CHAPTER 3

Economic Challenges of an Aging Population

IN 1993 THE ADMINISTRATION'S first job was to get the economy moving. The deficit reduction package enacted that year helped to reduce interest rates and restore business confidence. Since then the Federal deficit has been cut by more than half, and the economy has expanded robustly. The next task is to complete the work of deficit reduction. In 1995 and 1996 the Administration and the Congress both put forward plans to balance the Federal budget, but could not reach agreement at that time. The Administration is now submitting another proposal to balance the budget while protecting important national priorities. Legislation should be enacted this year to accomplish this goal.

Balancing the budget in the medium term, however, is not the end of the story. The United States faces two important economic challenges now and after the turn of the century. First, without changes in current policy, as the baby-boom generation retires, entitlement spending, particularly for health care, will rise rapidly and budget deficits will increase. Second, the Nation needs to raise its overall rate of saving to improve long-term economic growth. These two issues are closely related. The President believes that action on these issues can come about only from a carefully considered, bipartisan process. This chapter discusses these challenges.

THE AGING OF THE POPULATION

The proportion of the elderly in the U.S. population will rise sharply in coming decades. This aging of the population is the inevitable result of a long-term decline in fertility rates and an enormous improvement in life expectancy.

Over two centuries, the fertility rate—the number of children that an average woman will bear over her lifetime—has declined fairly persistently, from 7.0 in 1800, to 3.6 in 1900, to roughly 2.0 today (Chart 3–1). The post-World War II baby boom and the immediately preceding baby bust, associated with the Great Depression and World War II, were temporary aberrations in a long-run trend of declining fertility. As the baby boom ended, the fertility

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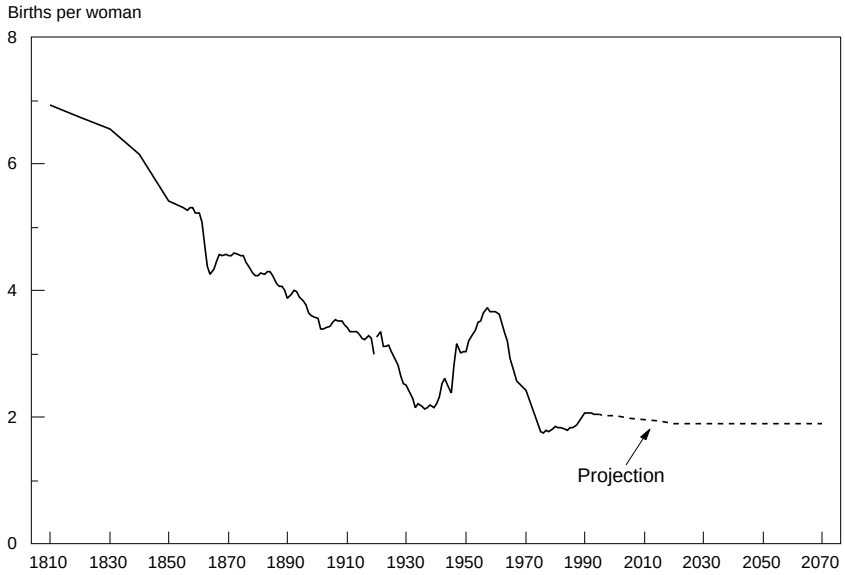
rate resumed its decline, reaching a low point of 1.7 in 1976 before rebounding to roughly 2.0 in recent years.

Chart 3-1 **Total Fertility Rate**
The total fertility rate has been falling steadily over time, with the exception of the post-World War II baby boom.



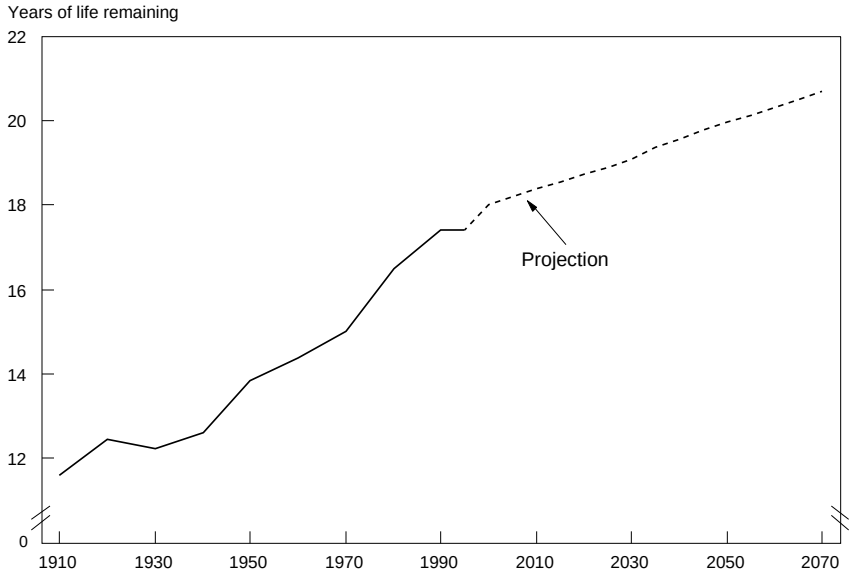
Note: The total fertility rate is the average number of births per woman during childbearing years. Data prior to 1920 are for whites only.
Sources: Data prior to 1920: Coale, A. and M. Zelnick (1963), "New Estimates of Fertility and Population in the U.S.;" 1920-1969: Department of Health and Human Services; 1970-2070: Social Security Administration.

The sequence of baby bust and baby boom thus has no impact on the elderly dependency ratio (the ratio of elderly Americans to those of working age) projected for 2070 and beyond; it does, however, alter the path to that ultimate ratio, and this has important implications for the medium term. The baby bust will produce a relatively constant ratio of retirees to workers over the next 15 years, as the small cohort born in the 1930s and 1940s reaches retirement, but the baby boom will produce a rapid swelling of the ranks of retirees after about 2010, as the large cohort born in the period from 1946 through 1964 retires.

Gains in life expectancy have been just as dramatic as the decline in fertility but have shown less fluctuation over time. In 1935, when Social Security was enacted and the retirement age was set at 65, life expectancy at 65 was about 12 years for men and 13 years for women (Chart 3–2). Today those figures are 15 years and 19 years, respectively, and by 2070 they are projected to be 18 and 22. The probability that a young adult just entering the workforce will survive to collect benefits has also risen dramatically. In the mid-1930s the probability of a 20-year-old man surviving to age 65 was only 58 percent, and that for a woman 66 percent. By the mid-

1990s these fractions had increased to 77 percent and 87 percent, respectively, and by 2070 they are projected to rise to 86 percent and 92 percent.

Chart 3-2 **Life Expectancy at Age 65**
Life expectancy has risen steadily and substantially throughout the 20th century. This rise is expected to continue.



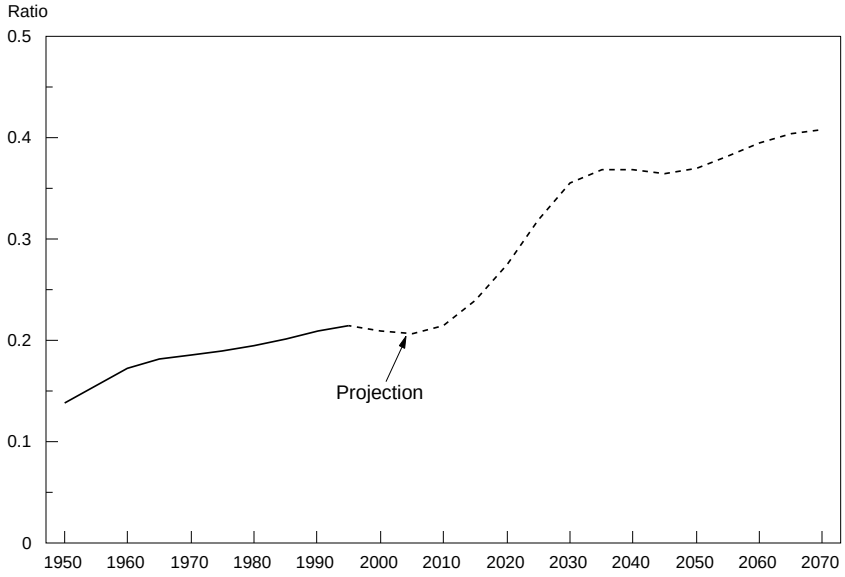
Sources: Data prior to 1995: Department of Health and Human Services; 1995-2070: Social Security Administration.

Declining fertility and mortality together produce a permanent increase in the elderly dependency ratio (Chart 3–3). Most of the increase in this ratio occurs by the time the last of the baby-boomers retires around 2030; the ratio drifts only slightly higher thereafter.

THE IMPACT OF DEMOGRAPHICS ON NATIONAL SAVING

Demographics can affect future national saving through effects on personal saving and on public saving. The first effect is captured in the simple life-cycle model. In this model younger people are expected to save some of their income in anticipation of retirement, and older people are expected to dissave—that is, to spend more than their income. According to this theory, the shift in the elderly dependency ratio should produce a dramatic increase in dissavers relative to savers, substantially reducing national saving. Even if the elderly do not dissave but only save at a lower rate than the

Chart 3-3 **Dependency Ratio of the Aged**
The ratio of retirees to individuals of working age will remain roughly constant through 2010, rise rapidly until 2030, and then increase slightly thereafter.



Note: The dependency ratio is population age 65 and over divided by population age 20-64.
Source: Social Security Administration.

working-age population, these demographics would be expected to affect national saving.

Given the already low U.S. saving rate, this prediction of the life-cycle model is a source of concern. The evidence, however, suggests that demographics may not be as important a determinant of saving patterns as the theory suggests. For example, several studies of individual behavior have been unable to document dissaving among the elderly. And during the 1980s the aggregate saving rate was quite low, even though the life-cycle model says that it should have risen because the increase in the proportion of the population in its prime saving years swamped the increase in the proportion that was old. Some simulations predicted that the personal saving rate should have been as high as 12.8 percent in the 1980s; instead it averaged 4.3 percent. Economists have been at a loss to explain much of the behavior of personal saving during the 1980s. (In fact, it is difficult enough to explain variation among households at a given point in time. One study using a variety of variables and models was able to explain only 7 percent of the total variation in the level of saving among households reported in the Federal Reserve's Survey of Consumer Finances.)

However uncertain the impact of demographics on *private* saving, its likely impact on *public* saving—unless significant changes are made in programs for the elderly—is clear. Growing deficits in the

Social Security program and the increasing costs of Medicare and Medicaid will tend to raise Federal outlays—that is, they will reduce government saving for any given level of revenue. Some economists have argued that lower government saving might cause an offsetting rise in private saving, as individuals anticipate an eventual rise in taxes due to the government's chronic failure to save. However, evidence for such a large offset is lacking. Thus, the most likely effect of demographically driven expenditure increases would be a net reduction in national saving.

THE IMPACT OF DEMOGRAPHICS ON THE BUDGET

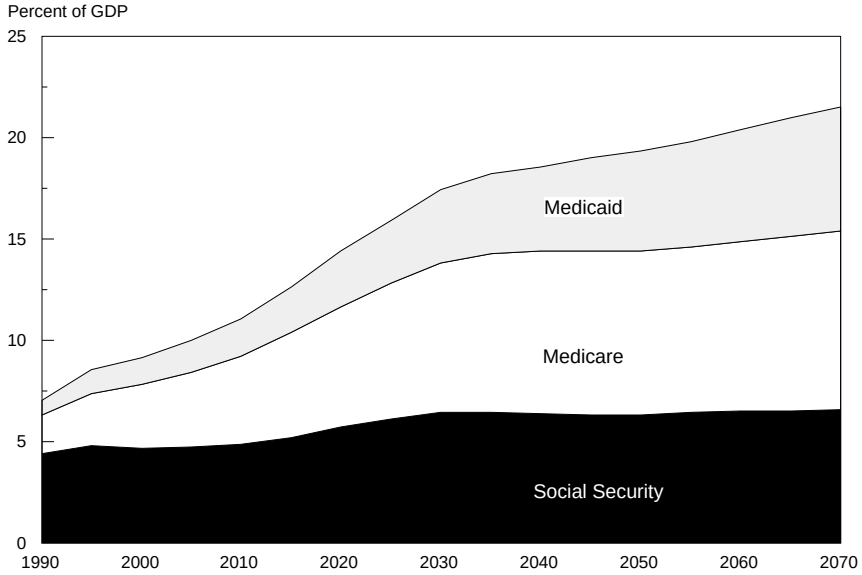
Without changes in policy, the costs of government programs that provide the elderly with retirement income and insure their health and nursing home care will rise rapidly as the number of elderly increases. In addition, social insurance taxes and contributions are likely to be pinched somewhat, because the number of people working—and paying taxes—will be growing more slowly.

