Entitlements and the Federal Budget

February 1996

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This paper is based in part on a conference entitled "Entitlements and the Federal Budget: Securing Our Future," sponsored by the National Academy on Aging, and held in Washington, D.C. on October 6, 1995. I would like to thank Robert Friedland and Eric Kingson for helpful comments on an earlier draft.

The appropriate role of federal entitlements is the subject of considerable current political and economic debate. The two largest categories of federal entitlements are medical care (Medicare and Medicaid) and retirement income (Social Security and federal employee retirement). Current Congressional and Administration plans for budgetary balance by fiscal year 2002 propose controversial changes in medical entitlements, while leaving Social Security virtually untouched. The 1994-95 Advisory Council on Social Security, on the other hand, is focusing specifically on the Social Security retirement program, and will soon propose changes in its tax and/or benefit structure. The Bipartisan Commission on Entitlement and Tax Reform, whose final report was issued in January 1995, took a broader view, and included changes in both federal retirement and medical programs in its recommendations.[1]

The October 1995 policy conference of the National Academy on Aging (NAA) focused on entitlements and the federal budget, with primary emphasis on Social Security and Medicare.[2] The purpose of this paper is to provide an overview of the issues facing society with respect to these important programs, and to a lesser extent, Medicaid, using the presentations made at the conference and other relevant materials. We begin with a description of trends in the federal budget, both its size and composition, with particular interest in Social Security and Medicare.[3] We then discuss the major themes of the conference and some smaller points that should be kept in mind in the debate. We end with a summary and conclusions.

The bottom line is that projected trends in federal entitlement spending, while manageable over the next several years, are not sustainable over the medium and long run. The combination of inevitable population aging and high medical care costs dictate that federal retirement and medical insurance programs receive prompt legislative attention, and the sooner the better. The Social Security retirement issues are more self-contained and manageable -- modest changes today can have significant effects on the deficits ahead. The Medicare and

Medicaid problems, on the other hand, are part of a much larger concern -- the provision of health care in America -- and solutions are more elusive.

America is a wealthy country. To exaggerate a bit, we can have anything we want, but not everything we want. For example, America can afford to provide the baby-boom cohorts of future retirees with the Social Security benefits that are currently legislated, not with currently legislated tax receipts, but with manageable tax increases.[4] The harder question is not "can we?" -- because the answer is always yes for any single program -- but "should we?" Is this (or any other particular program) the best use of resources in a nation with a large number of important competing needs?

I. Federal Budget Trends

The size of the federal budget: Despite popular impressions to the contrary, the size of the federal government relative to the economy as a whole has been remarkably stable over the past several decades. With two exceptions, one above and one below, annual federal receipts have ranged between 18.0 and 19.8 percent of gross domestic product (GDP) between 1970 and the present (see figure 1).[5] Over the past decade (fiscal years 1987 through 1996 (estimated)), the range is even narrower, between 18.4 and 19.2 percent. Federal expenditure data also reveal a surprisingly stable pattern, although less stable than for receipts because of the larger impact of business cycles on federal spending (figure 1). Since 1970, federal expenditures have ranged from a low of 19.2 percent of GDP in 1974 to a high of 24.4 percent in 1983, the latter during the worst recession since the 1930s, with official civilian unemployment rates near 10 percent. Over the past decade, the expenditure range has narrowed considerably, from a high of 23.3 percent in the early 1990s to estimated lows just under 22 percent in fiscal years 1995 and 1996.

Because an economic downturn both reduces tax receipts and increases expenditures, federal government deficits are countercyclical. The deficit rose substantially in the early 1980s, as the economy deteriorated, and peaked in 1983 at 6.3 percent of GDP (figure 1).

Since then, annual federal deficits have been declining relative to the economy, dipping under 3 percent in fiscal years 1995 and 1996.

The macro story is one of stability over the past several decades and improvements on the deficit front in the most recent years. What then has prompted the current crisis mentality about federal entitlements and deficits? Among the answers are the composition of the federal budget and demography, which combine to forecast a future very different from the recent past.

The composition of the federal budget: While the overall size of the federal government has been stable, especially when adjusted for the business cycle, the composition of expenditures has changed dramatically. As Eugene Steuerle argued during the conference, America has reallocated its defense budget. In 1953, defense outlays equaled 14.5 percent of GDP. They remained near 10 percent through the early 1960s, but have plummeted since then, dropping to 3.5 percent in 1996.[6] This four decade decline equals 11 percent of gross domestic product -- over $800 billion in 1996. Where have these resources gone?

Steuerle's figure (figure 2) makes the answer clear -- it has been reallocated to health and retirement. These are the priorities today. The health and retirement components in figure 2 (the bottom four elements) rose from about 10 percent of federal spending in 1950 to 30 percent in 1970, and well over half -- and growing -- today. Health, retirement and disability, and interest on the federal debt currently exceed two-thirds of all federal spending, leaving less than a third for defense and all other expenditures, which consumed nearly 80 percent in 1950.

Henry Aaron made the same point over the shorter run. From 1980 to the present, federal health and Social Security expenditures rose by 1.6 percent of GDP (with health spending responsible for three-quarters of this increase), very close to the 1.4 percent of GDP decline in national defense and international expenditures over the same 15 years. At the same time, domestic discretionary spending declined by 1.2 percent of GDP, almost exactly offset by the 1.3 percent increase in net interest costs.

Why is this reallocation of federal spending a problem? It isn't necessarily a problem today, but it will be in the near future, as two aspects of Steuerle's graph and some simple demographics make clear. The first aspect is the rate of change of the health and retirement components -- they are still increasing rapidly. The second aspect, already mentioned, is the size of the top two components -- they have shrunk dramatically. Were defense and "all other expenditures" to be eliminated entirely -- an unlikely prospect -- they would release only about a third of federal spending, about the fraction that was transferred to health and retirement during just the past 25 years. The days of transferring resources from defense to health and retirement within a fixed government pie (as a percent of GDP) are coming to an end -- and the baby-boomers haven't even arrived yet!

II. Demographic trends

Is there reason to believe that the rate of growth of retirement and health expenditures will abate on its own? Quite the contrary. The well-documented aging of America suggests that retirement and health expenditures will continue to increase, barring major institutional change. In 1990, about 21 percent of all Americans were aged 55 or older. This is projected to remain steady through the year 2000, but then increase sharply for two decades as the baby-boom generation approaches traditional retirement age. By 2010, only 14 years from now, the proportion aged 55 or older will equal 25 percent, and by 2020, it will approach 30 percent. Over the subsequent 30 years, the proportion 55 or older is projected to continue growing, but slowly, inching over 31 percent by 2050.[7]

Even within the elderly population, important changes are underway -- the elderly are aging. Between 1993 and 2010, for example, while the population aged 65 or older increases by 23 percent, the subsets aged 65-74, 75-84 and 85+ are projected to grow by 12, 24 and 80 percent, respectively. Over the longer run, these discrepancies continue -- between now and 2050, while the population aged 65-74 increases by about 80 percent, the number aged 75-84

is projected to increase by 135 percent, and those 85 or older, the fastest growing group in America, by over 400 percent - from under 4 million to nearly 19 million.[8]

The aging of America can be seen in figure 3, which shows the age distribution by 5-year intervals in 1950, 1989 and 2030 -- snapshots 40 years apart. The beginning of the baby-boom generation can be seen at the bottom of the 1950 chart and approaching the middle of the 1989 chart. Note the triangular shape of both, which generates a high ratio of Social Security contributors to recipients (see below). By 2030, however, the triangle has been replaced by a rectangle, and the ratio has dropped substantially. Here is the Social Security funding problem in a nutshell.

