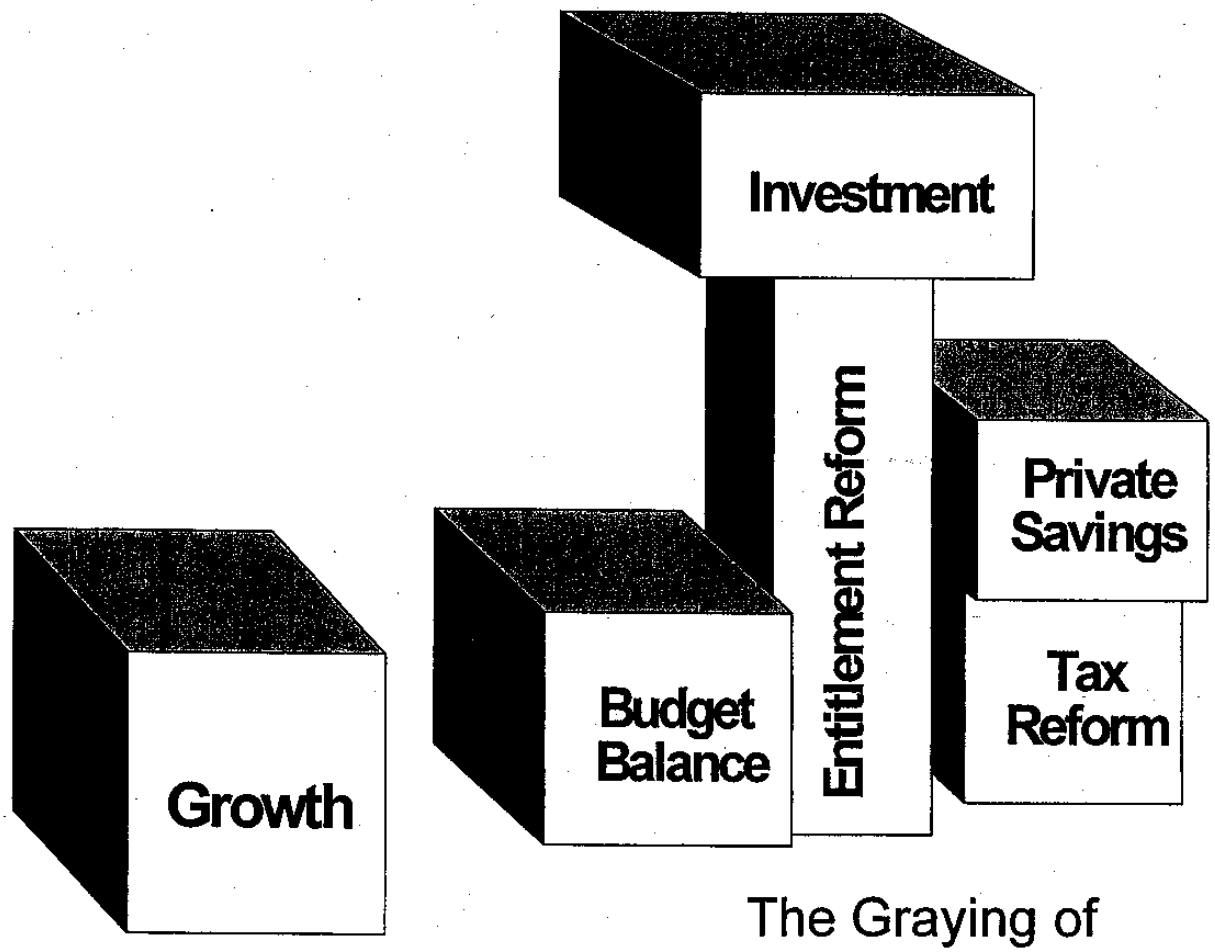
Building a Better Future



The Graying of America Project: Part 1

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Washington DC

The Graying of America Project

The Committee for a Responsible Federal Budget is a bipartisan private nonprofit organization created to educate the public about the Federal budget, the budget process, and other important economic issues. For fifteen years, we have worked to promote public understanding of the fact that Federal fiscal policy is unsustainable and encourage candid discussion of real choices to solve the problem. No single year's deficit is a serious danger, but the pattern of persistent, growing deficits and debt poses a serious threat to our future economy and standards of living.

Current public debate focuses on short term problems, diverting energy and attention away from more serious challenges we face over the longer term. Political leaders continue to discuss individual programs and policies as if each existed in a vacuum. But various aspects of spending and tax policy must fit together like a jig saw puzzle. Policy makers must take into account trade-offs among individual programs and consider the impact of spending decisions on tax policies. Changes at the Federal level affect other levels of government and the private sector. Moreover, current policy choices will affect future economic and social conditions. Unless policy makers keep all these separate pieces in view, choices they make in one area may foreclose desirable options in others.

Changing demographics make the problems we face much more urgent than they otherwise would be. Medicare, Social Security, and the tax system generally are viewed as sources of the long-term problem, and they must contribute to the solution. Ignoring the inter-relationships among these issues and their collective impact on the Federal budget and the overall economy is folly.

The Graying of America is a project we initiated in 1995 to examine the major public policy issues that impact and are impacted by America's changing demographics. This is a two-part initiative. This report completes the first phase. It documents why current public policies and private behaviors will have to change, highlights the ways in which issues overlap, and urges a strategic approach to public policy. In the second stage of the project, we will examine specific options to reform entitlements and tax policy.

Through this project, the Committee for a Responsible Federal Budget appeals for prompt, concerted, coordinated action. At this point, we have reached only these conclusions:

- Increased economic growth is imperative to our nation's future economic and social health;

- Major demographic trends must drive public policies for the future;
- Government must make decisions to solve the problems we face in an overall economic and budgetary context; and
- The Federal government alone cannot solve all of our problems. The private sector and State and local governments each must play a role.

The United States is a wealthy and vibrant country. It is well within our grasp to address these issues and solve these problems. The question is, do we have the will to do so?

We present here too much and too little information. We repeat much that we and others take to be common knowledge, because we believe the facts bear repetition. We do not propose specific solutions. We do hope to spur a new kind of debate about public and private responsibilities, the role of government and what we are willing to support with tax dollars, and about the kind of government we need to meet our entire population's needs and continue to lead the world into the 21st century.

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BILL FRENZEL	CAROL COX WAIT	TIMOTHY PENNY
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Chapter 1. Introduction

The population of the United States is aging, and it is becoming more diverse. The changes over the next fifty years will be dramatic and will bring new challenges to our social, economic, and political systems. Fifty years is a long time, but it is well within the lifetimes of the younger half of our current population.

Our nation has the strength and resources necessary to respond to the challenges of the 21st century through a combination of adjustments in public policy and private behavior. Future standards of living are at stake, not for aging baby boomers alone, but for the entire U.S. population.

These challenges should not defeat us, but demographic reality means we will have to change our expectations, change our behavior, or both. There is no immediate crisis. That is part of the problem. The absence of an immediate crisis permits procrastination, which works against us. The sooner we acknowledge the need for adjustments, the more time we have to prepare for them, the greater our range of choices, and the smoother the transition can be.

An Action Plan to Meet Our Future Needs

Relatively small adjustments can add up to big changes over the course of twenty, thirty, or fifty years. Basic steps include:

- Reach agreement on the problems and the goals.
- Build consensus on the kinds of solutions that will be effective and politically sustainable.
- Design backward: that is, begin with the future goals and work back to what we have in place today to design transitions that maximize a sense of fairness across generations.

The Federal government has powerful tools it can use to achieve these goals. Federal tax and spending policies redistribute resources throughout the economy. It restrains private activity through regulation. To be most effective, these policies must be complementary.

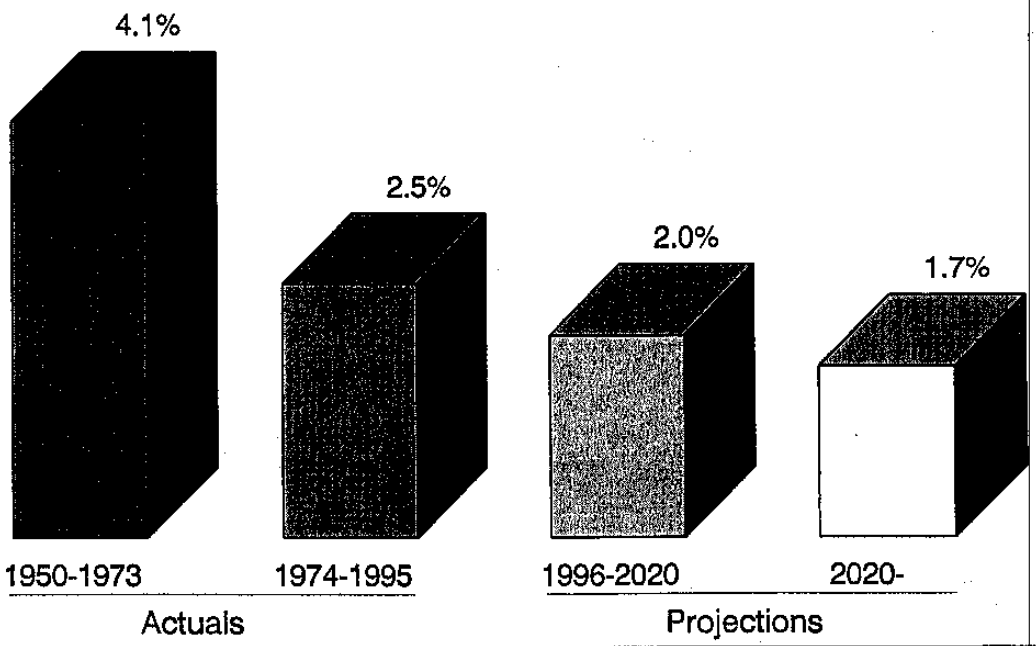
If we do this right, current beneficiaries and champions of current government policies should not feel unfairly singled out. It should be easier to forge an enduring consensus if we focus on where we are going, rather than on where we have been. That is in everyone's best interest.

The Challenges Ahead

Today, just below one out of eight people in the United States is age 65 or older. As the post-World War II baby boom generation retires, the number of elderly will grow. By the year 2030, one out of five Americans will be a senior citizen. With regard to age, the United States will be a "Nation of Floridas."[1]

As the population ages, there will be fewer workers relative to retirees and the economy will grow more slowly. (See Figure 1.1.)

Figure 1.1
Real GDP Growth
(Average annual change, in percentages)



SOURCES: CRFB based upon historical data from Bureau of the Census (1975) and *The Economic Report of the President* (1997); and CBO projections (March 1997).

[1] Peterson (1996).

Future workers and retirees will divide future economic output among themselves. These resources will be used to satisfy consumption and investment needs. If a greater portion of the population is retired, a greater share of future output will be required to support the retirees. Continued earnings from employment, accumulated savings, employment-based pension benefits, Social Security, Medicare and other government programs, as well as assistance from family and other sources will determine each retiree's share. The extent to which the income claims of older adults affects the nonelderly population will depend on the size of the overall economy. Dividing up goods and services is easier for growing economies than for stagnating ones and for richer nations than poorer ones. Although we cannot grow our way out of all problems, in this case, more is better because everyone can gain. This is true whether governments or private markets make the allocation decisions.

Thus public policies and private behaviors that promote investment today and faster growth tomorrow best serve our long-term collective interest. Investment and growth improve the ability of future workers to produce sufficient goods and services for themselves and their children as well as for the growing elderly population.

Instead, both individually and collectively through government, we are doing just the opposite. We are more interested in increasing current consumption than in investing for the future. Growth requires investment in human and physical capital by the public and private sectors. Investment takes savings. Savings lowers current consumption. By saving and investing too little, and by continually running Federal budget deficits, we implicitly agree to lower future levels of income and consumption than we otherwise might be able to enjoy.

None of this is a secret, at least not to policy makers in Washington DC and experts around the country. The public has a very short attention span. Thus the disconnect between current policies and long-term economic reality persists. Cutting current consumption is visible, while the payoffs are long-term and harder to recognize and appreciate.

The present political climate is the equivalent of quicksand. By the time we realize that we are in serious trouble, it will be very difficult to get out. Political incentives focus on the next election. Political campaigns are lengthening in duration and sometimes seem never-ending. Reformers and those who oppose them use misleading language, sometimes intentionally, but often times because the words have become entrenched in the policy vernacular.[2] Not surprisingly, the results of opinion polls indicate that the public does not understand the issues and is wary of major changes. Demagoguery works in the U. S. electorate, and politicians use it to their advantage. A small and growing number of elected officials are asking the right questions and are taking politically risky positions. The majority, however, seem content to remain silent or to stake out safe ground.

[2] For example, see the glossary of Social Security and Medicare terms in chapter 5.

Establishing a Comprehensive Agenda for the Graying of America

Ask a Washington politician what we must do to meet the needs of our aging population. Nine out of ten will respond: "Save Medicare" and "Preserve Social Security for our children." Those answers miss the point. Millions of seniors depend on Social Security and Medicare for their financial security. Millions more will look to government for similar assistance in the future. It is imperative that public assistance be there to meet their needs. Nevertheless, public strategies must prepare for the impact of demographic change on the entire population, including older Americans, not on "saving" existing programs.

We are not doing our children any favors if we ask them to shoulder the tax burden needed to continue current Social Security and Medicare benefits for one more generation. First, that probably cannot be done. And even if it could, our children cannot expect to enjoy those same levels of benefits when they retire. In fairness, we must pursue more equitable policies that seek a better balance of financing burdens and benefits across generations.

Stand-alone, program-centered approaches isolate the program and its beneficiaries from other issues. This approach narrows the discussion, makes problems appear more manageable, simplifies the policy options, and reduces the chance for major change. It focuses on "winners" and "losers," because any solution involves increasing taxes or cutting benefits from current levels. This approach also avoids looking at the cost of maintaining the status quo for anyone except program beneficiaries. It lets program supporters use the straw dog of "destroying" the program rather than engage in an open debate on overall priorities, the program's full merits, and proposed alternatives.

The disadvantages to this type of program by program debate should be obvious. Focusing on one program at a time frustrates discussion of larger issues, impedes establishment of priorities, avoids benchmarking against broader goals, ignores the wider effect of proposed solutions, and protects constituencies of existing programs at the expense of others. It presupposes public priorities and revenue sources inconsistent with current economic and demographic trends. In the end, this narrow perspective can lead to ineffective, short-sighted, even counterproductive policies.[3]

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[3] For example, the "Maintain Benefits" option proposed by the largest faction of the 1994-95 Social Security Advisory Council would reclaim revenues raised by taxation of Social Security benefits from the Medicare Hospital Insurance (HI) Trust Fund after 2010. This approach assumes that other sources of revenue will be found to finance Medicare. Instead, a comprehensive approach would avoid exerting ownership over specific revenue streams. It would look at the combined financial security needs of senior citizens together with the needs of other components of the population, establish priorities for Federal funding, and allocate revenues accordingly after considering the relative merits in terms of efficiency and equity for each type of revenue source.

Policy makers must set a more comprehensive agenda. This agenda would promote financial security for all segments of the population, fairly, within and across generations. Specific elements include:

- Policies to promote stronger economic growth, efficiency and competitiveness and to eliminate disincentives to work, save, and invest;
- Sound fiscal policy and budget discipline to achieve and sustain Federal budget balance over the near-term business cycle and over the long-term;
- Renewed commitment to taking care of the needs of the most vulnerable individuals in our population and strengthening incentives for individuals to assume greater responsibility for lifetime income;
- Reordering public priorities to favor investment and long-term economic growth over consumption and short-term political payoffs; and
- Improved equity within and across generations in tax policy and in government expenditures.

This agenda would require policy makers to adopt a strategic vision stretching well into the next century. It would require many difficult trade-offs, but, ultimately, they should prove more effective than ad hoc approaches. Policy makers should begin to build a new consensus about public and private roles and responsibilities and about public priorities. New priorities should dictate the options menu for the future. Sources of financing should reflect updated demographic and economic trends. Transition provisions should be designed to cushion the effect on individuals already in or near retirement.

Difficult Questions and Hard Choices

The proposed agenda is broad enough to trigger a long list of difficult questions. Public debate would benefit from an explicit discussion of these issues. It would focus on where the country should go and the hard choices we have to make to get there, not merely on where we are or have been. This agenda could provide the opportunity to reconfirm basic values, identify areas of consensus, define differences, and weigh trade-offs. There are no objectively right answers to these questions. However, it is difficult to design effective policies until we reach consensus on politically sustainable answers.

The most fundamental questions, including those listed below, concern political values. These focus on the division between individual and public responsibilities.

- When does self-reliance become a euphemism for selfishness?[4] Or, can society value self-reliance, and still make allowances for factors beyond individual control that potentially can affect anyone, especially the most vulnerable individuals in our society—the young, elderly, poor, sick, and disabled?

- Are universal benefits essential to a sustainable social safety net? Will most voters pay taxes only if they benefit personally? Or, are people willing to count societal benefits and public good as part of their return on investment? How do taxpayers determine whether they are getting their money's worth?

- Does concern for those less fortunate, and tax-supported assistance for some, reject or conflict with greater emphasis on individual responsibility and self-reliance?

- Should taxpayers subsidize individual choice? For example, in an era when most women work outside the home, should one-earner retiree couples continue to receive the same, if not greater, benefits from Social Security and Medicare as two-earner retiree couples who paid more in payroll taxes but had comparable pre-retirement incomes? Should people who smoke receive the same Veterans' or Medicare benefits as people who don't?

- Is there a reasonable trade-off between individual freedom and public dependence? Are limits on individual choice more acceptable in some areas than others? For example, is it all right to prohibit junk food purchases with food stamps, cap housing subsidies or limit their use to specific properties, and to provide subsidies only up to the cost of managed health care?

- To what extent should individuals and families be responsible for their own well-being over their lifetimes? When should we step in and help, collectively, through government? What criteria should we use to identify individuals who need assistance? Age? Income (annual or lifetime)? Wealth? Political clout?

- How much of their assets should older adults be allowed to preserve and still receive public income and health care support? Should the cost of their benefits be recaptured or should their assets pass on to their children and heirs? Can asset recapture rules avoid creating incentives to engage in evasion schemes and still protect the dignity of people as they age?

- How do we protect taxpayers from free-riders—those who do not act responsibly or contribute their fair share, then benefit from the availability of public assistance?

- Does society have an obligation to make sure that basic levels of support (i.e., access to health care, food, housing) are universally available?

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[4] For recent discussion of these issues, see Uchitelle, *New York Times* (January 13, 1997) and Sandel, *New Republic* (February 3, 1997).

- Is there a minimum standard of living below which no member of our society should be allowed to fall? If so, how do we reconcile that level consistent with our collective willingness to pay taxes?

The next group of questions focuses on establishing the scale and scope of the Federal role for the next several decades.

- How good is good enough? Within the last generation, average standards of living doubled. Is a 30 percent gain (as implied by current productivity rates) good enough for the next generation? Is it reasonable or desirable to reduce expectations regarding future incomes and standards of living?

- To what extent should public policies redistribute income within and between generations? Across regions of the country?

- If individuals choose not to save for their retirement, should government save for them? How should we determine the appropriate level of forced savings? Does government-mandated saving implicitly guarantee a minimum rate of return?

- How should we define adequate levels of financial security? Should standards vary by age? Should publicly guaranteed access to health care depend on age, income, or some combination of factors? Can programs, benefits, and services designed to meet the needs of the entire elderly population, rich and poor, be delivered at an affordable price?

- Should public assistance vary depending on income, age, place of residence, and so on, or should it be uniform? Are tiers of benefits acceptable so long as the lowest tier satisfies acceptable standards? Are tiered benefits more acceptable in some areas, for example, housing, than in others, such as health care?

- What should be the role of the government?

  > To provide a guaranteed income, that is, a negative income tax. Within this income, individuals then could decide how much to spend to meet needs such as food, housing, and health care.

  > To provide fixed assistance for specific purposes, for example, food stamps and two-bedroom housing vouchers?

  > To guarantee access to defined baskets of services, for example, a list of covered medical services and procedures or hospitalization for a specific number of days?

- Should eligibility for benefits and levels of assistance reflect life expectancy?

- Once public roles are defined, how can people be encouraged to meet individual and family responsibilities? Carrots such as tax deductions and credits, or penalties for would-be free riders?

- What should be the division of public responsibilities among levels of government, Federal, State, and local?

- Having agreed on the role of government, how can costs be controlled?

The effects of the aging of the population will cut across the economy, the population, and time. Broader goals and a comprehensive economic and budgetary perspective would bring necessary discipline to the debate. Policy makers and voters could better understand trade-offs and could make more informed choices. Strategic planning would force us to consider issues over a longer time horizon. It should facilitate coordination among budget, tax, and regulatory policy measures. That should make government more efficient and effective and provide an overall yardstick to evaluate progress.

The alternative to this strategic planning approach uses a shorter time horizon, engages in more myopic program-specific decision making, and puts less emphasis on macro effects for the whole population and the entire economy. Although far easier, this route will not prepare the Nation adequately for coming changes in the population and the economy.

Dimensions of the Demographic Changes

Between 1996 and 2030, the number of people aged 65 and above will double, growing to 20 percent of the overall population. The number of people aged 85 and above will triple. Not only will there be more elderly people in the population, but the average elderly person will be older.

- The population is becoming more racially and ethnically diverse, the young more rapidly than the old.

  > Today, 72 percent of those under age 65, and 85 percent of those age 65 and older, are White, not of Hispanic origin.

  > In 2050, ***51*** percent of those under age 65, and 34 percent of those age 65 and older, will be people of color or of Hispanic origin.

- The economic condition of the older adults has improved dramatically since the 1960s. Due principally to Social Security, Medicare, and other public programs, the overall poverty rate among the elderly has been cut in half, but groups of older adults still experience high poverty rates. Poverty rates for older African Americans and senior citizens of Hispanic origin are more than two-and-one-half times higher than for Whites. Poverty increases with age. Individuals 85 and older are more likely to be poor than younger seniors. Single women living alone are more likely to be poor than older men or elderly couples.

- On average, racial minorities and people of Hispanic origin have lower levels of income and wealth, higher rates of poverty, shorter life expectancies, and lower levels of educational attainment than Whites. If these trends do not change, a growing share of the future labor force could lack essential knowledge and skills the economy will need to support a larger retired population and larger segments of the future elderly population will be poor. These conditions could prove even more unfavorable to economic growth and could lead to increased social tensions.

Complex Economic Issues

The U.S. economy is a sum of domestic resources and productive activity. It involves millions of workers, families, and businesses as well as thousands of governmental bodies and other organizations. Relationships are complex and interrelated: there are a "lot of moving parts." There is much that economists have to learn about why the economy behaves the way it does and how public policies affect it.

We do know that economic growth depends on growth in labor, capital, and total factor productivity—TFP (e.g., technology). Holding the other two constant, the Congressional Budget Office (CBO) assumes the slowdown in the growth of labor will drop annual real GDP growth from 2.0 percent in 2005 to 1.7 percent in 2020.[5] The Social Security Administration (SSA) assumes an eventual 1.4 percent GDP growth rate. There is no magic bullet that will spur growth sufficiently to overcome the effects posed by the aging population, but investment in both physical capital and the education and training of the future labor force are essential to offset the slowdown in labor and to increase productivity and long-term growth.

- It is impossible to project standards of living 20, 30 or 50 years from now. Some economists believe that increased elderly consumption will be offset by reduced investment needs for a slower growing labor force. Others project the greater demands of a larger older population will slow, even stop, overall improvements in the standard of living.

[5] CBO (March1997).

- A Committee for a Responsible Federal Budget (CRFB) "back-of-the-envelope" calculation finds, even with the aging population, real per capita consumption would increase 31 percent by 2030 relative to 1995 levels.[6] However, this improvement may be optimistic. Unless changes are made, living standards may fall. CBO projects that current policies would produce large budget deficits, drive up interest rates, and lead to a *downward* economic spiral.

- Low net national savings rates lower investment and impede growth in productivity and output. A 1991 study estimated that if savings rates do not return to their pre-1980s levels, by 2020, consumption (although higher than current levels) will be an estimated 10 percent lower than it would be if savings rates had not declined.[7]

- Since the 1980s, the United States has used foreign capital to finance some domestic investment. The global population is aging. Other economically-developed nations have populations that are aging more rapidly than our own. Their public retirement programs, like Social Security, have large unfunded liabilities. The developed nations' needs for resources to finance public aging-related liabilities combined with ongoing needs for investment capital could raise global interest rates. As a result, financing Federal deficits could become even more expensive than currently anticipated.

- Federal budget deficits reduce national savings. Balancing the budget, even running sustained budget surpluses, is the most direct way government can free up domestic savings for new investment.

Unsustainable Federal Budget Policies

Congress and the President have reached broad agreement to balance the budget in 2002. This agreement includes spending increases and tax cuts. It seeks to extend Medicare HI Trust Fund balances until 2006. (Under current laws and policies, the HI trust fund would be exhausted in 2001.) The agreement does not address medium- and long-term imbalances in Medicare or Social Security. Thus the agreement takes advantage of currently favorable economic and demographic conditions to accomplish a minimal fiscal goal—budget balance in 2002—without setting in place any substantial measures to even begin to address the long-term issues.

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[6] If, instead, the ratio of workers to retirees did not change, consumption would be 47 percent higher. By comparison, consumption doubled between1960 and 1995.

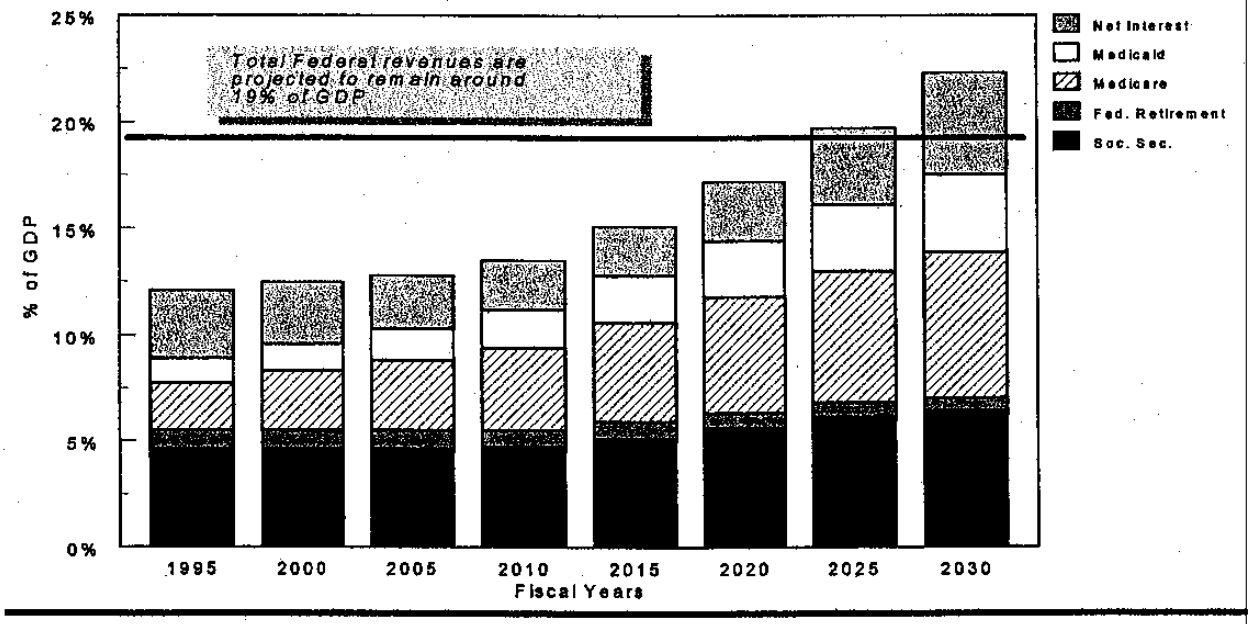
[7] Harris and Steindel (1991).

- Federal government deficits might be more justifiable it they financed investments (e.g., infrastructure, research and development). However, Federal spending increasingly focuses on consumption, largely in the form of individual transfer payments (entitlements), not investment, which is funded under the discretionary side of the budget.

- CBO projections of current policies indicate Federal spending, not counting interest, will increase 4 percent as a share of GDP between 1996 and 2030. This increase largely reflects increased Social Security, Federal retirement, Medicare, and Medicaid spending for retired baby boomers. If future taxpayers are unwilling to pay higher total taxes to fund this level of government, other programs will be crowded out, or Federal deficits and borrowing will spiral upward out of control.

- By 2030, annual budget deficits would explode, growing to 8 or even 12 percent of GDP (depending on the feedback effects of Federal borrowing on the overall economy), compared to 1.4 percent in 1996. Deficit financing would cause huge increases in interest expense. Federal borrowing from the public would exceed 100 percent of GDP and could reach 120 percent. Debt and deficits this high are unsustainable.

Figure 1.2
Social Security, Federal Retirement, Medicare, Medicaid, and Net Interest Consume Total Federal Revenues



SOURCE: CRFB based on CBO and OMB materials.

- Federal budgets are supposed to allocate resources according to national priorities. If this were true, it would mean that pension and health benefits for older adults are our highest priority. The Federal budget already allocates 71 percent of entitlement spending and 38 percent of all spending to programs benefiting the elderly. By 2030, the elderly population will be the only Federal priority. If current policies were to continue, spending for Social Security, Medicare, Medicaid, Federal pensions, and net interest would exceed Federal revenues from all sources. (See Figure 1.2).

- By comparison, State and local government budgets include significant expenditures for education and income support that benefit children and young adults. In 1995, States used about 60 percent of their general fund spending for elementary, secondary, and higher education, cash (welfare) assistance, and non-elderly Medicaid. On the one hand, because the younger population is projected to remain fairly stable as a percentage of the overall population, States budgets will not face the same type of demographically driven budget pressures as the Federal budget. On the other hand, larger elderly populations and smaller active working populations will affect State revenue bases in the same way as the Federal budget will be affected.

- If allowed to continue, these policies would be unfair to younger generations. Younger workers would face the prospect of higher and higher tax burdens and eroding standards of living in exchange for little assurance that they would receive similar benefits when they retire.

- The status quo does not serve the best interests of the groups that depend most on government assistance. As the competition for scarce budget resources heats up, the least politically powerful and the most vulnerable are at greatest risk for cutbacks.

How Will Baby Boomers Fare?

Baby boomers range from 32 to 51 years in age. They number 78 million, or 40 percent of the voting age population, making them a potentially powerful political force.

- As boomers focus on retirement, they should recognize how much they have at stake. Public policy change probably will affect boomers more acutely than other segments of the population. Individuals who are closer to retirement or already retired probably will be protected by transition provisions. Younger age groups have longer to adjust to changes. Boomers worry about their retirement while still supporting their children. Policy change affecting current retirees could affect boomers directly if they have to provide more financial support for their parents and indirectly through lower eventual inheritances.

- The oldest boomers became eligible to join the American Association of Retired People (AARP) last year, but their expectations are inconsistent with the reality of retirement. Almost half of the boomers plan to retire early, yet few are saving at the rates needed to maintain their current standards of living in retirement even if Social Security and Medicare benefits are maintained at current law levels.[8] The savings gap is even greater if any substantial changes to public retirement and health care programs are factored in.

- It is impossible to predict accurately how boomers will fare in retirement. Most studies expect retired boomers to match or exceed the standard of living currently enjoyed by their retired parents.[9] *But these projections assume no changes in Social Security, Medicare or tax policy that will adversely affect their pre- and post-retirement incomes.* Although matching their parents' current standard of living may not sound so bad to some, it means that standards of living in retirement will not reflect the real economic growth that even a more slowly growing economy will provide over the coming decades. Furthermore, it ignores the very modest standards of living in which many older adults currently find themselves.

- It is possible that the aggregate impact of boomers' retirement could dampen the value of financial assets and housing. Some economists project declines in the value of assets, particularly housing, when retired boomers sell them to finance retirement consumption. Without transition provisions, changing to a consumption-based tax system could have a negative impact on assets accumulated prior to the conversion and further erode retirement incomes.

- Growing disparities in income among current workers will be mirrored in retirement. White, well-educated males will have the highest incomes in retirement. Groups more likely to have low retirement incomes and to depend more heavily on public programs include women (particularly single heads of households), racial minorities, people of Hispanic origin, those with less education, and low-wage earners.

- Making more determined efforts in the near future to conform public policies and private behaviors to changing demographic and economic realities would permit more gradual transitions and wider sharing of resulting costs.

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[8] Employee Benefit Research Institute (EBRI), Matthew Greenwald & Associates, and American Savings Education Council survey results reported in *National Journal* (November 2, 1996). Most retirement planners use a 60 percent to 80 percent replacement of pre-retirement income as an estimate of what is needed to preserve pre-retirement standards of living.

[9] CBO (September 1993), Sabelhouse and Manchester (1995), AARP (1994).