The largest increases in programs benefiting the elderly are projected to be for Medicare and Medicaid. The Trustees of the Medicare program project spending to increase from 2.7 percent of gross domestic product (GDP) in 1996 to 8.1 percent in 2050. The Office of Management and Budget projects that under current policy Federal Medicaid outlays will rise from 1.2 percent of GDP to 4.9 percent over the same period. And the Social Security Trustees estimate that spending will grow from 4.7 percent of GDP to 6.3 percent between 1996 and 2050. This is a smaller increase, both absolutely and relative to current levels, than that projected for the health programs. Nevertheless, in combination, these forecasts suggest a more than doubling of expenditures on these key programs, from under 9 percent of GDP to roughly 19 percent in 2050 (Chart 3–4). By 2070 expenditures for the three programs are expected to reach 22 percent of GDP.

By contrast, Federal revenues have historically been around 18 percent of GDP. Hence, absent any changes, expenditures on Social Security, Medicare, and Medicaid could consume all government revenues by 2050 and exceed them thereafter.

The effect of these rising expenditures on the unified Federal deficit—the broadest measure of the deficit, which includes these programs and all other revenues and spending—is even more powerful than these numbers suggest: deficits in the early years must be funded with borrowing, and the interest on that borrowing will require even larger outlays in later years. Most long-term budget projections based on current policy show the deficit mounting to around 20 percent of GDP by 2050, while the debt held by the public reaches a level somewhere between two and three times GDP.

Chart 3-4 **Growth in Entitlement Spending**
Federal expenditures on Medicare and Medicaid are projected to increase rapidly over time as a percent of GDP, with slower projected growth in Social Security spending.



Note: Medicaid expenditures after 2050 are projected by the Council of Economic Advisers.
Sources: Social Security Administration, Department of Health and Human Services, Office of Management and Budget, and Council of Economic Advisers.

In fact, no one believes that the economy could withstand such large deficits and increases in debt, with their adverse effects on interest rates and growth. Something will be done before the deficits and debt reach these levels. The only questions are what will be done, and when. Delay has two consequences. First, as already noted, borrowing to cover shortfalls in the near term boosts later deficits as interest charges accumulate. Second, any reform that is adequate to the problem will need to be phased in gradually, to allow citizens time to adjust their personal financing plans accordingly. Thus, the most useful exercise is to examine the financial situation of each individual program separately and explore the various approaches to restoring balance.

SOCIAL SECURITY

Of the several financing problems to be solved, that of Social Security is the most tractable. Without changing current law in any way, Social Security can pay full benefits well into the next century. Thereafter, without any changes in the structure of the program, funding will be sufficient to cover about 70 percent of benefits even 75 years from now. Nevertheless, the program faces a funding gap over the 75-year projection period and permanent imbalance after 75 years. The challenge is to restore balance to the

program, raise national saving, and allow Social Security to continue to fulfill its many missions.

For almost 60 years, Social Security has provided elderly Americans with a basic level of retirement security. Currently, about 90 percent of "aged units"—married couples one of whom is aged 65 or older, and nonmarried persons aged 65 and over—get Social Security benefits. These benefits are the only form of retirement pension for about half of these households. Social Security is particularly important for the low-income elderly. For example, more than three-quarters of the money income (which includes earnings from work and interest, as well as retirement benefits) of households in the bottom two income quintiles comes from Social Security benefits. The comparable shares are about a quarter for the highest income quintile and about half for the second-highest.

Social Security benefits keep some 15 million people above the poverty line and millions more from near poverty. As recently as 1959, when these data began to be collected, the poverty rate among the elderly was more than twice that for the rest of the adult population. Since then this rate has trended lower and is now slightly below that for other adults. Social Security has been a key factor behind this drop. Moreover, although the benefit schedule is progressive and some benefits are subject to partial taxation, Social Security benefits are not subject to an explicit means test. The lack of means testing allows many people to add other resources to their Social Security benefits and achieve a level of income not too far below that when they were working.

Social Security also provides protection against loss of family income due to disability or death. Roughly 5 million disabled adults and 3 million children receive monthly benefits; about half the children receiving benefits have lost one or both parents. In short, Social Security is an extremely valuable program that has raised the living standards of millions of Americans and markedly increased their sense of economic security by providing fully indexed annuities in the event of retirement, disability, or death of a breadwinner.

THE SIZE OF THE PROBLEM

In their annual report, the Trustees of the Social Security system publish projections of the system's revenues and outlays for the next 75 years. Three sets of projections are made, corresponding to three sets of assumptions about future levels of system costs. The intermediate cost projections in the 1996 report show that, from now through 2011, the Social Security system will bring in more money than it pays out. That is, payroll tax receipts plus receipts from income taxation of Social Security benefits will exceed outlays.

By that time the baby-boomers will have begun to retire, and growth in the labor force will slow, reflecting the decline in the fertility rate that occurred after 1960. The resulting increase in the ratio of retirees to workers will cause the outlays of the system to rise above taxes. In the relatively short period from 2012 through 2018, the annual interest income on assets in the Social Security trust funds will, together with tax receipts, produce enough revenues to cover benefit payments. After that, if no action is taken, total income will fall short of benefit payments, but the shortfall can be covered by drawing down trust fund assets until the funds are exhausted in 2029. Of course, the exhaustion of the trust funds does not mean the end of Social Security benefits. Even if no changes are made on the tax or the benefit side of the equation, payroll and benefit taxation at current rates will provide enough money to cover 75 percent of promised benefits in 2040 and nearly 70 percent in 2070.

The financing of Social Security is projected to put increasing pressure on the Federal budget before the trust fund balances are exhausted, however. In the near term, Social Security reduces the annual unified budget deficit. The amount of that reduction and the number of years it encompasses depend on the budgetary treatment of interest payments from the Treasury to the Social Security trust funds. For example, Social Security income, excluding interest, exceeded Social Security outlays by $30 billion in fiscal year 1996. Thus, the effect of Social Security's *current* operations was to lower the deficit by $30 billion. This operating surplus remains at about that level for about a decade, then drops sharply. As noted earlier, by 2012 Social Security outlays exceed taxes. However, in 1996 the Treasury also paid more than $36 billion in interest to the Social Security trust funds, and this interest can be viewed as payments that the Treasury would have had to make to the public were it not for *past* Social Security surpluses. If they are included in the calculation, one can say that the current and past operations of the Social Security system shaved $66 billion from the unified budget deficit in fiscal year 1996. By this measure, the deficit-reducing effect of Social Security is projected to rise to more than $100 billion in less than a decade, remain above that level for more than 10 years, and then drop rapidly. Regardless of the treatment of intragovernmental transfers, by 2019 outgo exceeds income. Between 2019 and 2029, the subsequent shortfalls can be met by drawing down the investments in the trust funds, but this puts pressure on the unified deficit. This pressure gets progressively worse over time. Using the broader measure of Social Security's contribution to the unified deficit, Social Security currently reduces the deficit by nearly 1 percent of GDP, but by the time the trust

funds are exhausted in 2029 it will boost the deficit by nearly 1.5 percent of GDP.

When the Social Security surpluses in the early years are combined with the deficits in the later years, projected income falls short of projected benefit payments over the 75-year forecast period as a whole. Projecting the size of this shortfall over such a long horizon is very difficult. One measure provided by the Social Security Trustees, based on their intermediate assumptions, is that the 75-year deficit amounts to 2.19 percent of taxable payroll over that period. One way to think about a deficit of this magnitude is in terms of the hypothetical tax increase that would be required to eliminate it. That is, if the gap over the next 75 years were to be financed solely by raising taxes, today's combined employee-employer tax rate of 12.4 percent would have to be raised to 14.6 percent right away. No one proposes to meet the deficit in this way, but it provides a way to think about the solvency problem.

Social Security's long-term financing problem is somewhat more complicated than just described. Under current law the tax rate is fixed while costs as a percentage of payroll are rising, and this pattern produces surpluses now and large deficits in the future. As a result of this profile, each passing year adds another year with a large projected deficit to the 75-year projection period. Assuming nothing else changes, this phenomenon increases the projected 75-year deficit slightly (by 0.08 percent of taxable payroll with today's projected deficits) each year.

How Reliable Are the Projections?

Projecting costs for the next 75 years is necessarily an uncertain exercise. Imagine actuaries and economists in the Harding Administration trying to project fertility rates, life expectancies, wages, and so on from 1922 until the present. They would have had no idea about the coming Great Depression, World War II, or a host of other demographic, economic, and social developments. Nevertheless, such long-range planning is a useful exercise. Precisely because Social Security is such a long-run program, major demographic trends are important factors in its solvency. Short-run fluctuations in, say, fertility or mortality rates will not fundamentally alter the long-run financial picture. The usefulness of the exercise depends crucially, however, on the reasonableness of the underlying assumptions and on the ability to modify them as new information becomes available. The actuaries' calculations involve numerous variables, but two demographic assumptions and one economic relationship are key.

On the demographic side the primary issues are fertility and mortality; fluctuations in immigration and emigration are expected to have only modest effects. Fertility tells us how many people will be in the labor force paying taxes, and mortality how many people

will be receiving benefits and for how long. As already noted, the total fertility rate is currently about 2.0 children over a woman's lifetime. Demographers generally believe that U.S. fertility rates, like those in most other industrialized nations, will remain low. The intermediate estimates in the 1996 Trustees' report are based on the assumption that the total fertility rate in the next 75 years will be 1.9 children per woman, slightly below its recent level. The consensus is that mortality will continue to decrease; the question is how fast. For the 75-year projection, life expectancy at 65 is projected to reach 18.4 years for men by 2070 and 22.2 years for women.

On the economic side the important variables relate to changes in wages and prices. The system operates more or less on a pay-as-you-go basis, whereby taxes currently received from workers are used to pay old-age, survivors, and disability insurance (OASDI) benefits to current beneficiaries. In 1997, workers and their employers each pay taxes of 6.2 percent on the first $65,400 of earnings. Benefits are calculated by applying a progressive benefit formula to an average of the beneficiary's historical earnings, which have been indexed to reflect overall increases in average wages. After benefits are awarded, they are adjusted annually to keep up with inflation. In this type of pay-as-you-go system, a key relationship is the difference between the rate at which tax revenues rise (which, assuming no change in tax rates, is equivalent to growth in covered wages) and the rate at which benefits increase after retirement or disability (that is, the rate of increase in the consumer price index, or CPI). This difference is called the real-wage differential.

The assumption about the size of the real-wage differential is often viewed as the most controversial in Social Security forecasting, as the actual value has varied dramatically over time. During the 20-year period before 1973, when productivity growth was high, the real-wage differential averaged 2.2 percentage points. From 1973 to the present, however, it has averaged 0.3 percentage point. The question is how much weight to put on recent years as compared with the pre–1973 period. The Trustees have roughly split the difference and adopted a long-run assumption of 1.0 percentage point. What if they are wrong? By how much would a real-wage differential of 0.6 percentage point (the average for the 1980s and 1990s), rather than the assumed 1.0 percentage point, raise the 75-year deficit? Sensitivity analysis shows that such a miscalculation would increase the 75-year deficit by roughly 0.5 percent of taxable payroll. In other words, a relatively large error in this assumption, taken in isolation, would worsen long-term Social Security financing by a relatively modest amount during the next 75 years.