III. Federal budget projections

The shift in the age composition of the population towards those more likely to be retired and more likely to require medical care will have profound implications for Social Security retirement and Medicare expenditures, and therefore for the federal budget as a whole.

Social Security and Medicare projections: The combined Social Security retirement, survivors and disability program (OASDI) is currently running large annual surpluses. In 1994, payroll taxes and interest on accumulated reserves exceeded expenditures for OASDI by nearly $60 billion.[9] (This surplus is part of most federal budget deficit calculations, and reduces the deficit by this amount.) As the nation ages, however, the ratio of Social Security contributors to beneficiaries will fall (figure 3). Intermediate projections suggest that it will decrease steadily from its current level of 3.3 covered workers per beneficiary to 2.0 by the year 2030, and then decline very slowly after that.

As this ratio falls, so will the Social Security surpluses. The most recent Trustee's Report predicts that OASDI tax revenues will exceed expenditures through the year 2013, and that tax revenues plus interest earned on accumulated reserves will exceed expenditures though 2020. [10] After that, however, the trust fund reserves will begin to decline, and would be depleted under present law by the year 2030.

Traditionally, analysts have viewed Social Security finances from a 75-year perspective -- approximately a lifetime. The system is described as in actuarial balance if projected income equals projected expenditures over that period. This is obviously not the case at present, since the OASDI trust funds are projected to be depleted, under current law, in 35 years -- the near-term surpluses are inadequate to finance the long-term deficits. Over the 75-year accounting period, the average annual shortfall equals 2.17 percent of covered payroll, and rises annually as a current year of surplus is replaced in the calculation by a far distant year of deficit.

The Hospital Insurance (HI) component of Medicare is also financed primarily by payroll taxes.[11] Its financial situation is much more precarious. Expenditures are expected to exceed receipts this year (1996), and exhaustion of the trust fund is projected, under current law, by the year 2002, well before the major demographic shifts described above.[12] The annual average HI shortfall over the 75-year projection period is 3.52 percent of payroll -- about 60 percent higher that the analogous OASDI deficit.

The other component of Medicare, Supplementary Hospital Insurance (SMI), is financed on an annual basis by premiums paid by beneficiaries (31% of SMI revenues in 1994), general revenue contributions from the federal government (65%) and interest on the small SMI trust fund (4%). This program is best viewed as renewable term insurance, with the premium split between the beneficiaries (1/3) and the government (2/3). The SMI trust fund is used only to hold premiums before payments are made and to provide a small contingency sum. Unlike the OASDI and HI trust funds, it is not designed to accumulate funds to finance deficits anticipated in the future. Premiums are set each year to prevent any such deficits.

Concerns about the SMI program do not focus on long-term actuarial balance, but rather on recent rates of increase in total expenditures, and therefore in annual premiums and federal government outlay. Over the past 5 years, SMI expenditures have risen by over 50 percent (and 40 percent per enrollee) -- about 20 percent faster than the economy grew.[13] And

this occurred despite efforts to control costs and before the arrival of the demographic bulge that looms on the horizon.

Both Social Security and Medicare have grown substantially over time (as seen in figure 2) and are projected to grow further. Figure 4 combines actual and projected data on total OASDI and Medicare (HI and SMI) expenditure, as a percentage of GDP. Between 1962 and 1995, the sum of the two has tripled from 2.5 percent to 7.4 percent of GDP, and is projected to (nearly) double again, to 14.2 percent by 2030. Nearly three-quarters of the increase forecast over these 35 years comes from Medicare, and it comes sooner; only a quarter of the increase (about 2% of GDP, about the same increase as occurred during the 18 years between 1962 and 1980) comes from Social Security retirement and disability programs. This is worth remembering -- although Social Security retirement finances present serious problems that require attention, they are problems of a magnitude that have been addressed before. They are dwarfed by the larger, unprecedented Medicare increases that are currently underway.

It is worth noting that the statistics above exclude Medicaid, a federal-state matching program that provides medical assistance -- including long-term nursing home care -- for the poor. In 1993, total Medicaid expenditures equaled $125 billion (2% of GDP), and were projected to grow at 13 percent annually between 1993 and the year 2000.[14]

Federal deficit projections: Federal budget projections seem to change hourly, depending on the specific budget proposal under discussion and the source of the forecast. Congress' goal is to balance the federal budget by fiscal year 2002 (including Social Security flows), and various proposals have emerged from the Senate and the House to do so. The Administration's proposal uses more optimistic forecasts, and projects budget balance with fewer spending cuts and tax decreases.

Although there are no official budget estimates beyond the year 2002, analysts have been concerned about what happens after 2002, even if budget balance has been achieved by then. The full impact of some of the tax breaks go into effect near the end of the 7 year period.

For example, indexing on capital gains for newly acquired assets begins in 2001, providing an incentive for investors to realize prior capital gains then (a short-run source of revenue) and then to re-acquire the assets to establish the basis for indexing thereafter.[15] The subsequent decline in capital gains tax revenues does not appear in the 7 year forecasts, but will be a factor in determining deficits thereafter.

But the bigger change will be the aging of the population, and its effects on the federal budget. Barring major change, the Social Security surplus will be in decline, with (OASDI) expenditures exceeding payroll tax receipts in 2013, and exceeding all revenues (including interest on the accumulated reserves) 7 years later. Medicare and Medicaid will continue to grow. Eliminating the deficit by 2002, as difficult as that may be, is probably easier than what lies ahead.

IV. Major Themes of the Conference

A. Good news can be expensive: An important point that provides useful perspective on these issues is that many of the budgetary problems we anticipate stem from good news, not bad news. The good news is that Americans are living longer and healthier. More Americans are living to retirement age, and once they get there, they are living longer in retirement.

In 1940, soon after the passage of the Social Security Act, the life expectancies of American men and women were 61 and 66 years, respectively. By 1990, a half century later, they had risen to 71 and 79, increases of 10 and 13 years. By 2010, when the leading edge of the baby-boom generation reach early retirement age, life expectancies are projected to have increased by another 2-3 years.[16]

Much of this increased longevity has come from decreased infant and youth mortality. From a Social Security perspective, the more relevant "concern" may be the life expectancies of those who live to claim retirement benefits. These have risen significantly as well. For example, the life expectancy of an American man aged 65 has risen by 3 years between 1940

and 1990 (from 12 to 15 years), and is projected to increase by another year by 2010, and by yet another year by 2030. For women, the increase since 1940 is even higher (up 5.5 years, to 19 years), with additional gains similar to the men expected by 2010 and 2030.

Living longer does not necessarily mean living healthier. The "failure of success" hypothesis popular in the 1980s suggested that medical successes against chronic diseases would lead to increasing proportions of frail and ill elderly, those who would have died in earlier years. Although the debate continues, recent evidence tends to refute this hypothesis. Older American, on average, do appear to be living healthier as well as longer.[17]

Some of this good news is creating budgetary problems for retirement and medical programs. Society has to decide how to deal with the financial implications of increased longevity, but it is reassuring to remember that these problems, unlike poverty, crime and war, have at their root a trend we should celebrate, not lament.

B. <u>All entitlements are not alike</u>: Entitlements are often aggregated, and described as the source of government fiscal problems. The Bipartisan Commission on Entitlement and Tax Reform, for example, aggregates all federal spending into two categories: mandatory (entitlements and net interest payments) and discretionary, and documents the growth of entitlements over the past three decades.[18] Entitlements doubled from 23 percent of the federal budget in 1963 to 47 percent in 1993, and are projected by the Commission to increase further to 58 percent by the year 2003 -- with the retirement of the baby-boomer cohorts still ahead.[19] With the simultaneous doubling of the share of net interest payments (from 7% to 14% between 1963 and 1993), mandatory spending has risen from less than one-third (30% in 1963) of the federal budget to nearly two-thirds (61% by 1993), with further increase to nearly three-quarters (72%) projected for 2003. This is certainly a major change in priorities.