Analytic Issues

- Economists and other policy analysts are ill-equipped to anticipate and understand the outcomes of major policy reforms. There is a great need for additional data and research on very basic issues such as linkages among savings, investment, and growth.

- There is widespread agreement that economic growth is essential and that additional investment in human and physical capital is necessary to achieve it. There is, however, little agreement about which specific policies will achieve those ends. In part, that is because changes in one are of the economy are offset in other areas and produce only modest aggregate change. In addition, the success of many proposed policy options rests on changing individual behavior. Because, for example, there are numerous theories about why people save, it is difficult to predict whether they will increase net savings in response to specific policy changes.

- Questions about statistical measurements of the economy complicate the ability of policy analysts to inform policy makers. The accuracy of the consumer price index (CPI), for example, has been widely criticized. If the CPI overstates inflation, as many economists believe, real improvements in the standard of living have been understated and cost-of-living adjustments (COLAs) for Social Security and Federal employee retirement programs and indexing on the revenue side of the budget have been overly generous. A lower CPI significantly would improve long-term deficit projections and raise projections of real economic growth. In addition, a lower CPI would reduce substantially Social Security costs over the long-term.[10]

- Even among Federal agencies, economic and analytic assumptions vary. The absence of consistent assumptions across government agencies complicates the types of cross-cutting analyses a comprehensive framework requires. For example, the Social Security Actuary uses different economic assumptions than the CBO and different demographic assumptions than the Bureau of the Census. The Health Care Financing Administration (HCFA) uses different assumptions than the Bureau of Economic Affairs (BEA).

- As the population becomes more diverse, knowing how policy changes affect different population subgroups becomes more important. However, concerns about individual privacy conflict with the objective of knowing more about the economic and demographic characteristics of those receiving government benefits and tax breaks. Currently, policy analysts perform limited "snapshot" estimates of

[10] For example, a 1 percent reduction in the Social Security COLA beginning in 1996 would improve the long-run OASDI actuarial balance by 1.4 percent—over 60 percent of the currently estimated actuarial gap.

the average impact of policy changes. It is difficult to follow beneficiaries over time to assess the longer term effect of policies. Analysts know little about how subgroups of the beneficiary population are affected. Without this information, it is difficult to evaluate who really benefits from the sum of public policies, whether overall policy objectives truly would be fulfilled, and whether the results would be disproportionately burdensome or overly generous relative to lifetime tax burdens.

Setting Goals to Address the Graying of America

It may be difficult, but it is not impossible, to engage the public in a debate about these difficult issues and choices. The American public is smart enough to know that changes will have to be made. But it will take leaders who are willing to recognize that solving these problems will take more than politically expedient promises to "save" entitlement programs or to provide middle-class tax relief. It will take voters who are willing to accept that both of these options tend to lead in the opposite direction from where we need to go.

Given the challenges we face over the coming decades, agreement on broad goals is a prerequisite to adopting the types of public policies and private behaviors that support a brighter and more secure future. While the following suggestions are always relevant, they will be more important as the population ages.

- Promote stronger economic growth, productivity, and competitiveness.
- Promote adequate, stable financial security for the elderly.
- Promote equity of taxes and benefits both within and across generations,
- Encourage individual responsibility and promote individual opportunity,
- Minimize distortions of individual behavior,
- Exercise sound fiscal policy and enforce budget discipline.

Short-Term Goals

We cannot hope to build a consensus over sustainable economic and budget policies overnight. We will not develop and implement the changes needed to position the United States for the millennium in a year — perhaps not in a decade. But we can ill afford the status quo. In the short term, we can and should make progress.

- **Balance the budget.** Congress and the President have agreed to balance the budget by 2002. This is a good start. Now they must enact into law the specific measures to achieve that goal. Next, they should agree to keep the budget in balance thereafter, absent war, major emergencies, or economic exigencies.

- **Don't make the problem worse.** Weigh impending demographic changes when considering proposals such as "back-end loaded IRAs" and capital gains tax breaks. Expanded health care benefits for older adults are also problematic. None appears that costly over the short term. But all have the potential to explode just as the baby boom generation retires and budgetary pressures become exponentially greater than they have been during the last two decades. (Similarly, tuition tax credit proposals are less costly today than they will be when the baby boomlet reaches college in the next 10 to 20 years.)

  Discrete policy proposals must be accompanied by other changes to reduce spending dramatically in other areas of the budget or to raise taxes. Otherwise they could force future politicians to choose between huge deficits and canceling benefits.

- **Lower the level of rhetoric.** We must educate the public about these issues. No government mandate will be as effective as voluntary changes in individual attitudes and behavior. Elected leaders can play an enormously positive role by helping their constituents to understand the issues and trade-offs. Voters, in turn, should require elected leaders to define responsible policy agendas when they run for office to keep campaign promises once elected.

  > Increase the level of public understanding about issues and the need for change.

  > Change the scope of public debate from a program-by-program approach to a comprehensive perspective. Look at issues across the budget, the economy, and generations.

  > Discourage political rhetoric and quick fixes that make it harder to solve long term problems.

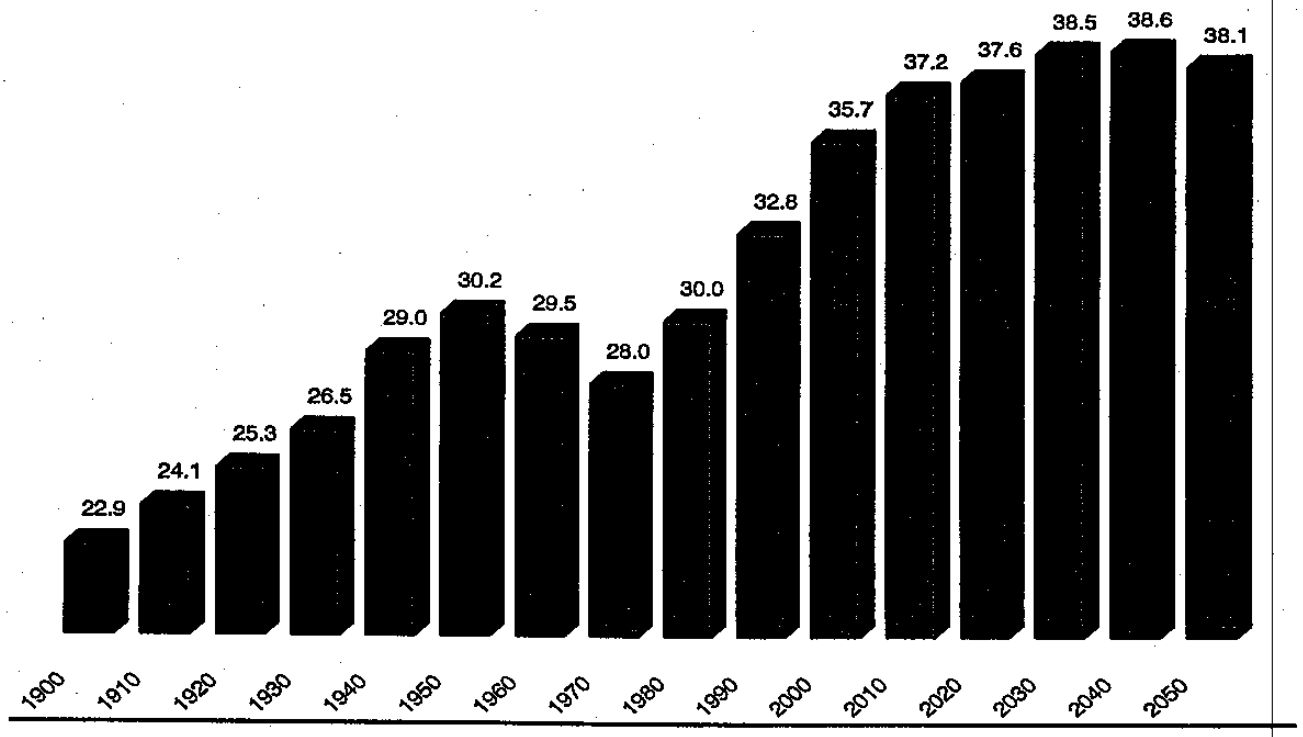
- **Promote consensus** around the need for common standards to measure proposed policy changes: What is the impact on net national savings and investment? Are results consistent with overarching policy objectives

- **Improve data collection and encourage further research** into economic implications of the aging of the population to increase understanding about which policy changes will work and which will not and how their effects will be distributed across the population.

Chapter 2. The Demographic Perspective

The population of the United States is aging.[1] Between 1970 and 2030, the median age of the population will increase by 10 years. (See Figure 2.1.)

Figure 2.1
Median Age of the U.S. Population



SOURCE: Bureau of the Census (1975 and February 1996).

[1] Unless otherwise noted, the source for data included in this chapter comes from the April 1996 Bureau of the Census publication *65+ in the United States* for statistics on the social characteristics of the elderly. Pre-1970 statistics are from the Bureau of the Census, *Historical Statistics of the United States: Colonial Times to 1970* (1975). Population projections are from Bureau of the Census, *Population Projections* of the *U.S. By Age, Sex, Race and Hispanic Origin*: 1995-2050 (February 1996). Other references are noted.

Why the Population is Aging

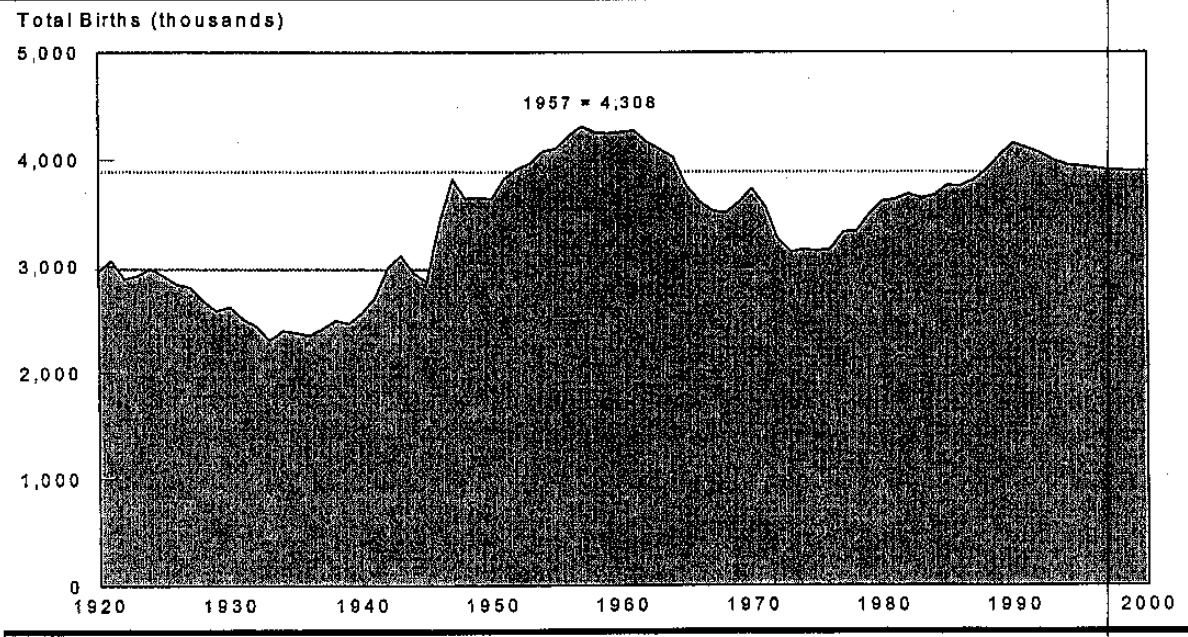
The aging of the population is the result of two factors: the large number of births following World War II (the baby boom generation), and dramatic improvements in life expectancy.

The Baby Boom

- Members of the post–World War II baby boom were born between 1946 and 1964. Today, they number 78 million. This is the only cohort in U.S. history to be larger than its successor—or "baby bust"—cohort. (See Figure 2.2.)

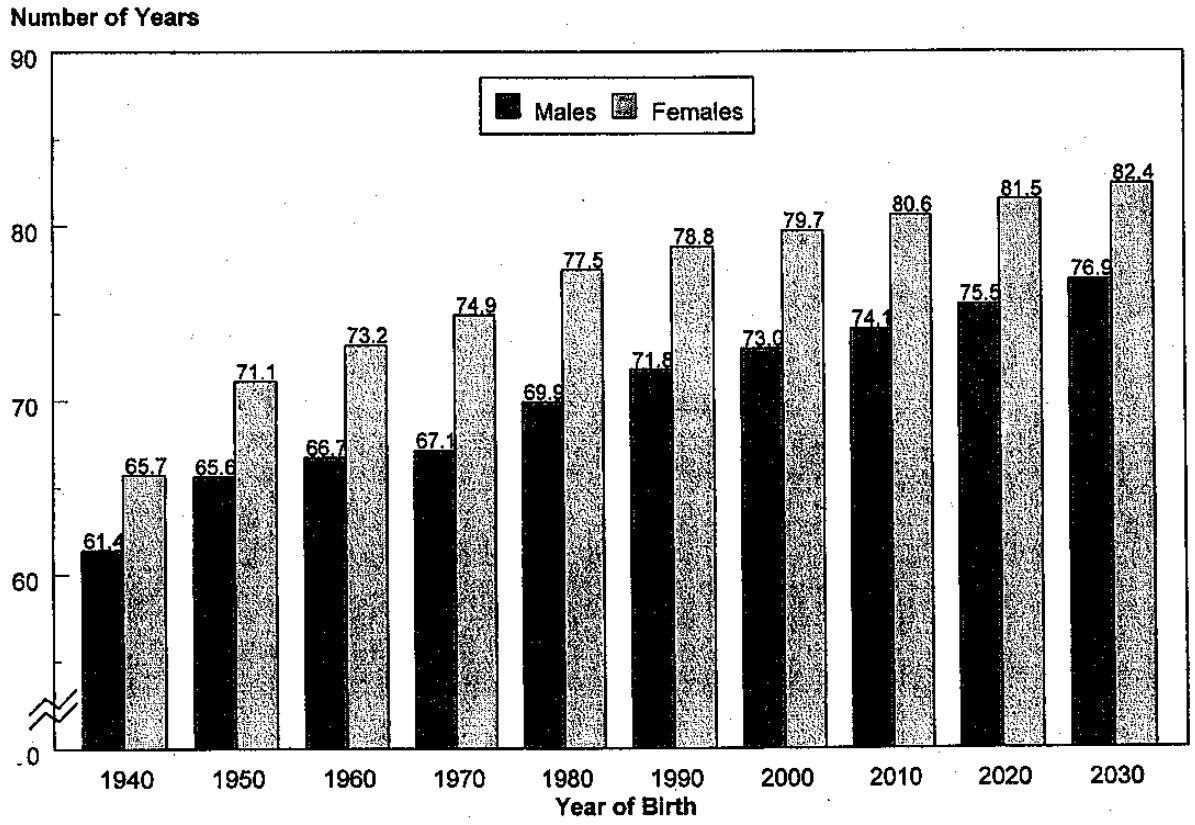
- The baby boomers will reach age 65 between 2011 and 2030. In those years alone, the number of people age 65 and older will increase by 30 million. In 2030, 69 million people will be 65 and older, and they will make up slightly over 20 percent of the population.

Figure 2.2
Baby Boom, Baby Bust



SOURCE: Historical data: Bureau of the Census (1975). Projections: Bureau of the Census intermediate assumptions (February 1996).

Figure 2.3
Life Expectancy at Birth



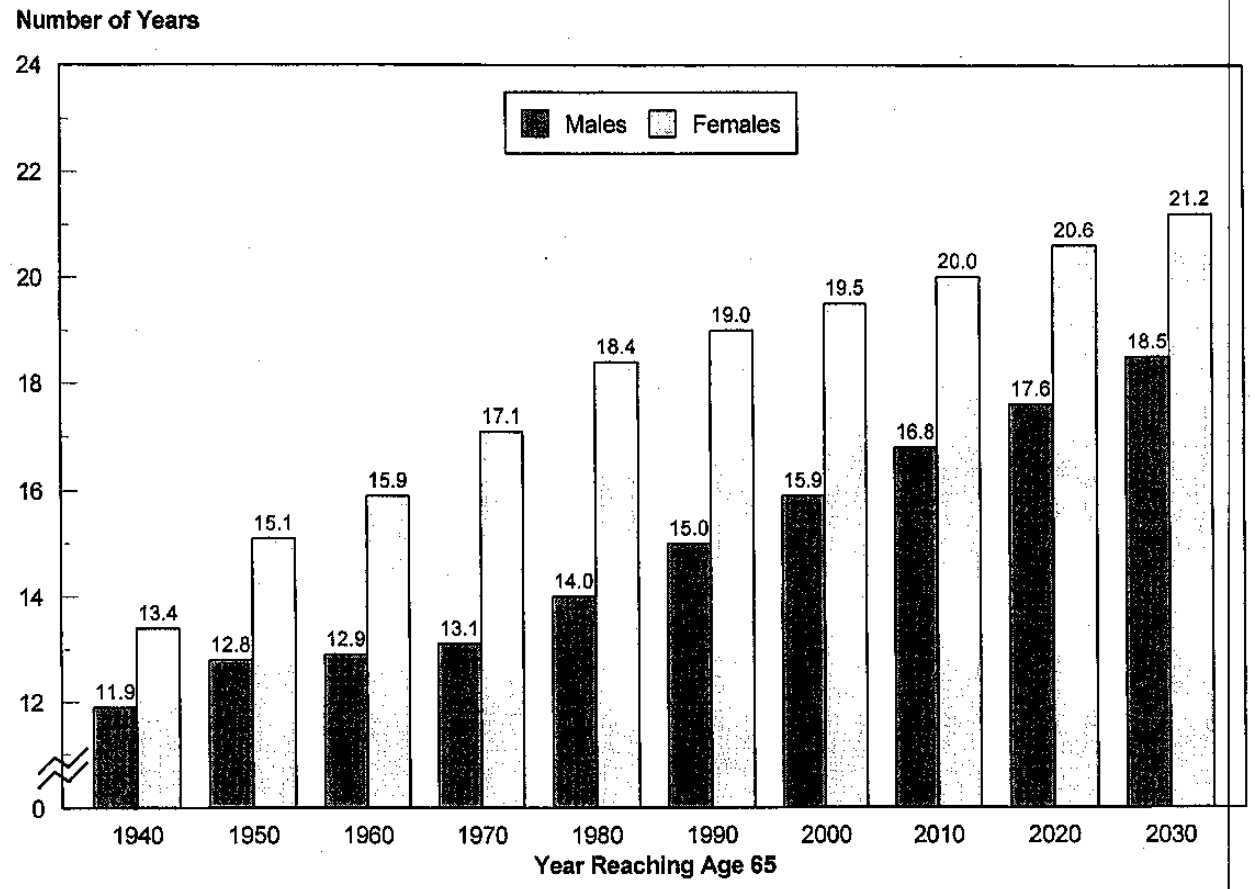
SOURCE: Historical data. Board of Trustees of the Federal Old Age and Survivors and Disability Insurance (OASDI) Trust Funds (1997). Projections: Bureau of the Census intermediate assumptions (1996).

Life Expectancy

- Between 1935 and 1995, average life expectancy at birth increased more than 12 years for men and 15 years for women. 80 percent of newborns in 1991 can expect to reach age 65, which is 33 percent more than in 1940. (See Figure 2.3.)

- Upon reaching age 65, men are now expected to live past 80, 3 years longer than in 1940. Women who reach age 65 are now expected to live to 84—almost 6 years longer than in 1940. (See Figure 2.4.)

Figure 2.4
Life Expectancy at Age 65



SOURCE: Historical data: Board of Trustees of the Federal OASDI Trust Funds (1997). Projections: Bureau of the Census intermediate assumptions (1996).

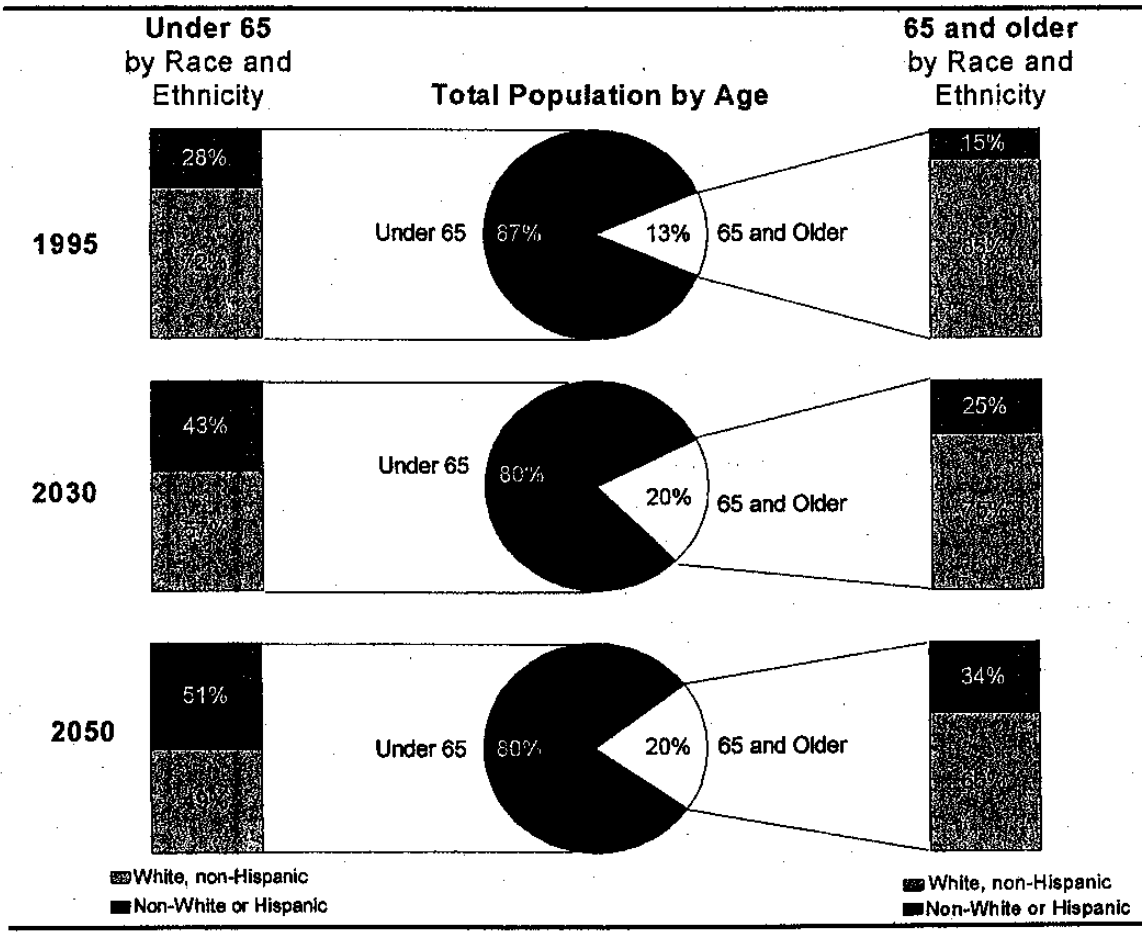
How the Population is Changing

- There will be more seniors and the average elderly person will be older. Since 1965, the number of people age 65 and above has almost doubled; and it will double again by 2035. The number of the oldest old (those 85 and above) has tripled and is expected to triple again by 2035. The population as a whole, however, is expected to grow by a third.

- The number of children and youth below the age of 20 also will increase, but only about as fast as the number of people in the prime working age range of 20 to 64. As a share of the total population, children and youth will decrease slightly from 29 percent to 27 percent between 1996 and 2030.

The population is becoming more racially and ethnically diverse, the young more quickly than the old. Asians and people of Hispanic origin are the fastest growing segments of the population. (See Figure 2.5.)

Figure 2.5
Racial and Ethnic Composition of the Population by Age

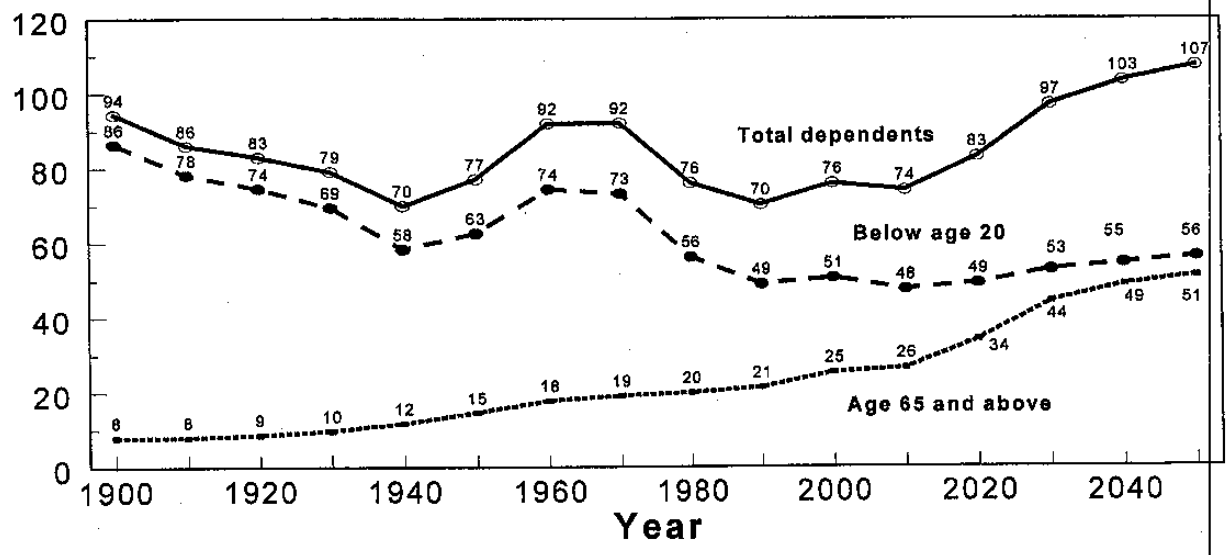


SOURCE: Bureau of the Census (February 1996).

As the population ages, each worker will have to support a greater number of dependents.[2] Currently, there are 71 dependents for every 100 individuals of working age. By 2030, the ratio of dependents for every 100 workers will increase to 97 due to the growing number of older adults. (See Figure 2.6.)

[2] Dependents are defined as children and youth below the age of 20 and seniors 65 or above.

Figure 2.6
Number of Dependents per 100 Workers



SOURCE: Bureau of the Census (February 1996).

Implications for Public Policy

It is clear that the population of the United States will change significantly during the next several decades. As the population becomes both older and more diverse, analysts can anticipate, but not accurately predict, economic and social changes. Future needs and priorities will be different. The challenge facing public decision makers is how to balance both present and future interests, as well as the needs of the different segments of the population.

Aging is, by definition, a dynamic process. As individuals age, their physical, economic, and social characteristics change. Economists assume that people take a "life cycle" perspective their individual economic situations. In other words, people should behave in ways that smoothes out consumption over their lifetimes (e.g., saving while working and earning incomes to maintain a higher level of consumption in retirement). Even so, it is not reasonable to assume that each generation will behave exactly as the preceding generation. Someone who is 35 today acts and thinks differently than today's 65 year old did 30 years ago. In 30 years, the 35 year old will not act just like today's 65 year old.

Just as the circumstances of today's older adults are different from past generations of seniors, tomorrow's elderly population will possess many different characteristics and have different needs. The availability of informal sources of support from family and other private organizations will change along with the availability of public support.

Existing trends may not hold up over the long term, but they provide the best indicators of what the future might look like. Thus they can help determine what future policy directions might be appropriate. While looking at the trends, it is important to keep in mind that averages can be misleading. Within the elderly and the nonelderly populations, economic, social, and cultural differences exist. While economic trends have generally been positive among all segments of the population, whether grouped by age, race, ethnicity, gender, or family structure, disparities continue to exist. The fact that we cannot predict whether these disparities will persist, worsen, or improve makes the policy issues more complicated. Policy makers need to be aware of evolving differences and take them into account as they design policy options.

The Growing Elderly Population

The elderly segment of the population is growing in absolute and relative terms, and will continue to do so in the future; the "oldest old" (individuals age 85 and above) are growing the quickest. (See Table 2.1.)

Table 2.1
Elderly Population, 1935-2050

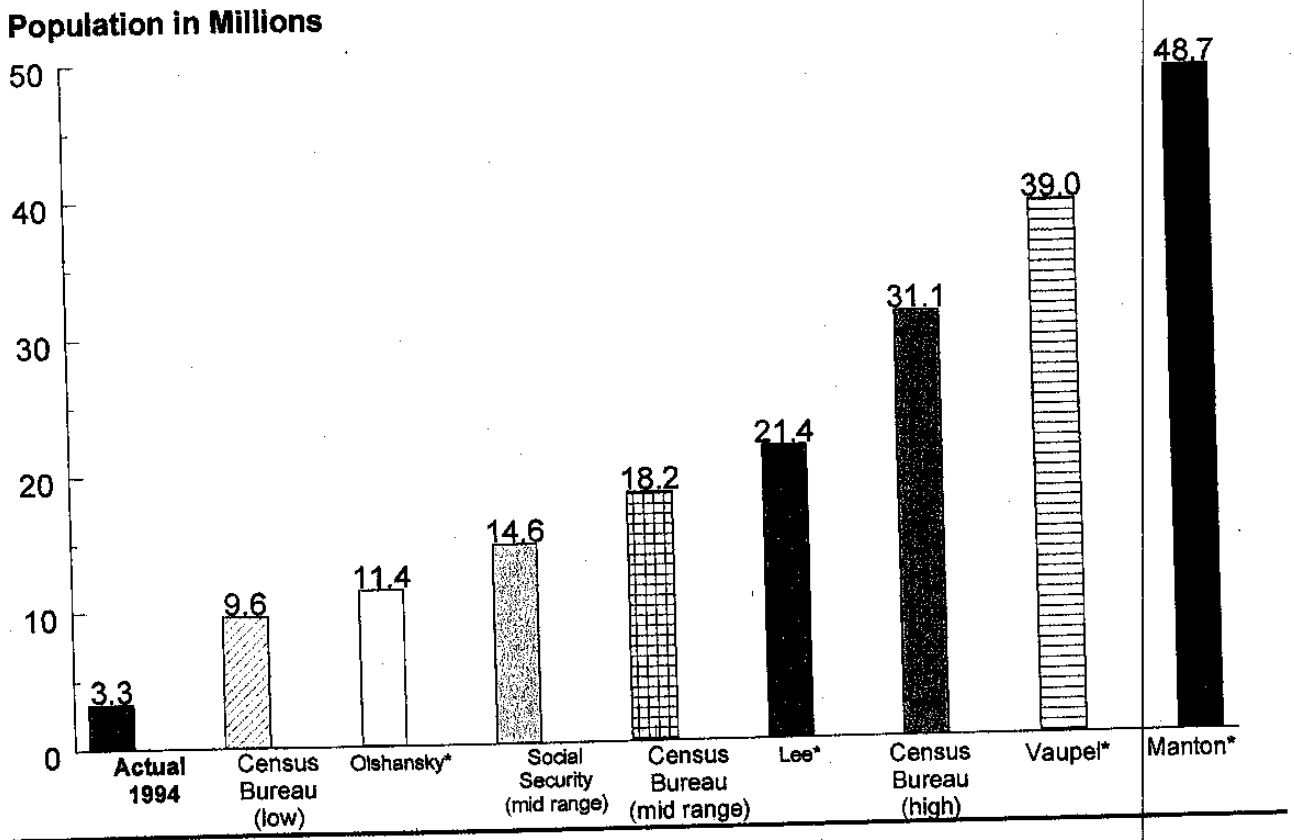
	1935	1965	1996	2010	2030	2050
People (in thousands)						
• 65 and above	7,804	18,451	33,872	39,408	69,379	78,859
• 85 and above	318*	1,169*	3,747	5,671	8,455	18,223
As a percentage of the total population:						
• 65 and above	6.1	9.5	12.8	13.2	20.0	20.0
• 85 and above	0.2*	0.6*	1.4	1.9	2.4	4.6
As a percentage of those age 65 and above:						
• 85 and above	4.1*	6.4*	11.1	14.4	12.2	23.1

SOURCE: Bureau of the Census (1975 and February 1996).

* Mid-point of decennial census data.

Ongoing research indicates that current Census and Social Security Administration (SSA) projections of the future number of the oldest old (individuals age 85 and above) may be conservative. (See Figure 2.7.) If so, current projections of Social Security costs may be too optimistic. The implications of longer life expectancies for Medicare and Medicaid are less certain. Some researchers believe that fewer seniors will be disabled and older people generally will be healthier.[3] If so, per capita Medicare and Medicaid costs would not be as high as current expenditure rates imply, but greater numbers of people living to advanced ages could mean that aggregate costs would be higher than currently projected. Healthier and longer life spans may delay, but not completely avoid, costly end of life health care spending.

