialist \$144,000. When the choice is between higher taxes on voters or lower payments to providers, politicians tend to become less gen-

erous paymasters. That's certainly the way it has worked in Europe.

So, American doctors could be in for a long-term decline in earnings—that is, unless more of them refuse to take patients covered by Medicare and other low-paying insurance plans. According to an American Medical Association survey, nearly a third of all primary care physicians "restrict

AMERICAN DOCTORS could be in for a decline in earnings.

the number of Medicare patients in their practice." One consequence of these changes could be further increases in the number of foreign-trained doctors and other medical professionals (who are generally paid less than U.S.-trained physicians) working in the United States.

Tax increases and benefit cuts. More than one-fifth of the projected \$1.1 trillion in "savings" from the new law comes from tax increases that take effect in 2013: A nine-tenths of a percentage point increase in the Medicare payroll tax and a 3.8 percent levy on net investment income on top of the existing investment taxes, both limited to couples making more than \$250,000 and individuals earning more than \$200,000. Beginning in 2018, there will be a new 40 percent tax on so-called Cadillac health insurance policies, defined as those that cost more than \$27,500 a year per family.

Many budget hawks have set their sights on the federal government's generous menu of tax subsidies for health care, including the exclusion of employer and employee portions of health insurance premiums from taxable personal income; the tax deductibility of corporate spending on health insurance; money deposited in tax-advantaged health savings plans and similar accounts; the value of benefits people receive from Medicare, Medicaid, and the State Children's Health Insurance Programs; and the income tax deduction for itemized health care expenses. (The congressional Joint Economic Committee estimates that these tax subsidies together accounted for about \$185 billion in lost revenue in 2007. To understand the stakes involved, compare that to the \$250 billion cost of the Bush tax cuts in that year.)

The new law also trimmed reimbursement payments

to Medicare Advantage programs by some \$135 billion over 10 years. These programs offer seniors a bigger menu of benefits (which can include vision and dental coverage, and assistance with Medicare cost-sharing) and analysts predict the cuts will lead to fewer benefits, higher fees, and lower enrollment.

Further cuts in benefits seem inevitable. The crude word for such decisions is rationing. Until the passage of the new law, care in the United States was rationed chiefly through limits on insurance coverage (such as annual and lifetime limits on the payments insurers would make) and on the assistance provided to people who lacked private insurance and Medicaid coverage. But this will change. The only question is how that rationing will be targeted.

Other affluent countries ration health care in various ways. The most obvious technique is to exclude a service or treatment from the basic government-provided health care package. In some cases, a whole sector of care is excluded (for example, vision and dental care in Switzerland), while in others particular services are. A number of countries, including Germany, the Netherlands, Switzerland, and Britain, have boards or committees that review particular services and determine if they will be included in the basic health care package. In Germany and Switzerland, the primary criterion is effectiveness, but in Britain cost is also taken into consideration. The London-based National Institute for Clinical Effectiveness (NICE), established under Tony Blair's government, uses a cutoff price of about \$53,000 per additional year of healthy life in assessing whether particular drugs and treatments are to be covered.

A second form of rationing is through global budgets. In Britain, the National Health Service provides portions of the health budget to 152 regional primary care trusts that manage how, when, and where patients are treated, depending on the available budget. This often results in long waiting lists for non-emergency care, a common feature of universal systems.

A third form of rationing restricts the number of advanced medical devices that are available. Canada, for example, has relatively few CT scanners and MRI machines relative to its population. With only 6.7 MRI machines per 1,000,000 people (as compared with 25.9 in the United States), Canada in recent years has seen waiting times for scans as long as three months.

A final form of rationing involves limiting payment for expensive treatments for patients near the end of life. Uwe Reinhardt and his colleagues write that most countries implicitly set an upper limit on how much they will pay to extend a patient's life through price controls or by limiting capacity to supply certain services.