But within the category of entitlements, as we have seen, are found very different components. The Social Security retirement, survivors and disability programs, the largest entitlement, are currently restraining the annual federal deficit -- by nearly $60 billion in 1994 --

not adding to it. In contrast, the Hospital Insurance component of Medicare, the second largest entitlement, began running a deficit in 1995.

The expected growth rates of the retirement and health insurance programs are also very different. Under current law, Social Security (OASDI) is expected to maintain its same share of GDP between now and 2005 (about 4.8%), and then increase by only 0.6 percentage points by the year 2015 (see figure 4). Between 2015 and 2025 is the largest one decade increase (from 5.4 to 6.4%), after which there is little additional growth relative to the economy.

Medicare problems, in stark contrast, are on the doorstep. Although Medicare starts smaller, it grows much more quickly. The Medicare share of GDP is projected to increase by over one percentage point between now and 2005, by another 1.5 points in each of the next two decades (2005-2015 and 2015-2025), and by more than one point more in the decade thereafter (figure 4). In about 20 years, Medicare is projected to pass OASDI in size, and still have a higher annual growth rate at that time.

Finally, the nature of the problems underlying these two important entitlements are very different. The retirement problem is more self-contained. It is primarily demographic (the baby-boom bulge) and partly behavioral (people, primarily men, are retiring earlier than they did decades ago.) Many manageable combinations of Social Security revenue increases and/or benefit decreases (including delays in the ages of eligibility) can restore the program to 75-year actuarial balance, and Thomas Jones provided one such program to the conference (see below).[20] Medicare's problems, on the other hand, are intrinsically intertwined with a much larger issue -- increasing medical care costs in America, which are rising at about the same rate as per capita Medicare costs.[21] This relative price inflation for medical care will soon be compounded by the demographic shifts noted above. There is no consensus on how to handle the broader cost problem, and nothing, so far, manageable about it.

C. Is Social Security viewed as insurance and redistribution or as investment? Social Security plays many roles in America. It is a savings program, like a savings account or a pension, reallocating income over the life span by collecting payroll taxes when one works and distributing benefits when one retires. It is also an insurance program, like fire or automobile insurance, offering benefits when certain eventualities occur, like the disability or death of a worker. Finally, Social Security is an income redistribution program, like the federal income tax and transfer system, transferring resources from the lifetime rich to the lifetime poor, both within and between generations.

The criteria appropriate to evaluate the program depend on the role being emphasized. The insurance and income redistribution goals are concerned with the income adequacy and financial well-being of American retirees and other Social Security recipients. These were primary initial goals of the program when it was initiated, and provided the framework against which success was measured. Recently, the savings role has received increasing attention, along with concerns about "rates of return" on individuals' contributions, as though Social Security were an individual retirement account.[22]

Since Social Security is one program with multiple goals, it has features that make sense according to one goal, but do not according to another. For example, its benefit formula explicitly transfers resources from lifetime high-earners to life-time low-earners, and therefore provides a higher "rate of return" to the latter. Banks, pension plans and insurance companies do not. It offers free spousal and survivor benefits, since married workers contribute no more than their otherwise identical but single co-workers. Pension plans and insurance companies do offer survivor benefits, but either charge an additional premium or lower the benefits for the primary beneficiary.

The topic allocated the most time at the NAA conference was the future of Social Security. Three major views on Social Security reform were presented and discussed -- that Social Security should be fine-tuned, that it should be altered significantly, and that it should be dismantled and replaced. In my estimation, one's view on this controversial topic is closely

correlated with whether one emphasizes the insurance and redistributional goals of Social Security, or the savings and investment aspects.

The first two types of proposals, incremental fine-tuning or more significant change but within the current structure of the program, were presented at the conference by two members of the 1995 Advisory Council on Social Security. Thomas Jones emphasized the many strengths of the program. Social Security is a (nearly) universal defined-benefit pension program that provides an important source of income for the elderly, especially the poor elderly.[23] It has played a major role in decreasing the poverty rate among older Americans from over twice the national average to less than the national average.[24] It insures workers against disability, death, and premature retirement and, as the only fully-indexed annuity universally available, it protects against the risk of living a very long life and out-living one's assets. It remains popular, is worth preserving and can be saved by "several incremental steps (which) in combination can restore long-range solvency without tearing out its roots."[25]

Jones outlined a plan of tax and benefit adjustments proposed by Robert Ball, a former Social Security Commissioner and a member of the 1995 Advisory Council on Social Security. The plan includes

-a small increase in the FICA payroll tax rate (1/4 percentage point increase for the employer and the employee);

-a more rapid increase than currently legislated in Social Security's normal retirement age (currently 65) to 67; [26]

-an increase in the number of years of earnings (from 35 to 38 years) used to calculate Average Indexed Monthly Earnings -- the equivalent of a 3 percent benefit decrease;

-additional federal income taxation of Social Security benefits;

-the inclusion of all new state and local government employees in the Social Security program; and

-additional revenues from a more diversified Trust Fund investment portfolio, including equity (1/3 of the Trust Fund assets) and corporate debt (1/6 of the assets).

All these proposals except the last represent incremental changes to current policy, designed, in combination, to eliminate the average annual deficit of 2.17 percent of covered payroll forecast over the next 75 years.

A primary objection to a plan of this type, which would increase taxes and decrease future benefits while maintaining the basic redistributive nature of Social Security, is that it would decrease further the already low "rates of return" that some current and future workers will "earn" on their Social Security contributions.

Because of the large ratio of Social Security contributors to recipients in the earlier years of the program (a chain letter effect), and because of the emphasis on income adequacy for older Americans, current and prior cohorts of retirees have received and will receive Social Security retirement benefits that vastly exceed what they and their employers contributed. For example, a man who retired at age 65 in 1980 after a lifetime of average earnings could expect to receive in Social Security retirement benefits nearly 4 times what his (and his employers') contributions would have equaled had they been invested in low-risk government securities.[27] Because of the explicit redistributional nature of the program, lower-wage earners retiring in 1980 could expect even higher benefit/contribution ratios, while higher-wage earners could expect less, but still enjoy ratios well in excess of 3.[28] As the ratio of workers to beneficiaries began to decline, so did these benefit/contribution ratios. Nonetheless, for new retirees in 1992, the ratios all still exceeded 1.00 for six categories of hypothetical retirees (men and women; minimum, average and maximum earners). So far, all cohorts of retirees have received Social Security benefits in excess of what reasonable low risk alternatives would have provided. It's been a great "investment." But as the demographic triangle turns into a rectangle (see figure 3), this will no longer be the case for some.

Steuerle and Bakija (1994) have estimated and forecast the net gain or loss under current law from participation in the Social Security retirement and survivors' programs, comparing hypothetical recipients reaching age 65 between 1940 and 2050.[29] They consider 12 combinations of earnings histories (low, average and high) and family structures (single

men, single women, 1-earner and 2-earner couples). Their results show that 11 out of the 12 hypothetical recipients retiring at age 65 in 1995 can expect a positive net transfer from OASI; i.e., more than an alternative low-risk investment would have provided. The only net loser today is the high-wage single man (with no spousal or survivors benefits), whose OASI contributions exceed his expected lifetime benefits by about $10,000.