Figure 2.7
U.S. Population, Age 85 and Older in 2050



SOURCE: National Institute on Aging (NIA) (1996).

* Research results supported by NIA.

[3] Manton *et al.* (1997).

Because women live longer than men, there are, and will continue to be, more older women than men, with the difference greatest among the oldest. Mortality rates for elderly women have improved more rapidly than for men, but the gap is projected to narrow. (See Table 2.2.)

Table 2.2
Elderly Population by Sex

	1935	1965	1996	2010	2030	2050
Percentage below 65 who are:						
• Men	50.4*	48.9*	50.0	49.8	49.8	49.9
• Women	49.6*	51.1*	50.0	50.2	50.2	50.1
Percentage of 65 and above who are:						
• Men	49.4*	46.5*	40.9	42.9	45.7	45.7
• Women	51.6*	56.4*	59.1	57.2	54.3	54.3
Percentage of 85 and above who are:						
• Men	42.9*	36.4*	28.0	31.2	35.7	38.6
• Women	57.1*	63.6*	72.0	68.8	64.3	61.4

SOURCE: Bureau of the Census (1975 and February 1996).

* Mid-point of decennial census data.

The elderly are becoming more diverse in terms of race and ethnicity, the young elderly more quickly than the old. (See Table 2.3.)

Table 2.3
Elderly Population by Race and Hispanic Origin

	1935*	1965*	1996	2010	2030	2050
Percentage 65 and above who are:						
• White	93.4	91.9	89.5	87.3	84.7	81.3
• African American	6.3	7.4	8.1	8.7	10.0	10.9
• Other	0.3	0.7	---	---	---	---
• Asian American	---	---	2.0	3.4	4.7	6.6
• Native American	---	---	0.4	0.6	0.6	0.8
*White, Non-Hispanic***	---	---	*85.2*	*80.8*	*74.6*	*66.0*
*Hispanic***	---	---	*4.7*	*7.2*	*11.2*	*17.5*
Percentage 85 and older who are:						
• White	---	---	90.9	90.1	86.7	84.7
• African American	---	---	7.6	7.0	7.5	8.6
• Asian American	---	---	1.0	2.3	5.0	5.9
• Native American	---	---	0.4	0.6	0.8	0.8
*White, Non-Hispanic***			*87.4*	*84.4*	*76.0*	*68.6*
*Hispanic***	---	---	*3.8*	*6.1*	*11.7*	*17.8*

SOURCE: Bureau of the Census (1975 and February 1996).

* Mid-point of decennial census data.
** People of Hispanic origin may be of any race.

The rest of the population is becoming diverse more rapidly than the elderly population. (See Table 2.4.)

Table 2.4
Nonelderly Population by Race and Hispanic Origin

	1935*	1965*	1996	2010	2030	2050
Percentage below 65 who are:						
• White	89.6	85.6	81.8	79.4	75.8	73.1
• African American	10.0	11.1	13.3	14.2	15.5	16.5
• Other	0.5	3.3	---	---	---	---
• Asian American	---	---	3.9	5.4	7.6	9.2
• Native American	---	---	0.9	1.0	1.1	1.2
*White, Non-Hispanic***	---	---	*71.5*	*66.2*	*57.0*	*49.5*
*Hispanic***	---	---	*11.3*	*14.8*	*20.8*	*26.3*

SOURCE: Bureau of the Census (1975 and February 1996).

* Mid-point of decennial census data.
** People of Hispanic origin may be of any race.

Life Expectancy

All subgroups of the population enjoy longer life expectancies than they did previously. The number of years of life remaining both at birth and at age 65 continue to increase. (See Table 2.5.) However, life expectancies vary among subgroups of the population. Longevity is influenced positively by levels of income, wealth, and education. Higher income, better educated people tend to live longer than those with lower incomes and less education.[4]

Women live longer than men. Whites have longer life expectancies than any other racial group. White women are most likely to reach age 85. In 1991:

- Fewer than half (46 percent) of African American men lived to age 65 or above, compared to 68 percent of White men.

- 62 percent of African American women lived to age 65 or above, compared to 82 percent of White women.

- However, since 1900, data indicate that at age 85, life expectancy rates for African Americans and Whites cross over. That is, African American men and African American women are expected to live longer than White men and women. More recent data indicate that this crossover pattern may have ended.[5]

[4] Preston and Taubman (1994).
[5] National Center for Health Statistics data (1991) cited by Bureau of the Census (April 1996).

Table 2.5
Life Expectancy at Birth and at Age 65
(In years)

	1940	1960	1996	2010	2030	2050
Life expectancy at birth						
Total						
• Men	60.8	66.6	72.6	74.1	76.9	79.7
• Women	65.2	73.1	79.4	80.6	82.4	84.3
White						
• Men	62.1	67.4	73.7	75.5	78.7	82.0
• Women	66.6	74.1	80.1	81.6	83.7	85.9
African American						
• Men	51.5	61.1	64.8	65.1	67.9	70.8
• Women	54.9	66.3	74.6	75.5	77.6	79.7
Life expectancy at age 65						
Total						
• Men	11.9	12.8	15.5	16.8	18.5	20.3
• Women	13.4	15.8	19.2	20.0	21.2	22.4
White						
• Men	15.1*	15.9*	15.8	17.3	19.3	21.6
• Women	17.0*	19.7*	19.4	20.4	21.9	23.6
African American						
• Men	13.2*	14.9*	13.6	14.3	15.4	16.5
• Women	14.2*	17.7*	17.7	18.3	19.3	20.3

SOURCE: Bureau of the Census (1975 and February 1996).

* Remaining life expectancy at age 60.

Economic Characteristics

The economic circumstances of the elderly have improved significantly since the 1970s. Elderly incomes have increased more in real terms than the incomes of the younger population. Much of this improvement can be attributed to government transfer programs, especially Social Security and Medicare. Poverty rates among the elderly are now lower than for younger people under age 35, but higher than for people between the ages of 35 and 64, the prime working years. However, incomes and assets vary considerably among segments of the elderly population, and some seniors, particularly single women age 85 and above, and elderly people of color, remain poor.

Labor Force Participation Rates

Labor force participation among those at and approaching age 65 has dropped substantially and is projected to continue to drop. (See Table 2.6.) The largest drops in labor force participation for both men and women occur at ages 62 and 65, the eligibility ages for early and normal Social Security retirement benefits. Although the combination of private pension and employment policies and Social Security normal retirement age explains the drop at age 65, it is likely that exits from the labor force are strongly influenced by Social Security's early retirement benefits at age 62.[6]

- For men, labor force participation rates drop 12 percentage points at age 62 and 10 percentage points at age 65.
- Women's participation rates drop 9 percentage points and 7 percentage points at ages 62 and 65.

Table 2.6
Labor Force Participation
(Percentage of subject population in the labor force)

	1950	1960	1996	2010	2030	2050
All ages	59.9	60.2	66.8	64.9	59.4	58.6
• Men	86.8	84.0	74.9	73.2	67.2	66.5
• Women	33.9	37.8	59.3	57.1	52.0	51.2
• 55 to 64	56.7	60.9	57.9	55.5	53.6	54.4
• Men	86.9	86.8	67.0	65.1	63.4	63.9
• Women	27.0	37.2	49.6	46.3	44.8	45.1
Above 65	27.0	20.9	12.1	10.2	9.6	8.7
• Men	45.8	33.1	16.8	14.5	13.5	12.4
• Women	9.7	10.8	8.8	7.2	6.7	5.9

SOURCES: Bureau of Labor Statistics:1950, 1960, and 1996. SSA mid-range projections: 2010, 2030, and 2050.

[6] Technical Panel on Trends and Issues in Retirement Savings (1995).

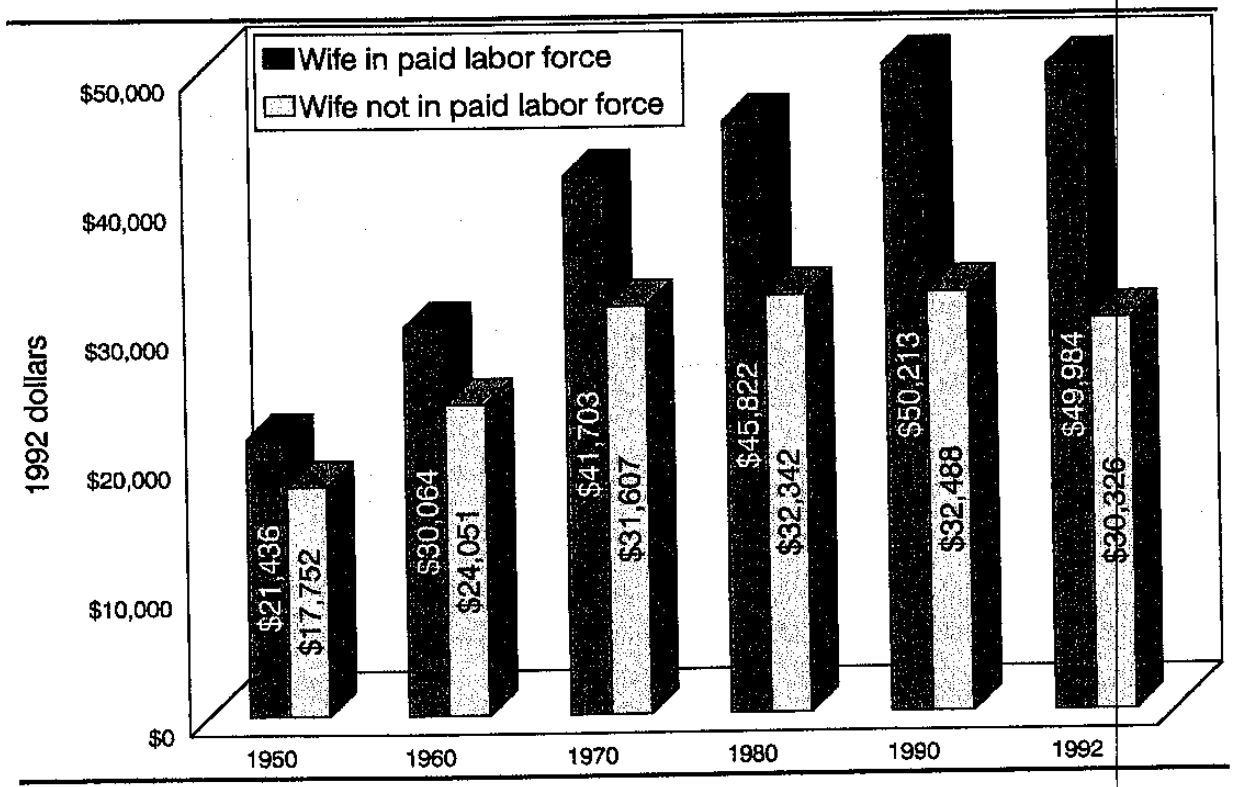
Between 1940 and 1995, the average age of new Social Security retirees dropped five years for both men and women. It now stands at 63.6 years. In 1995, 49 percent of men and 55 percent of women began receiving Social Security retirement benefits at age 62.

Some analysts believe that labor force participation rates among older workers are bottoming out. Reductions in public and private pension plans will create economic incentives for people to work longer. As the growth in the labor force slows, employers are more likely to encourage older workers to continue working instead of promoting early retirements.

Incomes

In the two and a half decades following World War II, strong economic growth produced growing family incomes. Economic growth continued in the 1970s and 1980s, but at a slower pace. If women had not entered the workforce in large numbers, real (inflation-adjusted) family incomes might have declined. (See Figure 2.8.)

Figure 2.8
Median Income of Married Couple Familiies



SOURCE: Bureau of the Census (September 1993 (b)).

Since 1950, the inflation-adjusted income of elderly persons has improved by more than 2.8 percentage points per year, a much stronger growth rate than experienced by any younger age group. (See Table 2.7.) Seniors' incomes continued to improve during the 1970s and 1980s when the incomes of some other age groups declined in real terms. Income transfers through Social Security and Medicare are largely responsible for these continuous improvements in the financial condition of older adults.

Table 2.7
Median Money Income of Persons by Age: 1950–90
(Average annual percentage change, 1992 CPI-U-X1 adjusted dollars)

	Age					
Years	20–24	25–34	35–44	45–54	55–64	65 and above
			Males			
1950–60	0.57	3.03	3.29	3.79	3.42	3.43
1960–70	2.19	2.76	2.93	3.28	3.39	3.51
1970–80	-0.08	-0.54	0.61	0.89	0.39	1.82
1980–90	n.a.	-1.44	-0.66	-0.23	-0.19	1.98
1950–90	n.a.	0.93	1.53	1.92	1.74	2.68
			Females			
1950–60	-0.14	0.53	2.38	3.25	2.27	2.32
1960–70	1.61	3.66	2.83	3.21	4.98	3.75
1970–80	0.39	0.82	-0.61	-1.39	-1.74	3.37
1980–90	n.a.	1.29	3.52	3.42	1.85	1.83
1950–90	n.a.	1.57	2.02	2.10	1.81	2.82

SOURCE: CRFB calculations based on Bureau of the Census data (September 1993 (b)).

Because incomes of older adults are growing faster than those of the rest of the population, the gap between the median income among elderly households and that of the rest of the population is narrowing. (See Table 2.8.)

Table 2.8
Median Income of Households
(1994 Dollars)

Year	1967	1975	1985	1994
Householders 15 years and older:				
• Total	$29,317	$31,117	$32,530	$32,264
• 65 and above	11,268	14,728	18,255	18,905

SOURCE: Bureau of the Census (September 1996 (a)).

Despite general improvements in median income, large disparities remain between men and women and by race for all age groups. (See Table 2.9.)

Table 2.9
Median Money Income of Persons: 1992

	Total	Below 65					65 and above		
	All Ages	Total	25–34	35–44	45–54	55–64	Total	65–74	75+
All races:									
• Male	$20,654	$22,013	$21,605	$29,827	$32,379	$25,271	$14,548	$15,737	$12,848
• Female	10,774	11,803	13,713	15,468	15,875	10,168	8,189	8,225	8,153
White:									
• Male	21,645	23,464	22,548	30,977	34,001	26,619	15,276	16,598	13,434
• Female	11,036	12,081	14,440	15,659	16,114	10,467	8,579	8,592	8,567
African American:									
• Male	12,754	14,162	15,456	19,425	20,639	14,837	8,031	8,432	7,437
• Female	8,857	10,142	10,632	14,495	14,351	8,177	6,220	6,481	5,927
Hispanic origin:*									
• Male	13,810	14,304	15,121	18,843	18,490	16,034	9,253	10,234	7,987
• Female	8,357	9,046	10,583	11,303	10,831	6,845	5,968	6,030	5,879

SOURCE: Bureau of the Census (September 1993 (b)).

*People of Hispanic origin may be of any race.

- In 1992, older White males had median incomes 90 percent higher than those of African American males and 65 percent higher than those of Hispanic males of the same age group.

- The gap between elderly White and elderly African American women was 33 percent. There was a 44 percent gap between White women and Hispanic women.

- Over the last 40 years, median African American family income has risen from about half to about two-thirds of the income of White families.

Poverty

The poverty rate among the elderly has declined dramatically since the 1970s and now stands at half of its former level.[7] Whereas the elderly were then twice as likely to be poor as the overall population, the elderly are now less likely to be poor. In contrast, the poverty rate among children has increased by a third. The rate for nonelderly adults has risen slightly. (See Figure 2.9 and Table 2.10.)

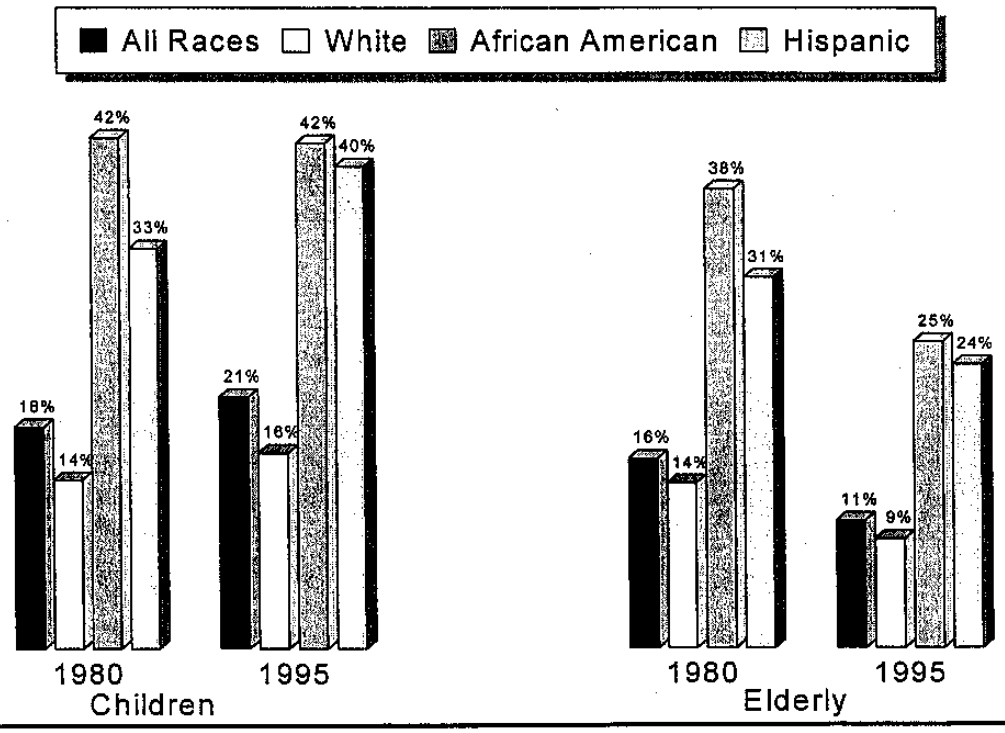
- In 1995, 10.5 percent of the elderly were poor, compared to 25 percent in 1970 and 16 percent in 1980. Although the poverty rate has declined, many individuals age 65 and above are still poor. Among the older population, poverty rates increase with age. Thirteen percent of all individuals age 75 or older were poor in 1995, compared with 8.6 percent of seniors ages 65 to 74. Over a fifth (21.2 percent) of individuals age 65 and older living alone were poor.

- Almost twice as many children as seniors were poor in 1995. Between 1970 and 1995, the poverty rate for children rose from 15 percent to 21 percent.

- Poverty rates for African Americans and Hispanics of all age groups are two or more times higher than poverty rates for Whites. In 1995, 9 percent of Whites age 65 and above were poor, while 25.4 percent of older African Americans and 23.5 percent of older Hispanics fell below the poverty threshold. Among the population age 75 and older, 11 percent of Whites, 33 percent of African Americans, and 27 percent of Hispanics were poor.

[7] The "poverty rate" used here is the official definition of poverty based on pre-tax income, only, excluding capital gains. It does not include the value of noncash benefits (e.g., employer-sponsored health insurance, food stamps, Medicare, Medicaid, housing assistance). A discussion of poverty rates under alternative definitions is included later in this chapter.

Figure 2.9
Poverty Rates by Race and Age: 1980 and 1995



SOURCE: Bureau of the Census (September 1996 (b) and Web site (1997)).

- In 1995, 42 percent of African American children and 40 percent of Hispanic children were poor compared to 16 percent of White children.

- The percentage of older adults at *or near* poverty, that is, with incomes below 125 percent of the poverty line, has fallen more slowly than the percentage in poverty. Since 1990, the percentage of elderly living near poverty has ranged between 18 percent and 20 percent, within a percentage point higher than the rate for the population as a whole.

The official definition of "poverty" is based upon money income, excluding capital gains before taxes. To evaluate the effect of taxes and benefits, the Census Bureau estimates poverty rates under alternative definitions that take into account government programs and taxes.[8] This analysis shows that the improved economic condition of the elderly can be attributed to government transfer programs. **Half** of all elderly persons, and 22 percent of all persons, would fall below the poverty level without income from Social Security and other Federal cash transfer programs.

[8] Bureau of the Census (September 1993 (a)).

Under the most comprehensive measurement of income (including imputed return on homeowners' equity, Federal nonmeans-tested and means tested programs, and taxes), the 1992 poverty rate falls from 12.9 percent to 6.2 percent for elderly persons and from 14.5 percent to 10.4 percent for all persons. (If imputed home equity is not included, the poverty rate would be 10.4 percent for people 65 and older and 11.7 percent overall.) Including the annuity value of home equity or the potential income that could be accessed through a reverse equity mortgage is controversial because most older adults stay in their homes and homeowners would have to pay housing costs for alternative living arrangements if they didn't own their own homes. Home equity represents a 44 percent of elderly assets .

Table 2.10
Poverty Rates by Age and Race

	1970	1980	1990	1992	1993	1995
Total:						
All races	12.6%	13.0%	13.5%	14.8%	15.1%	13.8%
White	9.9%	10.2%	10.7%	11.9%	12.2%	11.2%
African American	33.5%	32.5%	31.9%	33.4%	33.1%	29.3%
Hispanic*	n.a.	21.8%	26.2%	29.6%	30.6%	30.3%
65 and older:						
All races	24.6%	15.7%	12.2%	12.9%	12.2%	10.5%
White	22.6%	13.6%	10.1%	10.9%	10.7%	9.0%
African American	48.0%	38.1%	33.8%	33.3%	28.0%	25.4%
Hispanic*	n.a.	32.6%	22.5%	22.0%	21.4%	23.5%
Children below 18:						
All races	15.1%	18.3%	20.6%	21.9%	22.0%	20.8%
White	10.5%	13.9%	19.6%	16.9%	17.0%	16.2%
African American	41.5%	42.3%	44.8%	46.6%	45.9%	41.9%
Hispanic*	n.a.	33.2%	38.4%	39.9%	39.9%	40.0%
Below 125 percent of poverty:						
Total	17.6%	16.4%	18.0%	19.7%	20.0%	18.5%
Elderly	n.a.	25.7%	19.0%	20.5%	19.7%	17.7%

SOURCE : Bureau of the Census (September 1996 (b) and Web site (1997)).

*People of Hispanic origin may be of any race.

More than 93 percent of the individuals age 65 and above received Social Security benefits in 1994. (See Table 2.11.)

Table 2.11
Shares of Money Income from Earnings and Other Sources, 1994

Source of Income	Elderly Families		Nonelderly Families	
	Individual 65 or Older Living Alone or with Non-relatives, only	Family with Householder Age 65 or Older	Individual below 65 Living Alone or with Non-relatives, Only	Family with Householder below age 65
	Percentage of Families Receiving Income of Specified Type			
Earnings	13	42	85	93
Social Security	93	93	6	10
SSI	7	5	4	3
Other (public assistance, unemployment, workers' comp. Etc.)	8	15	20	30
Dividends, Interest, rent	64	76	52	67
Private pensions, annuities, alimony, other	39	54	6	16
	Percentage Distribution of Income, by Type			
Total percent	100	100	100	100
Earnings	11	29	88	89
Social Security	47	34	2	2
SSI	1	1	1	0
Other (public assistance, unemployment, workers' comp. Etc.)	2	3	3	3
Dividends, Interest, rent	20	14	4	4
Private pensions, annuities, alimony, other	19	19	3	3
Median Income	**$11,331**	**$26,402**	**$18,446**	**$41,941**

SOURCE: SSA (1996).

For most seniors, Social Security is the largest share of their income. Almost two-thirds of the elderly receive half or more of their annual income from Social Security. Social Security provides three-fourths or more of the income of 43 percent of the elderly, but less than a fourth of the income of seniors with the highest incomes. (See Table 2.12.)

Table 2.12
Distribution of Money Income by Source,
Aged Units 65 and Above, 1994

		Quintiles of Total Money Income				
	Total:	First:	Second:	Third:	Fourth:	Fifth:
	All Aged Units	Up to $7,734	$7,735–12,213	$12,214–18,731	$18,732–31,179	$32,180 or more
Number (000)	23,887	4,867	4,663	4,778	4,829	4,750
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Percent income from:						
Retirement benefits	60.8	84.4	88.5	80.0	72.1	43.8
Social Security	42.1	81.2	81.1	65.9	48.3	22.7
Railroad retirement	0.6	0.7	1.0	0.7	1.0	0.4
Government employee pensions	8.4	0.8	2.4	5.3	10.2	10.2
Private pensions and annuities	9.7	1.7	4.0	8.1	12.7	10.5
Earnings	18.0	0.2	2.2	6.2	10.9	28.5
Income from assets	17.6	2.7	5.4	10.3	14.4	24.4
Public assistance	0.9	11.0	2.0	0.8	0.4	0.1
Other	2.7	1.6	1.9	2.8	2.2	3.2

SOURCE: Grad (1996).

Assets and Wealth

As expected, the accumulation of savings over their lifetimes means that, at comparable income levels, the elderly hold higher median assets than the total population. For each income quintile, and for all quintiles combined, median elderly asset holdings in 1993 were more than double the median for the population as a whole, whether or not home equity is included as a part of the total. (See Table 2.13.)

- Over 40 percent of the net worth of elderly households is in the form of home equity, about the same share of net worth as for the total population.

- Wealth is highly concentrated, more so among the elderly than among the overall population. Among households headed by individuals 75 or older, the non-housing median net worth of the most affluent quintile was 78 times greater than that of the poorest quintile. Among all households, the highest quintile's median net worth was 48 times greater than that for the poorest quintile of all households.

- Measured net worth differs substantially by race. In 1993, the median net worth of white households was 10 times greater than that of African American or Hispanic households, with the greatest disparity among the lowest income quintiles.

Table 2.13
Median Net Worth by Age of Householder
(In 1993 dollars)

	1991	1993
Median net worth:		
• All households	$38,500	$37,587
excluding home equity	10,858	9,505
• 65 and above	94,074	86,324
excluding home equity	27,400	20,642
• 75 and above	80,636	77,654
excluding home equity	24,0540	18,125
Median net worth, lowest income quintile:		
• All households	5,406	4,249
excluding home equity	1,059	949
• 65 and above	33,523	30,400
excluding home equity	3,710	2,993
• 75 and above	33,601	32,149
excluding home equity	4,823	3,499
Median net worth, highest income quintile:		
• All households	121,423	118,996
excluding home equity	51,702	45,392
• 65 and above	454,599	354,781
excluding home equity	317,893	215,335
• 75 and above	525,312	475,498
excluding home equity	420,986	273,500

SOURCE: Bureau of the Census (1995).

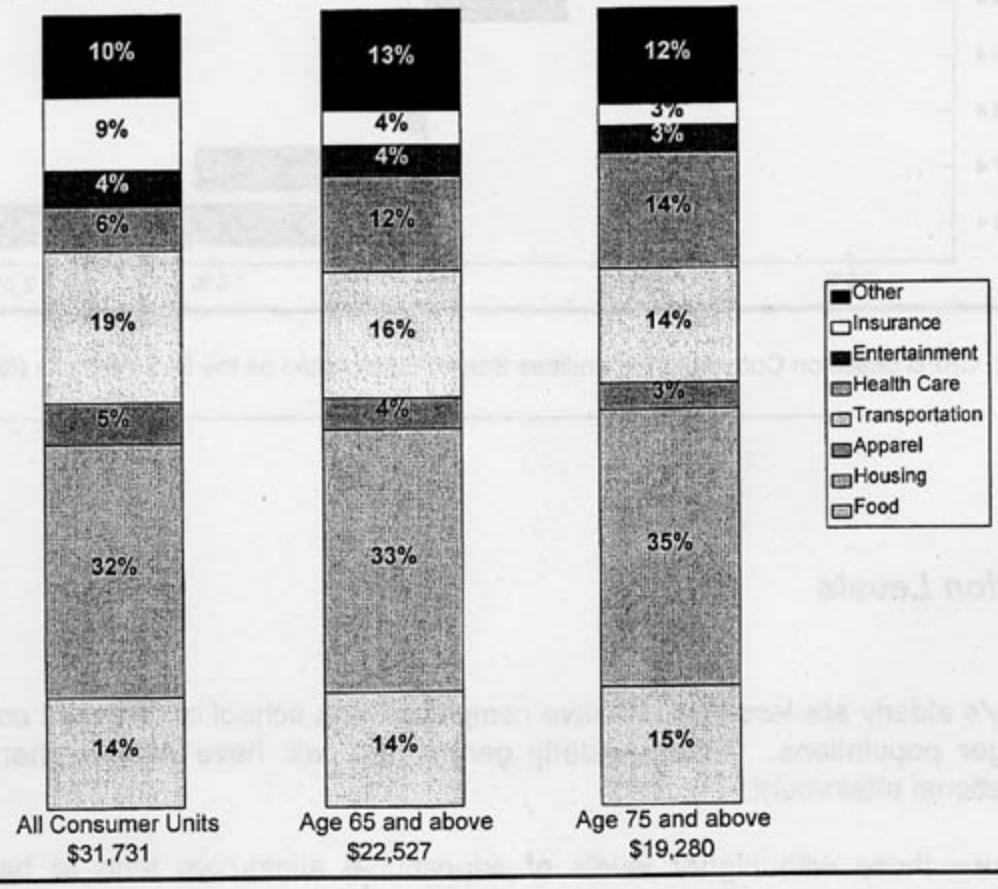
Consumption

In 1994 the elderly consumed 30 percent less than the average for the total population. (See Figure 2.10.)

- Financial planners suggest that retirement incomes of 60 to 80 percent of pre-retirement income are sufficient to maintain standards of living in retirement. That is because retirees can expect to consume less than the working-age population. They are largely finished raising children, they have fewer work-related expenses (transportation, clothing, etc.), and they perform themselves tasks they purchased when they worked (e.g., yard care, eating at home instead of dining out).

- Elderly households have higher health care needs. They spend more than twice as much of their income on health care as the overall population.

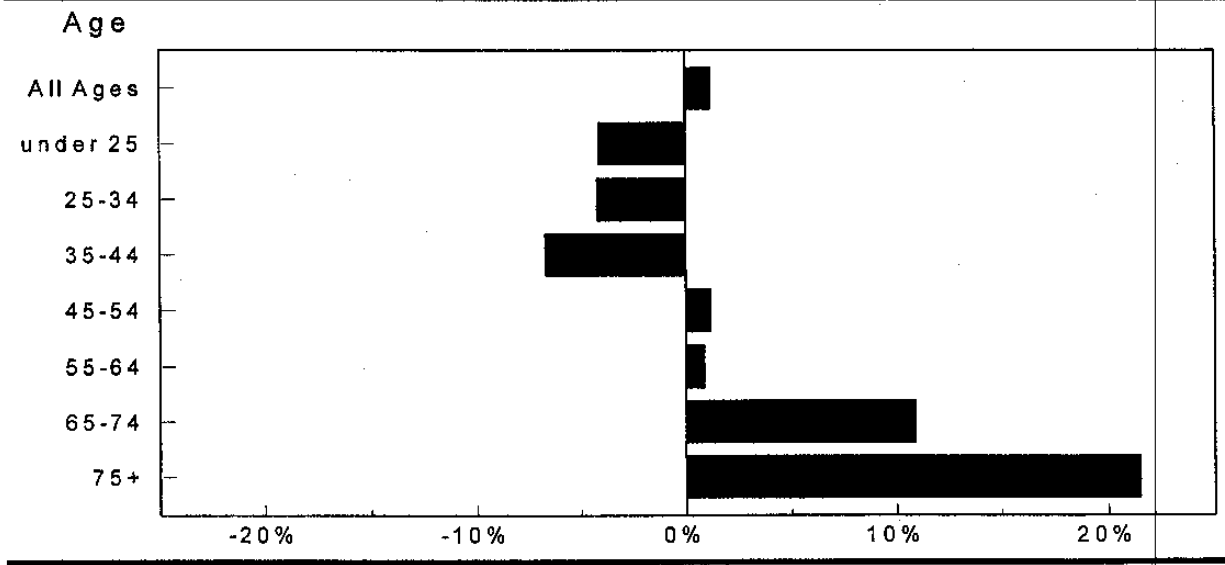
Figure 2.10
Composition of Consumer Expenditures: 1994



SOURCE: CRFB based on Consumer Expenditure Survey data posted on the Bureau of Labor Statistics (BLS) Web site (November 1996).

Consistent with improvements in income and reductions in poverty, the older adults consume more that they did 10 years ago. Between 1984 and 1994, consumer expenditures of the elderly aged 65-74 increased 11 percent in real terms. Those age 75 and above experienced an even greater gain of 21.5 percent. Consumer expenditures for younger age groups declined or stayed relatively flat. (See Figure 2.11.)

Figure 2.11
Changes in Consumption,
1994 compared with 1984
(Percentage change using 1994 dollars)



SOURCE: CRFB based on Consumer Expenditure Survey data posted on the BLS Web site (November 1996).

Education Levels

Today's elderly are less likely to have completed high school or attended college than younger populations. Future elderly generations will have even higher levels of educational attainment.