Of course, if a large number of assumptions all turn out optimistic, or all pessimistic, their cumulative effect could be quite large. The Trustees' reports show the results for two extreme cases: a "high-cost" alternative in which all of the main assumptions take pessimistic values, and a "low-cost" projection that assumes optimistic values. According to the 1996 report, under the high-cost alternative, the 75-year balance is in deficit by 5.67 percent of taxable payroll, more than twice the 2.19 percent deficit under the intermediate assumptions. In contrast, the balance under the low-cost assumptions is a small surplus of 0.46 percent of taxable payroll.

These two projections give a sense of the level of uncertainty about the long-term projections. Nonetheless, a 1994–95 Technical Panel to the Quadrennial Advisory Council on Social Security evaluated each individual assumption and concluded that, "The 'intermediate' projection . . . for the OASDI program provide[s] a reasonable evaluation of the financial status. Although the Panel suggests that modifications be considered in various specific assumptions, the overall effect of those suggestions would not significantly change the financial status evaluation."

In 1983 the Congress enacted legislation based on the recommendations of the National Commission on Social Security Reform. The Commission's reforms were intended to keep the Social Security system solvent for 75 years, with positive trust fund balances through 2060. Only a year later, however, the Trustees began to project a small deficit. The projected deficit has grown more or less steadily since then, to its current level of 2.19 percent of taxable payroll. How did this happen?

Three factors account for most of the projected increase in long-range costs. The first one was discussed earlier. That is, as time passes, the 75-year valuation period ends in a later year, so that more of the higher cost outyears are included in the projections. Including more deficit years raises the 75-year deficit. The second is that the disability caseload grew much faster than anticipated, primarily because of legislative, regulatory, and judicial action that made it easier for individuals to qualify for disability benefits. The third source of the post–1983 deficit reflects the net effect of one-shot changes in the methodology used in the projections.

Changes in economic and demographic assumptions are not on balance responsible for the reemergence of the deficit since 1983. Most of the discussion of Social Security's financing problems is couched in terms of the demographic shifts that will occur as the baby boom ages. Indeed, the numbers are impressive: whereas today 3.3 workers support each retiree, by 2040 that number drops to 2.0; it stabilizes around 1.8 in 2070. The problem with this story is that the projected decrease in the ratio of workers to retirees,

frequently cited as the cause of the emerging deficit, is little changed from 1983. This decrease was fully incorporated in the estimates at that time. Demographic developments since 1983 have been, if anything, positive—at least from the program's perspective. Life expectancy is lower and birth rates have been higher than were assumed in 1983, thereby reducing long-range costs. The positive impact on long-range costs from changing demographic assumptions was roughly offset, however, by changing economic assumptions. In particular, the Trustees gradually lowered the assumed rate of real wage growth as it became clear that the slower trend in productivity growth was likely to continue. On balance, the economic and demographic changes have roughly offset one another.

RECOMMENDATIONS OF THE QUADRENNIAL ADVISORY COUNCIL

The Quadrennial Advisory Council on Social Security was charged in 1994 with finding ways to eliminate the current deficit in the OASDI program. It released its report in January 1997 after more than 2 years of deliberations. Instead of offering a single set of consensus recommendations, this 13-person panel split and presented three very different visions for the future of the Social Security system.

All three are designed to restore 75-year balance, stabilize the trust funds in the 76th year, and address the decline in the rate of return to Social Security contributions that has occurred as the system has matured. It is important to remember that, although the Advisory Council distilled these three specific sets of options, many alternatives are possible. The report characterizes the three alternatives as the "Maintenance of Benefits," "Individual Accounts," and "Personal Security Accounts" proposals. The following descriptions are summaries of the three proposals and should not be viewed as endorsements of particular approaches.

The Maintenance of Benefits Proposal

The Maintenance of Benefits (MB) plan is designed to eliminate the Social Security deficit without altering the basic nature of the program. Roughly half the savings comes from long-discussed—but never accepted—proposals. These include extending coverage to State and local government employees hired after 1997 who under current law would not be covered by Social Security; making Social Security benefits taxable to the extent that they exceed worker contributions (this would make the program comparable in that respect to other contributory defined-benefit plans); lengthening the averaging period for the Social Security benefit calculation from 35 years to 38 years; and incorporating technical corrections in the CPI made by the Bureau of Labor Statistics in 1995 and 1996,

which reduced the upward bias in measured inflation by about 0.2 percentage point per year. These proposals are expected to eliminate about half of the 75-year deficit.

To reduce the rest of the financing gap MB proponents suggest three new proposals. The first is to explore the possibility of investing 40 percent of trust fund assets in corporate equities on a graduated basis beginning in 2000. The implications of such a change are discussed in greater detail below. Second, the plan would redirect into the OASDI fund the share of revenues from the taxation of Social Security benefits that are currently paid into the Medicare hospital insurance trust fund, phasing in the change between 2010 and 2019. Finally, to correct the tendency of the fund to drift out of balance, this plan would, if necessary, increase the payroll tax by 0.8 percentage point each on employers and employees starting in 2045.

The Individual Accounts Proposal

The Individual Accounts (IA) plan has two components: it would make certain changes to balance the existing program, and it would create a system of supplementary required savings accounts for all participants. The first part of the plan begins with three proposals that are also in the MB plan: coverage of newly hired State and local government employees, taxation of benefits that exceed contributions, and incorporation of the CPI changes. In addition, the IA plan would raise the normal retirement age to 67 faster than under current law and index it to longevity thereafter. Finally, benefits for middle- and upper-income recipients would be cut by roughly 20 percent to allow the current 12.4 percent payroll tax rate to cover the program's 75-year cost.

The mandatory savings portion of the IA plan would increase the employee's payroll contribution by 1.6 percentage points to fund government-administered individual accounts, beginning in 1998. Proponents of the IA proposal recommend that the funds in these accounts be allocated by workers to a relatively small number of government-managed index funds, which would provide a variety of investment alternatives at low cost. At retirement, the savings would be paid out as an annuity, with payouts adjusted for inflation, and added to the regular Social Security benefit. Total retirement benefits would thus depend on the returns achieved by the savings accounts.

Supporters of the IA plan argue that it would directly boost funding for retirement (although they acknowledge that individuals might reduce their non-Social Security saving to some extent). In terms of national saving, they view it as superior to increased funding through the Social Security trust funds because they fear that annual surpluses in the trust funds would simply be used to cover deficits in the non-Social Security part of the budget. They also be-

lieve that adding an individual account component is a way to introduce equity investments without raising all the issues associated with direct investment of Social Security in stocks, as suggested in the MB plan. It should be noted that under the proposal the accounts would be held by the government, and the government would constrain the range of investment alternatives in the individual accounts.

The Personal Security Account Proposal

The Personal Security Account (PSA) plan calls for a more extensive change in the structure of the system, phased in over a period of time. It would divert 5 percentage points of the 12.4 percent payroll tax into mandatory "personal security accounts." Unlike the individual savings accounts described above, which would be held by the government and annuitized upon retirement, these accounts could be placed with private investment companies, and individuals would have broader choice over how the savings are paid out during retirement. The remaining 7.4 percentage points of the payroll tax would pay for a flat retirement benefit for full-career workers equivalent to $410 a month in 1996 (and indexed for future wage growth beginning in 1998) and for reduced disability and survivor benefits. The $410 flat benefit by itself would provide an income about one-third below the poverty line for an elderly person living alone; the proceeds of the personal accounts would supplement the flat benefit.

The plan also would reduce the financing gap through many of the same features as the MB and IA proposals: it would expand coverage to newly hired State and local government workers, alter the taxation of benefits, speed up the increase in retirement age and index it to longevity (as in the IA proposal), and incorporate adjustments made to the CPI.

Social Security has, for the most part, operated on a pay-as-you-go basis, with benefits coming from workers' current contributions rather than from accumulated trust fund savings. Therefore moving to personal accounts to the extent provided for in the PSA plan would require the handling of substantial transition costs. Today's younger workers not only would have to support those already retired or nearing retirement, but would also have to contribute to a savings account for themselves. The PSA plan spreads these costs over 72 years, paying for them with a tax equal to 1.52 percent of payroll during this period. Because a level tax rate is used to finance the transition, the plan is underfunded in the early years and overfunded in the later years. This smoothing of the transition costs requires that the trust funds borrow roughly $2 trillion in 1995 dollars from the Treasury between now and 2035, repaying this debt with the proceeds of the 1.52 percent tax thereafter.

Supporters of the PSA proposal claim three main advantages over the others. First, their proposal would lead to greater national saving and investment by fully funding in advance a major component of the Social Security system. Second, it would avoid the potential for politicizing the investment decisions that they believe could arise with direct trust fund investment in equities. Third, they believe that private accounts would increase confidence in the system.

ISSUES FOR FURTHER STUDY

The Advisory Council's three proposals differ on a variety of dimensions and raise a host of issues that need to be considered. These issues include:

- the social insurance that Social Security provides in addition to retirement benefits
- the issue of defined benefits versus defined contributions
- the effect of Social Security on national saving
- the desirability of further changes in the normal retirement age
- the rate of return on Social Security contributions (the "money's worth" issue), especially for younger workers
- the risks and benefits of investing a part of the Social Security trust funds in equities
- the relative importance of other structural features of the Social Security system, and
- other considerations.

Social Insurance

Social Security plays an important role not only in providing retirement pensions but also in offering social insurance features that are of great value to both individual households and the Nation. The design of the reforms will determine the extent to which the system can continue to provide progressive benefits and other social insurance components.

At the beginning of our careers none of us know whether we will be financially successful or will have to struggle to make ends meet, or whether we will die early and leave behind a family, or become disabled, or live long into retirement. Social Security has an important redistributive dimension, whereby those with low lifetime incomes receive higher returns on their contributions than their higher paid counterparts. Social Security was intended to free the elderly from poverty, and in that it has made great progress (see Chapter 5). Social Security also offers protections against other risks. For example, it provides income for disabled workers and benefits to deceased workers' families. Public attitudes toward maintaining these protections will play an important role in evaluating the Advisory Council's proposals and other options.

Defined Benefits Versus Defined Contributions

The current Social Security system is a defined-benefit plan, whereby the insurer—in this case the government—guarantees a benefit based on a prescribed formula. Under the MB proposal Social Security would continue to be a defined-benefit plan, but under the IA plan, and to an even larger degree under the PSA plan, a portion of Social Security would become a defined-contribution plan. A defined-contribution plan is one in which the insurer prescribes periodic contributions, and the size of the benefit depends on the size of the contributions and the returns they earn.

Proponents of a move toward a defined-contribution arrangement cite several possible advantages. First, they assert individuals would be more directly involved in the investment of their funds, which may allow them to make investment choices that more closely match their preferences for risk and other investment features. Second, they believe that by creating a more direct link between contributions and benefits, defined-contribution plans may alleviate some labor market distortions of the current system. Finally, proponents argue that giving workers ownership rights over their contributions reduces political uncertainty surrounding the future level of benefits.

Critics of this approach claim that the primary result of a shift toward defined-contribution plans would be to transfer risk from the government to the individual. Payments under this system would depend on the performance of the investments selected. Individuals might opt for all low-yielding investments and end up with much less than anticipated, or load up with high-risk assets and be forced to claim benefits at a market low. In addition, critics claim that returns on contributions would be hurt by relatively high administrative costs: the Advisory Council estimates that administrative costs for PSAs would be about 1 percent of invested assets annually, as opposed to just 0.1 percent for the IA plan accounts and less than 0.01 percent for the MB plan. Some critics are also concerned that, if participants are not required to annuitize their withdrawals, some might underestimate the amount of money they need over their retirement years and use the funds for other purposes. Private annuities should help alleviate this problem, but so far the market is underdeveloped, in part because of adverse selection problems (see Box 3–1 later in this chapter). Finally, one of the major arguments cited in favor of defined-contribution plans in the private sector is portability, but Social Security already follows workers from employer to employer.

The Effect of Social Security on National Saving

When thinking about the impact of the Social Security system on national saving, it is useful to consider three time periods: the system's startup phase, the current mature system, and the future.

The Startup. The Congress enacted the Social Security legislation in 1935. Payroll taxes were first collected in 1937, and the first monthly benefits were paid in 1940. In 1939 the Congress made a series of decisions that slowed the buildup of reserves, and the system has operated mostly on a pay-as-you-go basis since then.