Without getting into the highly charged rhetoric of "death panels," it seems that the groundwork for the kinds of determinations such panels would make has been established in the new U.S. law in the form of the Patient-Centered Outcomes Research Institute. The institute is to fund "comparative effectiveness research" on drugs and medical procedures. For now, the institute is explicitly prohibited from using such research to implement cost-based rationing, which may explain why this method is estimated to save only \$300 million over 10 years. But that prohibition may not last forever. Especially given the fact that the new law removes limits on annual and lifetime benefits, some other means of constraining costs seems inevitable. There won't be "death panels," but many treatments could be deemed insufficiently "effective" to be used, even if no other treatment exists.

The biggest visible change under the new law is the establishment of American Health Benefit Exchanges, which states must create by 2014. The exchanges are to help individuals and small businesses obtain health insurance. Individuals with incomes up to 400 percent of the poverty level will qualify for tax subsidies to help pay premiums when they buy coverage through an exchange.

The exchanges are supposed to create a large and diverse risk pool, while also reducing administrative and marketing costs. The insurance plans will be heavily regulated, with standardized benefits, limits on copayments and deductibles, community-rated premiums, and prohibitions on using risk to adjust premiums or determine eligibility—which will make them much more like standardized commodities than is usual today. Standardization is designed to counter adverse selection, in which higher-cost enrollees flock to plans with attractive features.

In order to lower costs, the law requires participating insurance companies to cap their administrative expenses *and* profits at less than 20 percent of premiums. Many firms, especially small ones, are expected to have difficulty keeping overhead costs that low, one of several factors that will probably push a number of them out of the market. In most states, that will mean consumers will have fewer and larger insurance companies to choose from than today.

These large insurance firms will probably enjoy a modest but steady income, but they will have even less incentive to innovate and compete than they do today.

The primary purpose of the exchanges, however, is not to push down overall costs but to provide a mechanism for implementing universal coverage. In the absence of major legislative changes, they are unlikely to exert strong downward pressure on spending, a conclusion even optimistic projections suggest. Estimates of the savings vary widely. The CBO projects that the savings over 10 years will be only about \$27 billion.

In reality, no one knows how the exchanges will actually operate and whether they will succeed. And they remain a work in progress. Both Democrats and Republicans would like to make changes to the law. And much will depend on the regulations issued by the Department of Health and Human Services—and the responses of the uninsured, employers, and private insurance companies, as well as the states, which will operate them.

Based on the European experience, an equally if not more important question is how, or even whether, private health insurance purchased by people with incomes too high to participate in the exchanges will be regulated. The same question applies to the private market for supplemental insurance that could exist outside the exchanges (much as private Medigap insurance arose to supplement Medicare coverage). The many European countries that have basic universal coverage and are thus freed of the need to worry about protecting the interests of low- and moderate-income beneficiaries have allowed private-sector insurance companies relatively wide discretion in the services they offer and the prices they charge. Many analysts think this has had a positive impact on the varieties, quality, and costs of care. The new U.S. law seems to foreclose such unfettered competition, but that could change.

A common misconception is that Europe is home to socialized medicine, probably because it has long provided universal health care. But with a few notable exceptions, such as Britain's National Health Service,

most European systems require consumers to pay more money out of pocket for medical care than Americans do. According to Jacob F. Kirkegaard of the Peterson Institute for International Economics, "In reality, America's health care system is already more 'socialized' than in most European and other developed countries."

Although U.S. employer-provided health insurance plans increasingly require beneficiaries to bear more costs themselves—through paying deductibles, coinsurance, and

AMERICA'S HEALTH CARE system is already more "socialized" than most of those in Europe.

direct payments to medical professionals—such cost sharing is still much more common in Europe. In 2006, out-of-pocket payments made up about 12 percent of total U.S. health care expenditures. The average in Europe was about 17 percent, with a low of six percent in the Netherlands and a high of about 31 percent in Switzerland.

In many European countries, patients often make direct payments to physicians—to purchase treatment that is excluded from coverage, to move up in the queue, or to get better service. In France, individuals directly pay between 10 and 40 percent of their own costs, with different rates for drugs, lab work, and other services. Such cost-sharing requirements are means tested. In France, low-income consumers are eligible for free government-provided supplemental insurance that pays for any cost sharing, and in Switzerland, households receive an income-based subsidy.