Because those with higher levels of educational attainment tend to have higher incomes, a greater number of future seniors should have higher retirement incomes. The importance of a college education to earnings has increased over time.

In 1939, the annual average income of college-educated males 25 years old and above was 2.5 times higher than that of males who only completed elementary school. In 1990, the advantage was 3.7 times greater. (See Table 2.14.)

Table 2.14
Educational Attainment by Age and Race, Ages 25 and Above: 1995

	Percentage with		
	HS Graduate or More	Some College or More	Bachelor's Degree or More
All persons	81.7	47.8	23.0
Age in years:			
• 25 to 34	87.1	53.2	25.0
• 35 to 44	88.4	55.0	26.6
• 45 to 54	86.2	53.8	21.9
• 55 to 64	77.2	39.9	19.0
• 65 to 74	68.9	32.5	14.2
• 75 and older	56.8	26.6	11.2
Race:			
• White	83.0	49.0	24.0
• African American	73.8	37.5	13.2
• Other	75.4	49.5	28.5
Hispanic origin*	53.4	27.1	9.3
Non-Hispanic	85.9	51.1	25.4

SOURCE: Day and Curry (1996).

* People of Hispanic origin may be of any race.

Health

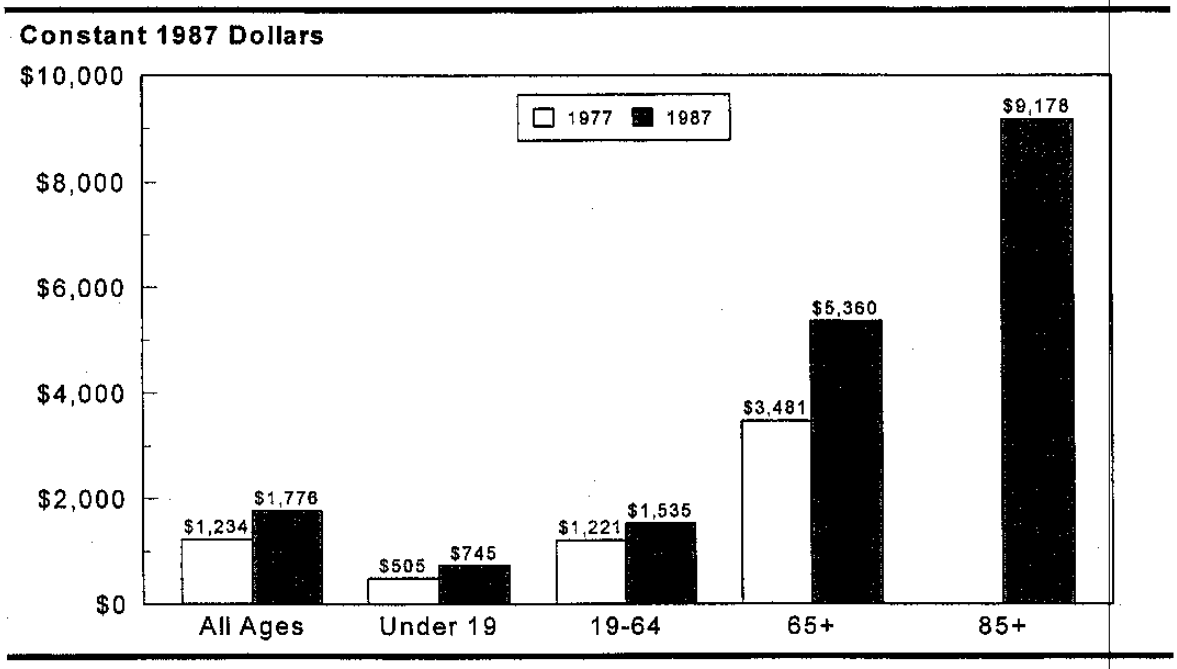
We do not know today what future advances in medical science will mean for the quality of health for an increasingly older population. People above 55 are already demanding changes from the health care system. Not only do they expect the best

care when they are sick, but they also want preventive care that keeps them healthy and functionally independent as they age.[9]

Although it is possible that future elderly populations will live longer, healthier lives, it is also possible that the growing elderly population will require additional resources for health care and supportive services. The Federal budget pays for about half of all elderly health care expenditures. Almost all elderly are covered by Medicare, and almost half of nursing home care is financed by Medicaid. As the population ages, more pressure will be put on the Federal budget to increase health care spending. (See chapter 4 for more on the budgetary issues.)

As people live longer and the number of the oldest old (age 85 and above) increases, total spending for health care is projected to grow rapidly, even if people are generally healthier. Health care spending per capita rises dramatically with age. Total per capita elderly spending for health care is 3.5 times the amount spent for people age 19 to 64.[10] Within the older population, health care spending varies substantially. The health care costs of people age 85 and above are 6 times higher than those for 19 to 64-year-olds and 2.5 times higher than those for the youngest old (age 65 to 69). (See Figure 2.12.)

Figure 2.12
Per Capital Health Care Spending by Age, 1977 and 1987



SOURCE: HCFA data cited by Bureau of Census (April 1996).

[9] National Committee for Quality Health Care (1996).
[10] Much of the detailed information about health care expenditures comes from the 1987 National Health Expenditure Survey. More recent data are not available.

Health care spending among elderly adults, is as highly concentrated as the younger population. Most elderly, even those 75 years old and above, consider themselves in good health.

- Seventy percent of the elderly identify their health status as good, very good, or excellent. This percentage has remained fairly stable over the last 20 years. (The fact that this percentage has been stable shows that increases in health care spending do not necessarily lead to better health status. Per capita personal health care expenditures for the elderly increased 50 percent in real terms between 1977 and 1987.)

- Seventy-five percent of 65 to 74-year-olds and two-thirds of persons aged 75 and above report good, very good, or excellent health.

Nevertheless, as age increases, so does the incidence of disease and chronic conditions.

- Men age 85 and above experience a death rate from heart disease 4 to 6 times higher than for men 65 to 69 years of age.

- Although the death rates from heart disease generally improved for Whites and African Americans between 1960 and 1991, death rates from cancer increased for all elderly age categories of both Whites and African Americans.

With advancing age, people are more likely to experience difficulty with performing personal care and household tasks. Half of persons 85 and above report they needed assistance with everyday activities.[11] Only 9 percent to 11 percent of those aged 65 to 74 indicate they needed help. No matter what their age, elderly women are more likely to need assistance than men. African Americans show higher rates of functional limitations than Whites, and their limitations are likely to be more severe.

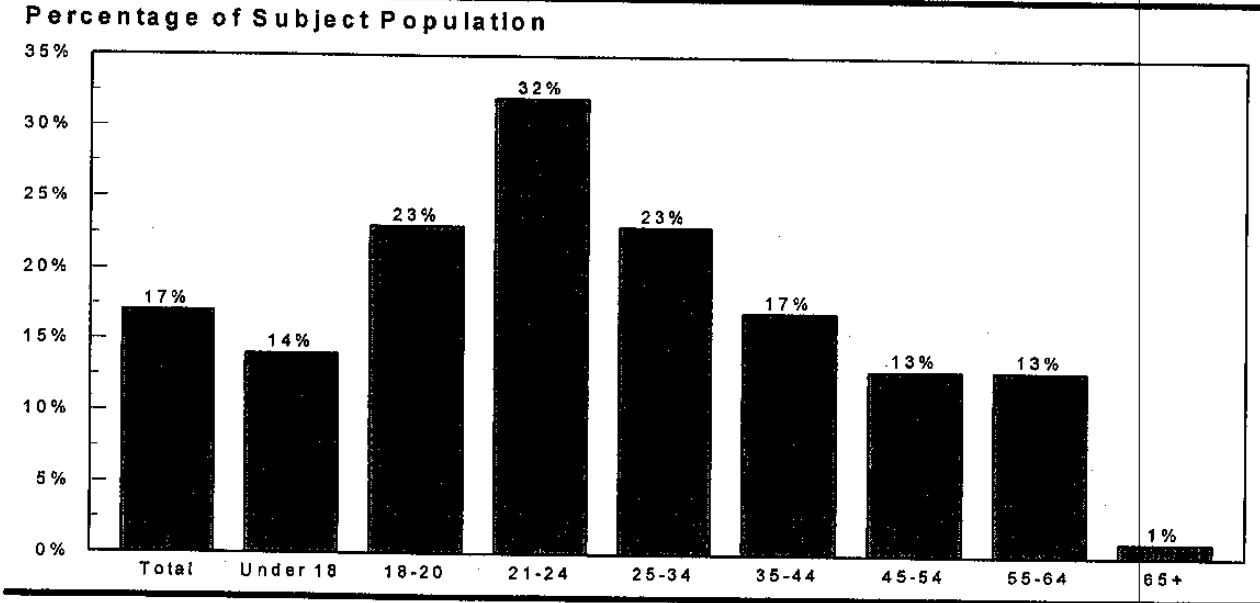
Health Insurance

The elderly are almost universally covered by Medicare. Fewer than 1 percent of elderly individuals have no health insurance. (See Figure 2.13.) Seventeen percent of the nonelderly population and 14 percent of children are uninsured. Younger adults, ages 21 to 24, have the highest uninsurance rate of any age group.

[11] From 1991 Census Survey of Income and Program Participation (SIPP).

Employment-based retiree health insurance is available to a sizable minority of workers.[12] The existence of this coverage may make it easier for workers to retire before age 65, when they become eligible for Medicare. Since 1992, employers providing retiree health insurance coverage are required to disclose these liabilities on their balance sheets. Although some employers have dropped retiree coverage, most employers seem to be instituting changes to limit their costs (and liabilities) for such coverage.

Figure 2.13
Uninsured Population by Age



SOURCE: EBRI (March 1996).

Social Characteristics

As people age and become more frail, their marital status, living arrangements, and other social characteristics help determine the need for services. Spouses and other family members are key sources of informal support and care. While elderly individuals who live alone tend to be in better health, they are also more likely to use formal social (community) services and to be institutionalized than those who live with others.

[12] In 1993, 38.7 percent of wage and salary workers between the ages 46 and 64—9.8 million individuals— reported employer-sponsored retiree health insurance coverage. For the vast majority of these workers, coverage under employment-based plans will continue throughout retirement. Only 14 percent would only be covered until they become eligible for Medicare at age 65. EBRI (July 1996).

Living Arrangements

Predictably, the number of elderly living alone increases with age.

- 64 percent of those age 65 to 74 were married and living with their spouse in 1993 compared to 24 percent of those age 85 or above.

- Between 1980 and 1993, the number of 65 to 74-year-olds living alone increased only slightly from 23 to 24 percent. Almost half of persons 85 or above lived alone in 1993, up from 39 percent in 1980.

- Elderly African American men and African American women of all age categories were more likely to be widowed than White men and White women of the same age categories. Thirty-five percent of African American men were widowed compared to 18 percent of White men. Elderly Hispanic men and Hispanic women were slightly more likely to be widowed than Whites.

The youngest old (65 to 74) are more likely to be married than the oldest old. Elderly men are twice as likely to be married and living with a spouse than elderly women. Elderly women are three times as likely to be widowed than elderly men.

- Overall, one out of three elderly women age 65 to 74 was widowed in 1993. The proportion increased to three out of four women age 75 to 84 and to four out of five for women 85 and above.

- Women are more likely to outlive their husbands not only because they have longer life expectancies than men, but because they also tend to marry older men. In addition, both divorced and widowed elderly women are less likely to remarry than divorced or widowed men.

- However, elderly women are twice as likely as elderly men to live with a relative other than a spouse. One out of seven women age 65 to 74 and 29 percent of women age 85 and above live with another relative.

In general, family size is shrinking. In 1970, 1– and 2–person households were 46 percent of all households. In 1995, they were 57 percent of the total. On average, Whites lived in households with fewer people. Elderly Hispanics lived in larger households than other groups, but the size of Hispanic households differs by national origin. (See Table 2.15.)

- About the same percentage of White (45 percent) and African American (46 percent) elderly people age 65 and above lived alone.

- Relative to Whites, almost two-and-a-half times as many African American elderly (22 percent) and almost three times as many Hispanic elderly (26 percent) lived in

households with three or four persons, reflecting more frequent presence of children and grandchildren.

Table 2.15
Average Number of Persons per Household

	All Ages	65 Years and Above	65 to 74 Years	75 to 84 Years	85 and Above
All races	2.63	1.77	1.91	1.61	1.44
White	2.59	1.72	1.87	1.58	1.41
African American	2.84	2.12	2.26	1.90	1.80
Hispanic*	3.41	2.20	2.33	1.96	---.

SOURCE: Bureau of the Census (April 1996).

* People of Hispanic origin may be of any race.

Institutionalization

The nursing home population increased 29 percent between 1980 and 1990. This is greater than the rate of increase of the overall elderly population (22 percent), but slower than the 35 percent growth rate for the oldest old.

Institutionalization increases with age.

- In 1990, 1.4 percent of the younger old lived in nursing homes. 24 percent of those 85 and above lived in nursing homes. From 1984 to 1988, the median age for the first nursing home admission was 81 for men and 84 for women.[13]

- Ninety percent of all nursing home residents are elderly. 42 percent of nursing home residents are age 85 and above—double the percentage in 1960. 70 percent of nursing home residents are women. Women 85 and above make up the largest single share (34 percent) of nursing home residents.

- Those reaching age 65 face a 35 percent to 43 percent risk of being institutionalized sometime during their remaining lifetimes.

Disability rates among the elderly appear to have declined between 1982 and 1994.[14] If this trend continues, a smaller percentage of future elderly may need nursing home care.

[13] Analysis of the Longitudinal Study on Aging cited by the Bureau of the Census (April 1996).
[14] Manton, *et al.* (1997).

Geographic Distribution

The most populous States also have the largest number of elderly residents. In 1994, the States with the largest populations also had over a million elderly residents each: California, Florida, New York, Pennsylvania, Texas, Illinois, Ohio, Michigan, and New Jersey. Florida (18.4 percent elderly) and Pennsylvania (15.9 percent elderly) also ranked among the States with the largest proportion of elderly residents. Other States where more than 14 percent or residents are age 65 and above are: Rhode Island, Iowa, West Virginia, Arkansas, North and South Dakota, Connecticut, Massachusetts, and Missouri.

- Today, Florida is the only State where elderly residents comprise more than 16 percent of the population. By 2020, 32 States will have elderly populations this size or greater.

- In 2020, the Census Bureau projects that over half of all elderly will live in ten States: the nine States that currently have the largest elderly populations, plus North Carolina.

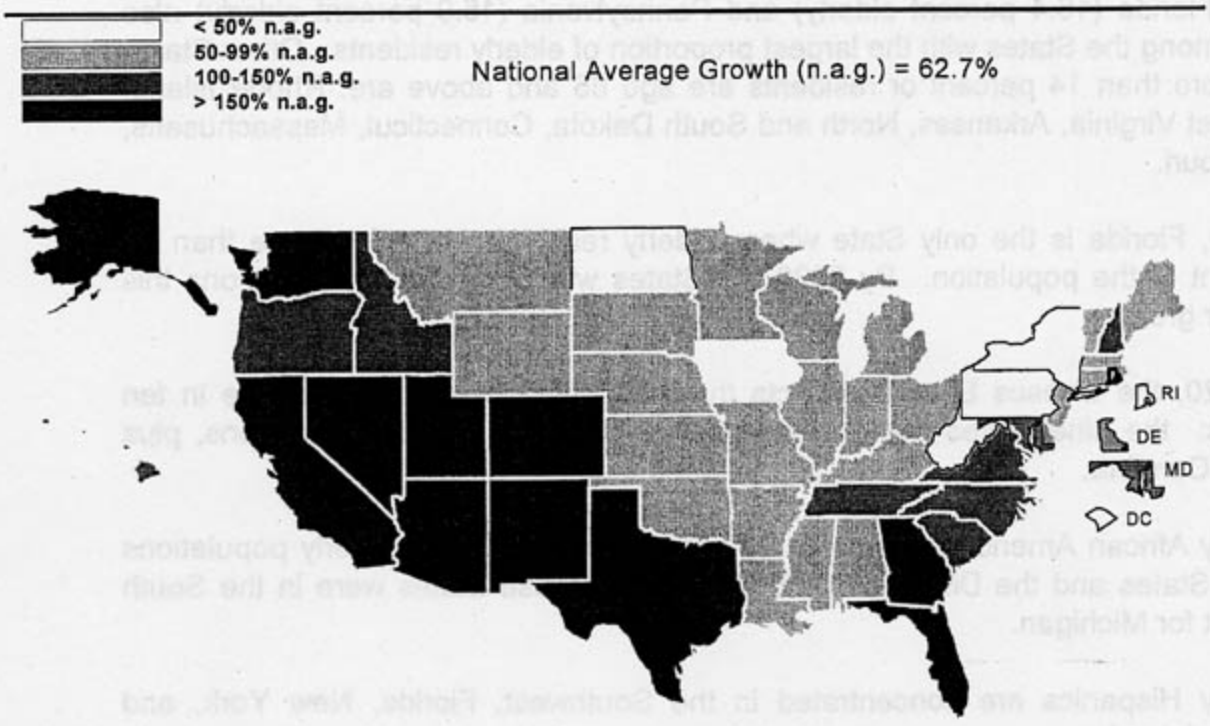
- Elderly African Americans make up 10 percent or more of the elderly populations of 12 States and the District of Columbia. All of these States were in the South except for Michigan.

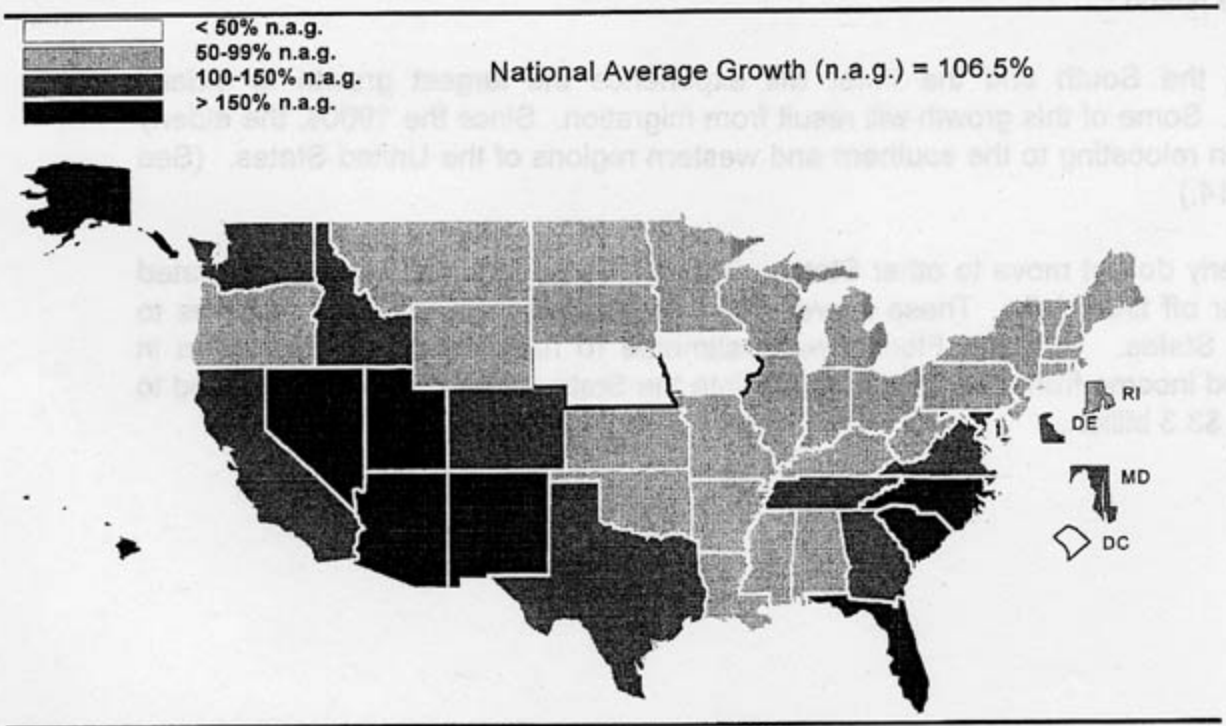
- Elderly Hispanics are concentrated in the Southwest, Florida, New York, and Rhode Island.

States in the South and the West will experience the largest growth in elderly residents. Some of this growth will result from migration. Since the 1960s, the elderly have been relocating to the southern and western regions of the United States. (See Figure 2.14.)

Most elderly do not move to other States. Those who do tend to be better educated and better off financially. These moves can bring substantial retirement incomes to receiving States. In 1989, Florida was estimated to have received $6.5 billion in transferred income from the elderly moving into the State. New York was estimated to have lost $3.3 billion.

Figure 2.14
Southern and Western States Will See Greatest Growth in Populations 65 and Above and 85 and Above
(Percentage change relative to national average growth rate, 1993–2020)





SOURCE: CRFB based on Bureau of the Census data (April 1996).

Conclusion

By the middle of the next century, the U.S. population will be dramatically different from today's population. The population will be older and it will be more racially and ethnically diverse. These major changes will reshape American society in the 21st century and will drive a redefinition of public and private roles and responsibilities.

As racial and ethnic minorities become majorities, they should gain better access to occupational and educational opportunities, reversing disparities in incomes, educational attainment, and life expectancies that disproportionately affect these population subgroups. If not, the future labor force will not be as productive as it could be, the overall economy will not grow as fast as it otherwise might, and the burden of supporting a larger elderly population will be heavier.

As baby boomers age, they have an essential role to play. By saving more, workers can reduce their future dependency on public sources of retirement income. In addition, they can provide the capital needed to fuel a bigger future economy. Greater educational attainment increases individual productivity and lifetime incomes. Healthier life styles can reduce long-term health care needs. Staying in the workforce longer decreases the number of unproductive years. These types of changes can help reduce the burden imposed by a larger elderly population.

Although policy makers cannot predict exactly how projected demographic changes will interact with current economic trends, they can take a longer perspective, anticipate the major issues, begin identifying the available options, and weigh the trade-offs that are necessary to balance the needs of older members of society with those of the younger, working age population. By turning their attention on these longer term issues, policy makers can focus the public debate on the types of questions that need to be addressed and, in the process, help raise public's awareness of the need for change public policies and private behaviors.

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Chapter 3. The Economic Perspective

Dollar bills don't taste very good. People don't eat Social Security, pension, or pay checks. What really matters is what they can buy with those payments, and that depends on the production and distribution of goods and services. As the population ages, workers will make up a smaller percentage of the population, and the percentage of the nonworkers will be larger. Active workers will have to produce sufficient quantities of goods and services to meet their own needs, as well as those of a larger population of retirees. Just to maintain standards of living, the economy has to grow as fast as the growing cost of supporting an aging population.

Economic growth is the answer to the aging challenge. A bigger, stronger, faster-growing economy would make the aging of the population easier on all—children, workers, and retirees. While stronger growth is the answer, it will only be part of the answer.

- There is no magic bullet that will allow us to grow our way out of the problem. According to Federal Reserve Chairman Alan Greenspan, we would have to ***triple*** the rate of annual productivity improvement just to grow out of the financial imbalances in Social Security. Growing out of demographically-driven Medicare and Medicaid problems would require additional boosts to productivity.[1]

- We are unlikely to sacrifice all other societal goals in favor of economic growth. The types of changes that promise the most economic efficiency have important distributional, equity, and policy implications. For example, a flat tax structure promises greater efficiency, but compromises progressivity in tax burdens. In addition, it would reduce retirement savings incentives.

- Sensible economic policies often fly in the face of political reality. The public undervalues benefits accruing to general society (social goods) and future gains. Powerful political constituencies will oppose changes adverse to them. Efforts to buy in political support easily can end up negating the potential benefits of changes.

[1] Remarks to the Union League of Philadelphia (December 1996). This estimate is consistent with the SSA Office of the Actuary's sensitivity analysis of GDP growth assumptions underlying its long-term OASDI projections.

Nevertheless, if we focus on four basic objectives, chances are we will achieve higher economic growth than if we don't set basic goals.

- **Increase national savings and investment.** Most economists agree: increasing national savings raises the capital stock and helps to fuel a faster growing economy. While higher levels of savings and investment would reduce consumption below what it otherwise would be, they would increase future standards of living. As the proportion of nonworkers to workers grows, each worker will have to be more productive. Greater investment in physical and human capital would help make that possible.

- **Balance the Federal budget**. Federal deficits and borrowing deplete the scarce pool of national savings. Conversely, **deficit reduction increases national savings**. Not only does a balanced budget potentially free up current resources for private investment, but lower borrowing reduces claims against the future economy and leaves more future income for future consumption. (See chapter 4 for a discussion of the Federal Budget.)

- **Encourage more people to enter the labor force and keep those who are working, working longer.** More workers mean a bigger economy. People are living longer. That is good news. But, if they don't use the additional years to add to the economy, they become a bigger drain on those who are working. This means we have to remove barriers that keep people from entering and staying in the labor force.

- **Encourage people to assume more responsibility for their economic security throughout their lifetimes.** Greater individual self-sufficiency reduces the need for publicly (tax) financed support. Government policies and programs play an important and a necessary role in the distribution of incomes, but too large a public role creates greater inefficiencies, complexities, disincentives, and unintended consequences. These reduce the equity of policies both within and across generations and contribute to popular perceptions that the government is intrusive and unfair. If we expect individuals to assume more responsibility for their economic security, we must facilitate their ability to acquire the knowledge and skills necessary to become more self-sufficient. In addition, the public must be educated about retirement savings. Individuals should understand better the need to begin planning and saving early for retirement and learn the mechanics of savings (specifically, the benefits of compound interest). And, they should learn to monitor more closely their pensions and other savings.

Recent Economic Trends

The post-World War II boom lasted a quarter of a century. During the 1970s, despite declines in productivity growth, strong growth continued as large numbers of women and baby boomers entered the labor force. Since the early 1980s, growth and productivity have slowed, and improvements in real hourly compensation have almost stopped. (See Table 3.1).

Table 3.1
Economic Trends, 1950–94
(Average annual percentage change from previous period)

	Real GDP	Output/Hour	Real Compensation/ Hour	Labor Force Growth	Personal Consumption Expenditures
1950–59	4.0*	2.8	n.a.	1.1	2.8
• *1950–54*	*4.7**	*3.1*	n.a.	*0.8*	*2.7*
• *1955–59*	*3.2**	*2.6*	n.a.	*1.4*	*2.9*
1960–69	4.4	2.8	2.6	1.7	4.3
• *1960–64*	*4.1*	*3.3*	*2.7*	*1.3*	*3.9*
• *1965–69*	*4.6*	*2.3*	*2.4*	*2.0*	*4.7*
1970–79	3.2	1.9	1.4	2.7	3.0
• *1970–74*	*2.8*	*2.1*	*1.5*	*2.6*	*3.2*
• *1975–79*	*3.6*	*1.7*	*0.9*	*2.7*	*3.7*
1980–89	2.8	1.0	0.2	1.7	3.0
• *1980–84*	*2.2*	*1.2*	*-0.2*	*1.6*	*2.2*
• *1985–89*	*3.4*	*0.9*	*0.5*	*1.8*	*3.9*
1990–95	1.8	0.9	0.3	1.1	*1.8*
1950–73	4.1	2.9	2.4**	1.6	*3.7*
1974–95	2.5	1.0	0.3	1.8	*2.7*

SOURCE: CRFB calculations based on the following: 1950-59 GNP, productivity, and personal consumption expenditure data from *Historical Statistics of the United States, Colonial Times to 1970* (1975). All other data from the *Economic Report of the President* (1997).

* Real gross national product (GNP).
** 1960–73.

The economic slowdown not only affects current standards of living, but also will affect future retirement incomes. Slower wage growth results in lower lifetime incomes and less retirement income. Low- and moderate-income families depend more on wages and salaries than do high-income families. Therefore, stagnant wages and salaries affect those families more than wealthier families.

Median family money income, which grew an average of 3.7 percent a year in inflation-adjusted terms during the 1960s, was $612 lower (after inflation) in 1995 than it was in 1990. During the 1960s, two-thirds of increases in family income came from increases in men's (husband's) earnings. Since the 1970s, improvements in family income are due largely to the rising number of two-earner couples. Median incomes for one-earner families have stagnated.[2] The growth of women's participation in the labor force appears to have leveled off, signaling the end of income growth from this source.

Trends in per capita income show increasing premiums for education and experience. Younger male workers began to experience declines in real money income during the 1970s. Younger male workers with lower knowledge and skill levels have fared the worst. Entry level, real hourly wages for male high school graduates dropped 30 percent between 1979 and 1993.[3] During the 1980s, on a per capita basis, real money income declined for all male age groups except the elderly. Entry level wages for female high school graduates dropped 18 percent during the same period. Although older women (age 35 to 64) suffered declines in real money income during the 1970s, women of all ages saw their income grow during the 1980s.

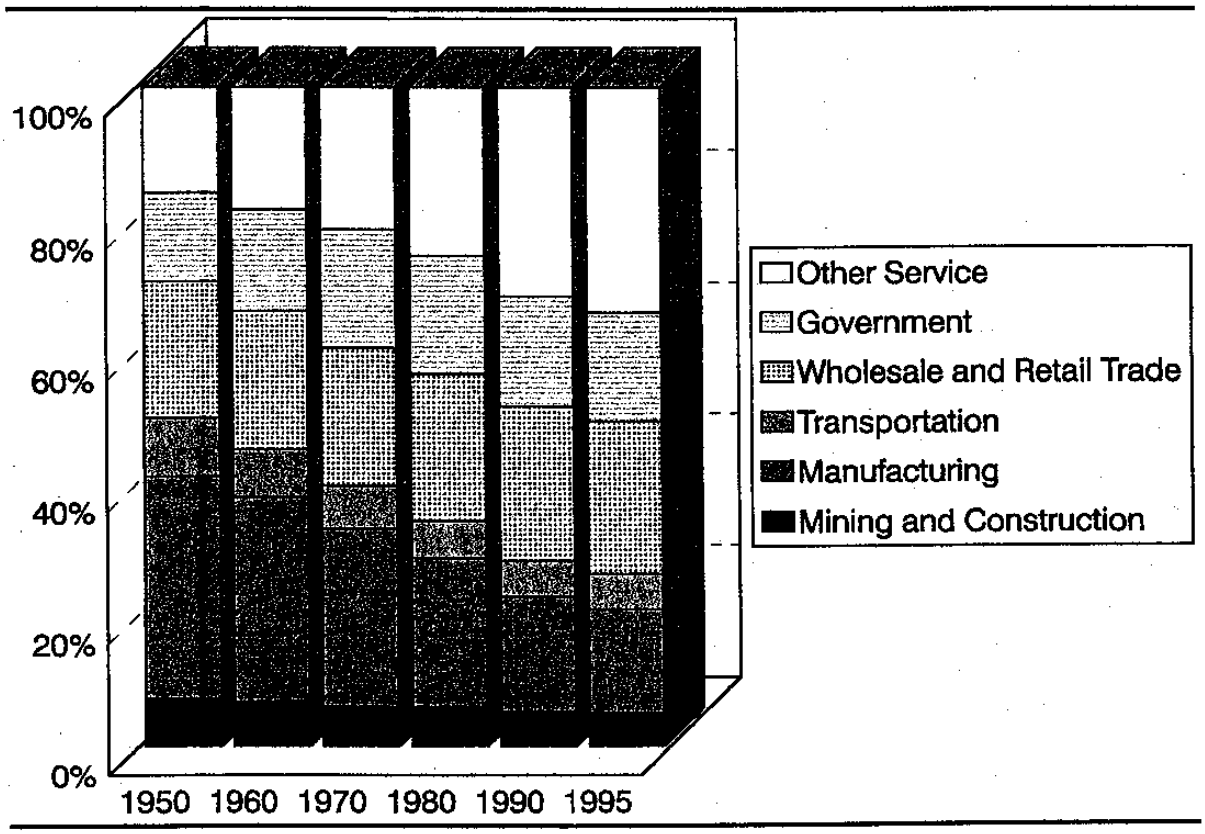
Essentially, we've gone from an era in which a rising tide lifted all boats, to an era of uneven tides in which everybody no longer rises and falls together. During good economic periods, the poor and the less-skilled have been left behind; they fared poorly both during recessions and during recoveries

Sheldon Danzinger
Presentation to the 1994-1995 Advisory Council on Social Security.[4]

[2] In 1970, on average, there were 3.58 persons per family, compared with 3.19 in 1995. Thus declining family size may have helped cushion standards of living from the effects of stagnating family incomes.
[3] Mishel and Bernstein (1996).
[4] Danzinger (1994).