This meant that the first generation of retirees received benefits far in excess of their tax payments. According to the life-cycle model, whereby individuals or households plan to consume all their income and wealth over their expected lifetimes, such an increment to lifetime income would increase consumption and reduce saving. That is, workers would perceive that they have received a wage increase in the form of a future annuity, and they would choose to consume part of that increase in the present. To increase their current consumption, they would have to either reduce saving or increase borrowing. Lower personal saving, without any offsetting accumulation of reserves within the Social Security system, would be expected to reduce national saving and leave future generations with a lower capital stock than they otherwise would have had.

A great many other things were happening in the economy at the same time Social Security was introduced; therefore isolating the program's effect on national saving is a daunting task. This might explain in part why a thorough review of the literature shows no compelling evidence of a sharp decline in saving in the wake of the introduction of Social Security. On the other hand, several plausible explanations are possible for the lack of any impact on saving. The first is that Social Security may have changed retirement expectations at the same time that it increased lifetime income. That is, before Social Security workers may have expected to work until they died, but *after* Social Security was enacted retirement at age 65 became the norm. To the extent that Social Security encouraged people to retire earlier, they may have chosen to save over a shorter working life for a longer retirement. This retirement effect would have increased personal saving. Similarly, before Social Security most elderly people lived with their children; after Social Security they were in a position to maintain their own households. The increased demand for independent living in old age could also have increased saving. Finally, many individuals save little or nothing at all, with or without Social Security. The only way they could have increased current consumption in response to the program's introduction would have been through borrowing. But these same individuals are likely to have had low or moderate incomes; as such, they may have been unable to borrow enough to achieve their ideal distribution of consumption over time. For such individuals, the introduction of Social Security would have left savings unaffected, dampening the effect on aggregate saving.

The Mature Pay-As-You-Go System. The existence of a mature pay-as-you-go Social Security system is one of many factors influencing the national saving rate. The permanent effect of a pay-as-you-go system on saving is determined primarily by its initial impact on saving and the capital stock; that impact then tends to be perpetuated through time. The permanent effect on the saving rate is thus likely to be small if the initial effect was small; similarly, the permanent effect is likely to be substantial if the initial effect was large. In addition, there is no reason to believe that the effect—whatever its size—will be exacerbated over time. Of course, it is still the case that a transition from a pay-as-you-go to a funded system could be expected to lead to some increase in the national saving rate and the capital stock.

The Future. Although the introduction of a pay-as-you-go Social Security system may not have had a discernible effect on national saving or the capital stock because of a variety of mitigating factors, moving toward a funded system could increase saving. This increase would reflect the lowered consumption of workers in the "transition generation," who pay the taxes to support benefits for the elderly while also saving for their own retirement. Even though the resulting increase in the saving rate is temporary, the higher capital stock is permanent. Once the transition to a fully funded system is complete, the saving rate is likely to drop back to near its level before the shift.

Prior to the question of whether particular changes in the Social Security system will increase national saving, however, is a more basic question: is this the best way to raise saving, or should it be done through other means—for example, through reductions in the non-Social Security budget deficit? Even if it is determined that changes to the Social Security system are the best way to boost national saving, that decision does not resolve the issue of how best to structure the program. The effect on national saving results from shifting Social Security further from a pay-as-you-go toward a funded system. This can be done through the trust funds—net of any offsetting effect on the non-Social Security portion of the Federal budget—or through individual accounts.

Raising the Retirement Age

Under current law, the normal retirement age is scheduled to increase in two steps from 65 to 67 years. It will rise gradually to age 66 for workers who attain age 62 in 2005, remain at age 66 for 11 years, and then start rising again to 67 for workers who reach 62 in 2022. Two of the Advisory Council's three proposals would raise the normal retirement age to 67 more quickly than scheduled under current law and then index it for increases in longevity thereafter.

The rationale for this change is that, since life expectancy has increased, so should the length of the work life. As was noted earlier, since Social Security was enacted in 1935, life expectancy at age 65 has increased by 3 years for men and 6 years for women. Moreover, these life expectancies are projected to rise by a further 3 years for both men and women by 2070. Proponents of a more rapid rise and indexation of the normal retirement age argue that a portion of these increases in longevity should be matched by additional years in the workforce. Increasing the retirement age would ease the pressure on Social Security financing by offsetting some of the increase in the elderly dependency ratio caused by the aging of the population.

Opponents of raising the retirement age offer two main arguments. First, greater longevity has not so far been accompanied by an increase in years worked; indeed, people are retiring earlier and earlier. Therefore, we should wait to see how people accept the currently scheduled increase to age 67. Second, opponents are concerned that accelerating the change in the retirement age would hurt those who are forced by poor health or lack of employment opportunities to retire before 65. The law already provides for an actuarial reduction in benefits of 20 percent for those who retire at age 62; this reduction will rise gradually to 30 percent with the scheduled increase in the normal retirement age to 67. Increasing the retirement age beyond 67 would reduce the age–62 benefit further still.

Two key issues emerge here. The first is empirical: how many people who retire at age 62 would find it a serious hardship to extend their work life? A preliminary analysis of early retirees shows them falling into two groups. One consists of relatively prosperous individuals with some wealth, who tend to be in good health. The other is made up of less wealthy, less healthy individuals, some of whom have irregular preretirement work histories. Raising the retirement age for the first group creates few problems; raising it for the second may well produce hardship. The second issue, therefore, is how to protect low-income individuals with no work possibilities. Those who cannot work because of physical disability might be eligible for disability insurance. Of course, a shift of early retirees to the disability insurance program would reduce the savings realized from the higher normal retirement age. A variety of options are possible, but any proposal to increase the retirement age should consider those unable to work the additional years.

The Rate-of-Return Issue

All three of the Advisory Council's proposals rejected an increase in current and future tax rates sufficient to establish long-term balance. In part this alternative was rejected because it would increase the costs of the program for current workers relative to the

benefits that they will receive. Current workers already face the prospect of making greater Social Security contributions relative to their lifetime earnings than was required of workers in the past without a fully compensating increase in their benefits. The consequent decline in the ratio of benefits to costs (commonly referred to as the "money's worth" ratio) is primarily the consequence of the maturation of a pay-as-you-go system. Workers retiring early in the program's history had only a few years of wages subject to the Social Security payroll tax. Over time, new retirees had more and more years of wages subject to taxation, and the additional tax payments sharply reduced the rate of return. The situation is actually somewhat more complicated in that benefit levels were raised several times over the period. Analytically, these increases in benefits can be seen as introducing new pay-as-you-go programs on top of the old, temporarily boosting returns. But the essence of the story is the maturation of a pay-as-you-go system.

In a mature pay-as-you-go system financed by a fixed tax rate on wages, the rate of return on payroll tax contributions depends on the rate of growth of aggregate real wages. Slower growth in aggregate real wage income, owing to slower population and productivity growth, has reduced the return that can be obtained from a mature pay-as-you-go system. Looking forward, with a constant or slow-growing working-age population, the rate of growth of aggregate wages will depend primarily on the rate of growth of productivity.

To address the problem of declining rates of return, all three plans at least consider allowing individuals to have some of their Social Security contributions invested in equities. Proponents of the Maintenance of Benefits approach suggest further study and evaluation of having the Social Security trust funds invest directly in equities. In the Individual Accounts proposal equity investments would be done through newly created private accounts, and the assets would be held by the government. In the Personal Security Account proposal individuals could invest in equities through individually owned and privately managed accounts. Because equities on average earn higher returns than other financial assets, proposals that produce the largest equity holdings yield the highest projected returns on Social Security contributions. Investment in equities also raises concerns about risk, as noted in the discussion of defined-benefit versus defined-contribution plans above, and in the following section.

Investing the Trust Fund in Equities

Proponents of the MB proposal suggest giving serious consideration to investing a share of the trust funds in equities. They argue that such investments are necessary to increase the return on the funds, which are currently invested entirely in Treasury securities. Both private pension plans and many State and local systems in-

vest a substantial portion of their assets in stocks. The Advisory Council estimates that investing 40 percent of the trust funds in equities could raise the ultimate projected return on trust fund assets from 2.3 percent to 4.2 percent. Proponents note that, if the higher returns on equities over long holding periods that have prevailed in the past continue, the change in investment strategy would extend the life of the trust funds, perhaps substantially.

Critics point out that investing a portion of the trust funds in equities would increase risk as well. Eight times in the last 70 years, a broad index of equity returns has declined by more than 10 percent over 1 calendar year; on three occasions the drop over a year or two was more than 35 percent. Such declines could cause anxiety among both retirees and those nearing retirement, undermine public confidence in the system, and possibly even lead to pressure to divest equities after a substantial drop. Proponents respond to this concern by arguing that, at least based on historical experience, the Social Security system is in a good position to wait out fluctuations in market value, particularly as the trust funds increase in size. Critics argue that the past may not be prelude and just as the last 15 years have seen an eightfold increase in the market, it is conceivable that the market could experience a dramatic multiyear decline. (For example, a broad index of Japanese stock prices fell more than 50 percent during the 1990–92 period.) Any proposal for equity investment must consider the consequences when markets fall.

Another criticism of allowing the trust funds to invest in equities is that such investments would primarily represent a reallocation of assets between those held in the trust funds and those held—either directly or indirectly—by households. It could improve the financial position of the trust funds, because of equities' historically higher average returns, but for a given level of saving it would not increase the returns for the Nation as a whole. Investing a portion of the trust funds in equities would raise the price and lower the return on equities, and lower the price and raise the return on Treasury securities. Higher Treasury yields would raise Federal interest costs and, all else equal, the non-Social Security portion of the deficit. No one can say with any certainty by how much interest rates on Treasuries would rise, and therefore what would be the likely impact on the deficit. (It should be noted that the MB plan incorporates other measures that do increase national saving; as a result, the net effect of that plan on the interest rates paid by the Treasury is ambiguous.) The analysis is complicated because the initial effects on rates of return could be moderated as corporations restructured their finances to take advantage of cheaper equity financing, and as international buyers increased their purchases of now-higher-yielding Treasury securities. The size of these

feedback effects is an important issue that would have to be explored in a thorough assessment of any equity investment proposal.

An additional set of issues involves the practical operation of the trust funds. For example, critics claim that political interference in investment decisions could hurt returns. Proponents argue, however, that this problem could be addressed by having the trust funds hold a broad portfolio whose performance mimics an index of the overall market. They suggest that an expert board could select, through competitive bidding, one or more private sector managers to achieve this end. An obvious concern, however, is that although such an arrangement could be implemented as part of a reform package, changes could be made later that would allow much political influence on investment policies. Another issue is how the government should vote the shares it holds. Proponents of the MB plan suggest that once the portfolio shift was complete, the trust funds' equity holdings would still be less than 5 percent of the market, but such projections are uncertain, and the actual share could well be higher. In any case, advocates of equity investments contend that so long as legislation provided that government shares were either not voted, or voted in the same pattern as other common shareholders, government ownership could be structured so as to not affect private control. Critics respond that, because this policy could be changed in the future, government-owned shares could allow the government to influence firms regardless of the protections in existing law. It is clear that the administrative aspects of investing in equities would require solving some tough problems.

Investing a portion of the Social Security trust funds in equities would be a dramatic departure from current procedure. All the considerations discussed above demonstrate that such a proposal would require careful scrutiny.

Structural Issues

Although the Advisory Council focused most of its attention on the financing aspects of the Social Security system, it recognized that the structure of the program also raises some equity and efficiency issues.

Household Composition. Under current law, Social Security benefits for spouses are equal to either the amount that they could receive on their own, or 50 percent of the benefits of the primary earner, whichever is greater. When the primary earner dies, the surviving spouse receives 100 percent of the primary earner's benefit. Married couples with a single earner do better under this system than unmarried single earners or two-earner married couples with similar earnings. The spouse's benefit was introduced at a time when most wives stayed home and cared for children; today, however, married couples in which both husband and wife work make up the majority of families. The Advisory Council's IA and

PSA proposals include reductions in benefits for nonworking spouses and increases in survivors' benefits when one member of a couple dies.