According to Steuerle and Bakija's calculations, net social security transfers are now in decline across-the-board (see figure 5). By the year 2005, retiring average- and high-wage single men, high-wage single women (not shown in figure 5) and high-wage 2-earner couples can expect receive a return less than the 2 percent real return assumed for a low-risk alternative investment. Couples (except for high-wage two-earner couples) continue to do well, because of the subsidy provided by spousal benefits, but less well than they used to. And there will be many recipients who may consider their mandatory Social Security contributions a poor investment relative to what they could do on their own.

These estimates assume the current Social Security tax and benefit structures, which are known to be inconsistent - the former cannot pay for the latter. When Social Security taxes are raised and/or benefits reduced, these "investment returns" will decline even further. The exact nature of the declines depends on the distributional aspects of the eventual Social Security changes.

Focusing directly on the social adequacy and individual equity aspects of the Social Security system, Sylvester Schieber, another member of the 1995 Advisory Council on Social Security, discussed a more significant set of changes. They included very gradual increases in both the normal and early ages of eligibility (from 65 to 68, and from 62 to 65, respectively, at a rate of 1 month per year beginning in the year 2000), some investment of the Trust Funds in equities, and the separation of the social adequacy and individual savings goals of the program through the creation of a system with two "decks."

In the current system, both the degree of social adequacy and individuals' rates of return are determined by a single benefit formula which relates one's Primary Insurance Amount

(PIA, what a single individual first claiming benefits at the Normal Retirement Age, age 65, would receive) and one's Average Indexed Monthly Earnings (AIME). The PIA formula has three brackets separated by two bend-points. In 1996, for example, one's monthly PIA equals

90% of the first $437 of AIME

plus 32% of any AIME between $437 and $2,635

plus 15% of any AIME above $2,635.

As a result, workers with very low lifetime earnings (low AIMEs) get larger returns on their contributions (90% of their AIMEs) than do persons at the upper end of the distribution, for whom an additional dollar of AIME adds only $0.15 to the monthly benefit. There is no zero percent bracket, so there always is a relationship, at the margin, between covered earnings (and therefore contributions) and eventual benefits, but the nature of the relationship at the margin differs dramatically by lifetime earnings level.

In the proposed "double-decker" system, there would be two separate components with different functions. The lower deck would provide a flat benefit, independent of AIME, and would address social adequacy concerns. This would provide a minimum benefit for those meeting the eligibility requirements, a minimum which does not exist in the Social Security rules today.[30] The upper deck would have no redistributional component, and would address the individual equity concerns by providing a benefit exactly proportional to lifetime covered earnings (and therefore exactly proportional to contributions). In the specific example that Sylvester Schieber provided, PIA = $407 + 0.165 (AIME). This formula would lower the long run replacement rate for average- and high-wage workers from what they are heading to under current legislation (a source of savings for Social Security, which is one of the primary goals of the reform proposal), but would increase the replacement rate above where it is headed for low-wage workers, those least likely to have employer pension coverage, savings or other assets.[31] This addresses the social adequacy goal.

Total savings are estimated at 2.46 percent of covered payroll over the next 75 years, about 0.45 percentage point higher than the Jones/Ball plan above. Nearly all of the savings

come from the increases in the eligibility ages (0.97%) and from the replacement of the PIA formula with the double-decker scheme (1.15%).

The primary advantage (or disadvantage) of introducing a double-decker system is that it makes the two goals of the system, and their costs, more explicit. As proposed, about half of the Social Security revenues would be allocated to each, but future generations could easily change this balance by trading off the lower deck amount ($407 above) against the AIME factor (0.165). For those happy with the current tradeoff between social adequacy and individual equity, this separation and increased transparency of the goals may be a source of concern. One could later argue, for example, that the flat, lower-deck should be means-tested, then that it should be financed by the more progressive income tax, and finally that it should really be part of SSI rather than part of the Social Security system. This, of course, would change Social Security in a very fundamental way. Whether this would be good or bad depends on one's perspective.

The double-decker system does not directly address the rate of return objection to the current Social Security system -- that some contributors could do better investing their payroll taxes on their own -- because it would still have an explicit redistributional component. But a third set of proposals, much more radical that either of those discussed above, does.

Michael Tanner of the Cato Institute presented the case for dismantling or privatizing Social Security, arguing "that Social Security, quite simply, is a bad investment (because) the return you earn on Social Security is far lower than what you could earn in the private capital markets." His proposal is to redirect the old age and survivors portion of the Social Security tax (currently, 5.6% of covered payroll for both employer and employee) into individually owned private retirement accounts.[32] The advantages are that these accounts would become part of individuals' estates (i.e., they would not disappear at death, as do the Social Security benefits of a recipient without a surviving spouse or eligible dependents) and that individuals could earn higher returns on their investments than they are likely to receive from Social

Security. Individuals could choose the risk/expected return combination for these funds (perhaps within regulated limits) that most suited their preferences and needs.

The Bipartisan Commission on Entitlement and Tax Reform (1994: 59-60) discussed a proposal under which individuals could choose to divert 1.5 percentage points of their (but not their employer's) Social Security contribution, and invest the proceeds in a personal retirement account. In legislation sponsored by Senators Kerrey and Simpson, the Personal Investment Plan Act of 1995, the proportion was 2 percentage points. Those who chose this option would receive lower Social Security benefits upon retirement, with the exact decrease dependent on the age at which the initial (and irrevocable) diversion was selected. In the Bipartisan Commission's Final Report (1995: 26), both the payroll tax decrease (1.5%) and the equivalent contribution to a personal retirement account were mandatory, and there was no decrease in Social Security benefits. These proposals all represent partial privatizations of the system, some optional, some mandatory.

As Tanner readily acknowledged, a major issue associated with privatization is the treatment of the unfunded liability currently owed to workers and retirees. The payroll tax revenues currently anticipated are inadequate to finance the benefit obligations that exist under current law, and the proposal here is to divert even this revenue flow elsewhere. How would the benefits currently promised be paid?

There are several options. The first, stated in the starkest terms, is partial default -- do not meet all the promised obligations. Any reduction in future benefits, either directly through changes in the benefit formula or indirectly through increases in the ages of eligibility, can be viewed as a form of partial default, and nearly all Social Security reform proposals contain an element of this. Tanner suggests that many young workers might be willing to forego distant Social Security benefits entirely for the opportunity to earn higher returns from now on. A second option is to reduce other types of government spending and use the proceeds for Social Security benefits, or sell government assets (e.g., the West) for the same purpose. A third is to fund the liability through taxation -- some combination of payroll taxes (i.e., if privatization is

introduced gradually) and general revenues. Finally, one can delay the inevitable by borrowing the funds -- selling bonds -- and then either cut spending, sell assets or tax when the bonds come due.

The bottom line is that an unfunded liability currently exists, and someone has to pay for it -- either future Social Security recipients, if the promised benefits are not paid in full, and/or other Americans whose taxes are raised or transfers reduced. How this unfunded liability is dealt with is a very important political decision, but one that is conceptually separable from the issue of structural Social Security reform and the appropriate mix of the public and private sectors in providing for future retirees.[33]

The emphasis on individual rate of return is a relatively new phenomenon in the Social Security debate. It was not central when the system was created, when the system was much smaller and when favorable rates of return, by cohort even if not by individual, were all that appeared on the near-term horizon. Now Social Security is big, and many of those anticipating retirement do not expect favorable rates of return.[34] This relatively new emphasis on individual returns diverts attention from other important aspects of Social Security -- insurance against disability and early death (no one grumbles about the poor rate of return on fire insurance premiums when his house doesn't burn down!) and its more communal goal, redistribution toward those less well off. Those who emphasize the communal insurance and redistributional goals tend to favor addressing the fiscal imbalance within the basic structure of the current Social Security system. Those who take the individualistic rate-of-return viewpoint are more likely to favor scrapping the present system and putting more reliance in the future on individual savings initiatives and private capital markets.