The economy is shifting toward services and away from manufacturing and goods producing sectors. (See Figure 3.1). Some rapidly growing service jobs are highly compensated (e.g., communications, computer-related and professional specialty areas). However, some of the greatest growth in service sector employment has taken place in low-wage business services and retail trade. Most important, these employers are less likely to sponsor health insurance and pensions.[5] Between 1983 and 1994, these two sectors accounted for 33 percent of new jobs. During the same period, the share of jobs in the goods producing sector, which generally pays higher wages and provides more benefits, fell 5 percent. In 2005, goods producing industries will represent 19 percent of total employment, compared with 27 percent in 1983.[6]

Figure 3.1
Employment Share by Major Industry



SOURCE: Bureau of Census (October 1996).

[5] For more information about employer-sponsored benefits, see chapter 9,Private Retirement Plans.
[6] BLS (December 1995).

As a consequence of these and other trends, income disparity is increasing. In 1995, the top 5 percent households received 21 percent of all household income, whereas the bottom 40 percent received 12.8 percent. Twenty years earlier, the shares were 15.9 percent and 14.9 percent, respectively.[7] Between 1975 and 1995, average income for the top quintile of households increased 35 percent in real terms (from $80,834 to $109,411). Over the same time period the average income of the bottom quintile increased only a net 1.5 percent (from $8,227 to $8,350). Average income of the bottom quintile actually fell 0.5 percent between 1990 and 1995. Median household income also declined by 2.4 percent.

The implications of these economic trends for an aging population are many.

- Individuals with lower lifetime incomes accumulate lower personal savings and are less likely to participate in employer-sponsored pension and health insurance plans. If greater numbers of workers have low lifetime earnings and little or no privately-sponsored pension and health benefits, larger numbers of future retirees will have low retirement incomes and will be more dependent on public programs.

- It is easier to raise taxes when incomes are growing. Social Security and Medicare payroll taxes increased 15 times between 1950 and 1980, and only 6 times since then. If incomes are stagnating or declining, people are more likely to resist tax increases that reduce incomes and consumption.

- Payroll taxes are regressive to begin with. Stagnating or declining real wages compound this problem. Low-wage, lower skilled, and younger workers are disproportionately burdened by payroll taxes. Unlike higher income, better skilled workers, low-wage, low skilled workers do not have the same prospects for improving their incomes over their lifetimes. This means that the burden of payroll taxes will not lessen as they grow older.

[7] Bureau of the Census (September 1996(a)).

The Importance of Savings and Investment

Since 1960, the net national savings rate (national savings less depreciation) has declined from above eight percent of GDP to below 2 percent. The decline in net national savings is about equally shared between Federal budget deficits and the decline in private savings. (See Table 3.2).

Table 3.2
Net National Savings and Investment
(In percentage of GDP)

	1960–69	1970–79	1980–89	1990—94
Total net savings	**8.1**	**7.0**	**3.8**	**1.9**
• Total government savings	-0.1	-1.0	-2.6	-3.3
Federal government savings	-0.2	-1.7	-3.5	-3.6
State/Local government savings	0.0	0.7	0.9	0.3
• Total private savings	8.3	8.0	6.5	5.2
Business savings	3.2	2.4	1.5	1.5
Personal savings	5.1	5.6	4.9	3.6
Total net investment	**7.9**	**7.6**	**4.1**	**2.4**
• Net private investment	7.2	7.3	5.7	3.4
• Net foreign investment	0.6	0.2	-1.6	-1.1
Statistical discrepancy	-0.3	0.6	0.2	0.5

SOURCE: Survey of Current Business (1997).
Totals may not add due to rounding.

Because economic growth requires investment and investment requires savings, policy makers are concerned with how to increase national savings. Increasing retirement savings is an important subsidiary objective. If more individuals engaged in higher levels of retirement saving, they would assume greater responsibility for and control over their own retirement incomes. In addition, once retired, they would rely less on public income support programs.

One question of keen interest to policy makers is whether it is possible to increase pension savings without having adverse effects on other components of compensation, employment, and the federal government budget deficit. The answer appears to be no.

Technical Panel on Trends and Issues in Retirement Savings
1994-1995 Advisory Council on Social Security[8]

Although there is widespread agreement about the need to increase savings, there are no easy answers.

- The way to increase Federal savings is to balance the budget, even run budget surpluses. This increases the level of current resources available for private investment and reduces future debt burdens. (This topic is addressed more fully in chapter 4.)

- The major result of many proposed policy changes may be to shift resources around. Current proposals to increase retirement savings range from using the sovereign power of government to mandate saving to relying on the persuasive power of tax incentives to encourage saving. The trouble is, while both have the potential to increase retirement savings, neither promises to increase net savings at the aggregate level. If net national savings do not increase, there are no additional resources to invest.

- Policy objectives can conflict. Policy options to increase private savings and investment rely, by in large, on using tax incentives or eliminating disincentives to save under the tax code. Because they lower Federal revenues, these options can conflict with efforts to reduce Federal budget deficits. Economists disagree about the ultimate impact of tax cuts on the budget. Supply-side theorists argue that the positive feedback effects of tax cuts and corresponding higher savings and investment will more than offset the revenue losses. Others argue that revenue losses will be greater than the gains from higher growth. Under current "scorekeeping" rules, budget estimators project that tax cuts will lose revenues and increase the deficit.[9]

[8] Technical Panel of Trends and Issues in Retirement Savings (1995).

[9] For example, the 1995 Congressional Budget Resolution proposed to cut capital gains taxes. Although supply-siders argued that the reduction in capital gain taxes would produce higher investment and more robust economic growth, and thus produce greater revenues to the Treasury, the Joint Congressional Committee on Taxation scored the provision as losing $119 billion in revenues over 10 years.

Personal Savings

The level of personal savings declined sharply after 1985. (See Table 3.3).

Table 3.3
Personal Savings: 1971–93
(Percentage of net national product (NNP))

Type of Saving	1971–90	1981–85	1986–90	1991–93
Net personal saving	7.2	8.1	5.8	5.9
Retirement	3.7	6.7	5.7	5.6
Pensions	3.7	5.4	4.4	4.2
Individual	n.a.	1.3	1.3	1.4
Life Insurance	0.5	0.3	0.6	0.5
Other	3.0	1.1	-0.5	-0.2

SOURCE: Sabelhaus (1996).

This causes concern because personal savings historically have contributed half or more of national savings. Economic theories about why personal savings have declined abound, but none provides a fully satisfactory explanation. A combination of explanations is likely.

- When people feel wealthier, they are less inclined to save. The decline in personal savings coincided with the tremendous run-ups in the real estate and stock markets. Not only did the savings rate fall during the late 1980s, but consumer debt increased as people took advantage of higher asset values to finance consumption, housing, and durable goods.

- Savings behavior may be countercyclical. When people are confident that their incomes will grow in the future, they feel less need to save. Consumer confidence was high during the recovery following the 1981–82 recession. Personal savings fell from 9.1 percent of disposable income in 1981 to 4.8 percent in 1989. Savings rose during the 1990–91 recession, reaching 5.9 percent in 1992, but falling to 3.8 percent in 1994, once the economy recovered.

- The number of people in their "peak savings years" (ages 45 to 64) declined and the number of retirees increased. People who are approaching retirement have more income and are more concerned about saving. Retirees are expected to stop saving, even use up accumulated savings, to maintain their standards of living. However, the timing of the demographic changes does not coincide with the decline in savings, and the size of the demographic shifts were relatively small. People ages 45 to 64 declined as a share of the adult population from the 1960s to the mid-1980s. The proportion of retirees grew beginning in the early 1970s.

- Government policies inhibit savings.

  > **Tax policies** affect after-tax income and wealth. The current tax system taxes savings and investment more than other uses of income. With lower after-tax returns, people have less incentive to save. Although it is not possible to estimate what the savings levels might have occurred under different tax policies, it is possible to assess changes in savings as a result of tax provisions. Table 3.3 shows that people respond to tax incentives to save. Since 1970, as various tax-advantaged retirement saving options have grown (IRAs, 401(k)s, Keoghs, etc.), retirement savings have risen. At the same time, overall personal savings rates have declined. Today, nonretirement savings are negligible.

  > Workers may feel **less need to save** if they expect Social Security and Medicare to take care of post-retirement incomes and health care needs.[10] Or, they may not understand that payroll taxes are not personal savings.[11] Retired people are able to consume more because Social Security and, more importantly, Medicare, provide benefits guaranteed to last through their remaining years.[12] Some economists argue against this explanation because the timing is off. The creation of Medicare and Medicaid in 1965 and the rapid expansion of Social Security benefit levels in the 1970s pre-date the decline in personal savings in the 1980s.

  > **Means-tested programs** like Medicaid may cause people to use, avoid, use up, or give away savings to qualify for benefits.

[10] Polls, however, indicate growing numbers of respondents believe that Social Security and Medicare are in trouble or that benefit levels will be cut back by the time they retire. For example, see EBRI (January 1997), Farkas and Johnson (1997), and AARP (1995).

[11] A 1995 DYG telephone survey of 2,000 Americans age 18 or older conducted for the AARP found that four-fifths of respondents think of payroll taxes as retirement savings. AARP (1995).

[12] Gokhale *et. al.* (1996).

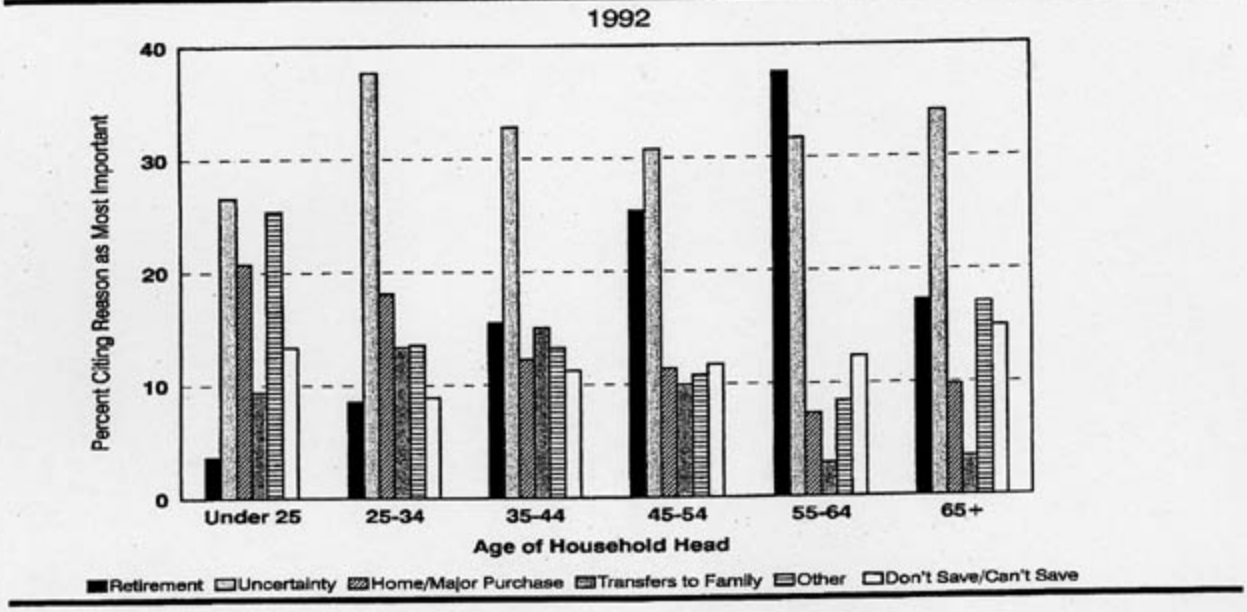
Why Do People Save?

In work examining how changes in tax policy might affect savings behavior, Andrew Samwick has looked at why people save.[13] He finds that people save, often simultaneously, for a number of reasons.

- *Retirement savings:* This type of savings smoothes out income over lifetimes, making it possible to maintain a higher standard of living in retirement.
- *Savings for a major purchase:* People save because they want to buy a house or a new car.
- *Uncertainty:* The unexpected can happen. Precautionary savings act as a cushion against job loss, major illness, or some other unforeseen event.
- *Transfers to other family members:* People save to pay for their children's college education. The desire to leave an estate (bequests) can extend savings into retirement. Bequests can be planned or unplanned because of the uncertainty of how long retirement will last.

Based on responses to a 1992 survey, Samwick shows that people's reasons for saving can differ by age. A third of all households mentioned retirement as the most important reason for saving, tied with "uncertainty" as the most important reason for saving. Although the focus on "retirement" grows dramatically with age, "uncertainty" is consistently cited by all age groups as the major reason for saving.

Figure 3.2
Household Reasons for Saving by Age, 1992



SOURCE: Samwick, based on the 1992 Survey of Consumer Finances (1997).

[13] See Samwick (1997).

- **Increases in elderly consumption** have caused net national savings to decline.[14] Social Security and Medicare provide seniors with annual (annuitized) sources of income (in the case of Medicare and Medicaid, in-kind income). Because they no longer have to fear outliving their resources, seniors can and do consume more. In addition, Social Security and other government transfer programs give the elderly more income to consume. Skeptics of this theory again point to the timing problem. The expansion of government transfer programs pre-dated the decline in national savings. They also doubt that the increases in elderly consumption are large enough to account for the decline in saving.

- People do not know how much they should save to maintain their pre-retirement standards of living after retirement.

  > Public opinion studies indicate that people are not aware of how much they should be saving for retirement.[15] When they are better informed, 40 percent to 50 percent of those polled indicate a willingness to increase their personal savings rate.

  > Although three-fourths of workers are confident about their retirement income prospects, 25–30 percent of them had not saved anything for retirement.[16]

The Impact of the Decline in Savings

Although it is not possible to know exactly the extent to which the decline in domestic savings have affected the economy, current and future consumption levels are likely to be lower than they would have been if no decline had occurred.

- A 1991 study[17] estimated that if the decline in savings observed since the 1980s is permanent, consumption in 2020 (while higher than today's levels) will be 10 percent lower than it would have been had savings levels stayed at their 1980s levels.

- According to CBO, during the 1980s, people enjoyed twice the standard of living their parents enjoyed when they were the same age. Now, because of low savings rates, slower growth in the labor force, and lower productivity, CBO estimates that it will take ***three*** generations for standards of living to double.

- Foreign debt is being used partially to offset the decline in domestic savings. Income and interest payments on these investments leave the country. For the first time, in 1994, U.S. payments on foreign-held assets in this country exceeded

[14] Gokhale, Kotlikoff, and Sabelhaus (1997).
[15] Luntz (1994); EBRI, 1996 Retirement Confidence Survey (January 1997).
[16] EBRI, 1995 Retirement Confidence Survey (December 1995).
[17] Harris and Steindel (1991).

receipts on U.S.-owned assets abroad. The size of payments leaving the country will grow if we continue to depend on foreign sources of capital. Depending on foreign capital may become more difficult. The rest of the world faces similar, even more acute, demographic pressures. (See next section.)

The good news is that the damage can be undone. Permanently balancing the budget and running consolidated budget surpluses equal to annual Social Security surpluses would restore savings to approximately the pre-1980 level.

Global Perspective

The United States is not alone – the global population is aging. (See Table 3.4). It is not possible to predict what impact this change will have on the world economy. As with the U.S. domestic situation, the greater the size of the world economy, the easier it will be to accommodate the competing claims for resources and output.

- Other developed nations are facing more acute and more immediate problems than the U.S. (See Tables 3.5 and 3.6). They will have proportionately larger elderly populations than we do, and their public commitments to provide income assistance are greater. Under current policies, these countries are projected to run large budget deficits to meet the needs of their elderly citizens. Between 2000 and 2030, public debt will increase due solely to the aging of the population by as much as 190 percent of GDP in Japan to a low of 2 percent in Iceland. U.S. public debt will rise 44 percent of GDP due to aging.[18]

Table 3.4
Population over Sixty Years Old
(Weighted average percentage by region)

Region	1990	2010	2030	2050
OECD	18.2	23.1	30.7	31.2
Latin America and Caribbean	6.9	9.3	16.0	23.5
Eastern Europe and Former Soviet Union	15.3	18.2	22.7	26.5
Middle East and Northern Africa	7.0	8.1	12.4	18.1
Sub-Saharan Africa	4.6	4.5	5.9	9.9
Asia	7.4	9.5	16.3	22.1
Memo:				
United States	16.6	19.2	28.2	28.9

[18] OECD (1996).

- High levels of public borrowing will put significant upward pressure on global interest rates. It will be harder to attract the investors that currently help make up for low U.S. domestic savings rates. Public and private borrowing costs will go up worldwide, making it much more difficult to finance public programs and new investment.

Table 3.5
G-7 Nations: Elderly as Percent of Working-Aged Population
(Population 65 and above as percent of population age 15 to 64)

Country	1960	1990	2010	2030
Japan	9.5	17.1	33.0	44.5
Germany	16.0	21.7	30.3	49.2
France	18.8	20.8	24.6	39.1
Italy	13.3	21.6	31.2	48.3
United Kingdom	17.9	24.0	25.8	38.7
Canada	13.0	16.7	20.4	39.1
United States	15.4	19.1	20.4	36.8

Source: OECD(1996).

Table 3.6
G-7 Nations: Total Dependency Ratio
(Population ages 0 to 14 and 65 and above as a percent of population age 15 to 64)

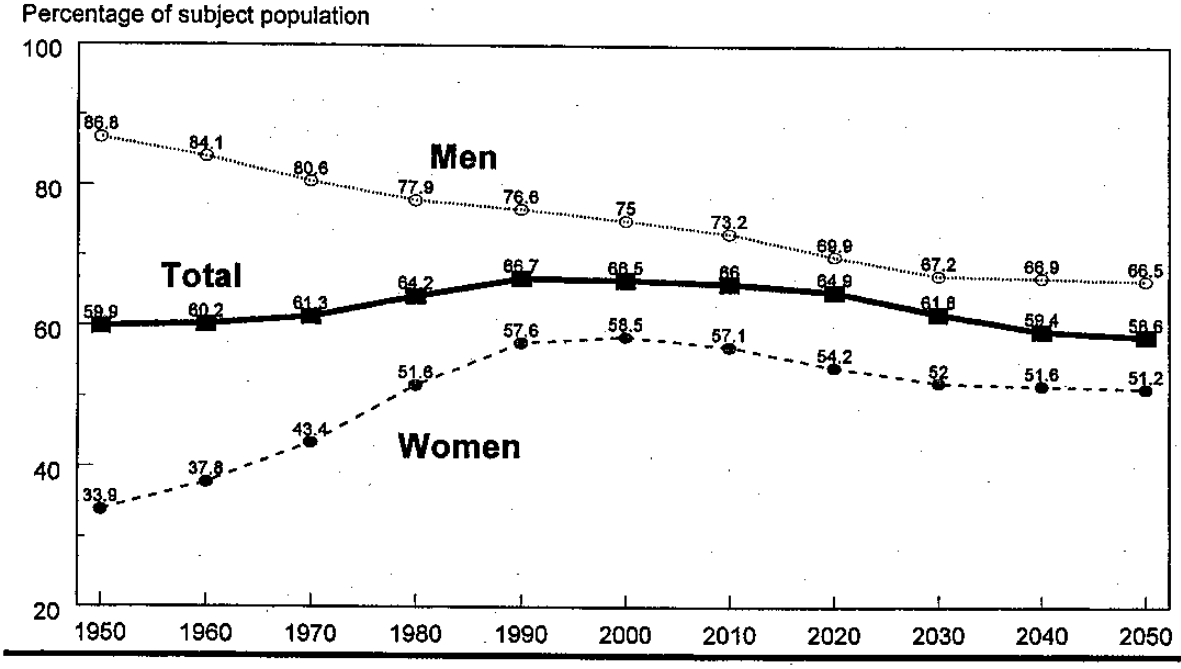
Country	1960	1990	2010	2030
Japan	56.6	43.5	56.7	70.5
Germany	47.4	45.3	50.0	75.1
France	61.3	51.1	51.2	67.9
Italy	47.9	45.5	51.5	72.7
United Kingdom	53.7	52.9	52.3	68.0
Canada	70.5	47.5	47.5	69.0
United States	67.4	51.7	50.5	68.0

Source: OECD(1996).

Labor Force Issues

Between 1950 and 1994, the labor force more than doubled in size. Over half the increase occurred between 1960 and 1980, when the baby boomers entered the labor force. Labor force participation rates for men have been falling, but the growth in working women has more than offset this decline. As a result, overall labor force participation rates have increased. Two-thirds of the population age 16 and above is now in the labor force, compared with 60 percent in 1950. (See Figure 3.3).

Figure 3.3
Labor Force Participation



SOURCE: SSA (December 1992).

Since World War II, Americans have been retiring earlier and are living 3 to 5 years longer in retirement.

- In 1950, 87 percent of men age 55 to 64 and 71 percent of men age 65 and above were in the labor force. In 1995, two-thirds of men 55 to 64 years of age and 17 percent of men 65 and above were in the labor force.

- In 1995, almost half of women age 55 to 64 were in the labor force, compared with about a fourth in 1950. However, over the same period, the number of women workers age 65 and above dropped 11 percent (from 20 percent to 9 percent).

As the population ages, a smaller proportion will be of working age. During the twenty years in which baby boomers will turn 65 (2011 to 2030), SSA projects the labor force will grow by 5.7 million workers. By contrast, the labor force grew by 4 times that number during the 1970s.

Total economic output equals output per worker times the number of workers. A growing number of workers produce a growing economy. Conversely, a slowdown in the growth of new workers will slow down economic growth. After 2010, the growth of the labor force will slow to a trickle (0.2 percent according to SSA). CBO estimates that as the population ages, GDP growth will slow from 2.1 in 2005 to 1.7 percent in 2020.[19]

The bottom line is there will be more retirees for each worker to support. The combination of a growing number of elderly and a near stagnant working age population will reduce the ratio of persons age 18 to 64 to persons age 65 and above. In 1940, the ratio was 9.1 to 1. Currently, the ratio is 4.8 to 1. In 2030, the Census Bureau predicts it will be 2.8 to 1. Add children and young people below the age of 20 together with persons age 65 and above and the ratio of workers to dependents will be only 1.03 to 1 in 2030, compared with 1.43 to 1 in 1940, and 1.37 to 1 in 1995.

There are three ways to offset the economic effects of the slowdown in growth of the labor force.

- **Keep workers in the labor force**. To encourage people to work longer, public and private pension plans will have to stop promoting early retirement, barriers to older workers will have to be reduced or eliminated, and opportunities for part-time work will have to expand.

- **Make each worker more productive**. Investment, in physical and human capital stock, increases worker productivity. Higher levels of national savings permit greater investment. Investments in education and training increase the knowledge and skill levels of the workforce.

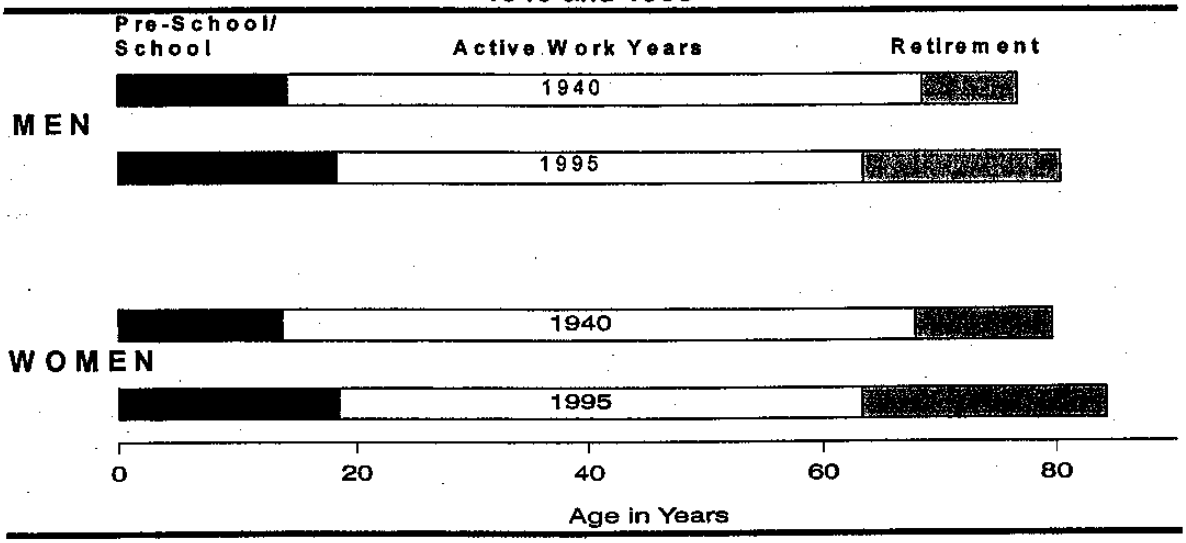
[19] CBO (March 1997).

- **Increase immigration of working-age individuals.** Higher levels of immigration could boost the size of the labor force. However, the country is unlikely to accept the levels of immigration necessary to offset fully the aging of the population. In its long-term projections, SSA assumes annual immigration of 900,000 persons.[20] In 1990, the ratio of covered workers to beneficiaries was 3.4 to 1. To maintain that ratio, annual immigration would have to almost double through 2010 and nearly **quadruple** by 2030.[21] By 2030, a cumulative 110 million additional workers—equal to 32 percent of the projected population—would be needed to maintain the 1990 ratio. The actual number of immigrants would have to be even larger because in any given year, about one-fourth of immigrants are children or older than age 65 and additional immigrants would be needed to replace those who retire.

Longer Life Expectancies, Shorter Working Lives

People now stay in school longer and retire earlier than they did in 1940. Today, people spend slightly more than half their lifetimes working, compared with more than two-thirds in 1940. Since 1940, life expectancy at age 65 has increased 3 years for men and almost 5 years for women. But working lives have shortened. (See Figure 3.4).

Figure 3.4
Longer Life Expectancies, Shorter Working Lives
1940 and 1995



SOURCE: CRFB based on SSA and Bureau of the Census data.

[20] The Immigration and Naturalization Service (INS) reported 720,500 legal immigrants for 1995 and 804,000 for 1994. The SSA assumption of 900,000 includes 600,000 legal and 300,000 "other than legal" immigrants.
[21] CED estimates based on SSA intermediate projections. (1995).

On average, people today stay in school four years longer than they did 50 years ago. Spending more time in school should have positive benefits for individuals and for the overall economy. Better educated workers are more productive. Those with higher levels of educational attainment are more likely to be in the labor force and are less likely to be unemployed. Although disparities in earnings continue between men and women, and among individuals of different racial and ethnic backgrounds, higher educational attainment consistently is associated with higher earnings. (See Table 3.7).

Table 3.7
Mean 1994 Earnings by Educational Attainment
Persons Age 18 and Above

	Total	Not a High School Graduate	High School Graduate	Some College or Associate Degree	Bachelor's Degree	Advanced Degree
Total	$25,852	$13.697	$20,248	$22,226	$37,224	$56,105
• Male	32,087	16,633	25,038	27,636	46,278	67,032
• Female	18,684	9,189	14,995	16,928	26,483	39,905
Race and Ethnicity						
• White	26,696	13,941	20,911	22,648	37,996	56,475
• Black	19,772	12,705	16,446	19,631	30,938	48,653
• Hispanic*	18,568	13,733	17,323	21,041	29,165	51,898

SOURCE: Day and Curry (August 1996).

* People of Hispanic origin may be of any race.

The Retirement Decision

With longer life expectancies, improvements in health, and less physically demanding labor, why don't people work longer? Almost half (46 percent) of current workers plan to retire before age 65. Only 12 percent plan to continue working after age 65.[22] Earlier retirement lengthens the period of dependency during which people rely on savings, pensions, Social Security, and Medicare. Shorter working lives allow less time to build up those retirement resources. To the economy, retirement often represents the loss of the most knowledgeable and highest skilled workers. As the growth of the labor force slows, keeping older individuals working longer will be important to overall productivity.[23]

[22] Survey by EBRI, Matthew Greenwald & Associates, and American Savings Education Council. Survey was performed in July 1996 and reported in the *National Journal* (November 2,1996).

[23] The discussion in this chapter about retirement trends and issues is based upon the report of the Technical Panel on Retirement Issues and Trends (1995).

Retirement Age

Retirement at age 65 is partially customary (see box that follows), but retirement decisions are strongly influenced by the age at which individuals are eligible for private pension and Social Security benefits. To encourage people to work longer, the retirement eligibility age will have to be changed for Social Security and private retirement plans.

- Labor force exit rates peak noticeably at ages 62 and 65, the Social Security early and normal retirement ages. Male labor force participation rates drop 12 percent at age 62 and 10 percent at age 65. Corresponding women's rates drop 9 percent and 7 percent. Other labor transition points are observed at age 55 and 60, indicating that private pension provisions also influence people's decisions about when to retire.

- More people start receiving Social Security retirement benefits at age 62 than at any other age. Men first became eligible for early retirement at age 62 in 1961. (Early retirement was made available to women in 1956.) By 1965, 30 percent of new male retirees were age 62 to 64. In 1995, 67 percent of new male retirees and 75 percent of new female retirees were age 62 to 64.

- Private pension plans contribute to the popularity of retirement at age 62. Over 40 percent of medium and large private establishments and almost 50 percent of small establishments allow normal retirement (full benefits) at age 62 or younger.[24] In addition, almost all private plans allow early retirement with reduced benefits. Two-thirds set age 55 as the minimum early retirement age.

- Employer-sponsored retiree health insurance coverage also encourages early retirement. Unless they are disabled, retirees under age 65 are not eligible for Medicare. Retiree health benefit plans are more common among medium and large firms. A third of employees ages 45 or above work for employers who sponsor retiree health benefits.[25] Since 1992, when employers were first required to note retiree health insurance liabilities on their financial statements, retiree coverage has been falling. Erosion in retiree coverage for retirees younger than 65 could deter more workers from early retirement.

[24] EBRI (1995).
[25] ERBI analysis of 1993 Current Population Survey (April 1997).

Why Age 65?[26]

In 1935, there was no gerontological or scientific basis for setting the normal retirement for Social Security at age 65. Policymakers chose between age 65 or age 70 (nothing in between), and the decision, once reached, was relatively uncontroversial.

- Age 65 was consistent with the 1934 Railroad Retirement Act. (Railroad workers, who were among the first workers with pension plans, successfully won a retirement age of 65, down from age 70, in that legislation.)
- Private industrial and union plans had age requirements of 70 or lower. Britain and Germany provided old age benefits at 65. Of the 30 states that had old age assistance programs, almost half (14) had a minimum age requirement of 70. Only one had an age lower than 65, and it applied to women.

The decision was based on pragmatic political reasons. A higher age would have been unpopular, primarily because it would not help ease sufficiently the level of unemployment. A lower age would have been prohibitively expensive.

To Retire or Not to Retire

Before workers reach the eligibility age for retirement, they earn regular wages and accrue higher future retirement benefits. Pre-retirement earnings largely determine post-retirement benefits. Social security retirement benefits are based on earnings during covered employment. Employer contributions to defined contribution pension plans typically are based on earnings. More than 80 percent of private defined benefit pensions are based on earnings at the end of a career or years of service.[27]

Under defined benefit plans, workers face a trade-off when they reach retirement age: retire and begin receiving benefits immediately, or keep on working and forgo current benefits in exchange for higher benefits later. If the additional benefits earned as a result of continued work are larger than the retirement benefits forgone, then it is to the worker's advantage to keep on working.

[26] See Cohen (1957).

[27] Under defined contribution plans, employers make specified contributions on behalf of employees into individual investment accounts. Benefits equal assets in these accounts at retirement. Under defined benefit plans, the employee is promised a specific level of benefits upon retirement based on years of service and earnings. See chapter 9 and appendix 1 for more information about private pension plans.

- **Reduced benefits for early retirement**. Generally, workers who retire early receive reduced annual retirement benefits in exchange for more years of benefit payments.[28] An "actuarially fair" trade-off is a 7 percent benefit reduction for each year retirement precedes the normal retirement age. "Actuarially fair" means that the value of benefits is equivalent, whether higher payments for fewer years or smaller payments for more years. If the benefits are not sufficiently reduced, the worker has an incentive to retire as soon as eligible; a larger-than-actuarially-fair reduction for early retirement penalizes early retirees. (Employees whose primary coverage come from defined contribution plans do not face such trade-offs. As long as contributions continue, retirement wealth grow.)

- **Life expectancy differences**. Assuming they have a choice, individuals with shorter life expectancies may be better off if they retire earlier. Individuals who expect to live longer than the actuarial assumptions built into the early retirement benefit level also may gain from early retirement because they will live long enough to receive greater lifetime benefits even at the reduced annual rate.

- **Substantial penalties for working too long**. Social Security and many private pension plans discourage working beyond the normal retirement age.

  > In Social Security, future benefits are increased by a "delayed retirement credit" for each year worked beyond age 65. The current delayed retirement credit (5 percent for individuals the normal retirement age of 65 in 1997) is not actuarially fair—the amount of the increase is not high enough to offset the benefits lost because of continued work. Increases in the credit are being phased-in. By the time boomers retire, individuals who work beyond the normal retirement age of 66 will receive delayed retirement credits of 8 percent per year of continued work, an amount that is considered actuarially fair.