Effect on Labor Supply. As already noted, some Advisory Council proposals would increase the retirement age, but in general, issues of labor supply were not a focus. Social Security is thought to have little effect on the labor supply of younger workers for two reasons. First, although economists profess a range of views, most believe that labor supply generally is not very sensitive to changes in after-tax wages. Thus, to the extent that Social Security is viewed as a tax, the substitution effect, by which the lower after-tax wage discourages work in favor of leisure, is roughly offset by the income effect, whereby lower after-tax wages require individuals to work more to maintain their consumption. Second, to the extent that individuals view their Social Security taxes as a form of forced saving, those taxes exert even less of the modest disincentive effects usually associated with a tax.

It is possible that Social Security, in combination with private pensions and nonpension wealth, encourages retirement at age 62, the age of first eligibility. Economists remain divided, however, concerning the size of this effect. Most previous research has found little evidence to suggest that even substantial changes in the structure of Social Security would have much effect on the average retirement age as long as benefits continued to be available at age 62. Critics of this research argue, however, that it is difficult to capture the impact of large benefit changes with existing models. They also cite the increased generosity of Social Security benefits and the expansion of private pension benefits as a major reason for the shift toward age–62 retirement.

One Social Security provision that formerly provided an incentive to withdraw from the labor force was the sharp decline in the lifetime value of benefits for those who retire after age 65 as compared with the lifetime value for those retiring at age 65 or earlier. Although benefits have long been fully actuarially reduced for retirement *before* age 65, until 1983 no parallel provision was made for retirement *after* 65. The 1983 amendments will eventually raise the delayed retirement credit to a full actuarial adjustment of 8 percent a year for each year benefits are postponed after age 65; that credit will be phased in completely by 2008. Although the increase in the credit will increase the system's costs somewhat, it will remove a disincentive for postponing retirement beyond 65.

Other Considerations

The economic analysis presented earlier makes it clear that the impact of the Advisory Council's three proposals on national saving depends primarily on how benefits and contributions are changed. That is, the impact depends on how far the proposal would move

Social Security from a pay-as-you-go toward a funded system. Whether the accumulated reserves are held by Social Security trust funds or by individuals should, according to economic theory, have little impact on overall national saving. Therefore, the economics alone cannot explain why proponents of the various positions argue their cases so vehemently. Although the *Economic Report of the President* generally focuses on the economic aspects of issues, in this case some additional considerations raised in the Advisory Council's report need to be noted in order to understand the debate.

Proponents of individual accounts argue that economics is only half the story. They contend that "The IA plan provides...new saving and the MB plan does not." Since the MB plan does boost funding, this argument must be based on the assumption that either the public is unwilling to see large surpluses build up in the public sector or, if such surpluses emerge, they would be used to cover deficits in the rest of the budget. This has occurred since 1983, and IA supporters may view it as likely to continue in the future. Therefore, they conclude, the only way to increase national saving is to fund retirement saving through individual accounts.

Supporters of the PSA proposal also contend that investing the Social Security trust funds in equities would be harmful to the economy: "We believe that with the accumulation of such vast equity holdings...the pressures to use the funds for socially or politically 'desirable goals' would be tremendous, putting at risk not only workers' taxes and retirees' benefits, but also the allocation of capital in the economy."

Proponents of the MB proposal put much less weight on these arguments and instead focus on what they see as the dangers of moving toward individual accounts. First, in addition to the economic arguments advanced above, they foresee a good chance that funds in the IA and PSA accounts will not be held until retirement: "If the money is seen as belonging to the individual as it builds up during the worker's career, he or she will feel aggrieved if access to the funds is denied." They believe that "[E]xceptions will undoubtedly be sanctioned, and in many cases the individual's PSA funds will have been reduced or exhausted before retirement, with the individual left to rely on the low-level flat benefit." Second, they contend that even the more modest IA proposal contains the "seeds of dissolution": "...[A]s the plan developed over time, with beneficiaries doing less and less well under the reduced Social Security plan compared to individual accounts (at least those of the more successful investors), there would be every reason for many average and above-average earners, particularly, to press for further reductions in contributions to Social Security in order to make more available for their individual accounts. Thus, the IA plan is

inherently unstable, and could lead to the unraveling of the redistributional provisions that are so integral to Social Security and so crucial to its effectiveness."

Whatever weight one assigns to these political economy considerations, they help explain the strength of feeling about the future direction of Social Security.

CONCLUSION

Social Security retirement and disability benefits now equal 4.7 percent of GDP. According to the intermediate assumptions in the 1996 Trustees' report, outlays will amount to 6.6 percent of GDP in 2070. Although this is a substantial increase, it can be explained entirely by the growth in the elderly as a share of the total population. With no changes to current law, the Social Security system will be able to meet all of its obligations well into the next century, and a large portion of those obligations indefinitely. Nonetheless, the Social Security program is running a deficit over a 75-year projection period and faces a permanent imbalance thereafter. These long-term challenges to Social Security need to be addressed in a bipartisan manner, as was done in 1983. A variety of approaches should be considered, but any possible changes must also ensure that the benefits of reduced poverty and increased economic security for the aged and disabled are not put at risk.

MEDICARE

Medicare is the largest public health program in the United States. It covers virtually all Americans age 65 and older and most recipients of Social Security disability benefits. Since its enactment in 1965 it has contributed substantially to the health and well-being of older and disabled Americans. Medicare operates with relatively low administrative costs and enjoys widespread public support. Today, however, Medicare faces serious financing problems and continues to have important gaps in coverage. This Administration has taken significant first steps to address Medicare's short-term financing and has proposed additional reforms to strengthen Medicare's trust fund to 2007. This will provide more than enough time to establish a bipartisan process to develop additional reforms to guarantee the strength of the program for future generations.

Medicare presents a much greater challenge than Social Security, both in the magnitude of the projected deficits and in the complexity of the issues. Unlike with Social Security, reform involves not simply selecting among a list of plausible options, but rather figuring out how to control long-run costs and ensure the efficient

delivery of quality care in one component of a very complicated health care system.

Medicare is composed of two parts. Part A (hospital insurance) covers inpatient hospital services, care at skilled nursing facilities, home health care, and hospice care. Part B covers primarily physician and outpatient hospital services. Part A is financed by a 2.9 percent payroll tax, shared equally by employers and employees. Like their Social Security counterparts, the Medicare Trustees project the status of the hospital insurance trust fund over a 75-year period. These projections are highly uncertain given the time horizon and the difficulty in estimating future medical costs. Nevertheless, they constitute the best available estimate of the status of the Part A portion of Medicare. The projected 75-year deficit in Part A is more than twice the Social Security deficit in absolute terms, and many times larger relative to the size of the program. As a fraction of GDP, Part A expenditures are projected to triple over the next 75 years, from 1.7 percent in 1996 to about 5 percent in 2070.

Medicare Part A is also facing a pressing short-term problem. If no action is taken, the Part A trust fund is projected to be exhausted by 2001, and the gap between revenues and benefit payments widens very rapidly thereafter. Medicare reforms proposed by this Administration would extend the life of the Part A trust fund well into the next decade. Enacting these reforms is an absolutely necessary first step, but none of the current proposals completely solves the long-run problem.

Medicare Part B is financed primarily from general revenues and enrollee premiums. In 1996, premiums contributed about 25 percent of Part B income, with most of the remainder from general revenues. Although spending from this fund has grown rapidly, insolvency is not an issue, since general revenues are required to cover any shortfalls. However, the growth in Part B spending increases Federal expenditures and contributes directly to the unified deficit.

Reforming Medicare will require slowing the growth in health care prices and utilization. Since either Medicare or private insurance pays for most health care expenditures for the elderly, individuals have little incentive to seek out the most cost-effective delivery of medical care. Moreover, fee-for-service payment still dominates the Medicare market. Approximately 90 percent of Medicare beneficiaries have fee-for-service care, compared with fewer than 30 percent of the nonelderly. Hence, some Medicare providers may have an incentive to supply costly services that offer uncertain medical benefits. This potential misalignment of incentives is reinforced by the fact that the relative effectiveness of alternative

treatments is often poorly understood, and consumers generally rely on providers' recommendations.

For the nonelderly, any tendency toward overuse of medical services is increasingly kept in check by employers and their insurers. The dramatic movement toward managed care (discussed below) reflects determined efforts to ensure that health care is delivered in a cost-effective manner. Some working individuals may also have incentives to keep costs down because they face substantial out-of-pocket payments. These incentives may be muted for retirees, who frequently have virtually complete insurance coverage on a fee-for-service basis for an array of services.

In short, incentive issues are likely to be more important for Medicare than for Social Security. Any changes in incentives, however, must recognize the system's important advantages, such as the wide array of choices available to beneficiaries and their ability to continue longstanding relationships with physicians and other providers.

Moreover, altering incentives is not a call to reduce benefits. Discussions of Medicare are often framed as if the program were excessively generous and the problem one of cutting back. In fact, Medicare's coverage is less comprehensive in some ways than much private sector insurance. For example, Medicare does not cover prescription drugs and provides only very limited mental health benefits. Nor does Medicare place an upper bound on cost-sharing responsibilities for hospital stays, skilled nursing care, or physician services. As a result, participants who have long and complicated illnesses and lack insurance (called medigap insurance) to cover what Medicare does not may incur tens of thousands of dollars of out-of-pocket expenses. Thus, the challenge is not only to control the costs of the benefits currently provided by Medicare, but also to create some room for improvement in the benefit package.

SOURCES OF THE FINANCING PROBLEMS

The easiest way to understand the nature of Medicare's financing problems is to contrast Social Security with Medicare. Both programs provide a defined benefit—the one cash, the other insurance for a package of medical services—to roughly the same population: the aged and disabled. In recent years the Congress has not changed significantly either the population covered or the benefits provided under either program. (The 1988 Medicare Catastrophic Coverage Act added a drug benefit, limits on out-of-pocket expenditures, and an income-related premium to the program, but those provisions were repealed shortly after enactment.) Yet whereas Social Security is expected to remain solvent for more than 30 years and faces a relatively modest 75-year deficit, Medicare's hospital

insurance trust fund, as already noted, is projected to be exhausted in 2001 and to deteriorate rapidly thereafter, if no action is taken.

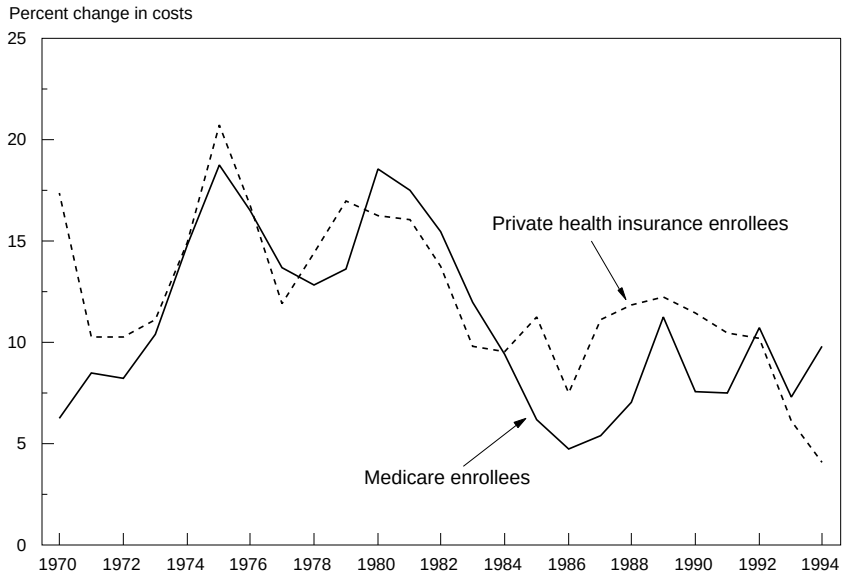
This very different outlook can be explained by two factors. First, whereas the cost of Social Security is precisely defined by the benefit provided, the cost of Medicare's bundle of health services depends on health care prices in the economy at large and the volume and intensity of services used by Medicare beneficiaries. Thus, even though the types of services reimbursed by Medicare have remained substantially unchanged, outlays have soared, as overall health care costs per capita (not just those paid for by the government) have risen at twice the rate of inflation. Second, as a result of these accelerating costs, Medicare financing has been aimed at staving off short-term insolvencies; Social Security, in contrast, was put in projected long-run actuarial balance in 1983. As a result, Social Security tax rates were set taking into account the upcoming retirement of the baby-boomers, while Medicare's Part A tax rates were set only to cover short-range outlays, and no prefinancing is provided for Medicare Part B. The result is that the demographic shifts looming after the turn of the century, when the baby-boom generation retires, have a much more profound impact on the long-run outlook for Medicare than for Social Security.