D. <u>Health care entitlement issues are different</u>: The issues facing Medicare (primarily for the elderly) and Medicaid (for the poor) differ in many ways from those facing the Social Security retirement system. The problems are more difficult and, as we have seen, more immediate. Although Medicare and Medicaid, in total, are currently about the same size as OASI, they are growing much more rapidly.[35] Medicare and Medicaid, like Social Security,

will face the demographic bulge arriving between 2010 and 2030 -- the aging of the baby-boomers -- but, unlike Social Security, they face significant funding problems long before then. These problems are part of a much larger and more intractable one -- the cost of medical care in America.[36]

Because Medicare and Medicaid pay for services rather than provide cash, there are issues and complications about price, quantity and quality that are absent in the retirement debate. When the price of certain procedures increase, or the approved medical procedures for particular maladies change, Medicare and Medicaid expenses change automatically. Technological advances are good, but often expensive. The payments go not directly to the recipients, but to venders and providers, so some of the reform burden can be directed at them.[37] Finally, since the benefit is insurance coverage for certain types of medical care rather than cash, it is more difficult to fine-tune expenditures, although block grants represent an attempt to do this from the federal perspective.[38]

Medicare and Medicaid expenditure issues can be usefully disaggregated into two components. First, what are the appropriate growth rates of expenditures per recipient, and how should we lower the current per capita growth rates to the (presumably) lower ones? Second, once per recipient expenditures are under control, how do we then deal with the facts that there will soon be many more elderly Americans on the Medicare and Medicaid roles and they will be living longer? [39] There seems to be little consensus on either issue.

Barring changes in legislation, Medicare and Medicaid expenditures are projected to increase by 137 and 118 percent between 1995 and 2002; annual growth rates of 13.1 and 11.8 percent respectively. The Congressional budget resolution passed last year contains major reductions in projected Medicare and Medicaid expenditures, by $270b and $182b over these same 7 years (with over half of the reductions in the last 2 years), reducing the expenditures growth to 55 and 53 percent, still over 6 percent per year.[40] Some of this is growth in expenditures per recipient, and some is growth in the number of recipients. Judy Feder, citing Congressional Budget Office statistics, estimates that the per capita growth rates in federal

expenditures implicit in this budget resolution are 4.9 percent for Medicare and 1.4 percent for Medicaid -- both substantially less than the CBO's estimate of 7.1 percent annual growth for private health insurance expenditures.[41] What changes could create differentials of this magnitude?

As with Social Security, some of the reform proposals are incremental, working within the present system, while others would alter Medicare and Medicaid more fundamentally.[42] For example, proposed short-run incremental reforms designed to reduce federal Medicare expenditures by $8 billion in FY 1996 include some decreases in provider payments (a freeze on hospital reimbursements, reductions in the reimbursement adjustment factors for teaching hospitals and for hospitals with disproportionate shares of low-income patients, and a reduction in physician fee schedules), and some increases in revenues (additional coinsurance on some services and an increase in Medicare SMI premiums).[43] Another possibility is the restriction or the elimination of certain types of coverage. Another much more controversial option is the taxation of the value of Medicare benefits. This has the advantage of progressivity, but the substantial political disadvantage of taxing a benefit that is usually not viewed as "income" and whose value differs dramatically by individual. These proposals all aim at some combination of lower quantity of health care services, lower price per service, cost shifting to providers, other payers or recipients, and greater efficiency (the provision of the same quality and quantity of service at lower cost).

The larger reductions anticipated in the future require more fundamental changes, such as an accelerated movement toward managed care or the transformation of Medicare from a defined benefit to a defined contribution program. One mechanism for the latter would be the use of vouchers, allowing beneficiaries more choice in the type and coverage of the health insurance they receive.[44] The experience with these more structural changes is limited and the evidence on the outcomes is far from definitive.

Medicare beneficiaries already have the option of managed care, but few take advantage of it.[45] There is evidence that the medical costs of managed care patients are less than the

costs of other patients, but it is not clear to what extent this is due to increased efficiency (e.g., efficient preventative medicine or the reduced use of unnecessary procedures) and to what extent it is due to selectivity bias (i.e., those in better health to begin with are more likely to join a managed care program.) It is also not clear how enthusiastically managed care providers will compete for the business of the older, more frail and poorer populations. Finally, additional purchase of managed care by the government for Medicare patients will mean significant premium expenditures on some patients who currently cost Medicare nothing (i.e., those whose annual expenditures do not exceed their deductibles).

Another important issue concerns risk pools. One of the advantages of Medicare, like Social Security, is that the risk pool is very broad, including nearly all Americans aged 65 or older. The selectivity problems that plague voluntary health insurance and annuity markets are much less serious here. But some reform proposals will introduce selectivity problems. Although all Medicare recipients would be encouraged to join managed care programs, those in good health are more likely to accept the financial incentives to do so. The same is true for medical savings accounts. Those in poor health are more likely to find the certainties of traditional fee-for-service care -- the devil they know -- more attractive, leaving that pool disproportionately populated by those with the highest health care costs.

The impact of proposed Medicaid changes is even harder to predict, because the programs differ from state to state. There is considerable state discretion at present, and it would be increased even further under reform proposals that would turn Medicaid into a block grant. Although a higher proportion of the Medicaid population is already under managed care than is true for Medicare (about 1 in 4 compared to 1 in 10), those covered tend to be the relatively healthier categories of recipients, such as families receiving AFCD, children in poor families and pregnant women. Only recently have Medicaid programs initiated managed care coverage for chronically ill, disabled or cognitively-impaired beneficiaries.

Medicaid is the major public program providing long-term care, mostly nursing home care for the elderly. But because Medicaid is a program for the poor, receipt of long-term

assistance requires low levels of assets and income, which in turn creates potential for abuse concerning asset transfer. Private long-term care insurance does exist, but so far it is purchased by few and unaffordable to many. Expansion of federal and state long-term care coverage would be very expensive, and politically unlikely in an era of government retrenchment. The system of long-term care in America is grossly inadequate at present, and will become much more so if changes do not precede the graying of the baby-boomers.

Given the uncertainties surrounding Medicare and Medicaid, it is not surprising that there exist a wide range of opinions about the impacts of fundamental reform on the expenditures of the federal government, state and local governments, health care providers and recipients. This is poorly charted territory. Even if these reforms do succeed in lowering the price and/or quantity of the medical care purchased by the federal government, we may simultaneously heighten the financial problems of certain health care providers (like teaching hospitals or community hospitals serving low-income populations), other payers and the recipients themselves.[46] Cost reduction and cost shifting may look the same from a federal budget deficit perspective, but they are very different to the others involved.

Finally, unlike Social Security, all this discussions, analyses and reform proposals are just preludes to the coming demographic changes. They are necessary preludes, because there is little hope of success later without first getting per recipient costs under control. If these efforts are successful, then we will then be in position to discuss how we plan to handle the doubling of the elderly (i.e., Medicare and nursing home) population between now and 2030.