  > Research on private plans shows penalties for working beyond initial retirement eligibility age can be substantial.[29] One study estimated that men in one plan who worked until age 68, instead of retiring at age 60, lost 40 percent of their lifetime retirement incomes.

- **Benefit formulas offer different incentives**. Three-fifths of defined benefit plans base benefits on years of service and earnings at the end of employment (terminal earnings). Over one-fifth of plans multiply years of service by a fixed dollar amount, and 11 percent use career earnings (as does Social Security). The net lifetime pension benefit gained from additional years of work is likely to be higher in the first two types of plans than in the third.

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[28] For example, Social Security benefits claimed at age 62 are 20 percent lower than benefits at age 65. This is considered to be actuarially fair.

[29] Research cited in the final report of the Technical Panel on Retirement Trends and Issues in Retirement Saving (1995).

Barriers to Working for Older Workers

Age discrimination could explain declining labor force participation rates for older men. If so, eliminating age discrimination and other barriers could keep older workers working longer. However, there is inconclusive evidence that these factors account for the decline in labor force participation rates of older workers.

Older workers have lower unemployment rates than younger workers. Older and younger workers are equally likely to be laid off. But older workers who lose their jobs are unemployed for longer periods. When they do find work, they face greater reductions in earnings than younger workers. They are more likely to become discouraged and drop out of the labor force altogether (therefore not counted as officially unemployed).

- Five percent of men and 4 percent of women ages 55 to 64 were unemployed in 1993, while the rates for men and women ages 25 to 34 were just below 7 percent.

- In the mid-1980s, about one-third of laid-off workers ages 55 to 64 and three-fourths of those age 65 or above left the labor force, compared with fewer than 10 percent of those ages 20 to 54.

Employers may be reluctant to hire older workers because they feel that younger workers, who have the potential for longer job tenure, are a better investment. Older workers are likely to have more health problems and, in smaller companies, could raise group health insurance costs. Finally, employers may fear that older workers are harder to train, less able to cope with technological change, and less productive because they have lower levels of motivation, commitment to work, and ambition.

Part -Time Work

Another way to keep older workers in the labor force is to increase opportunities for part-time or temporary work. Part-time work offers older workers a more gradual transition into retirement. A 1994 survey indicates that more older workers would like to work part time. A fifth of men ages 55 to 64 and over two-fifths of women ages 50 to 59 indicated that they would like to work part-time, but only 6 percent and 9 percent respectively were part-time workers. More older workers may be reluctant to work part time because compensation and benefits are lower. Furthermore, employers who are reluctant to hire older workers may find even stronger rationales against hiring them for part-time positions.

Part-time and contingent (temporary) workers are likely to be paid at lower wage rates and receive fewer benefits than full-time workers. Part-time workers comprise approximately 20 percent of the labor force.[30]

- Fourteen percent of men work part time. Men ages 60 to 64 are more than twice as likely to work part time as men ages 25 to 59.

- Women of all ages are more likely to work part time than men. A third of women ages 60 to 64 work part time, compared with a fifth of women ages 25 to 59. Overall, 30 percent of women in the labor force work part time.

Individual Responsibility for Retirement Incomes

At age 50, the oldest baby boomers can now be classified as "older workers." Although these leading edge boomers are only 15 short years away from the normal retirement age, many may not be accumulating sufficient resources to support themselves once they cease working.

Estimates of how much baby boomers need to increase their savings rate to avoid significantly lower standards of living in retirement vary, but researchers agree that boomers should save more.[31] The size of the savings gap increases if future reductions in Social Security benefit levels or increases in taxation are factored in. The estimate of required additional savings decrease if bequests and home equity are considered a source of future retirement income.[32] Even if boomers begin to save more as retirement age approaches, not all increases in personal savings necessarily would end up being used for retirement savings. (See discussion earlier in this chapter on why people save.)

Retirement income comes from three sources: Social Security, employer-sponsored pension benefits, and individual savings and assets other than contributions to employer plans. Increasingly, older adults are using continued employment in "bridge" jobs or part-time work to transition into full retirement.

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[30] Part-time workers grew as a percentage of the labor force from 15 to 20 percent during the 1970s and early 1980s, the same time growing numbers of women entered the labor force. Since that time, the figure has remained about 20 percent .

[31] Bernheim (1996), Sabelhaus and Manchester (1995).

[32] Home equity could be accessed through instruments such as reverse equity mortgages.

Table 3.8
Defined Benefit Pension Plan Replacement Rates: 1992–93
(percentage of final annual earnings)

	Final Annual Earnings					
	$15,000	$25,000	$35,000	$45,000	$55,000	$65,000
	20 years of service					
State and local government : 1992						
• Pension benefits only	33.4	33.4	33.5	33.6	33.7	33.8
• Combined pension and primary Social Security	70.5	63.4	60.1	57.2	54.2	55.1
• Pension only: Not covered by Social Security	42.8	42.8	42.8	42.8	42.8	42.8
Medium & large private enterprises: 1993						
• Pension benefits only	24.5	21.4	20.1	19.4	19.0	19.2
• Combined pension and primary Social Security	62.8	51.9	47.3	43.8	40.9	37.7
	30 years of service					
State and Local government: 1992						
• Pension benefits only	50.2	50.4	50.6	50.7	50.8	50.9
• Combined pension and primary Social Security	96.7	89.5	84.1	78.1	73.8	70.4
• Pension only: Not covered by Social Security	63.2	63.2	63.2	63.2	63.2	63.2
Medium & large private enterprises: 1993						
• Pension benefits only	36.8	32.0	30.0	29.2	28.8	28.9
• Combined pension and primary Social Security	84.2	71.7	64.6	58.1	53.3	49.7

Source: EBRI Databook, Table 4.14 (1995).

In general, financial planners estimate that it will take 60 percent to 80 percent of pre-retirement income to maintain the same pre-retirement standard of living in retirement. For most workers, neither private pensions nor Social Security alone will be adequate to maintain pre-retirement standards of living in retirement. (See Table 3.8). Although combined Social Security and private pension benefits are close to reaching target replacement rates for some workers, these levels at best are optimistic because Social Security benefit levels are likely to be reduced.

- As Table 3.8 shows, even those workers who have private pensions will have to supplement pension income with income from other sources.

- Social Security has a progressive benefits formula. It is designed to replace a higher portion of the earnings of lower wage workers than of higher wage workers. Under current law, Social Security replacement rates for workers retiring in 1997 at age 65 range from 59 percent of earnings in the 12 months preceding retirement for low-wage earners to 25 percent for earners who always earned the maximum taxable wage. [33] By itself, Social Security does not preserve pre-retirement standards of living, even for low-income earners whose benefits replace a greater share of pre-retirement earnings.

- It is possible that Social Security reforms will be enacted before 2010. These reforms likely will reduce benefits for some, if not all future beneficiaries, and raise payroll taxes, if not by raising rates, by increasing maximum taxable earnings or other measures. Workers will need to save more and work longer, or they will experience reduced standards of living in retirement.

Savings Requirements

Figure 3.5 shows how important it is to begin saving early. The figure shows how much an individual should save (in the form of private pension and other retirement savings) to replace various levels of pre-retirement income. Social Security would provide addition retirement income, depending on the replacement rates in effect at retirement.

[33] "Low wage" earners are defined as those with earnings of 45 percent of the projected average wage index.

Figure 3.5
The Miracle of Compound Interest
Savings required to achieve desired retirement income (as a percentage of salary)

Desired Retirement Income as a Percentage of Annual Salary	Years to Retirement					
	10	15	20	25	30	35
30%	36%	21%	13%	9%	6%	4%
40%	48%	27%	18%	12%	8%	6%
50%	60%	34%	22%	15%	10%	7%
60%	72%	41%	26%	18%	12%	9%
70%	84%	48%	31%	21%	14%	10%

SOURCE: CED (1995).

Note: These estimates are based on a 6 percent real rate of return. Zeldes (1995) estimates the historical average arithmetic real rates of return are 9 percent for equities and 2 percent for intermediate bonds

Retirement Savings

The 1996 EBRI Retirement Confidence Survey[34] indicates that workers are aware of the need to save.

- Only 26 percent of workers surveyed think Social Security will be the most important source of their retirement incomes. Slightly over 60 percent think their contributions to employer-sponsored retirement plans will be the most important source of their retirement incomes.

- By comparison, 64 percent of current retirees surveyed report Social Security as their most important source of retirement income.

- Although most workers are confident that they will have enough money for a comfortable retirement, only a third have tried to figure out how much they have to save to achieve their retirement objectives, and only a third of these were confident that they had determined an accurate figure. This means that although they are saving, they may not be saving enough.

[34] EBRI (January 1997).

The good news is that workers are thinking about retirement. Although they are not saving enough, the majority of workers report saving regularly for retirement. Three-fourths of workers who are offered retirement savings plans (e.g., 401(k)s, 403(b)s, salary reduction plans) report they are contributing to the plans. However, over 40 percent of workers do not have access to employer-sponsored plans, and only 44 percent of workers who have access to employment-based plans actually participate in such plans.

Individual Retirement Accounts

Workers can supplement retirement savings through individual retirement accounts (IRAs). IRAs provide favorable tax treatment for retirement savings for some workers. In 1993, 8 percent of all workers contributed to IRAs. The average contribution was $1,789. Workers with other pension coverage were more likely to contribute to IRAs than workers with no coverage.

Some members of Congress have proposed expanding IRA tax incentives to encourage additional retirement savings. However, IRAs cost the Federal government an estimated $8 billion in revenue losses in 1996. IRA expansion would result in further Federal revenue losses that would have to be offset in order to maintain deficit neutrality. Although retirement savings might increase, as noted in the earlier discussion about personal savings, if expanded tax incentives induce people to shift taxable savings into tax-advantaged savings, not to increase their net personal savings, no macroeconomic benefit will be realized.

Lump Sum Distributions

One of the important advantages of defined contribution private pension plans is that they are more portable. Workers typically receive lump sum distributions when they change jobs or the plan terminates. These amounts can be rolled over into other tax-qualified retirement savings vehicles—an existing or new IRA, for example.

However, lump sum distributions offer workers early access to retirement savings. Despite incurring income tax and an excise tax penalty (typically 10 percent) on any amounts that are not rolled over into other retirement savings, workers are using lump sum distributions for other purposes. As a result, their eventual retirement incomes will be lower than they would have been if workers could not have accessed these funds.

In 1993, fewer than a fifth of recipients of lump sum distributions reported that they put the full amount into tax-qualified retirement savings.[35] Over two-fifths used some of the distribution for retirement savings.

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[35] EBRI (1993).

- Smaller distributions (under $4,500) are more likely to be consumed than larger amounts. Higher income and better educated individuals are more likely to use the funds for retirement savings.

- Individuals between the ages of 51 and 60 when they received lump sum distributions were the most likely to roll them over into tax-advantaged savings. Over 40 percent of them rolled over the full amounts; another 20 percent rolled portions into retirement savings.

- Men were slightly more likely to roll over some of their lump sum distributions than women (43 percent for men compared to 40 percent for women). Two-fifths of Whites, 37 percent of Blacks, and 50 percent of individuals of other races used some of their distributions for tax-qualified retirement savings.

Conclusion

Polling results on retirement issues consistently indicate major contradictions between individual expectations and economic behavior. The polls show that baby boomers expect to retire before age 65 and live comfortably. They say that they, not government and not younger generations, are principally responsible for their retirement security. They do not support raising payroll taxes, but they are unwilling to support cuts in Social Security or Medicare benefits. Yet, most respondents are not saving enough and have not even figured out how much they need to save in order to live comfortably in retirement.

These contradictory responses indicate large gaps in public understanding of basic economic issues. Until the public is better informed, individual attitudes toward saving and consumption are not likely to change. And, if attitudes don't change, behavior won't change. In addition, until better informed, voters are not likely to support the types of adjustments in public policy that are required to address changing demographic and economic conditions.

The reports about efforts to educate workers about retirement issues appear encouraging.[36] Similarly, efforts to educate the public about broader economic issues and how they are related to retirement security issues could change individual behavior as well as help create a political climate that would support more responsible fiscal and economic policies. Absent greater public understanding of these complex issues, broader public policy goals (e.g., increase net national savings, keep people working longer), at best, are likely to be only modestly successful.

[36] See, for example, EBRI analysis of employer efforts of educate workers about defined contribution pension plans and retirement investment issues (January 1996).

Chapter 4. The Federal Budget Perspective

Forty percent of all Federal program spending is for benefits and services for older adults. Without this assistance, half of the elderly population would be poor. Put another way, take away Social Security, Medicare, Medicaid, housing, and other elderly support programs and the poverty rate among people over 65 would increase fourfold.[1] Many seniors depend on these programs for their financial security. So much of Federal spending is directed to the elderly that projected demographic changes will greatly affect the Federal budget.

Between 1965 and 1996, entitlements and other mandatory programs doubled from 5.5 percent of GDP to 11 percent. Medicare and Medicaid contributed almost of two-thirds of that growth in spending. Under current laws and policies, between 1996 and 2030, Social Security, Medicare, and Medicaid are projected to grow from 8 percent to 17 percent of GDP.

The flip side of entitlement growth is discretionary spending shrinkage. Defense, international affairs, space, science, environment, and grants to State and local governments for highways, housing, education, and job training take up ever smaller shares of the budget even though new activities are added.

Entitlements have had a parallel effect on Federal revenues. Although policy makers have not been able to raise overall revenues as fast as entitlements have grown, social insurance payroll taxes have grown from below 2 percent to 7 percent of GDP. This growth in dedicated social insurance taxes leaves a smaller revenue base to fund the remainder of government.

CBO projects if current laws are not changed Federal program spending would grow to 23 percent of GDP in 2030, compared with 18 percent today.[2] Social Security, Medicare and Medicaid will grow by 8 percent of GDP, while other programs shrink by 4 percent. Federal revenues will remain at 19 percent of GDP. A 20 percent tax increase, program cuts equally large, or elimination of whole functions of government would be required to close this gap and avoid running ever larger deficits.

These are optimistic estimates. The demographics are not likely to change. If anything, research suggests boomers may live longer than current projections assume. If so, the cost of supporting retired boomers could be even higher. Furthermore, the projections assume uninterrupted, moderate growth and no adverse economic shifts or other emergencies that would make the projections even worse.

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[1] Bureau of the Census (September 1993).
[2] CBO (March 1997).

In short, current budget policies are unsustainable over the long term. They would result in growing deficits and debt that eventually would lead to higher taxes, a downward economic spiral, and declining standards of living. Under these policies, future retirees would get all of the governmental benefits and services, while future workers would pay the tax bills. Future workers may have neither the means nor the desire to support this burden.

In the interest of sound, long-term fiscal policy, current public decision makers must find ways to make the financing of elderly programs more equitable and to control their growth. Unless they begin to address these age-related issues, future public decision makers will be faced with harder budget decisions and tougher economic issues. Yet, neither the current political climate nor the budget process lends itself to an open, constructive debate about the issues and problems we face.

Senior citizens are a potent political force. They follow public issues and they vote. They are naturally concerned about the fate of Social Security and Medicare. They are not alone: public opinion polls show that these programs enjoy widespread popular support.[3] Substantial majorities of people of all ages believe that these programs should continue. These programs provide economic security to retirees and relieve younger family members of some of the direct burden of supporting their elderly family members. In addition, workers look forward to Social Security and Medicare for their own retirement.

Why bother with long-term policy projections knowing that they are unsustainable and will never come to pass?

Because current policies are so clearly unsustainable, they will have to be changed. This leads some policy experts to dismiss long-term budget projections as unrealistic and unnecessarily pessimistic. Others argue that because policies will change, the problems we face are not as bad as they appear. This is a "Catch–22" situation. If long-term projections were to assume sustainable policies, these same observers could use them to deny the need for change. Thus long-term projections of current policies are useful illustrations of why current policies must, and eventually will, be changed.

Nevertheless, it is important to remember that slight changes in assumptions can multiply into significant differences over the long term. In May 1996, CBO estimated that the deficit would reach 12 percent of GDP in 2030 assuming current policies and no economic feedback effects from Federal deficits and borrowing. In March 1997, CBO estimated a 2030 deficit of 8 percent of GDP, a third lower. What changed? Among other smaller adjustments, the more recent estimate assumes slower projected growth rates in Medicare, Medicaid, and welfare programs over the next 10 years and 0.3 percent higher total factor productivity after 2007. Under the newer projection, debt held by the public reaches 100 percent of GDP in 2030 compared to 157 percent in the 1996 projection. These changes demonstrate that relatively small policy changes enacted in the near term could brighten the long-term picture considerably.

[3] See, for example, AARP, *Social Security and Medicare: Anniversary Research* (1995) and Public Agenda, *Miles to Go* (1997).

Popular opinions likely would change if voters understood better the issues and trade-offs. However, Social Security and Medicare lack transparency. That is, most people do not understand how these programs are financed and what they mean to our economic future. For example, four-fifths of respondents to one poll think of payroll taxes as retirement savings, put away and earmarked in some way to pay for their individual benefits. [4] The public generally thinks of the Social Security and Medicare trust funds as assets, not as liabilities of the Federal government and, therefore, of taxpayers. Elected leaders do little to enlighten their constituents. Under these conditions, it is difficult to move the public toward interest in fundamental reform of these programs. Lack of popular support makes it all but impossible to develop effective, coherent strategies to address changing economic and demographic conditions.

The "baby boom, baby bust, baby boom echo" situation demands that public decision makers pay attention to the problems of potentially inequitable outcomes among generations when transfers and taxes are taken into account. Payroll taxes finance Social Security and Medicare. Medicaid uses general revenues. Although the distributional effects differ, both types of taxes transfer resources from younger, working people to retirees. Younger generations benefit from improvements in the standard of living produced by the generations preceding them. But the "baby boom, baby bust" cycle means that the benefits-to-taxes ratio for younger workers when they retire will not be anywhere near as advantageous as it is for current retirees or as current law promises baby boomers it will be when they retire.

The Current Budget Debate

It will take time before the political agenda can turn to these long-term budget issues. In the nearer term, Congress and the President have identified balancing the budget by 2002 as their top priority. In many respects, they are laboring under the best of circumstances.

- The economy is in a period of sustained, steady growth. Inflation and unemployment are both low. Interest rates are stable. Federal budget deficits are lower as a percentage of GDP than at any time since 1974.

- Current demographics work for us. Entitlement spending is projected to rise more than a third between 1996 and 2002, but only 18 percent of that growth is due to projected increases in the number of beneficiaries.[5] The elderly population is growing at about the same rate as the overall population, and the good economy reduces the number of beneficiaries in other programs.

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[4] AARP (1995).
[5] CBO (January 1997).

- Most elected officials agree on the big chunks of the budget: essentially, they want to continue the status quo; reduce the growth in Federal spending for almost everything except Social Security; do what they must to stave off insolvency in the Medicare Trust Fund for a few more years; but few want to tackle structure reforms in the context of balancing the budget. Oddly, officials do not want to be accused of cutting Social Security or Medicare to balance the budget. They say those programs should be treated separately— that the objective should be to save them for future generations. By implication, they are ignoring the effects of these programs on other parts of the budget. Indeed, listening to the current debate, one could begin to question whether Social Security and Medicare are even government programs.

Despite favorable economic, demographic, and political conditions, neither the current budget process nor the current budget arithmetic makes it easy for Congress and the President to reach a consensus on a specific plan to balance the budget.

- **The United States has no budget.** Under the current budget process, the President has a budget, the Congress has a budget, but Congress and the President never enact into law a single blueprint for fiscal policy.[6]

- **Some say Congress and the President are trying to do too much. In fact, they are not bold enough.** Social Security and defense are "off the table." They must pay interest. They choose to cut taxes. They seek short-term fixes for Medicare. As a result, they have little room to maneuver within the budget. Under these conditions, there are few options to balance the budget. The decisions are difficult, but none of the likely approaches redress the long-term structural imbalances within the budget. Even though Congress and the President agreed in 1997 to balance the budget in 2002, future Congresses and Presidents will have to revisit the budget repeatedly. The task would be easier and the long-term results would be much more satisfying if public officials imposed fewer constraints on themselves and on the debate.

- Policy makers are postponing serious discussion about the medium- to long-term viability of current fiscal policies. Ignoring issues because they are politically difficult only makes them more difficult. A more comprehensive, honest, and open debate could help educate voters about these issues and move the country toward consensus about long-term policies. Political leaders cannot develop a road map to guide the country through these very rocky issues if they don't know where we are going, and that takes a big picture perspective.

There Is No Budget

Each year, the President sends his budget to Congress. The President's budget is often declared "dead on arrival." Some years, Congress ignores it. Some years,

[6]The 1997 Balanced Budget Agreement is a broad outline guiding FY 1998 appropriations and reconciliation legislation. It will not be enacted into law.

Congress officially votes it down. Congress never votes to adopt it. Congress has its own less detailed plan, which is called a "budget resolution." The Congressional budget resolution is not intended to become law. Normally, the House and Senate compromise among themselves, but they have no incentive to compromise with the President. The President does not sign or veto budget resolutions. Thus the President and Congress never enact a budget for the country.

In 1997, Congress and the President agreed on a plan to balance the budget in 2002. This outline was the basis for the Congressional budget resolution for the 1998 budget. Even with this level of agreement, the Congress and the President will wrestle over many separate pieces of legislation covering appropriations, taxes, and entitlement programs. But at least they are working from the same set of blueprints. Normally, they never have to agree whether they are building a bridge or a tunnel. They never have to compromise on aggregate levels of revenues or expenditures, let alone on how resources should be allocated among competing priorities.

Budget resolutions, which assume spending cuts or tax changes, may include reconciliation instructions. Reconciliation is a packaging device: specific committees are instructed to report modifications in existing laws to cut spending or to change revenues to make them conform with budget resolution levels. The media almost always report enactment of reconciliation bills as an "adoption of a budget agreement." But these bills only deal with changes to parts of the budget, and if the President or Congress reaches an impasse at any point in the process, the status quo prevails for tax policy and entitlement programs.

The Budget Process Favors the Status Quo

When there are large political differences, the process can break down. All too often, inertia sets in and fiscal policy remains essentially unchanged. That is part of the reason it is so hard to change budget policy. The budget process is biased in favor of the status quo.

- The Federal budget process starts with a "baseline"— that is, a projection of spending and revenues under current laws and policies often adjusted for inflation and other factors to hold service levels constant. Almost all changes to existing programs are defined as cuts. Changes that bring in more revenues are defined as tax increases.

- This process seriously disadvantages new programs or tax policies. Everything on the books is in the base. To make room for anything new, Congress and the President must cut something else or raise taxes.

- Current law becomes the standard to determine winners and losers. Proposals that would increase spending less rapidly than existing law create losers even though beneficiaries receive higher payments. If current law includes scheduled tax reductions, any diminution of those cuts is described as a tax increase, even if tax bills remain unchanged, even if they actually go down.

Congress and the President compare budget proposals by highlighting their differences *over* differences. That is, relative to their opponents, each side talks about how much more or less they would *change* existing tax and spending levels (e.g., "My proposed Medicare cuts are $100 billion smaller than theirs," or "Our tax cuts are $100 billion larger"). Often, it is difficult to distinguish between baseline differences and policy differences. This debate tells the public little about priorities because it doesn't tell how much proponents would raise in taxes or spend in money. The budget debate should be a discussion about the size, scope, and role of government. Increasingly, it is a battle about marginal changes to existing programs and policies.

The Budget Arithmetic: The Problem Is the Problem [7]

Budget arithmetic is easy. To reach budget balance, Congress and the President only have to cut spending, raise taxes, or combine the two. The problem is that although that both sides agree that the budget should be balanced, there is no political consensus about the size and scope of the Federal government.

Federal Deficits and Debt

Federal deficits can cushion the economy against unemployment and other effects of economic slowdowns. However, running deficits during periods of growth puts upward pressure on interest rates and inflation, and also reduces savings that otherwise could fund productive investment. Over the long term, persistent deficits erode our capital stock and undermine productivity and economic growth. Conversely, budget analysts at CBO and OMB assume balancing the budget will produce lower interest rates and stronger economic growth.

Under current laws and policies, budget deficits will grow gradually in nominal dollars and as a share of the overall economy. (See Figure 4.1.) Deficits increase despite the absence of wars, recessions, new programs, or tax cuts. This upward projection highlights the growing mismatch between voters' willingness to pay taxes and the benefits they expect to receive from government. Much of the problem lies with popular middle-class elderly entitlements, Social Security and Medicare. These programs affect revenues and outlays similarly; they consume an ever growing share of each. Resources spent for these programs are not available for other programs. This makes funding the rest of government increasingly difficult.

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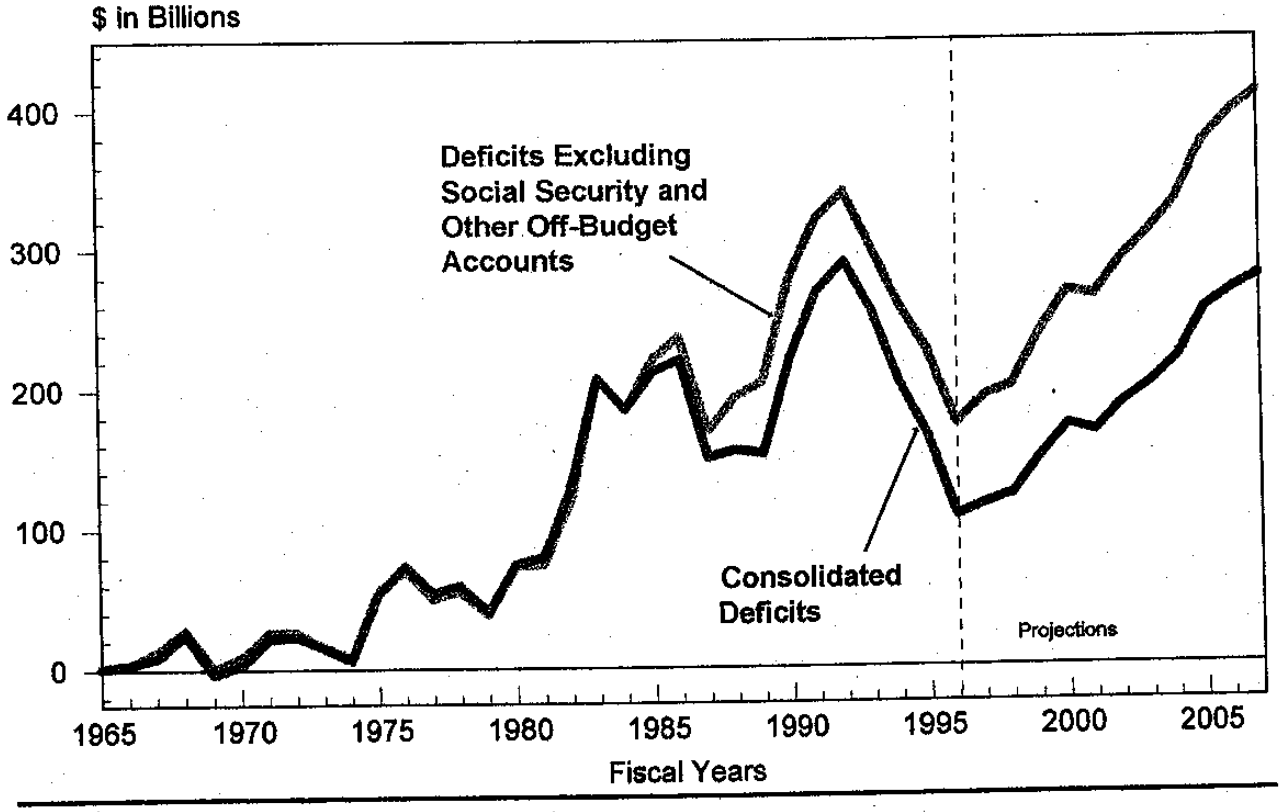
[7] Because legislation enacting the 1997 Balanced Budget Agreement had not been enacted at publication time, this chapter reflects current policy projections. It uses Office of Management and Budget's (OMB) *Historical Tables* accompanying the *FY 1998 Budget* (1997(b)) for historical data and CBO's *Economic and Budget Outlook: Fiscal Years 1998-2002* (January 1997) for projections.

Figure 4.1

Annual Federal Budget Deficits



SOURCE: OMB (1997(b)) and CBO (March 1997).

In 1996, a combination of revenues at the upper limit of the historic range and spending at the low end (measured as shares of GDP) produced the lowest deficit since 1974. (See Table 4.1.)

Table 4.1

Federal Budget: Fiscal Years 1996 and 2007

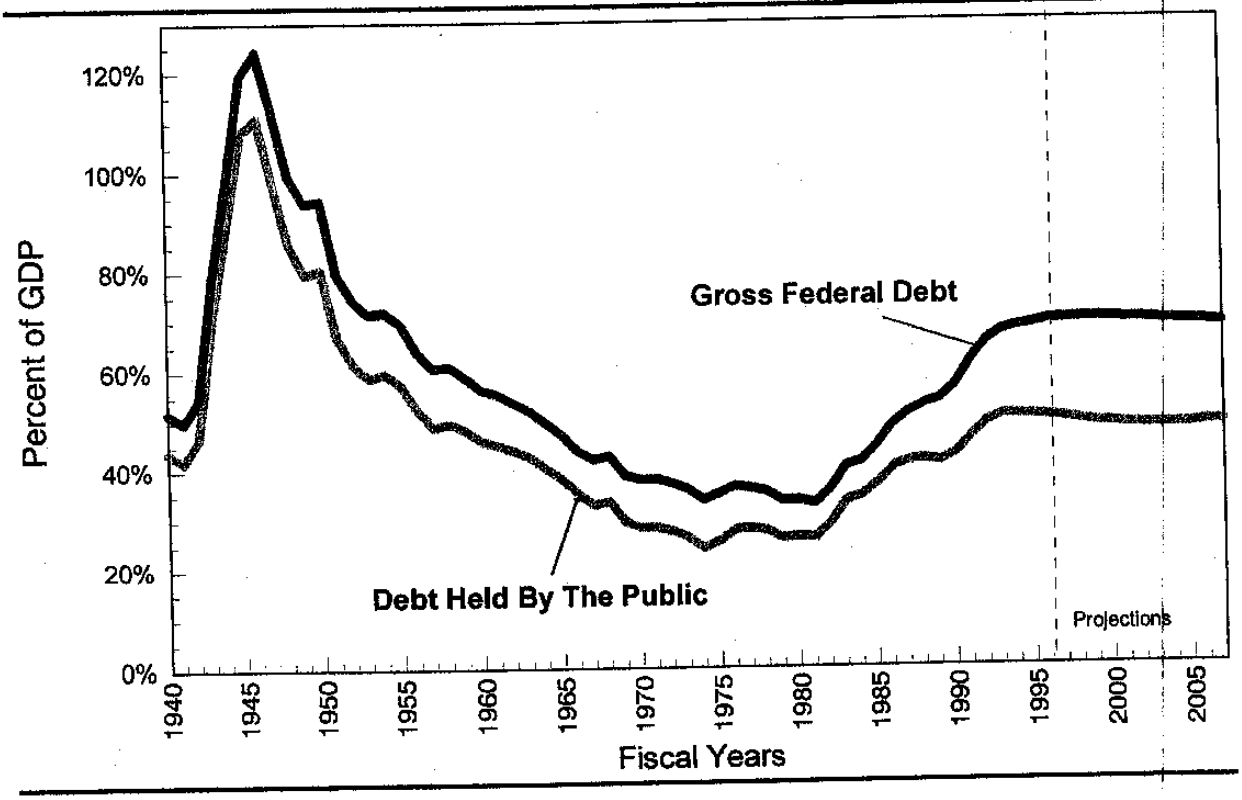
	Receipts	Outlays	Deficit
1996 (actual)			
Dollars in billions	1,453	1,560	107
Percentage of GDP	19.4	20.8	1.4
2007 (estimate)			
Dollars in billions	2,333	2,611	278
Percentage of GDP	18.8	21.1	2.2

SOURCE: CBO (March 1997).

The good news is short-lived. Under current laws and policies, these revenues and spending levels will not continue. (Even under the 1997 balanced budget agreement, deficits will go up before they are projected to go down.) Over the next ten years, revenues will fall below 19 percent of GDP. Spending will increase gradually to more than 21 percent. By 2007, CBO projects a deficit of 2.2 percent of GDP, 50 percent higher than it was in 1996.

National debt is the cumulative effect of annual Federal budget deficits. The debt-to-GDP ratio measures the debt burden over time. From the end of World War II to the mid-seventies, the debt-to-GDP ratio declined steadily. The economy grew faster than new Federal borrowing. (See Figure 4.2.)

Figure 4.2
Federal Debt Relative to GDP



SOURCE: OMB (1997(a)) and CBO (March 1997).