For most of Medicare's history, the increase in outlays per capita reflected the general rise in health care prices and a general increase in the volume and intensity of health services, rather than a particular problem with Medicare. As Chart 3–5 shows, Medicare and private health insurance costs per enrollee have tracked each other closely since the early 1970s, despite considerable year-to-year fluctuations. On a per-beneficiary basis, Medicare's average annual growth rate was actually lower than that of the private health insurance market between 1969 and 1994 (10.9 percent versus 12.2 percent).

For the last few years, however, health spending per capita in the private sector has slowed. One reason is rapidly increasing enrollments in managed care plans, but the slowdown is not limited to these plans. The growth of expenditures in private fee-for-service plans has also declined, as these providers have responded to the greater competition from the managed care segment of the market. Medicare spending has not slowed commensurately, in part because the current system for setting managed care payments probably raises rather than lowers program costs. Program costs have also been pulled up by rapid growth in services such as home health care that private insurance often does not cover.

Two other factors complicate Medicare reform. First, more players are involved than with Social Security. Social Security has two main stakeholders: taxpayers and current beneficiaries. Besides these two groups, Medicare must deal with health care providers—

Chart 3-5 **Growth in Per-Enrollee Costs of Health Care**
Since the early 1970s, health care costs per enrollee have generally risen at similar rates for Medicare beneficiares and persons with private health insurance plans.



Source: Department of Health and Human Services.

doctors and hospitals—and, to some extent, the private insurance industry. More players mean more decisionmakers and more sets of incentives and disincentives to consider.

Second, adverse selection plays a far more important role in the Medicare program than it does in Social Security (Box 3–1). For any structure of premiums, insurers have a strong incentive to cherry-pick the healthiest individuals. Healthy beneficiaries also have an incentive to opt for low-cost programs, since they pay a low price and still get all the health care they need. Although government can *reduce* adverse selection through risk-adjustment mechanisms, which peg the payment made by the government to the health status of the individual, risk adjustment is currently, and is likely to remain, very imperfect. Any proposed reform, therefore, must limit the extent to which insurers can cherry-pick and to which individuals can select health plans based on their health status.

SHORT-TERM OPTIONS

As explained above, until recently Medicare's short-run problems were caused mostly by the same factors that were increasing health expenditures in the private sector. The long-run problem, discussed in the next section, is driven both by the projected continuing rise in expenditures per capita and by demographic factors

Box 3–1.—The Problem of Adverse Selection

Adverse selection is a potentially serious problem for many types of insurance markets. It commonly occurs when the purchasers of insurance have more information about their risks than do insurance companies. Those who expect to incur losses are more likely to buy insurance than those who do not. This raises average expenses per beneficiary and forces insurance companies to raise premiums. Higher premiums discourage persons with lower risks from buying insurance. A cycle of increasing insurance premiums and decreasing participation could ultimately make the insurance unavailable. This is one justification for public provision of some types of insurance.

Adverse selection problems are likely to be particularly severe for health insurance, and there they may take several forms. When employers offer a number of different insurance plans, healthier workers are likely to choose less generous plans than workers who expect to require more health care. Similarly, if public health insurance programs such as Medicare offer more than one type of coverage, with rebates going to those choosing lower cost plans, sicker individuals (or households) will probably choose policies with more comprehensive coverage, whereas those with lower anticipated risks are likely to select less generous plans. As a result, those with higher risks will incur higher costs or may lose coverage altogether. Conversely, if the total premium expense is the same for all types of insurance, plans will have strong incentives to seek out those individuals expected to have relatively low health expenditures. Plans that are less able to select beneficiaries with low expected costs are then likely to be left with those with high average expenses. Adverse selection may also occur over time. For instance, individuals may select a relatively low cost insurance plan with limited coverage when they are healthy, but then to switch into a more comprehensive plan when they get sick.

Adverse selection can be eliminated if all individuals are placed into a common insurance pool. However, doing so reduces or eliminates choice and, under some circumstances, may reduce incentives for plans to operate efficiently. Alternatively, the problem could be avoided by risk-adjustment mechanisms that take into account all differences in risk that are known by the individual. However, mechanisms with the required degree of precision do not currently exist and are likely to be extremely difficult to develop.

that will increase the number of beneficiaries. When the demographics kick in, a broad array of options, including changes in eligibility and benefit design, are likely to be considered in a bipartisan context to resolve the program's financing problems. Short-run changes are required immediately, however, to extend the solvency of the hospital insurance trust fund. These changes, which are likely to focus mainly on reimbursement rates and policies, will also help balance the Federal budget. The Administration proposed a set of reforms along these lines last year and has submitted similar reform proposals in its current budget.

Controlling Provider Payments

Medicare's major tool for controlling short-run costs is adjusting payments to providers. Indeed, this represents the primary source of Medicare savings in the 1980s and 1990s. The two important payment innovations during this period were the prospective payment system for inpatient hospital care and the relative value scale for physician services. The prospective payment system substantially altered the incentives of hospitals by providing a fixed payment for an entire episode of care. Since hospitals no longer received additional revenue for additional services, they had a strong incentive to limit lengths of stay and unnecessary procedures. The reform in physician payments based on relative value scales tied physician payments to a schedule, which placed additional limits on the amount they could charge.

These innovations have helped control inpatient costs and physician prices, but they have not succeeded in curbing total Medicare spending, because they have little effect on the volume and intensity of certain services and because the types of services provided change rapidly. Also, spending on the portions of the Medicare program not yet subject to reform—outpatient services, skilled nursing facilities, and home health care—has risen at a rapid pace. Several factors may explain this outcome. First, many of these services, particularly home health care, differ from traditional medical services in ways that may make demand for them more sensitive to price and raise uncertainty regarding the medically appropriate level of care. Moreover, the supply of home health care providers is virtually limitless given that they do not require extensive training as do doctors and other medical personnel. Second, improvements in technology have made it easier to substitute outpatient care for hospitalization. Finally, spending controls on physician and inpatient hospital services create incentives for providers to substitute other types of services in order to maintain their incomes.

As noted above, most previous efforts to hold down price increases have been aimed at inpatient hospital care and physician services. Partly as a result, these are now the two slowest-growing components of Medicare. Some additional savings are achievable in

these areas, but squeezing down on prices has its limits. If prices become too low, physicians and hospitals might eventually become less willing to accept Medicare patients. Moreover, as already noted, it is hard to curb expenditures by focusing on prices alone. For example, the introduction of the Medicare fee schedule in 1992 placed additional limits on the reimbursements physicians could receive for services to Medicare beneficiaries. Yet until the last year or so Part B spending continued to increase markedly, in part because of higher volumes and new technologies.

The limit to how much Medicare can save by controlling payments to hospitals and physicians is likely to be determined by what happens in the private sector. Historically, Medicare payment-to-cost ratios have been well below those of private payers. However, as employers have turned to managed care in order to constrain costs, this gap has narrowed considerably: between 1991 and 1994, the private insurer-Medicare differential for hospitals fell from 48 percent to 28 percent. The reduction in the gap between public and private sector payments makes providing care to Medicare beneficiaries relatively more attractive than in the past. On the other hand, even if Medicare were able to hold down fees, total expenditures could rise if the volume of services provided increased. Moreover, if Medicare remains the primary insurer of fee-for-service care, cost containment efforts in the private sector may tempt providers to supply extra services to Medicare enrollees in order to maintain their incomes.

Expanding Prospective Payment—Getting Providers to Control Costs

Medicare has paid for inpatient hospital care on a prospective basis since 1983. Acute care hospitals receive a fixed fee for most inpatient episodes, regardless of how long the patient stays or how many services are performed. The fixed payment encourages hospitals to control the costs of treatment and has been credited with reducing Medicare inpatient costs. Despite concerns that prospective payment might lead to too little treatment, evidence suggests that hospitals have not compromised quality in their efforts to reduce costs. However, the prospective payment system may encourage hospitals to transfer patients quickly out of the acute care hospital and into a skilled nursing facility or long-term care hospital, which continue to be paid on a fee-for-service basis. This incentive could be contributing to the high growth rates of Medicare spending in these areas.

Some have suggested bundling more services together as a method of combating these perverse incentives and controlling costs. In general, the broader the set of services in the bundle, the stronger the incentive to reduce costs and the greater the scope for trading off treatment alternatives in a cost-effective manner. Some ana-

lysts advocate, for example, incorporating services for care following hospitalization into the fixed amount provided under the prospective payment system. Hospitals would be paid a fee for both the hospital stay and for all related medical services for a limited period of time thereafter. This might lower costs by preventing premature discharges that move patients from prospective payment hospitals into fee-for-service facilities. Bundling acute and postacute care, however, raises a number of challenges. For instance, it may be more difficult to set the reimbursement rate appropriately when a more diverse set of services is covered. Also, the need for postacute care may depend on factors beyond the hospital's control, such as the quality of care available at home, and this may place some hospitals at financial risk, unless appropriate adjustments can be made in the payment rate.

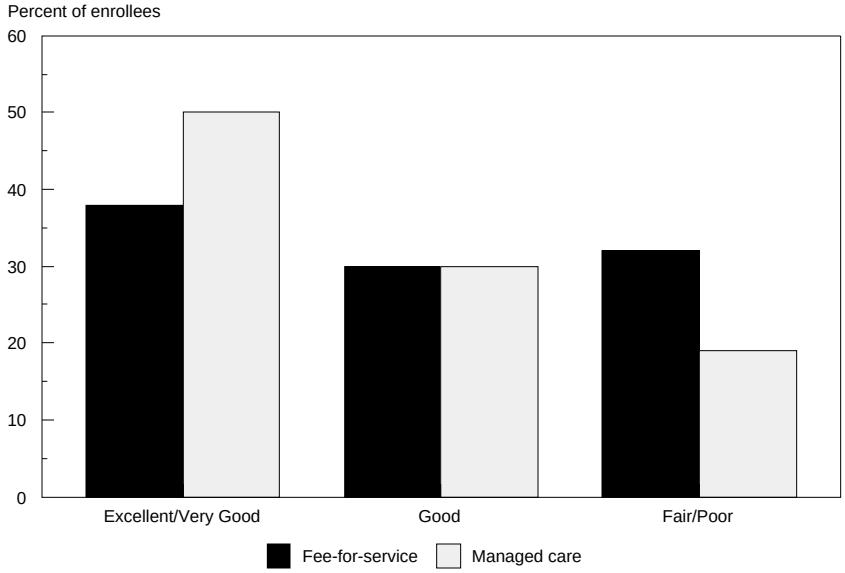
An alternative to bundling is to extend some type of prospective payment to those areas of Medicare where costs are increasing most rapidly. As already discussed, prospective payment reduces or removes the financial incentive for providers to supply additional services, and so may reduce costs. The Administration has proposed significantly expanding the use of prospective payment for Medicare services. New long-term care hospitals (defined as those with average stays of more than 25 days), which are currently paid on a fee-for-service basis, would become subject to the hospital prospective payment system. Skilled nursing facilities would also be moved quickly to prospective payment. Similarly, a prospective payment system would be established for home health services, one of the fastest growing areas of Medicare expenditure. Finally, a prospective payment system for hospital outpatient services is proposed, with implementation around the turn of the century. One challenge associated with reimbursing these services prospectively is that the episode of care, on which the fixed payment is based, may be harder to define than for hospital visits.

Improving Medicare Managed Care

The dominant form of Medicare managed care is the health maintenance organization (HMO), which receives a fixed payment for each covered beneficiary. The government's payment to a Medicare HMO is 95 percent of fee-for-service Medicare spending per capita in the same county, adjusted for a limited number of risk factors. Only about 10 percent of Medicare beneficiaries are enrolled in managed care plans, compared with 74 percent of workers in large companies, and the evidence suggests that those Medicare beneficiaries who do switch to managed care probably cost, rather than save, the program money. Part of the reason is flaws in the reimbursement formula, which exacerbate the problem of adverse selection, and part relates to the inherent difficulty of preventing adverse selection.