IV. Selected Other Issues Before the Conference

A number of other important points were made during the conference, some of which I will mention briefly.

a. Social programs interact. Although Social Security, medical care and welfare programs are often discussed separately, they should be analyzed and reformed together, because there are important interactions between them. About 6 percent of Social Security recipients aged 65 or older, for example, also receive Supplementary Security Income (SSI), which "taxes" Social Security benefits dollar for dollar after a small disregard.[47] About two-thirds of aged SSI recipients also receive Social Security benefits, which in fact are the largest source of income for those on SSI.[48] Decreases in Social Security benefits to those receiving SSI, therefore, are automatically offset by SSI increases. The savings in one program are matched by additional expenditures in the other.

Medicare and Medicaid are also closely intertwined. Under current law, State Medicaid programs pay some of the Medicare deductibles, copayments and the premiums of low-income elderly. About 10 percent of Medicare beneficiaries also receive Medicaid payments. Increases in deductibles, copayments and the premiums will help Medicare finances, but at the cost of increased Medicaid expenditure, both from general federal revenues and from the states. Finally, since Medicare premiums are deducted directly from Social Security payments, larger Medicare premiums and lower Social Security benefits can be identical from the recipient's point of view.[49]

Social Security retirement and disability programs are both potential sources of income for some older Americans. Although the latter is fraught with the uncertainties of meeting stringent eligibility requirements, the disability benefits are higher than retirement benefits for those younger than 65.[50] If the normal retirement age and the actuarial reduction at age 62 are increased, as is currently legislated, some of those on the margin will apply for and some will receive disability benefits, offsetting some of the anticipated savings.

b. Pitching is important. How proposals and their alternatives are described dramatically influences the degree of public support as measured by polls. As Humphry Taylor explained to the conference, what Americans want depends on what the alternatives are. Do Americans favor cuts in Medicare spending? Yes, maybe and no. According to Taylor, most people oppose "cuts in Medicare," but many favor "decreases in the rate of growth of Medicare spending." What does this mean? A decrease in the projected rate of growth is a cut -- a cut relative to what would happen without legislative change. It also may mean a cut relative to today's real per capita expenditure (if the recipient population grows faster than Medicare spending) and, even more likely, a cut in the level of access or the amount of service provided per person (if the combined growth rates of medical care prices and the recipient population exceed that of Medicare spending). Would this last scenario -- continued, but reduced, real growth in total Medicare spending, but declining services per recipient -- be a "cut in Medicare," and therefore opposed, or just a cut in the rate of growth, and therefore favored? There are poll questions to support either answer.

Support for decreases in the rate of growth depend critically on the reason for the decrease. Taylor reports that a huge majority favors these reductions in order to save Medicare from bankruptcy, while a modest majority oppose them to balance the budget, and an overwhelming majority oppose them to pay for a tax cut. Similarly, those who favor a Constitutional amendment to balance the federal budget tend to withdraw support "if balancing the budget required cuts in Social Security."[51]

Social Security benefit declines provide another example where pitch may matter. An increase in the normal retirement age (currently 65; legislated to increase to 67) is nearly identical to an across-the-board benefit decrease. The former means getting less at any age of initial benefit receipt; the latter means waiting longer to obtain any given amount. For an upward sloping line (envision a graph with monthly benefit on the vertical axis and the age of initial receipt on the horizontal), a shift down (a benefit cut) is the same as a shift to the right (a delay in the normal retirement age). Yet they may be interpreted very differently. The first

may imply that Social Security benefits are too high, while the latter may suggest that the amount is right, but the age is wrong. Given the dramatic increases in life expectancy since the age 65 was initially chosen, people might consider a benefit cut unreasonable and its functional equivalent eminently reasonable.

Polls suggest an odd contradiction concerning Social Security -- people overwhelmingly support the program but have little confidence in its future. A 1994 Gallop poll, for example, found that 80 percent favored "the fact that a part of every working person's income goes to support the Social Security program," and 73 percent opposed a reduction in Social Security benefits. At the same time, only 40 percent expressed confidence in the future of the Social Security system.[52] Some of this is due to the fact that poll responses often represent gut reactions rather than thoughtful reflection, and recent experiences with small focus groups suggest that this is the case.[53] But the point remains that the Devil can quote Scripture -- and polls results as well.

c. Economic and demographic assumptions matter. Some combination of Social Security benefit cuts (directly, or indirectly through increased taxation or delayed receipt) and revenue increases are clearly necessary. But how much change is necessary, and on whom should this burden fall? On the current cohort of elderly, which has received a large windfall gain from Social Security, or on future generations? A very useful piece of information to have is whether future generations will be better off economically than current retirees. If they will be, then the net transfer from them to current retirees may make sense, since redistribution from lifetime rich to lifetime poor is one of Social Security's goals.[54] But if future generations will be worse off on average, then this intergenerational transfer is more questionable. How future generations will fare depends critically on the future growth rates of real wages. Will they reflect the very disappointing stagnation of the past two decades, or the much more favorable long run growth experiences of the 20th century? It matters very much, and we don't know.

The size of the future Social Security budget problem also depends critically on future economic and demographic trends -- on wage growth, interest rates, and fertility, immigration and labor force participation trends. In December 1995, a small increase in the Congressional Budget Office's growth assumption "eliminated" $135 billion of deficit between 1995 and 2002.[55] Small changes have much more dramatic effects on projections 75 years out.

These uncertainties suggest to me that partial solutions to future problems like Social Security finances may suffice. Critics point out that a plan to eliminate the 75-year Social Security fiscal imbalance (e.g., raise the payroll tax by 2.17%) will be inadequate one year later, because a large deficit year (76 years hence) will have replaced a large surplus year today. True, but 75 years is a long way from now, and all of our current assumptions are undoubtedly wrong. Why not permit future generations, armed with better estimates, to make some of the choices based on what looks best at that time. A counter argument is that this keeps Social Security debate on the table, with possible detrimental effects on public confidence in the system.

d. Sooner is better than later. Whatever changes in Social Security are eventually introduced will have important impacts on people's economic well-being. People who have made plans under one set of assumptions will have to adjust to a new set. Some may decide to save more; others may choose to work longer than they currently anticipate. The sooner they know what the future holds, and sooner they can begin corrective action. Implementation lags are a good idea, because they can ease the costs of transition. But this means that the decisions about what should be done should be made sooner rather than later, both because people should be given time to adjust to the change, and because the size of the change needed grows the later it is put into effect. Delay until the crisis is imminent also increases the chances that reform efforts will focus on short-term cash-flow fixes, which can be implemented rapidly, rather than on long-term structural reforms whose fiscal impacts occur only gradually.[56] Keeping Social Security, currently the biggest entitlement of all, off the table may be good politics but it is bad public policy.

e. Short-term gains may create long-term losses. Social Security remains a popular program partly because of its universal scope -- nearly all Americans take part, and benefits are perceived as a right earned by a lifetime of contributions. Wealthy Americans have less need for Social Security benefits than poor Americans, and this is reflected in the redistributive nature of the benefit formula and, more recently, in the decision to tax some of the benefits of high-income recipients. Proposals have also been made to means-test benefits directly; that is, to have benefits depend on the annual income (not just the earnings) of the recipient. Some retirees might receive no benefits at all. This may see like a good idea, consistent with the progressivity built into the Social Security and the federal income tax systems. But in addition to penalizing savings, it may threaten the sense of universal ownership that Social Security has enjoyed in the past. Influential sectors of the economy may begin to view Social Security as a program "for them" but not "for us." This can be seen already in the increasing emphasis on the program's "rate of return" to individuals. At some point, the short term gain to Social Security finances from additional progressivity may be offset by the loss in political support of those who are net contributors.