- Since 1974, the debt-to-GDP ratio has increased. The debt held by the public now stands at 50 percent of GDP; gross Federal debt (including debt held by Social Security and other Federal trust funds) is 69 percent of GDP.

- If current fiscal policy does not change, debt held by the public will grow faster than the economy. It could be more than **100 percent** of GDP in 2030. According to CBO, interest payments would grow at an "explosive" rate and the total amount of Federal debt "would reach levels the economy clearly could not support."[8]

- When the Federal government runs deficits, it borrows from the pool of domestic savings or from abroad. Borrowing need not reduce economic growth if the Federal government incurs deficits to finance productive investment. These investments would contribute to a stronger economy capable of repaying borrowing costs. However, most of the projected future deficits would not go into investment. They largely would finance increased consumption by the elderly and interest on the debt. The General Accounting Office (GAO) estimates that gross investment amounts to only 7 percent of total annual Federal outlays.[9]

- Increases in current consumption come at the expense of domestic and foreign investment that would raise future levels of consumption. Deficits constrain the capital stock and may reduce the productivity and incomes of future workers below levels that could have been obtained had those funds been invested. Foreign borrowers will have larger claims against U.S. output, leaving less for domestic consumption.

- Under its scenario in which the economy responds to fiscal policies, CBO's long-term projections assume Federal borrowing at the levels necessary to sustain current policies would drive up interest rates. Not only would higher interest rates ripple through the economy, hurting private investment and borrowers, but it would also raise the cost of Federal borrowing. This, in turn, would set off a vicious circle of higher interest costs and larger and larger borrowing.

- Because the rest of the world is also facing similar, if not more severe, demographic changes, it may not be as easy in the future as it is today to finance deficits abroad. Global capital conditions may mean even higher borrowing costs than CBO or OMB project currently.

Receipts

The Federal government collects revenues from a variety of sources, the largest of which are individual and corporate income taxes and social insurance taxes. Social insurance taxes are made up of Social Security and Medicare Hospital Insurance payroll taxes, unemployment insurance premiums, and Federal employee retirement contributions. (See Table 4.2.)

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[8] CBO (March 1997).
[9] GAO (1997).

Table 4.2
Federal, State, and Local Taxes
(Annual averages as a percentage of GDP)

	Federal						
	Social Insurance	Income Taxes	Excise Taxes	Other	Total Federal	State & Local Taxes	Total Taxes: Federal, State & Local
1940–49	1.6	9.8	2.6	0.6	14.6	—	—
1950–59	2.0	12.2	2.5	0.5	17.2	—	—
1960–69	3.4	11.7	2.0	0.8	17.9	8.5	26.4
1970–79	5.0	10.9	1.1	1.0	18.0	10.4	28.4
1980–89	6.4	10.2	0.9	0.9	18.4	10.2	28.5
1990–96	6.7	10.0	0.7	0.9	18.3	10.7	29.1
1997–2007	6.7	10.8	0.6	0.9	18.9	—	—

SOURCE: Committee for a Responsible Federal Budget (CRFB) calculations based on OMB (1997(a)). 1997–2007 based on CBO January 1997 projections.

- Over the last 50 years, total Federal receipts have averaged 19 percent or less of GDP. Federal revenues grew as a percentage of GDP in the 1940s and 1950s. Since 1960, receipts have averaged 18.6 percent. They were as low as 17.4 percent in 1965 and as high as 20.2 percent in 1969 and 1981.

- Social insurance taxes have quadrupled as a share of GDP, primarily because of increases in Social Security and Medicare. These taxes currently are 35 percent of total Federal revenues.

- Since the 1950s, Federal income taxes and other revenues have declined as a percentage of GDP, offsetting the growth in social insurance taxes. Federal taxes have not risen above 19 percent of GDP for any significant period.

- Between 1950 and 1996, total Federal, State and local government revenues increased by 20 percent, from 25 percent of GDP to 30 percent. Almost all of this increase can be attributed to increases in State and local taxes, and most of that increase took place between 1950 and 1970.

There is no analytically "right" level of taxation, but if the last 45 years are any guide, Americans have little tolerance for Federal taxes much higher than 19 percent of GDP or total taxes in excess of 30 percent of GDP for all levels of government.

Outlays

In the early sixties, defense and other discretionary programs made up two-thirds of annual Federal spending.[10] Federal spending on defense was the largest piece of the budget, comprising over half of total spending. Now, entitlement programs and net interest are two-thirds of the budget and discretionary programs are one-third. Unless current policies change, this trend will continue. (See Table 4.3 and Figure 4.3.) If the proposals essentially to freeze discretionary spending at current nominal dollar levels are enacted, discretionary programs will shrink to 22 percent of total spending (4.3 percent of GDP) by 2007.

Table 4.3
Federal Outlays
(Annual averages as a percentage of GDP)

	Discretionary		Entitlement Programs				
	Defense	Total Discretionary	Social Security	Total Entitlements	Net Interest	Total Outlays	Health Programs*
1962–69	8.7	12.5	2.6	5.9	1.3	18.8	0.7
1970–79	5.9	10.5	3.8	9.1	1.5	20.1	1.8
1980–89	5.8	9.9	4.5	10.5	2.8	22.3	2.8
1990–96	4.5	8.2	4.6	10.9	3.2	21.7	3.9
1997–2007	3.1	6.3	4.7	12.0	2.9	20.8	5.0

SOURCE: CRFB calculations based on OMB (1997(a)). 1997–2007 based on CBO projections (January 1997).

* All health spending, including discretionary spending for the health benefits of civilian and military employees and health-related research.

In real (inflation-adjusted) dollars, Federal non-interest spending increased by 142 percent between 1965 and 1996. Growth did not take place evenly across the budget.

Some programs, particularly health care entitlements, grow faster than the overall budget. Spending for other programs is decreasing as a share of the budget. Total discretionary spending has not kept up with inflation. Since the end of the Gulf War, annual defense spending has declined by more than $89 billion in real terms (27 percent). Non-defense discretionary programs increased 10 percent ($22 billion) in real terms.

[10]"Discretionary" programs are funded on an annual basis through appropriations legislation. Congress and the President have the discretion to set funding levels each year. The Federal government is legally required to provide funding for entitlement programs.

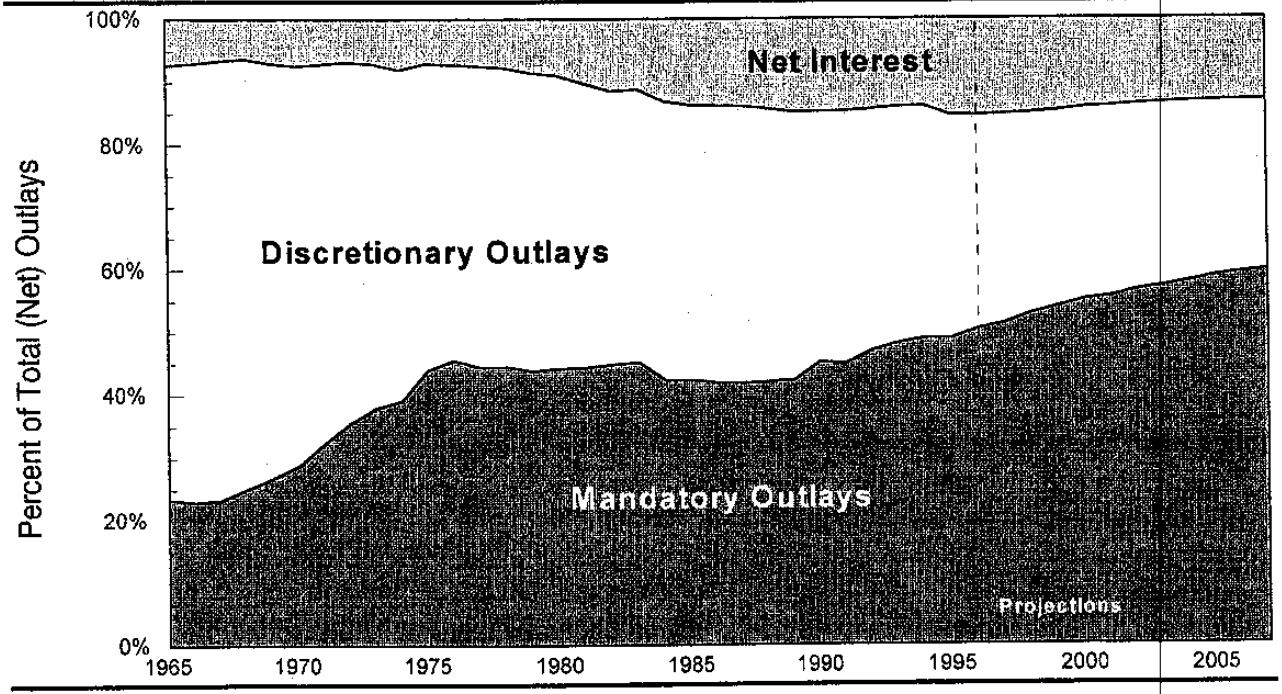
Congress and the President do not have to enact annual legislation to fund entitlements. All individuals who meet statutory eligibility criteria are "entitled" to such benefits. Entitlements also go to States who administer the funds on behalf of individuals. Over the next decade, entitlements and other mandatory programs are projected to reach 60 percent of total Federal spending. Major entitlements include the following:

- Social Security and Medicare provide nearly universal coverage for elderly income support and health care.

- Means-tested programs to assist low-income individuals, including Medicaid, which is the largest payer of long term care for the elderly and disabled, Temporary Assistance to Needy Families (TANF), food stamps, Supplemental Security Income (SSI), and the refundable portion of the earned income tax credit. Means-tested entitlement programs represent one-fourth of entitlement spending and one-eighth of all Federal outlays.[11]

- Other entitlement programs include Federal civilian and military pensions, veterans benefits, and agricultural subsidies.

Figure 4.3
Changing Composition of Federal Spending

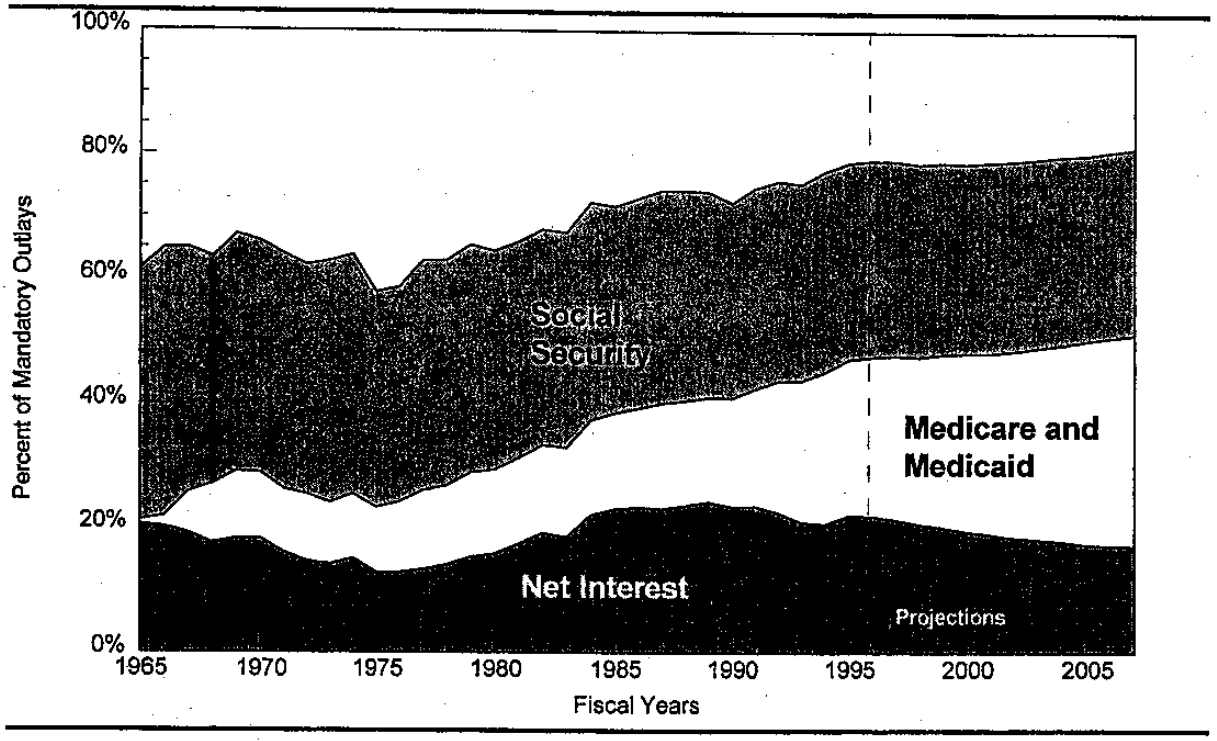


SOURCE: OMB (1997(a)) and CBO (March 1997).

[11] Including discretionary programs, means-tested programs totaled 17 percent of total 1994 Federal outlays. See Committee on Ways and Means *Green Book* (1996).

Social Security, Medicare and Medicaid are almost three-fourths of entitlement spending. (See Figure 4.4.)

Figure 4.4
Social Security, Medicare and Medicaid Dominate Mandatory Spending



SOURCE: OMB (1997(a)) and CBO (March 1997).

Entitlement programs reach almost all of the elderly. Elderly families make up 21 percent of all families but receive 58 percent of all entitlement benefits. Just below half of all families in the United States receive benefits from one or more entitlement program. (See Table 4.4.)

- Social Security, Medicare, Medicaid payments on behalf of the elderly, and pensions of retired civilian and military employees totaled an estimated 71 percent of entitlements and 38 percent of all Federal spending in 1996.

- Over the next ten years, annual spending will increase by more than $700 billion, or 80 percent compared with current levels. Social Security payments will grow at about the same rate as the economy. Medicare and Medicaid are projected to grow 3 percent to 4 percent faster. Growth will explain only 18 percent of the increase in entitlements: the balance is due to statutory or formula-driven benefit increases, including cost-of-living adjustments.

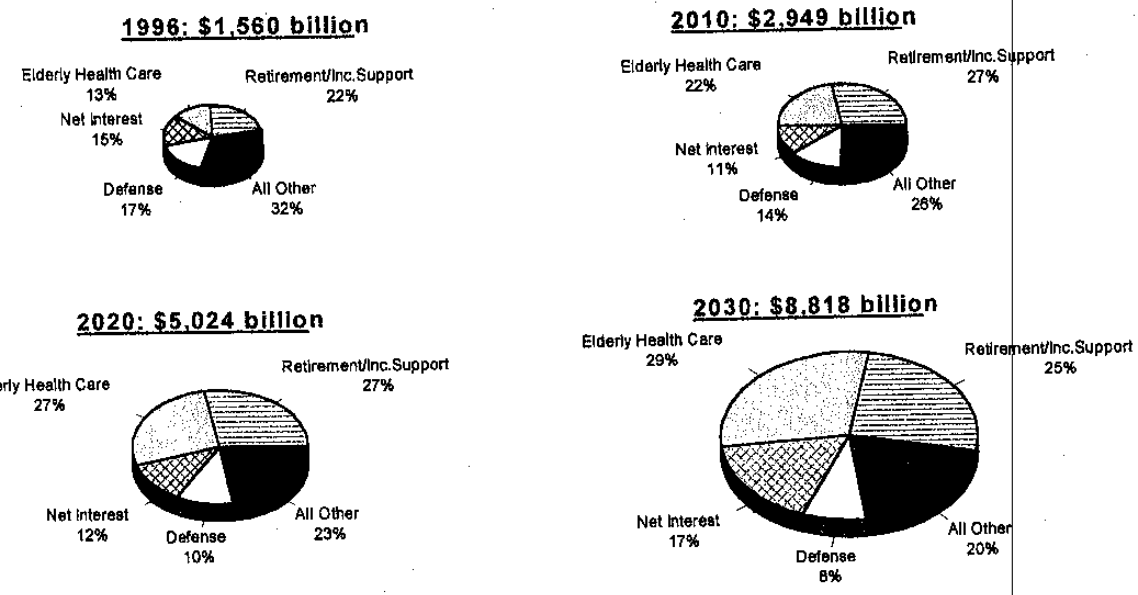
Table 4.4
Entitlement Programs: Recipient Families, 1990

Family Category	Percentage of All Families	Percentage of Families Receiving Benefits	Avg. Benefits per Recipient Family (1990 dollars)	Percentage of All Benefits
All Families	100	49	10,320	100
Income (1990 dollars)*				
• 1–29,999	57	58	9,590	63
• 30,000–99,999	39	37	11,710	33
• 100,000 or higher	4	31	15,220	4
Type**				
• With children	34	39	8,200	22
• Elderly	21	98	13,970	58
• Other	45	32	6,930	20

SOURCE: CBO (September 1994).

* Family income is all cash income plus the face value of food stamps. It excludes the value of other benefits received in kind. Families with zero or negative income included only in totals.
** Families with children are all families with at least one member under age 18. Families with elderly members and children are included in the families with children category. Elderly families are all families without children who have at least one member age 65 or older.

Figure 4.5
Federal Spending for the Elderly 1995–2030



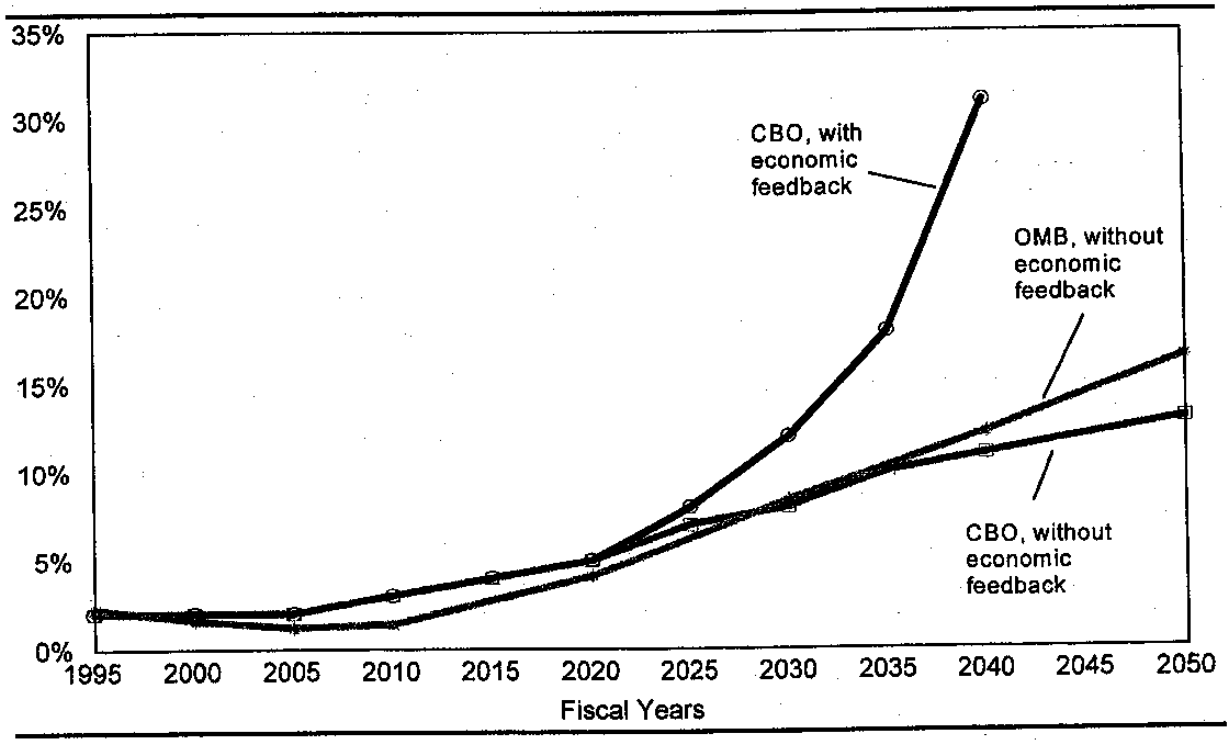
SOURCE: CRFB based on CBO (1997) and OMB (1997) data.

- If current policies do not change, by 2030, spending for Social Security, Medicare, elderly Medicaid payments, employee pensions and net interest will consume almost three-fourths of the budget and will exceed total Federal revenues. (See Figure 4.5.) Policy makers either will have to borrow to fund all remaining programs—defense, science and education programs, housing assistance, welfare, etc.— or they will have to raise taxes.

Long Term Projections: The Implications of Current Fiscal Policy

The political debate pays a great deal of attention to relatively minor differences in economic assumptions used by OMB and CBO. Over the long term, the OMB and CBO deficit projections are more similar than different. If current policies continue, deficits will rise substantially as a percentage of GDP. CBO also provides a more dynamic projection, showing deficit levels if interest growth rates react to persistent and growing Federal borrowing. Under this "economic feedback" scenario, deficits rise even more sharply through a cycle of borrowing, rising interest rated, larger interest costs, even higher borrowing. (See Figure 4.6 and Table 4.5.)

Figure 4.6
Current Policy Deficit Projections



SOURCE: OMB (1997(a)) and CBO (March1997).

Experts agree that current fiscal policy is unsustainable over the long term. The economy cannot support the Federal borrowing implied by current tax and expenditure policies. These policies would be a drag on economic growth. Eventually, standards of living actually could decline.

Table 4.5
Deficits Under Current Policy
(Percentage of GDP)

	1996	2000	2010	2020	2030	2050
OMB	1.4	1.6	1.4	4.1	8.4	16.5
CBO:						
• without economic feedback	2.0	2.0	3.0	5.0	8.0	13.0
• with economic feedback	2.0	2.0	3.0	8.0	12.0	n.c.

SOURCES: OMB (1997(b)) and CBO March 1997).

Notes. All projections assume real discretionary spending stays constant (grows with the rate of inflation) after 1998. The OMB projection does not assume economic feedback from Federal borrowing. CBO's economic feedback projection reflects higher interest rates from growing Federal debt and lower growth. In 1995, the GAO published long-term projections showing similar increases in the deficit. However, these projections are not included here because they do not reflect current economic conditions and would be inconsistent with OMB and CBO projections.
n.c. = not computable (debt would exceed levels that the economy could reasonably be expected to support).

Generational Accounting

Generational accounting[12] is a somewhat controversial way to assess the effect of current policies over the long term. Generational accounting attempts to measure net lifetime tax burdens by age group. Because lifetime benefit commitments to currently living generations exceed the lifetime taxes current generations would pay under existing laws, this approach assigns the full amount of the revenue shortfall to future

[12] See Laurence J. Kotlikoff, *Generational Accounting: Knowing who Pays and When, for What We Spend* (1993). Generational accounting estimates lifetime streams of taxes and benefits by year of birth based on current laws and transforms them into amounts equivalent to the amount they would be worth if received all at one time (present value). This makes it possible to derive a lifetime net tax rate (taxes paid less benefits received). The complex and numerous assumptions that this approach makes have been criticized, but the methodology provides useful insight into the impact of policy across generations. This perspective is absent from the current cash-based deficit accounting.

generations. Consequently, those future cohorts could face net tax rates as high as 78 percent. (See Table 4.6.)

Critics of generational accounting argue that generational accounting's assumptions are flawed. Given the broad scope and long-term nature of the approach, relatively small changes in assumptions can have significant impact on the findings. For example, changing the interest rate used to discount lifetime flows of benefits and taxes can radically change the results. Whatever its weaknesses, however, generational accounting produces many important insights into the generational impact of policies that the current cash flow government accounting system overlooks.

Table 4.6
Estimated Lifetime Net Tax Rates by Year of Birth
(Averages for males and females, in percents)

Year or Birth	Net Tax Rate
1900	24
1910	28
1920	29
1930	31
1940	32
1950	34
1960	35
1970	36
1980	37
1990	37
Future generations	78

Source: CBO (November 1995) using Kotlikoff generational accounting model.

...the projected imbalance between spending and revenues—particularly with regard to health care and retirement programs—will together with interest on the Federal debt, undermine America's capacity to make appropriate investment in the well-being of our citizens and undertake other essential government functions, such as national defense.

1994 Bipartisan Commission on Entitlements and Tax Reform

Conclusion

As the growth in entitlement spending clearly indicates, the Federal budget is bound by the policies and priorities of previous Congresses and Presidents. Many of the programs designed to address pressing problems 30, 40, even 60 years ago are still with us. Similarly, policies adopted by the President and Congress today will affect future budgets and future taxpayers.

Economic and demographic factors combine with entitlement and revenue policies to exert a strong influence on the Federal budget. The combination of post-World War II economic and baby booms provided resources that supported rising standards of living for most of the population. In that environment, policymakers expanded dramatically programs and services to assist the oldest members of society. The United States economy has grown less rapidly since the mid-1970's than it did in the immediate post-World War II era; and we are unlikely to see growth equal to that era again in the foreseeable future. Demographic conditions remain favorable for now, but are becoming less positive. Demographics projections become downright problematic, from the point of view of the economy and the budget, as we move into the 21st century.

None of this is news. The economic changes have provided fodder for academic treatises and political campaigns. Problems associated with changing demographics were forecast years ago. Policy makers should begin now to reconfigure Federal policies and programs. The Federal budget must provide a framework for much of the public discourse that is a necessary predicate to major shifts in public policy in a representative democracy.

The Federal budget first allocates resources between Federal sector and all other sectors of the economy. Then the budget distributes resources among competing Federal government priorities. The budget defines the nature and scope of the Federal government and identifies who pays the bills. Public sector budgeting is the quintessential political activity. But public sector budgets have significant economic and social effects. Therefore, as major reforms are debated, it is imperative that policy makers respect two principles: the budget must be comprehensive—i.e., it must cover all programs, activities and functions of government; and it must be transparent—i.e., easy for citizens to understand. Otherwise, voters cannot hold elected officials accountable.

Chapter 5. Overview of Elderly Entitlements

Social Security, Medicare, and Medicaid provide essential financial security to older adults.[1] Social Security provides retirement, disability, and survivors' benefits to workers, their spouses, and dependents. Medicare provides near universal health insurance to seniors.[2] Medicaid pays for many seniors' long term care, as well as acute care expenses. Social Security benefits are limited by formulas based on lifetime earnings, whereas Medicare and Medicaid provide open-ended benefits.

In 1996, Social Security, Medicare, and the elderly Medicaid benefits cost more than half a trillion dollars, equal to a third of all Federal spending. According to CBO projections of current laws and policies, in 2030, spending for these activities will consume over half of the Federal budget. Social Security and Medicare have been in actuarial difficulty practically since their inception. Neither is currently in actuarial balance. Expenses of the Medicare Hospital Insurance (HI) trust fund already exceed dedicated tax receipts. The HI trust fund will reach a zero balance in 2001. Social Security benefit payments are projected to exceed payroll tax receipts in 2012, and the Social Security trust fund will reach a zero balance in 2029.[3]

Confronting elderly entitlements involves difficult political and policy questions. Budget reality demands that the cost of these programs be restrained, but that runs counter to public opinion polls indicating strong support for Social Security and Medicare. Elected policy makers have little political incentive to attempt any major reforms, particularly because options would involve painful benefit cuts or tax increases.

Social Security, Medicare, and Medicaid pose many difficult challenges:

- The programs are poorly understood by the public. Misleading language creates part of the confusion. (See the following box for a glossary.) Complicated benefit and financing structures also contribute to popular misperceptions. Voters do not know how these programs work or who pays for them. They tend to think that Social Security resources are separate from the rest of the Federal government's resources. They do not understand Medicare's effect on the overall health care system. Even though Medicaid is the largest single payer of long term care expenses, 85 percent of which benefits elderly individuals who do not receive cash welfare assistance, they don't think of Medicaid as an elderly health care assistance program.[4]

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[1] In addition to the following chapters, more information about these programs can be found in appendices 1, 2, and 3.

[2] Medicare also provides benefits to eligible disabled individuals under the age of 65.

[3] The combined Old Age Survivors and Disability Insurance (OASDI) trust funds are commonly referred to as the "Social Security trust fund".

[4] Liska *et al.* (1996).

- Financing these programs involves large transfers of resources across generations and raises difficult questions about equity within and between generations. Contrary to popular belief, the people who receive benefits are not the ones who pay for them. As long as successive cohorts of beneficiaries got a fair return on their contributions, people were relatively happy. Now, costs are increasing while the projected rates of returns are decreasing. Those who are receiving the benefits want them to continue, but those who are paying the bills may become increasingly reluctant to pay into a system they think will not be around to provide them any benefits. Younger workers are more likely to favor Social Security "privatization" schemes than older workers because they think they'll end up better off.

Glossary of Social Security and Medicare Terms

Actuarial balance. As used by the Social Security and Medicare trustees, the difference between income and costs over a given period. "Long-range" refers to a 75-year period. "Short-range" is a 10-year valuation period. These projections compare program resources (claims against future tax receipts in the form of "trust fund assets" (see below), anticipated streams of income from payroll taxes, or interest from "trust fund assets," and Medicare premium contributions) to estimated benefit costs under specific economic and demographic assumptions.

Contributions. Also known as payroll taxes. Amounts based on employment earnings that employees and employers (on behalf of employees) must pay to the Federal government for OASDI/HI. Most economists believe that employees bear the full burden of payroll taxes, that is that the employer's share of the payroll taxes ultimately comes out of employee compensation, not out of profits.

Trust funds. Federal accounting devices set up to account for Social Security, Medicare, and other trust fund program receipts and expenditures. Payroll tax receipts and other income are credited to the appropriate trust fund accounts. Expenditures for benefit payments are charged against the accounts. Account balances represent income in excess of current expenditure needs and constitute pledges to provide future Federal resources to meet future program expenses. Account balances are invested in special non-marketable Treasury securities and add to gross Federal liabilities. (See "Trust fund assets.")

Trust fund assets. Receipts in excess of benefit payments are held for investment purposes in the form of Treasury notes and bonds and other securities guaranteed by the Federal government. Trust fund assets represent IOUs from one part of government—Treasury, the agency responsible for government financing—to others—Social Security, Medicare, and other trust fund programs. If trust fund account balances were invested in non-Federal securities, intergovernmental debt would be lower, but the Treasury would have to borrow more from the public. When payroll taxes and other income are not sufficient to meet benefit payments, trust fund assets can be redeemed. To redeem these securities, the Treasury uses proceeds from public borrowings or general revenues.

- Rapidly increasing Medicaid costs have prompted some States to question the current division of responsibility between the Federal and State governments. Medicaid is a State-administered program whose costs are shared between States and the Federal government. States are generally responsible for the poor, and the Federal government is responsible for the elderly and the disabled. Some Governors have suggested that the Federal government assume full responsibility for Medicaid elderly, long-term care beneficiaries, possibly by adding new long term care benefits to Medicare. Elderly long-term care beneficiaries comprise 5 percent of the total Medicaid population but represent 20 percent of Medicaid spending.

- Medicare and Medicaid serve populations with the most expensive health care needs—the elderly, the disabled, and the poor. Although, the Federal government has undertaken a growing share of the responsibility for financing the health care of these populations, not every member of these groups needs Federal assistance and not all barriers to health care are financial. Increasing Federal spending on these programs is not the answer to all health care problems. It likely would fuel faster growth rates in national health care spending to the detriment of all Americans.

- The Federal government has become such an important player that Federal policies have a significant effect on the national health care delivery system. As policy makers respond to budget pressures by trying to contain Federal health care costs, they risk shifting costs to private payers, thus jeopardizing the financial stability of some health care providers and, ultimately, disrupting access to and the quality of health care for the entire population.

- Intergenerational equity is difficult to achieve with a baby boom, baby bust demographic pattern. The combination of larger numbers of seniors, lengthening life expectancies, and slowing economic growth progressively increases the cost of elderly programs for younger workers.

- Social Security and Medicare HI are financed with payroll taxes. Tying these benefits to wage- and salary-based contributions gives them the appearance of "earned" benefits. However, payroll taxes are more regressive than broader based income taxes. Payroll taxes fall more heavily on workers, particularly lower income workers, who depend on wages and salaries for a greater share of their incomes than higher income individuals.

- Although two individuals qualify to receive benefits, they may receive very different levels of benefits simply because of demographic and socio-economic differences.

  > Higher income, better educated individuals receive larger nominal dollar benefits. They have longer life expectancies and collect benefits for longer periods than lower income, less educated retirees.

> Because Social Security benefits are based on the "primary" wage earner, and no tax contributions are required to receive Medicare benefits, one-earner couples receive higher benefits relative to tax payments than two-earner couples with the same family income.

Budget Transparency and Elderly Entitlement Programs

A fundamental principle of good budgeting is that programs and policies should be "transparent." Voters should be able to tell where the funds are coming from as well as where they are going. Without transparency, the electorate does not understand the issues and options and cannot hold public officials accountable for their taxing and spending decisions.