HMOs tend to enroll relatively healthy people at low risk of requiring expensive care (Chart 3–6). The payment made to HMOs for Medicare patients should reflect the lower costs associated with serving this relatively healthy population. To the extent it does not, Medicare payments may be higher than if the patients were in fee-for-service plans. Previous health history is a good indicator of future health expenditures, and one study indicates that the medical expenses of seniors shifting into HMOs were 25 to 30 percent lower than those of the average Medicare enrollee in the year or so immediately prior to their enrollment in the plan. Another analysis estimates that the introduction of managed care has increased Medicare costs by 7 percent per HMO beneficiary.

Chart 3-6 **Self-Described Health Status of Medicare Enrollees**
Medicare beneficiaries in managed care plans typically report better health than those in the traditional fee-for-service program.



Source: Department of Health and Human Services.

The selection problem is exacerbated by two additional factors. First, if healthier individuals migrate into managed care, average costs in the fee-for-service sector will rise. Since the reimbursement rate for managed care is based upon fee-for-service costs, this will drive up the HMO per capita payment. Second, HMOs have an incentive to offer coverage in counties with high reimbursement rates and to avoid counties in which the per capita payment is low. The current reimbursement formula results in payments that are almost four times larger in some counties than in others. By con-

trast, local input prices (labor and supply costs) vary by only a factor of two.

HMOs' incentives to cut costs may be limited somewhat because they are not allowed to earn higher profit margins on plans covering Medicare beneficiaries than on those for their private sector enrollees. In cases where the allowed per capita payment would generate a higher rate of profit, the HMO has the option of providing coverage not normally included in Medicare, such as for prescription drugs, or waiving some or all of the premium that it could otherwise charge. Thus, profit margins will not directly increase if HMOs develop or implement more cost-effective methods of providing care for Medicare beneficiaries. However, total profits may increase because of larger numbers of plan participants or economies of scale that raise profits on private sector enrollees.

To address selection bias, the Administration has proposed reducing the size of local variations in per capita payments, testing new risk-adjustment methodologies aimed at linking reimbursements more closely to predicted expenses, and making the reimbursement formula less generous. The use of more-uniform payment rates should lessen the tendency of HMOs to locate mainly in high-cost areas. But the likelihood of identifying risk-adjustment mechanisms accurate enough to eliminate the remaining selection bias is poor. The best currently available risk-adjustment mechanisms are likely to account for only a fraction of the variation in annual health care spending that individuals or insurers can anticipate. A less generous reimbursement formula further recognizes and attempts to take account of the remaining tendency of HMOs to enroll relatively health people.

To provide better incentives for cost reduction, the Administration has proposed some experimentation with competitive price setting and with the creation of partial payments, whereby plans would be paid on a fee-for-service basis but would also share in any cost savings achieved beyond some minimum threshold. The Administration has also proposed to broaden the range of managed care plans available to Medicare beneficiaries by adding options for coverage by preferred provider organizations, provider service networks, and for expanded availability of point-of-service plans, all of which are increasingly popular in the private sector. The goal in offering these new plans is both to expand the choices available to beneficiaries and to encourage plans to compete on the basis of quality of care rather than risk selection.

Increasing Part B Premiums

When Medicare was enacted, Medicare enrollees were required to pay a premium equal to 50 percent of the costs of Part B. The costs of physician services rose so quickly, however, that legislation in 1972 limited premium increases to inflation. As Medicare costs

soared, the premium dropped rapidly to 25 percent, and would have fallen further had legislation not been enacted to maintain this level. Most Medicare beneficiaries also pay a premium for their supplemental medigap policies. These premiums plus copayments and deductibles bring total out-of-pocket expenses to about 20 percent of family income for the typical elderly household and cover about 40 percent of their total costs of medical care. Proposals to increase Part B premiums have included both across-the-board increases and income-related options.

Shifting the Financing of Home Health Care

Since 1981 home health care has been financed under Medicare Part A. The rapidly increasing expenditures for these services are therefore contributing to the deteriorating financial condition of the hospital insurance (Part A) trust fund. The Administration proposes to continue reimbursing under Part A the first 100 visits following a hospital stay of 3 days or more, but shift the payment for all other home health care services to Part B. This change is consistent with the notion that Part A should be dedicated to hospital-related services, and Part B to expenditures for ambulatory care. Although this shift would not reduce total Medicare spending, it would extend the life of the hospital insurance trust fund, without excessive reductions in payments for hospitals, physicians, or other providers, and would restore the apportionment of home health care payments between Part A and Part B to that existing in law before 1980. It would not affect the Part B premium.

Global Budget Caps and Medical Savings Accounts

Two options sometimes considered for reforming Medicare are global budget caps and medical savings accounts (MSAs). In a global target system, the budget cap would limit total Medicare spending per enrollee at a congressionally mandated amount. Typically, separate spending targets would be established for HMO and fee-for-service Medicare expenditures. Projected spending (for example, in the fee-for-service category) would then be calculated by using estimated services and allowable prices. If total spending exceeded the sector target, prices for all services in the sector would be reduced proportionately to achieve the target level of spending.

MSAs combine a high-deductible insurance policy with a tax-advantaged savings account to cover expenditures below the deductible. A fixed dollar amount would be allocated to each beneficiary, out of which Medicare would then pay the premium for the high-deductible insurance policy and deposit any remaining funds into the beneficiary's savings account. Withdrawals from this account could be made for qualified medical expenses on a tax-free basis—or for other types of consumption as taxable income. Since individuals covered by MSAs would be responsible for all medical ex-

penses up to the deductible, MSA proponents say they would have incentives to avoid care in circumstances where the costs exceed the benefits.

Global targets and MSAs have some attraction, but both also have potentially serious problems. In particular, unless risk-adjustment methodologies become much more sophisticated, selection bias could create grave difficulties under either approach, especially (for the former) if a separate budget cap were established for fee-for-service and managed care plans. If relatively healthy persons enrolled in managed care in disproportionate numbers, and the risk-adjustment methods failed to capture fully the differences in expected costs, fee-for-service spending per capita would rise relative to that in managed care. The fee-for-service budget cap would likely be reached, leading to relatively large reductions in prices. Pressure on providers would be likely to lead to lower quality of service and would encourage more beneficiaries to enroll in managed care. This process could continue in a vicious cycle, until only the sickest individuals remained in the traditional Medicare program, and the allotted prices might then be far too low to address their medical needs. The end result could be, in effect, more limited choice for most individuals and, if prices were too low, queuing for some types of medical care, as some providers became less willing to provide services to Medicare enrollees.

MSAs have a similar problem. Relatively healthy individuals may have a strong incentive to opt for the MSA, since payments into their savings accounts would exceed their expected medical costs. This would leave the less healthy in the fee-for-service part of Medicare, raising costs there. Higher costs might encourage further shifts to MSAs and could set up a dynamic similar to that created by the global caps. In addition, individuals in MSAs who fell ill might want to switch back into the fee-for-service program. Thus, Medicare would be likely to pay higher costs for the healthy individuals who accept the MSA option than it would if they stayed in fee-for-service, but the program would still have to pay the high expenses of sicker individuals. For example, in 1996 the Congressional Budget Office projected that one Medicare MSA proposal would have increased Medicare spending by $5 billion over 7 years.

LONG-RUN OPTIONS

Incremental changes in Medicare such as those outlined earlier can provide substantial budget savings in the short term, create incentives for more efficient delivery of health care, and extend the life of the hospital insurance trust fund. Nonetheless, in the long run, the combination of demographic developments and continued cost pressures resulting from improvements in medical technology and increased volume of services will require additional reforms.

The President has proposed policies to address Medicare's short-term financing and has called for a bipartisan process to develop solutions for Medicare's long-run challenges.

The remainder of this section briefly reviews some of the approaches that analysts outside this Administration have proposed to improve the long-term financing of Medicare. None of them is a magic bullet; claims of spectacular benefit from any single approach should be viewed with skepticism. Some combination of policies is likely to be needed to meet the long-run challenges. All raise issues that must be examined and resolved in a bipartisan fashion.

Increasing the Age of Eligibility

Some have suggested raising the age of first eligibility for Medicare in order to reduce the number of beneficiaries and cut expenses. Retirees are now eligible for Medicare benefits at age 65; some have suggested raising this to 67 to reflect the scheduled increase in Social Security's normal retirement age. As with Social Security, this is likely to pose few problems for those persons who retire early because they have considerable wealth, good pensions, and retiree health insurance from their former employers. Others, however, have low incomes, poor job prospects, and poor health.

Denying health care coverage to this latter group could produce considerable hardship, because some elderly people may not have access to any protection other than Medicare. Unless other measures were taken in tandem, raising the eligibility age would probably increase the number of uninsured, and at least some of those losing coverage would be likely to have high medical costs. To reduce these problems, persons retiring before the age of 67 would have to be guaranteed some way of getting health insurance. One possibility would be to extend existing continuation-of-coverage provisions, whereby individuals who leave jobs are able to purchase group health insurance through their previous employer for a limited period. This could allow persons retiring at age 62 or later to maintain continuous coverage until they become eligible for Medicare. However, since individuals using this option would pay the full coverage premium plus a small administrative charge, the costs of obtaining health insurance might be quite high. Employer health expenses would also rise if older and less healthy individuals were added to the insurance pool.

Alternatively, some have suggested that Social Security beneficiaries between the ages of 62 and 67 could be allowed to buy Medicare coverage at unsubsidized rates. Although this would improve access to insurance, Medicare might still lose money on these beneficiaries, since persons in poor health would have particularly strong incentives to enroll. Some provision would also have to be made to reduce the burden on low-income individuals, probably

through Medicaid, which might reduce the financial savings and introduce other complexities.

Increasing Cost Sharing

The annual Medicare deductible for physician services is $100, whereas that for inpatient hospital care is $736. The former is relatively low by historical and private sector standards, but the latter is relatively high, especially when combined with substantial copayments for lengthy hospital stays. Home health care coverage has no deductibles or copayments of any kind. This means that Medicare has very high cost sharing on those services where inappropriate use is unlikely—namely, inpatient hospital services—and very low cost sharing where individuals have a lot of discretion—namely, physician visits and home health care. Since one goal of cost sharing is to give individuals the incentive to use services carefully, the current structure might at first glance seem in need of immediate reform.

The difficulty is that Medicare does not operate in isolation. Approximately three-quarters of senior citizens have some type of medigap coverage, either provided by their former or current employer or purchased directly. Medigap insurance pays for some or all of the cost-sharing requirements of Medicare and often covers services not included in Medicare, such as prescription drugs or preventive care. In addition, some 13 percent of enrollees with low incomes have secondary coverage through Medicaid. For those individuals with the lowest incomes, Medicaid covers all Medicare copayments and deductibles, as well as the entire Part B premium. Those with slightly higher incomes can also have their Part B premiums paid through Medicaid but are responsible for the other types of cost sharing.

Since so many beneficiaries have secondary sources of insurance, changes in Medicare cost-sharing arrangements may be unlikely to reduce total medical expenditures unless accompanied by changes in the structure of the supplemental coverage. The most likely effect would be merely to shift some of the expense away from the Federal Government and onto individuals (in the form of higher medigap insurance premiums) or State governments (in the form of higher Medicaid expenses).

Secondary Insurance Reform

Because medigap policies and Medicaid provide first-dollar coverage for most services, they shield individuals from the incentive effects of cost sharing. When individuals are not responsible for any of the costs, they tend to consume more health care and incur higher expenses. Thus, medigap policies and Medicaid coverage are likely to raise Medicare costs.

Several reforms have been suggested to avoid the problems associated with current medigap policies. One possibility would be to require any medigap policy to cover Medicare's basic package as well as any supplemental coverage. The insurance company would receive a payment from Medicare equal to the expected costs of the basic package and would bear any additional cost caused by incentives for overuse. This approach is quite similar to that currently used in Medicare's managed care plans, which frequently combine Part A and Part B coverage with additional insurance, and is fully consistent with efforts to increase the use of managed care arrangements. However, adverse selection may again be a problem since the health plans would have incentives to cherry-pick the healthiest beneficiaries.