VII. Summary and Conclusions

Entitlements are a very important part of the federal budget. According to the Bipartisan Commission on Entitlement and Tax Reform, entitlements have grown from 23 percent of the federal budget in 1963 to 47 percent in 1993, and are projected to increase further to nearly 60 percent by 2003. When net interest payments are added, "mandatory" spending is projected to approach three-quarters of the federal budget by 2003. And these changes occur before the early wave of baby-boomers reach the age of eligibility for Social Security retirement and Medicare benefits. As Eugene Steuerle argued, since 1950 America has chosen to reallocate most of its defense budget to health and retirement, but this reallocation cannot continue, because there is relatively little defense budget left. Hard choices lie ahead.

Social Security (OASDI) and Medicare are the two largest federal entitlements, and therefore they should both be major topics of current debate. Although they have much in common (e.g., they are both designed primarily for older Americans, whose numbers will grow dramatically early next century), they are very different as well. Medicare is smaller, but is growing much more rapidly. Social Security is currently running sizable annual surpluses, and therefore is restraining the federal deficit, while Medicare began running deficits in 1995. Social Security's problems are primarily demographic, and therefore insolvency (were no changes to be made) does not threaten until the baby-boom generation is well into its retirement, about three decades hence. In addition, Social Security's (75 year) financing problems are of a magnitude similar to those that have been addressed in the past, and various proposals to close the gap between revenues and expenditures have been proposed. They may be good ideas or bad ideas, but the are manageable ideas. Medicare's problems, in contrast, are part of a much larger and more intractable problem, health care costs in America. There is no consensus on how medical care costs should be restrained. In Henry Aaron's words, the major entitlement problem in America "is health care, stupid."

Much of the debate about the future of Social Security stems, I think, from competing views about the fundamental nature of the program. Those who emphasize its insurance and redistributive components tend to favor retaining its basic structure, and closing the funding gap with revenue increases and/or benefit reductions, usually disproportionately on the wealthy. Those who emphasize the savings aspects of Social Security point out that is already a "bad deal" for many current workers (whose contributions could earn higher "returns" elsewhere), and that it will become an even worse deal if contributions are increased or benefits decreased. These analysts tend to be more favorably disposed to the privatization of Social Security and the explicit separation of its redistributive and savings components.

Social Security, Medicare and Medicaid should all be on the table. The earlier reforms are enacted, the better, and the more modest they can be. Especially in the case of Social Security, which is a vital determinant of individuals' retirement plans, some implementation lag

is a good idea, to allow people to adjust whatever changes are enacted. This makes prompt legislative action all the more important.

America can afford many things, but it cannot afford all things. We have chosen to shift federal spending away from discretionary items and toward mandatory items, primarily entitlements. Barring major institutional change, demographic forces are about to increase entitlement spending substantially. As a society, we must decide if this is the best allocation of our abundant resources, and if not, what changes in current allocations and future trends are most appropriate.

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[1] Entitlements are payments that must be made by the government to any entity that seeks payment and meets the legal eligibility requirements. Programs costs are not made directly through the appropriations process, but rather indirectly through laws that create the eligibility rules and benefit levels. See Moon and Mulvey (1996), p. 38.

[2] Medicare is part of Social Security -- it is the Health (H) in the Old Age, Survivors, Disability and Health Insurance (OASDHI) program. In this paper, I will use "Social Security" to refer to OASDI component, which is primarily retirement, and Medicare to refer to the Health Insurance component.

[3] According to the Congressional Budget Office, Social Security. Medicare and Medicaid (also discussed below) account for about two-thirds of all federal entitlements. See Moon and Mulvey (1996), p. 41.

[4] The baby-boom cohorts refer to the 76 million people born from 1946 through 1964. One should remember that those born at different times during this period may have had very different experiences, despite all being lumped together as baby-boomers.

[5] The two years outside this range were 1971 (17.8%) and 1981 (20.2%). In nearly all the years since 1952, receipts as a percentage of GDP have been in the high teens. The receipts, expenditures and deficit figures appear in the Economic Report of the President (1995), table B-78.

[6] Council of Economic Advisors (1995), table B-78.

[7] These are the most recent middle series projections from the Bureau of the Census (1993: table 2). For a thorough discussion of the aging of the population, but with slightly earlier projections, see U.S. Senate (1991), chapter 1 or U.S. Bureau of the Census (1992), chapter 2.

[8] U.S. Bureau of the Census (1993: table 2).

[9] The Social Security retirement and disability statistics and projections are drawn from the 1995 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds; see page 7 for these 1994 data.

[10] Nearly all of the "tax" revenue are F.I.C.A. contributions on current covered earnings. The other component ($5 billion out of a total of $381 billion in 1994) are receipts on the federal income taxation of up to 50% of the Social Security benefits of high income beneficiaries.

[11] The Social Security Medicare (HI and SMI) statistics and projections are drawn from the 1995 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and the Supplementary Medical Trust Funds.

[12] It is interesting to note that 9 of the past 25 Hospital Insurance Trustees reports have predicted trust fund depletion within 5 years, and it has never happened. See Friedland (1995), p. 11.

[13] Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, *1995 Annual Repor*t, p. 3.

[14] See Social Security Administration (1994), pp. 99-101. About 57 percent of total Medicaid outlays are paid by the federal government; the remaining 43 percent by the states, although the proportion varies with the wealth of the state.

[15] I am indebted to Charles Schultze for this example.

[16] U.S. House of Representatives (1994), table A-2.

[17] In a recent article, Manton, Stallard and Corder (1995) used the National Long-Term Care Surveys to examine the prevalence of 16 specific medical conditions among U.S. elderly. They report that the average number of these conditions per person fell by 11 percent between 1982 and 1989. Declines were observed consistently across age, sex and disability level groups. Nonetheless, it is important to remember the diversity of the aged. Although improvement may be observed across the spectrum, there remain important differences in average health status across education, class and racial categories.

[18] The Bipartisan Commission (1994; footnote 2) defines a program as an entitlement "if a court would find that a public law legally obligates the government to make payments to persons meeting the program's eligibility criteria."

[19] See Bipartisan Commission on Entitlement and Tax Reform (1995), chart II.

[20] It is true that these proposals still have very large annual deficits at the end of the 75 year period, and are therefore not complete long-term equilibrium solutions. It is also true 75 years hence is as far away as 1920, and I, for one, would have been hard pressed to forecast at that time what has happened since.

[21] Moon and Mulvey (1996: 89-89) argue that, since the mid-1980s, Medicare has been more successful than private sector health insurers at restraining per capita medical care costs when the analysis is limited to those services which are covered by both.

[22] For a thorough and nontechnical discussion of Social Security "money's worth" issues and the appropriate usages and limitations of this concept, see Leimer (1995).

[23] In 1992, Social Security provided 40 percent of the aggregate income of elderly units (married couples with at least one spouse aged 65 or older and nonmarried persons aged 65 or older). The average is deceptively low, because of the very large incomes of the wealthiest elderly. By income quintile, the Social Security shares of total income were 81, 77, 62, 46 and 20 percent. See Grad (1994), tables VII.1 and VII.5.

[24] In 1969, the elderly poverty rate was 2.1 times the overall poverty rate in the U.S. -- 29.5 percent to 14.2 percent. During and after a series of large increases in real Social Security benefits between 1969 and 1974, the elderly poverty rate and the ratio began long steady declines. By 1982, the elderly rate had fallen to 14.6 percent, lower, for the first time, than the overall rate, which had increased slightly to 15 percent. The elderly rate has remained below the overall rate ever since. In 1993, the elderly poverty rate was 12.2 percent, and the overall rate 15.1 percent. See Quinn (1987), table 10, and U. S. Bureau of the Census (1995: table C).

[25] See Jones (1995), p. 1.