Cost sharing serves two separate purposes: It keeps public costs down, and it discourages unnecessary care. If recipients are required to pay for a particular service or procedure, they will have a direct incentive to limit its use. In the United States, however, fear that some will not get needed medical care because of its cost (along with pressure from labor unions and interest groups such as AARP) has restricted cost sharing.

In light of the success of cost sharing in Europe and the pressures in the U.S. market, it seems fair to expect that American consumers will also be required to pay more out-

of-pocket expenses. Already, Medicare has significant cost-sharing provisions. In 2006, Medicare beneficiaries paid for about 25 percent of the care they received, through Medigap insurance or direct payments such as deductibles. (As in Europe, low-income patients are protected; Medicaid covers the costs for eligible seniors.)

The new health care law is actually expected to reduce overall cost sharing in American health care by about \$237 billion between 2010 and 2019, according to the chief actuary of Medicare, Richard Foster. The reasons: the expansion of coverage for the uninsured, subsidies for insurance premiums and cost sharing, and limitations on cost sharing in the exchanges. Relieving consumers of the sense that they are helping to pay for their own health services runs counter to developing practice for private insurance in the United States, as well as long-standing European practices. Over time, we should expect higher levels of cost sharing, especially for more affluent consumers.

These developments—cuts in payments to providers, the creation of commodity-like plans for the new insurance exchanges, and the rationing of services in taxpayer-supported insurance plans—could accelerate the development of a two-tiered U.S. health care system. One tier would offer a pared-down version of today's benefits for low- and middle-income citizens (much as in Europe), the other a better-cushioned system for the more affluent who are able to spend their own money to buy additional services.

The unfunded promises of the modern social welfare state mean that we (and our children) are not nearly as rich as we thought we were just a few years ago. Unaddressed, this burden threatens to create a prolonged period of economic stagnation, if not worse, with a palpable reduction in living standards. Sooner or later, government borrowing on the scale that is now required will raise the cost of public and private borrowing, thus reducing the productivity of American industry by starving it of capital investment and making U.S. companies less competitive in the global marketplace.

In the past, the United States did reasonably well by muddling through crises. But this time, temporizing may not serve us as satisfactorily. The needed medicine is bitter. Tax increases in the trillions of dollars appear necessary, and they probably won't be politically possible unless accompanied by similarly large—and permanent—cuts in government-

provided retirement and health benefits. So, despite the political rhetoric on both sides and the emergence of a Tea Party movement that instills the fear of higher taxes in Washington, we are still betting on the politicians to cut a deal. Call it a "grand social welfare compromise."

The immediate concern must be to find a way to close the long-term budget gap; but how it is closed is just as important. The understandable temptation will be to tinker—to raise a tax here and there, and to trim benefits in one way or another, in the hope that a series of small changes will solve our long-term budget problems. That may be the most appealing course politically, but it is not likely to work, and it certainly will not maximize domestic productivity and international competitiveness. The key will be to raise taxes and trim benefits in a way that minimizes disruption and hardship while creating incentives for saving and investment. This will take analytic smarts and political savvy.

Countries around the world are grappling with many of the same issues that bedevil the United States, and while no one has found a silver-bullet solution to the insolvency of the social welfare state, a pattern does emerge—and it is not a testament to the wonders of socialism.

First, even in nations that pride themselves on providing "universal" social welfare benefits, the middle class has been excluded from entire categories of benefits for reasons of economy. And, whether it knows it or not, the middle class in these countries pays for the benefits it does receive through an array of direct and indirect taxes. Our political system does not seem ready to accept the mathematical reality that benefits must be paid for or dropped.

Second, even some of the most fervently committed advocates on the left seem to appreciate the importance of competitive forces and market pricing in the provision of social welfare benefits. While they continue to provide a safety net for the poor and other low-income groups, most countries are moving, however hesitantly, to shift the middle class to market-based government pension and health care systems. For now, the United States seems to be going in the opposite direction.

It took decades for shortsighted and self-serving policies to get us into this mess, and in the end politics will decide whether there is a grand compromise, and what it will contain. Let's hope our politicians—and the electorate—appreciate what is at stake in getting it right. ■