Alternatively, some have argued that medigap policies could continue to be used as a supplement to Medicare but with a payment assessed to compensate for the overuse caused by first-dollar coverage, or with restrictions to prevent the policies from covering the initial copayments or deductibles for some types of services. Were this done, new types of medigap policies would presumably emerge that would mitigate the adverse incentives in the current system while providing some of the types of protection found in current policies. The challenge would be to find the right balance between incentives and protection.

Others have suggested that Medicare require at least some cost sharing for Medicare beneficiaries who also receive Medicaid. They argue that even modest deductibles are associated with significant reductions in health expenditures for individuals with average incomes. Deductibles and copayments for Medicaid beneficiaries could perhaps be set at levels considerably below those faced by other Medicare enrollees. Even low levels of cost sharing may be sufficient to induce more careful use of services among those with limited incomes. But they also might place some persons with low incomes at additional financial risk or deter them from seeking medically necessary care.

Switching from a Defined-Benefit to a Defined-Contribution Plan

Medicare currently offers a defined package of services to all enrollees. This places the government at significant risk for any rise in the cost of these services, whether it is related to changes in technology, prices, or volumes. Some have suggested that the government could limit future expenses by guaranteeing a specified contribution toward health insurance expenses for the elderly, while leaving the choice of the specific insurance plan to the individual.

For such a proposal to have any chance of being viable, the size of the fixed payment would have to be carefully determined. If the

amount were set in a base year and simply indexed thereafter, it could quickly become inadequate (if, for example, technological improvements led health expenditures per capita to rise faster than the rate of inflation) and place the elderly seriously at risk. To surmount this problem, some advocates have proposed asking health plans in a given geographical market to bid on the cost of insuring a minimum package of services and then using the average of the bids to set the dollar payment for each Medicare beneficiary in that market. Beneficiaries who wanted lower deductibles or copayments could then use their own money to buy more expensive policies, whereas those who wished to save money could join cheaper plans and receive the difference between the fixed payment and their premium contribution. The competitive bidding process is likely to tie the average payment somewhat more closely to costs. Success, however, would depend crucially on defining the market appropriately: defining it too large might result in considerable heterogeneity in medical costs within the region, whereas defining it too small could lead to inadequate competition in the bidding process.

Switching to a defined-contribution system has a number of other potential problems, the most serious of which is selection bias. Unless sophisticated risk-adjustment methods, which currently do not exist, could be used to vary the government payment rate with the level of expected medical expenses, market forces would put those in poor health at particular risk. Healthy individuals would have incentives to take policies with low premiums and limited coverage, which would drive up costs in the more comprehensive plans favored by less healthy persons. Better risk-adjustment mechanisms are needed. But solutions should be constructed with an understanding that our ability to adjust for risk is currently quite poor and may be inherently limited.

CONCLUSION

The conclusion that emerges from this brief overview of Medicare's financing problems is that, whereas short-term savings are currently achievable, long-run viability will require consideration of innovative reforms that will need to be agreed upon in a bipartisan process. Bold but thoughtful efforts to solve some of the issues raised here could lay the foundation for addressing one of America's greatest long-run challenges.

The most constructive approach would be to implement the structural reforms and savings proposals included in the President's budget and to continue the Administration's use of demonstration projects to explore different approaches to reining in costs and ensuring protection. Efforts are also needed to develop risk-adjustment mechanisms to alleviate the adverse selection problems. The Administration's proposals to extend the life of the Part A trust

fund and to control Part B spending should buy enough time to allow careful evaluation of a range of alternatives in a bipartisan process. With more evidence under its belt, the Nation will be able to proceed with more confidence.

MEDICAID FINANCING OF LONG-TERM CARE

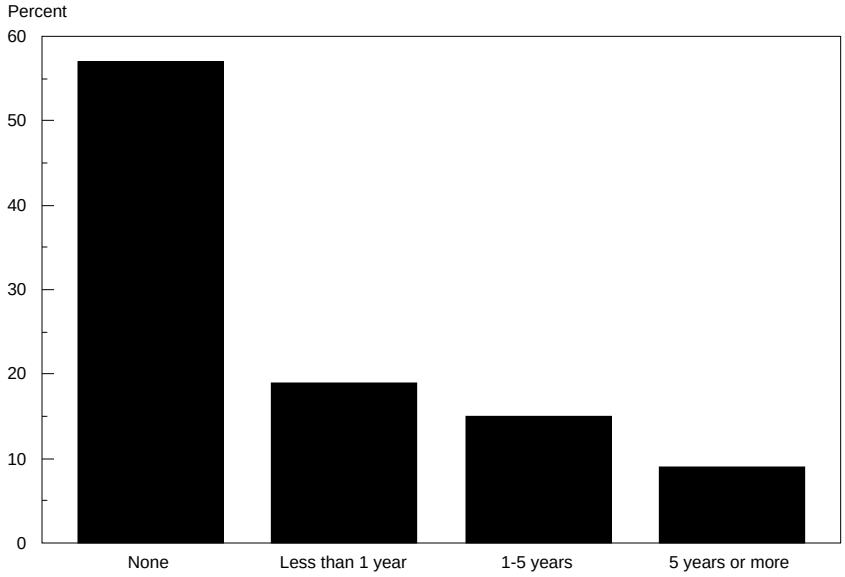
Medicaid was enacted, along with Medicare, in 1965 to provide health and custodial care for people with extremely low incomes. It continues to finance much of the medical care for the worst off in our society. Medicaid also pays for nursing home care for those who have low incomes and few assets. Since nursing home residents are typically quite old, the program provides significant financial support to the sick elderly. In 1995 roughly one-third of total Medicaid expenditures went to those aged 65 and over; the remaining two-thirds were split about equally between people with disabilities and the nonelderly, nondisabled poor. About half of all nursing home expenditures are paid for by Medicaid.

Medicaid expenditures have been growing rapidly over time, as a result of rising numbers of beneficiaries combined with higher costs for each. The nursing home component of Medicaid has also increased rapidly over the last 25 years, although at a slightly slower pace than other program expenses.

The aging of the population will significantly increase the number of people needing long-term care assistance. Not only will the number of older people increase, but so will the average age of those over 65. People over 85 made up about 10 percent of the elderly population in 1994; the Census Bureau projects that by 2050 this figure will be almost 24 percent. The very old are much more likely to reside in nursing homes: in 1993, about 25 percent of those 85 and older were in nursing homes, compared with just 5 percent of the general population over 65. If this rate of nursing home utilization is maintained, population aging will bring significant increases in the nursing home population and in expenditures on long-term care.

Some analysts suggest that one way to hold down future Medicaid nursing home outlays is to shift the financing of long-term care to some form of insurance. By its nature, insurance is particularly desirable for events that are rare but expensive. A majority of persons reaching age 65 can expect never to receive care in a nursing home. Of the rest, most are likely to stay a relatively short time. Only 9 percent will spend more than 5 years in a nursing home (Chart 3–7). With the cost of skilled nursing home care averaging over $35,000 per year and rising over time, a lengthy stay can be extremely expensive. Therefore the need for long-term nursing home care is an event for which insurance may be appropriate.

Chart 3-7 **Projected Lifetime Nursing Home Use by Current 65-Year-Olds**
Only a small fraction of the aged will have an extended stay in a nursing home.



Note: Data projected for persons who reached age 65 in 1990.
Source: New England Journal of Medicine.

Yet even though nursing home stays are relatively rare, and the costs high, the market for private nursing home insurance is underdeveloped. Just 3 percent of nursing home expenditures were paid by private insurance in 1994. Several factors are likely to account for the limited importance of private long-term care policies.

First, Medicaid pays the long-term care expenses of persons who have no financial assets or who spend down their assets after entering a nursing home. To the extent that people think government will pick up the tab, they have less incentive either to engage in precautionary saving or to purchase insurance for long-term care.

Second, premiums for private insurance are relatively high. One reason is that the vast majority of long-term care policies are individual rather than group policies, and individual policies have higher administrative costs. Another is that those who do purchase long-term care insurance, especially when they are older, may be less healthy than others their age, and this will be reflected in premiums. This is another example of the familiar problem of adverse selection, discussed above. Finally, premiums will be higher to the extent that people with insurance use nursing home care in situations where they would not if they had to pay the full cost at the time of use.

Third, many disabled elderly persons are currently cared for by family members. Senior citizens who consider nursing homes less

desirable than living with family might not be interested in purchasing insurance that reduces out-of-pocket nursing home expenses if, as evidence suggests, this makes their families less willing to care for them.

A limited private insurance market means that most people reaching age 65 remain vulnerable to catastrophic nursing home costs that could potentially wipe out their assets. It also means that Medicaid outlays are larger than they would be if the private insurance market were more extensive. Medicaid outlays are also higher to the extent that seniors needing long-term care are able to find ways to transfer assets to family members, despite provisions in current law designed to prevent this, rather than spend them on nursing home care before becoming eligible for the program.

The proportion of the elderly with long-term care insurance could be increased in a number of ways, although all raise serious issues. One possibility would be for the government to require universal coverage, either directly through Medicare or indirectly through the purchase of private insurance (ideally at a young age and possibly through one's employer). Alternatively, individuals could be provided with stronger incentives to buy insurance within the current voluntary system. To a large degree, the recently enacted Kassebaum-Kennedy legislation (the Health Insurance Portability and Accountability Act of 1996) does so by offering tax advantages for some long-term care insurance expenses similar to (and in some ways more generous than) those previously provided for other medical costs or health insurance premiums. A third possibility would be to increase the ability of individuals to exempt some of their assets from the "spend-down" requirements of Medicaid if they purchase sufficient amounts of long-term care insurance.

Insurance of nursing home care for individuals with a lifetime of low income is a good example of a program that the private sector is unable or unwilling to supply. However, the presence of a safety net for the poor may also reduce the incentives for those who are better off to save for nursing home expenses. Unless people can be encouraged to put aside more money for this purpose, the aging of the baby boom is likely to put an increasing burden on the Medicaid system—and thus on the finances of the Federal Government and the States.

CONCLUSION

Each of the government programs for the elderly discussed in this chapter poses different policy challenges. The costs of providing Social Security benefits are going to increase as the population ages. Although this trend has largely been taken into account

through 75-year budgeting, the system needs additional revenue or benefit changes to restore long-run balance. A range of options has already been described and proposed.

The problems facing Medicare, and those facing Medicaid's financing of long-term care, are more complicated and the solutions more elusive. Unless action is taken, the Part A trust fund is projected to be exhausted by 2001, and to face growing deficits thereafter. Adequate provisions have not yet been made for Part B spending increases, or for future Medicaid nursing home outlays. Innovative approaches are needed to provide quality health and nursing care to an increasing number of elderly Americans.

Many of the key elements of any solution are already known. We must improve the incentives for individuals to seek and providers to supply quality care in a cost-effective manner. Better risk-adjustment mechanisms are needed to mitigate adverse selection. Where possible, market-oriented approaches should be used to help determine the size and form of third-party payments.

The various government programs supporting our elderly represent different ways in which each generation of taxpayers offers assistance to its parents. In combination, these intergenerational transfers limit the resources available for other worthwhile purposes. Historically, Federal revenues have averaged around 18 percent of GDP. In 1970, Social Security, Medicare, and Medicaid expenditures were equivalent to 4 percent of GDP; in 1996 they stood at about 9 percent; they are projected to grow to roughly 19 percent of GDP in 2050. These programs as currently structured ultimately could crowd out virtually all other government spending.

Examining how society distributes its resources between the aged and the rest of the population provides one lens through which to view these programs. Economics cannot answer how the allocation should be made, but it does offer the fundamental lesson that society faces choices. The choices are often difficult because the tradeoffs are between two or more worthy objectives. Economics can help illuminate the nature of the choices and provide theoretical arguments and empirical evidence about the impacts of alternative policies. Armed with this information, we must then make the hard decisions within a bipartisan process and with full awareness of the difficult tradeoffs they imply. The choices we make will say a great deal about the kind of society we are and the kind of society we aspire to become.