[26] In the 1983 amendments, the Normal Retirement Age was legislated to increase from 65 to 66 for those reaching age 62 in the years 2000-2005, then remain at age 66 for 11 years, and then grow to age 67 for those reaching age 62 in years 2017-2021. The Ball plan, and many other proposals, would eliminate this 11 year hiatus.

[27] The ratio is even higher for women -- 4.4. These estimates exclude the disability, survivors and Medicare components of Social Security, and ignore those who died prior to receiving retirement benefits. See U.S. House of Representatives (1993), pp. 1293-1305.

[28] In 1980, although the expected benefit/contribution ratio declined with income, the absolute dollar size of the windfall gain (the present discounted value of benefits minus the value of the "invested" contributions) grew with income (ibid.).

[29] See Steuerle and Bakija (1994), figure 5.4 and table A.3. These estimates adjust for the probability of survival in each year after age 21, and include the value of expected spousal and survivors benefits. They ignore the disability and health insurance components of Social Security, both taxes and benefits.

[30] The minimum Social Security benefit was eliminated in 1982. The lower deck flat rate might depend on the number of years one had contributed, but not on the amount of covered earnings during those years.

[31] Current replacement rates (the ratio of Social Security benefits to the last year of earnings) are about 57, 43 and 25 percent for low-, average- and high-wage earners, respectively. Because of the increase in the normal retirement age (from 65 to 67) already legislated, which is nearly identical to an across-the-board benefit cut, the replacement rates are scheduled to drop to 49, 37 and 24 percent. According to Schieber, the replacement rates under the proposed double-decker system would be 56, 30 and 20 percent. The decreases at the average and upper-wage replacement rates are designed to help restore long-run fiscal integrity to the system.

[32] The Bipartisan Commission on Entitlement and Tax Reform (1994: 59-60) discussed a proposal under which individuals could choose to divert 1.5 percentage points of their (but not their employer's) Social Security contribution, and invest the proceeds in a personal retirement account. Those who chose this option would receive lower Social Security benefits upon retirement, with the exact decrease dependent on the age at which the initial (irrevocable) diversion began. In the Entitlement Commission's Final Report (1995:26), both the 1.5 percent

payroll tax decrease and the equivalent contribution to a personal retirement account were mandatory, and there was no decrease in Social Security benefits. These are all partial privatizations of the system.

33 The current public sector:private sector income mix for older Americans is about 40:60. According to Grad (1994: tables VII.1 through VII.5), aged units (65 or older) in 1992 received about 40 percent of their total income from Social Security (39.5%) and public assistance (0.9%). The remainder came from earnings (17%), asset income (21%), employer pensions (20%, including government employee pensions, considered "private sector" in this context) and other sources (2%).

The Social Security component increases with age (it is over 50% for those aged 80 or over), is higher for nonmarried persons than for couples (47% vs. 35%), is higher for blacks and Hispanics than for whites (48% and 45% vs. 39%), and declines dramatically by income quintile (81%, 77%, 62%, 46% and 20%).

As Gary Burtless argued at the Conference, the policy question is whether the public sector to private sector ratio should be moving up, moving down or staying about the same.

34 In 1950, employers and employees each paid 3 percent on the first $3,000 of covered earnings -- a maximum of $90 each per year. In 1995, each paid 7.65 percent of the first $62,100 (**get 1996 numbers**) -- a maximum of $4750 each -- and 1.45 percent each on all earnings above that (the Medicare tax).

35In 1993, total OASI expenditures (including administrative expenses) were $273b. (Social Security Disability expenses were an additional $36b.) Combined Medicare (HI and SMI: $154) and Medicaid ($126b; 57 percent paid by the federal government and 43 percent paid by state governments) expenditures totaled $280. See Social Security Administration (1994), tables 4.A1, 4.A2, 8.A1, 8.A2 and page 324.

36 Health care inflation has dropped significantly in recent years, down to 4.7 percent in 1994 and 3.9 percent in 1995, the lowest annual increase since 1972. These were still higher than the overall inflation rates of 2.6 and 2.5 percent. See Employee Benefit Research Institute, 1995b, p. 6, and the Boston Globe, 2/2/96, p. 28.

37 According to Moon and Mulvey (1996: 88-89), this may be one reason why Medicare and Medicaid are "on the table" in the current budget talks, and Social Security is not. Legislators can argue that they are cutting payments to (wealthy? less deserving?) health care providers, without seriously reducing services to the recipients. Whether the latter is true is certainly debatable.

38 Moon and Mulvey (1996: 87) call the medical benefits "lumpy." Certain types of care can be included or excluded, with discrete effects on total expenditures, but it is more difficult to pare outlays by a particular percent, as a change in the Social Security retirement benefit formula could easily do.

39 Two important components of Medicaid expenditure for the poor elderly are for long-term care (nursing homes) and the medical insurance (primarily Medicare) premiums and deductibles.

[40] See Friedland (1995), pp. 6 and 21.

[41] Judy Feder, lunch time remarks at the Conference.

[42] Moon and Mulvey (1996: chapters 5 and 6) discuss a wide range of incremental and fundamental reform options for both Medicare and Medicaid.

[43] See Friedland (1995), table 1.

[44] See Moon and Mulvey (1996:114-123) for a detailed discussion of the pros and cons of various types of structural change for the Medicaid program.

[45] According to Friedland (1995: 15), about 9 percent of Medicare beneficiaries were in managed care plans in 1994, and most of them were in urban areas in a small number of states. Twenty-eight states have almost no managed care enrollment.

[46] Out-of-pocket spending on health care and health insurance premiums equals about one-fifth of the income of all elderly, with the proportion falling with income (it is about one-third for those under the poverty threshold) and rising with age (about 30% for those aged 80 or older). See Moon and Mulvey (1996), table 2-11.

[47] See Grad (1994), table I.2. The percentage of aged beneficiaries who receive SSI is higher for nonmarried persons (8 percent) than for married couples (2 percent). The disregard is $20 per month.

[48] See U.S. House of Representatives (1994), p. 212.

[49] See Moon and Mulvey (1996), p. 157.

[50] Disability payments equal 100% of one's Primary Insurance Amount, and are not actuarially reduced for receipt prior to age 65 as retirement benefits are.

[51] See Baguette, Shapiro and Jacobs (1995), p, 422.

[52] See Reno and Friedland (1996). Similar support for Social Security is found in polls going back to the late 1970s. The level of confidence in the system's future fluctuates much more than its popularity, and seems to decline during times of public debate about the program, like the early 1980s (before the 1983 Amendments prompted by the Green span Commission) and now.

[53] See Friedland (1994), who suggests that a lack of information leads to a lack of confidence. Many people do not understand the financing of the system, and find it difficult to express confidence in something they do not understand. Many are still affected by the media coverage of the Social Security crisis of the mid-1980s, and are convinced that the declining ratio of contributors to beneficiaries means lower benefits ahead. (Only 24% of Americans responding

to a 1995 Retirement Confidence Survey were confident that "the Social Security System will continue to provide benefits of equal value to that of the benefits received by retirees today," down from 33% in 1992. The same percentage (24%) was confident that Medicare benefits would maintain their current value. See Employee Benefit Research Institute, 1995a, p. 10.) They are probably correct here, but this is a far cry from the common complaint that "Social Security will not be there for me."

54 It is worth remembering that intergenerational transfers can be altered by bequest behavior. The large windfall gains from current workers to current retirees may eventually be bequeathed right back to these workers. Some have argued that this is where much of current workers' saving is, in their parents' accounts, not (yet) in theirs.

55 See Employee Benefit Research Institute (1995c).

56 See Steuerle (1995) for this point, and for an extensive list of structural reform proposals.