Social Security is the prime example of how the absence of transparency has stymied constructive policy discussion. Many people think their Social Security payroll taxes are retirement savings, flowing into and residing in equivalents of private pension accounts. They believe that Social Security benefits are employees' rightful returns from payroll tax contributions. From their perspective, proposals to cut benefits unfairly would deny earned benefits and to use trust fund receipts for any purpose other than paying benefits constitutes outright theft.

The designers of first, Social Security, and then, Medicare, did their best to promote this popular interpretation of these programs. The original architects sought to distinguish these programs from other government programs. Each program has its own dedicated sources of revenue. Separate trust funds account for program revenues and expenditures. Trust fund balances have accumulated from revenues, including interest earnings, in excess of current benefit payments. Trustees oversee the programs to ensure that each is managed in the best interest of its beneficiaries (not the general taxpayer).

The misperceptions of the trust funds largely have limited public policy concern about Social Security and Medicare to the narrow issue of actuarial imbalance. Thus most policy options focus on fixing the actuarial imbalances in the trust funds by raising new revenues or cutting benefits. Few reform options attempt to address the larger effect of growing Social Security and Medicare spending on the rest of the Federal budget or on the overall economy.

Despite appearances, Social Security and Medicare are not independent from the rest of the budget. The resources to support them come from the same source as the revenues supporting the rest of the Federal government—American taxpayers. During a rapidly growing economy, policy makers were able to expand benefits and raise the payroll taxes.

But because the public has limited tolerance for taxes, these expansions have come at the expense of other revenues and, consequently, other Federal activities.

Social Security, Medicare, and Medicaid Cost Projections

Each year, the Social Security and Medicare trustees report on the financial condition of these programs. Although the reports give limited, stand-alone perspectives of Social Security and Medicare, they provide ample evidence that the programs are in trouble.[5]

Social Security is not in long-term (75-year) actuarial balance. The 1997 Social Security Trustees' Report indicates that an immediate 2.23 percent payroll tax increase (or equivalent benefit cut) is necessary to bring the program into long-term balance. Without it, payroll taxes will be insufficient to cover benefits. Between 2012 and 2029, interest income and then accumulated trust fund balances will have to be used to finance benefits By 2029, the combined OASDI trust funds will be insolvent, and there will be resources to pay only 75 percent of promised benefits.

The Medicare HI program is in even worse shape. Beginning in 1995, trust fund balances had to be used to pay benefits. The trust fund will be depleted in early 2001, leaving insufficient resources to pay all benefits. The current 2.9 percent payroll tax would have to rise an additional 4.3 percent to bring this program into long-term balance.

The other part of Medicare, the Part B Supplemental Medical Insurance (SMI) program is financed through a combination of beneficiary premiums, a small amount of interest income, and general revenues. The SMI trust fund is in no danger of becoming insolvent.[6] The level of general revenue support for SMI is unlimited—it equals the gap between SMI expenses and premium income.

- Originally, beneficiaries shared SMI costs 50-50 with the Federal government. Because Congress wanted to protect Medicare beneficiaries from high health care cost growth rates, premium increases were restricted to the level of cost-of-living adjustments (COLAs) provided to Social Security beneficiaries.

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[5] Projections in this report reflect the intermediate projections used in the 1997 Social Security and Medicare trustees' reports. The trustees' reports also include two alternative projections using more pessimistic and optimistic assumptions.

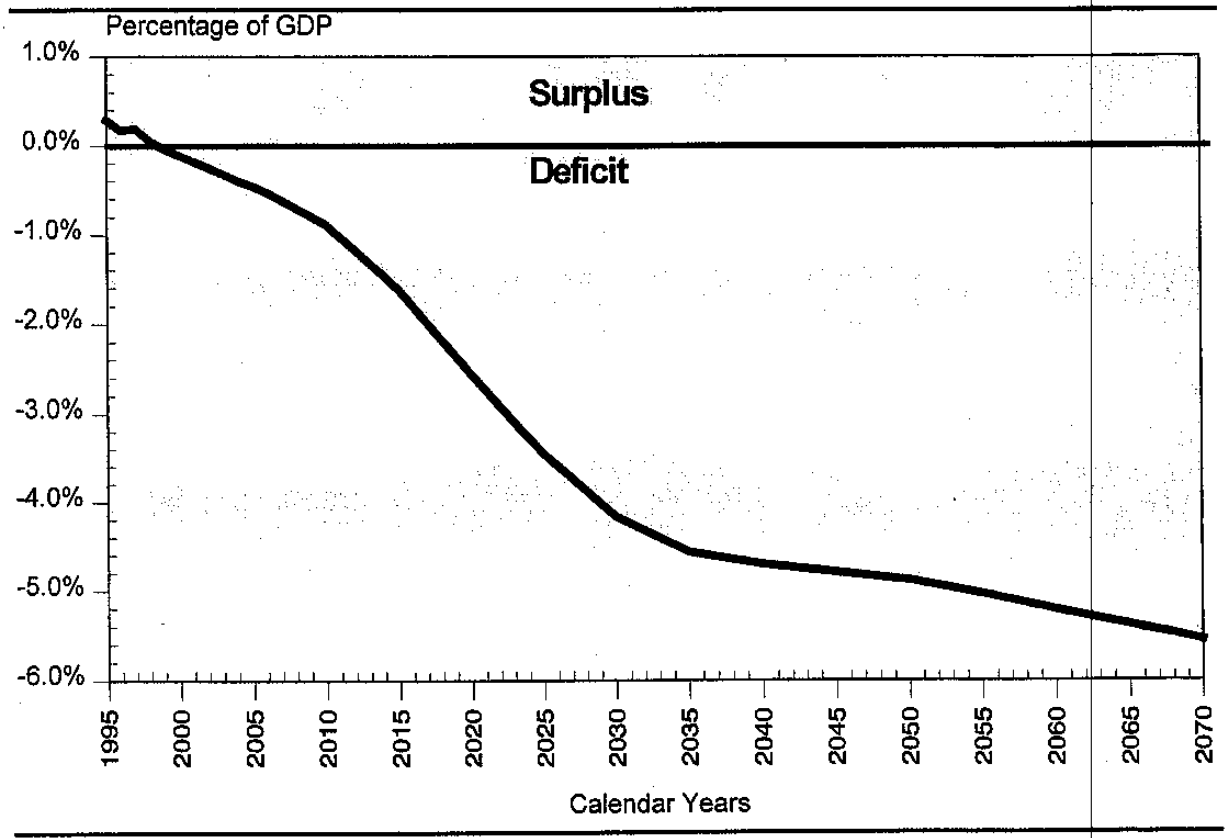
[6] President Clinton has proposed to move home health services from the Medicare HI program to SMI. This transfer is a budget gimmick. It would not change total Medicare spending. It would make the HI trust fund balances last longer, helping to address the "crisis," but the same level of spending would come out of the SMI trust fund.

- Current law requires beneficiary premiums to cover 25 percent of SMI costs through 1998. After 1998, however, increases in Part B premiums will again be limited to Social Security COLA increases. If no changes are made to maintain SMI premiums as a percentage of program costs, by 2030, SMI premium income is projected to fall to 8 percent of SMI costs.

The trustees' intermediate projections show combined shortfalls in Social Security and Medicare payroll taxes of 4.2 percent of GDP in 2030. (See Figure 5.1.)

Figure 5.1

Social Security and Medicare (OASDI/HI) Deficits as a Percentage of GDP



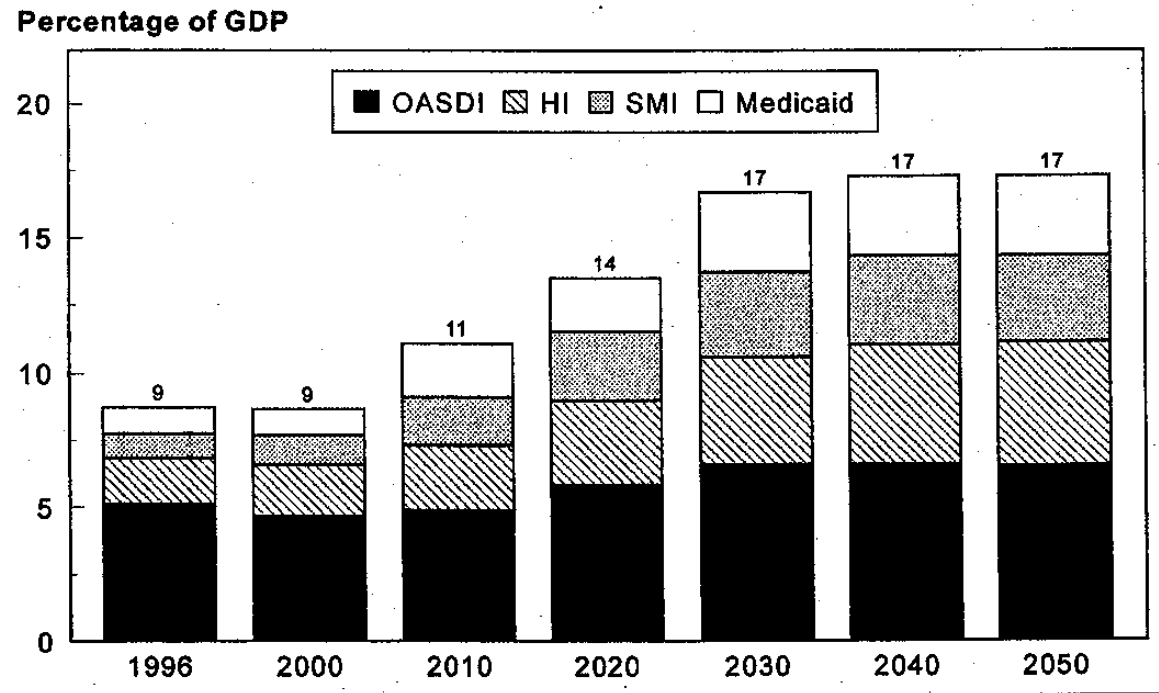
SOURCE: Boards of Trustees of the Federal OASDI and HI Trust Funds (1997).

Under current laws and policies, Social Security, Medicare, and Medicaid expenditures will increase from 9 percent of GDP in 1996 to 17 percent in 2030. In 2030, these programs will consume almost four-fifths of Federal revenues. (See

Figure 5.2.) Unless taxes are raised substantially or huge deficits are incurred, insufficient funds will remain to pay interest on the national debt and fund other Federal programs.

Figure 5.2

Social Security and Medicare Expenditures as a Percentage of GDP



SOURCE: Board of Trustees of the Federal OASDI Trust Funds (1997) and CBO (March 1997).

Payroll Taxes

In the 1930s, Social Security's planners were concerned that the employer's share of payroll taxes would be passed through to consumers in the form of higher prices. That, they argued, would tax the employee twice.

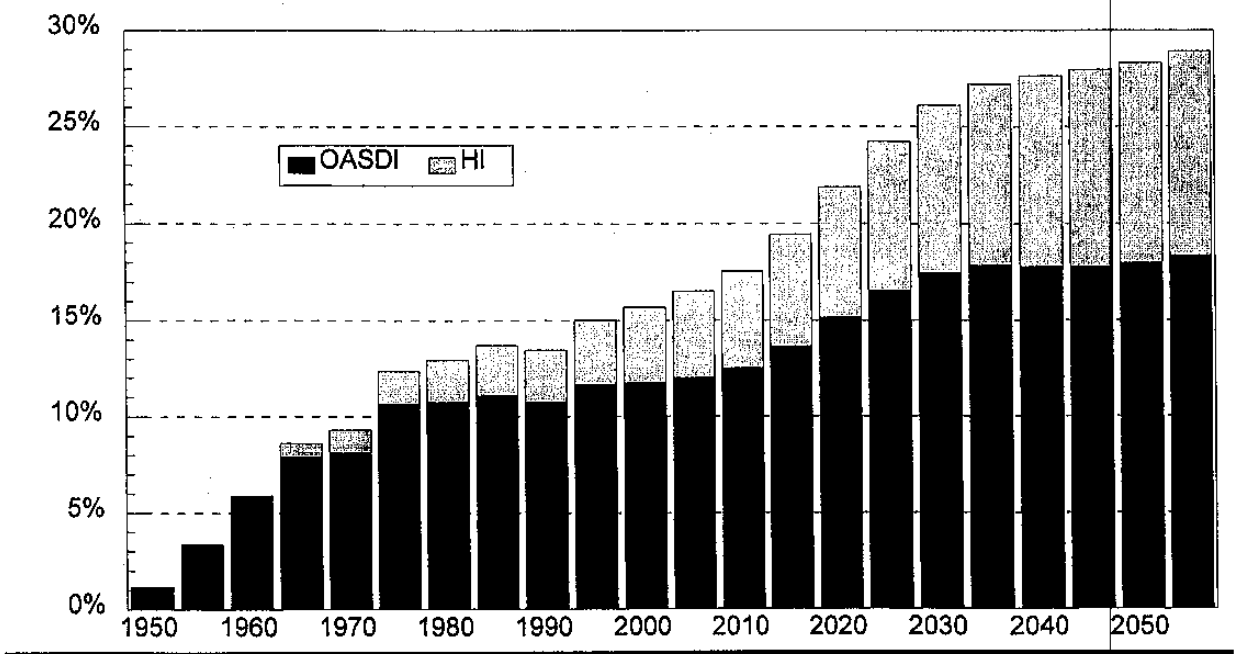
In today's more competitive conditions where increased cost cannot be passed through easily in higher prices, most economists believe that employer-paid payroll taxes, like non-cash benefits, come predominantly from employee compensation.

- **Payroll taxes are regressive**. Higher income individuals pay less of their income in taxes than those with lower incomes. The same tax rate is imposed on workers no matter what their wages. Wages above the OASDI taxable maximum ($65,400 in 1997) are not taxed. Non-wage income is completely exempt from OASDI and HI taxes. In contrast, low-wage earners pay taxes on nearly all of their incomes.

- **Payroll taxes now represent more than a third of employee benefit costs**,[7] up from a fourth 25 years ago. Amounts paid in payroll taxes could be used instead for cash wages or other types of benefits.

- **Social Security and Hospital Insurance benefit payments are growing faster than taxable payroll, their source of financing**. As a percentage of taxable payroll, these benefits will rise from 15 percent in 1997 to 26 percent in 2030. (See Figure 5.3.) General revenues, not payroll taxes, finance SMI benefits. But if SMI costs are taken into account, total Social Security and Medicare expenses in 2030 will equal 34 percent of taxable payroll.

Figure 5.3.
OASDI/HI Expenditures as a Percent of Payroll



SOURCE: Boards of Trustees of the Federal OASDI and HI Trust Funds (1997).

[7]EBRI (1995).

The Social Security and Medicare HI trustees report that an immediate 6.6 percent payroll tax increase is needed to bring the OASDI/HI programs into long-term actuarial balance. **That would raise the payroll tax rate to 22 percent.** Some observers have portrayed this increase as manageable. They point out that payroll taxes increased 10 percentage points between 1965 and 1990. But they ignore three important factors.

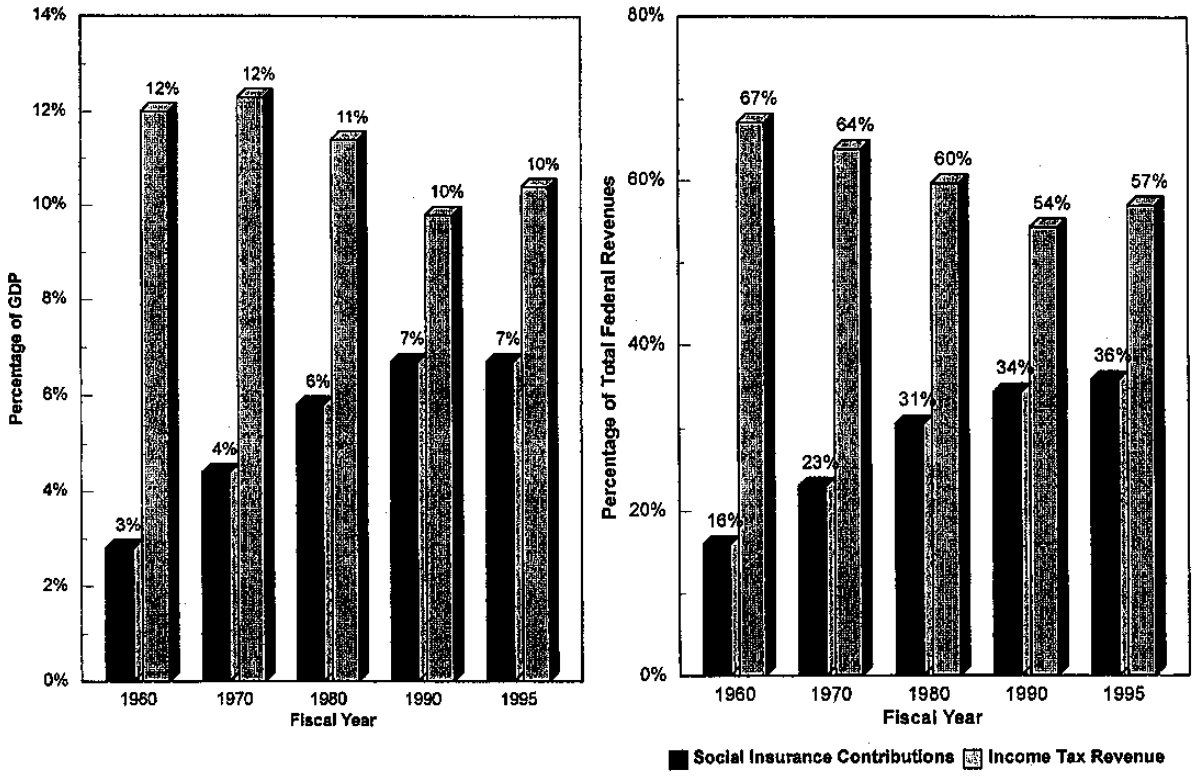
- The effect of successive payroll tax rate increases gets progressively harder to bear because less income is available to tax. For example, increasing the payroll tax from the current 15.3 percent by another 6.6 percentage points represents an 8 percent tax increase.

- Larger shares of income are now included in the taxable base. In 1965, 36 percent of workers had incomes in excess of the maximum taxable level. This percentage fell gradually to 10 percent in 1979. Today, only 5 percent of workers have incomes above the Social Security taxable maximum, and all wage and salary income is subject to the HI tax.

- Future expected growth in real wages, especially for low-wage earners, is not expected to match growth observed between 1965 and 1990.

In the past, increases in social insurance payroll taxes have not resulted in comparable increases in overall Federal taxes. Payroll tax increases largely have been offset by declines in other sources of Federal revenue. Thus rising payroll taxes could decrease the level of resources available for other programs or, if other spending is not reduced commensurately, cause overall budget deficits to increase. (See Figure 5.4.)

Figure 5.4
Changing Composition of Federal Government Receipts



SOURCE: OMB (1997(b)).

Chapter 6. Social Security

The 1935 Social Security Act created a State-administered unemployment compensation system and a federally-administered old age pension system. At the time, the country was in the midst of the Great Depression. Twenty-five percent of the workforce was unemployed. Fewer than 10 percent of the nonagricultural workers were covered by private pension plans in 1929. By 1935, most private plans were bankrupt.

To help the unemployed and to get people back to work, the New Deal created unemployment assistance and massive public works programs. In addition to providing income support for the elderly, the old age assistance program helped to reduce unemployment by creating a way out of the labor force for older workers. The public assistance programs provided cash assistance to low-income aged or blind persons and dependent children.

Prior to the creation of Social Security, most elderly had little old age income. They had to keep on working, rely on support from extended family, friends or social service and charitable organizations, or all four. An early SSA study[1] found that in 1937, the first year Social Security paid benefits, only 35 percent of older adults had sufficient earnings, savings, pensions, or annuities to subsist independently. As many as half of these turned to friends or relatives for greater comfort (food, clothing, shelter). More than three-fourths of older people were wholly or partially dependent on children, other relatives or friends, or public or private social agencies. Only 4.5 percent received private pensions or annuities. Another 2.2 percent received Federal, State, or local government pensions.

Today, almost all workers are covered by Social Security, and almost all retirees receive Social Security benefits. (See appendix 2 for a description of Social Security coverage and beneficiaries.) Social Security benefits are the largest source of income for the elderly population.

Social Security is a very popular program. It should be. Until recently, participants could expect to get more back from the system than they put in. Many have received greater returns than they could have earned by investing their money elsewhere.

[1] Shearon (1938).

Now, workers are right to be pessimistic about the chances that their Social Security benefits will represent as good a return on their payroll taxes as those provided to today's retirees.[2] Younger generations cannot expect their money's worth from the system. In part, this is an inevitable result of a maturing pay-as-you-go system.[3] Other factors, including longer life expectancies and the post–World War II baby boom (which create greater numbers of retirees), expanding benefits, and progressively higher lifetime payroll tax contributions, also have contributed to an increasingly burdensome system for successive generations of workers.

Issues

In the absence of Social Security, older Americans would be dependent on continued income from employment, their own savings and pensions, contributions from family and friends, and support from other public or private organizations. Social Security replaces a major share of what once was a matter of individual responsibility and informal support mechanisms with formal, collective, taxpayer-financed support.

Social Security is a participatory, pay-as-you-go system. Politically, this system is very attractive. The same payroll tax contributions satisfy simultaneously the retirement income needs of both retirees and workers. Although current contributions support current retirees, current workers receive promises of future retirement benefits. Economically, of course, contributions can be spent only once. Those promised future benefits are unfunded liabilities of future taxpayers.

Social Security is a public means of transferring resources within and across generations. It determines how much each cohort of workers has to contribute to pay for the retirement of preceding generations of workers. It defines each retiree's benefit level. The debate about Social Security reform re-examines and questions the nature and scope of this Federal role.

- What is the appropriate Federal role in elderly income security? Social Security is now the primary source of elderly income. Is it displacing, rather than supplementing, private retirement savings?

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[2] A 1996 poll found that 79 percent of respondents were "not too confident" or "not at all confident" that Social Security would continue to provide benefits equal in value to those provided today. EBRI (January 1997).

[3] In a pay-as-you-go system, current contributions pay for current benefits. At the time Social Security was created, retirees had not contributed toward newly-created benefits. They, like successive cohorts of retirees, depended on the contributions of workers. Initially, because the number of beneficiaries is small relative to the number of contributing workers, contribution rates are low. As more and more retirees collect benefits (unless the number of contributors grows sufficiently), rates have to increase to support larger aggregate benefit payments.

- Social Security redistributes income within and across generations. Given current and future economic and demographic trends, some of these outcomes will no longer be reasonable. How should the distribution of costs and benefits be reconfigured?

- Can Social Security be sustained in anything close to its present form? What is Social Security's impact on the rest of the budget and the overall economy? What role does the trust fund play in fiscal policy? Why do sources of financing matter?

- What criteria should be used to evaluate reform alternatives? Does any other option besides preserving Social Security have any political feasibility? Social Security is a pay-as-you-go system with substantial unfunded liabilities. Many reform proposals would convert Social Security to a pre-funded system. How could the transition to this type of system be handled? What are the inter- and intragenerational consequences of this type of change?

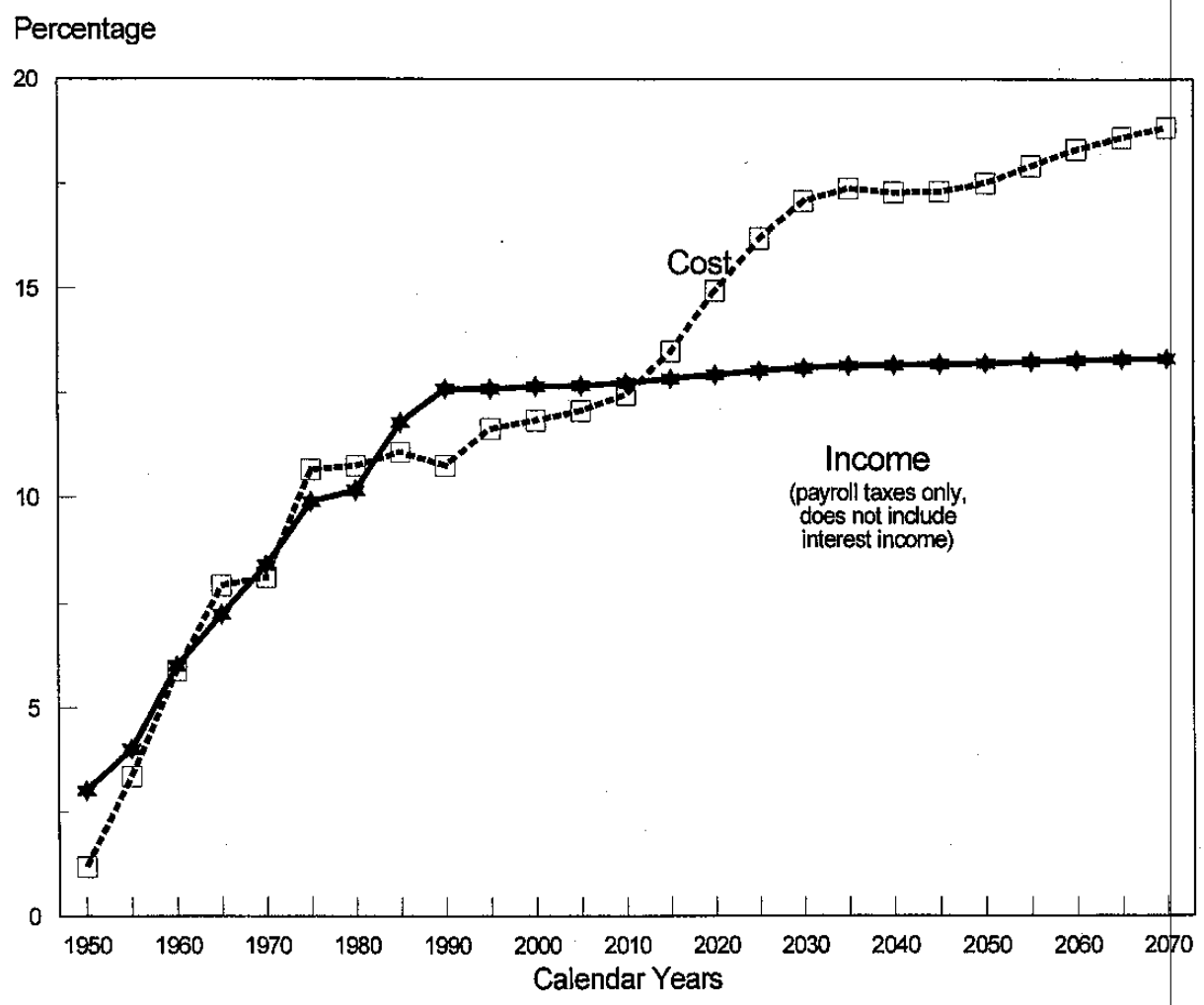
Although Social Security is currently running annual operating (cash flow) surpluses, the system faces a large unfunded liability. Current law OASDI benefits for current and future retirees already exceed current trust fund balances and projected revenues by **$3.4 trillion in present value** terms, and this shortfall is growing. In total, taxpayers will have to provide the equivalent of some **$20 trillion** (in present value terms) over the next 75 years for Social Security benefits.[4] If the current Social Security program was transformed to a different system, accrued benefits under the old program would exceed trust fund balances and income from the taxation of benefits by **$9 trillion** (in present value terms). As the baby boom generation retires, the cost of providing benefits will increase at the same time that the proportion of active workers supporting the system decreases. Social Security's financial difficulties can be measured in several ways.

- According to the 1997 Social Security Trustees' Report, the combined Social Security Old Age Survivors and Disability Insurance (OASDI) Trust Funds (hereafter referred to as the "Social Security Trust Fund") assets will peak at 245 percent of annual benefits in 2011 and will be exhausted in 2029.

- Benefit payments will first exceed payroll tax income in 2012. By 2030, the size of the gap between benefits and payroll tax income will equal 4.4 percent of taxable payroll (9.8 percent if Medicare HI benefits are included). In 2030, Social Security benefits will cost 17.5 percent of taxable payroll (**26 percent** when combined with Medicare HI benefits). (See Figure 6.1).

[4] Goss (1996).

Figure 6.1. OASDI Income and Costs
(Percentage of taxable payroll)



SOURCE: Board of Trustees of the Federal OASDI Trust Funds (1997).

- Social Security benefits will increase from 4.7 percent of GDP in 1997 to 6.6 percent in 2030. By 2030, Social Security and Medicare benefits together will *represent one out of every seven dollars* produced by the entire domestic economy (13.7 percent of GDP).

On paper, financial distress appears to be more than a decade and a half away, making it hard to classify Social Security as a "crisis." Policy makers are likely to avoid addressing Social Security until it is in a crisis. Delay, however, only makes the problem worse.

- Ten years ago, the trustees identified the need for a 0.62 percent increase in the payroll tax to make projected dedicated Social Security resources equal to benefit payments over the 75-year projection period. In the trustees' 1997 report, the needed increase is 2.23 percent. If no changes are made until 2002, the required increase in payroll taxes will rise to 2.5 percent.

- Changes to Social Security will redistribute the cost of the program. The sooner changes are made, the more broadly they can be shared. Acting sooner enables current retirees, who are receiving substantial returns for their contributions, to share in solutions. It also gives workers needed time to adjust their savings behavior and their retirement plans.

- Changes should be phased in gradually over many years. The sooner the phase-in starts, the more gradual change can be. As the time to make changes shortens, elected policy makers will have fewer options from which to choose, and each of these will be more difficult to implement.

The Federal Role in Providing Income Security for the Elderly

Retirement income for today's older adults comes from two primary sources: private savings and tax-financed public benefit programs. Retirees also may receive informal support from children and other family members or social service and charitable organizations.

- Private savings consist of both formal employment-sponsored retirement savings and individual savings. Federal tax policy encourages many forms of retirement savings.

- Tax-financed public retirement benefits include Social Security, Federal employee pensions, and other income support programs.[5]

Social Security's Contribution to Current and Future Retirement Incomes

Social Security is the largest source of elderly income. This is true for men and women, Whites, African Americans, and Hispanics, single individuals and married couples, and for all income categories except the highest quintile. Social Security benefits are annuitized and indexed, providing seniors with lifetime, inflation-protected incomes. Forty-two percent of elderly units (defined as couples with at least one member age 65 or older or singles age 65 or older) receive income from employment-based pensions. Ninety-one percent of all elderly receive income from Social Security.

[5] Social Security also provides workers and their families with important insurance protection against disability and death of the primary wage earner.

Designing Social Security

In 1934, Social Security was designed as much to meet political concerns as economic ones. Sixty years later, the debate about how to reform Social Security faces many of the same issues.

President Franklin D. Roosevelt identified three conditions that had to be satisfied by the new retirement program: "No money out of the Treasury would go into Social Security; benefit payments would resemble private pensions more than general welfare; and the program had to be actuarially sound."[6]

President Roosevelt's 1934 Committee on Economic Security chose to follow the German system of social insurance, a compulsory program of wage-based taxes and benefits, instead of social assistance, as adopted by Denmark and other Scandinavian and English-speaking countries. [7] [8]

The Committee settled on payroll taxes for employers and employees to finance the system. These addressed Roosevelt's first two conditions. To meet his third, the working population had to contribute enough to pay benefits for current retirees and to create reserves to help with future needs. Rather than invest these surplus funds in private securities, they were invested in special Treasury debt instruments.

The payroll taxes and the reserve fund also served other purposes. They avoided making the system dependent on annual Congressional funding actions. But, more important, they strengthened the program politically. Some of Roosevelt's advisors had argued against payroll taxes on the grounds that they would place too great a burden on workers. Reflecting on his decision to use payroll taxes, Roosevelt later commented:

> ... those taxes were never a problem of economics. They were politics all the way through. We put those payroll contributions there so as to give the contributors a legal, moral and political right to collect their pensions and their unemployment benefits. With those taxes there, no damn politician can ever scrap my social security program.[9]

Roosevelt's political instincts were right. The contributory tax and trust fund accounting structures used to establish Social Security have obligated the Federal government in ways that make it very difficult to alter the commitment to pay benefits.

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[6] Schlesinger (1958).

[7] Social Security is heir to the social insurance system adopted by Germany in the 1880s. The German system included compulsory insurance programs against illness, accident, disability, and old age. These social insurance programs featured wage-related taxes and benefits. Employers, employees, and the government shared the responsibility for financing the programs. Excess contributions accumulated in trust funds, which were available when contributions were not sufficient to cover benefits.

[8] Denmark and other Scandinavian and English-speaking countries chose a social (or public) assistance approach. They adopted programs that provided benefits to needy individuals and were financed with general revenues. Under a public assistance system, benefits are either uniform amounts provided to all eligible individuals or vary according to need. Means-tested programs such as Supplementary Security Income (SSI), family assistance programs, and food stamps are modern U.S. examples of social assistance programs.

[9] Schlesinger (1958).

Initially, Social Security covered workers from "commerce and industry," or about 60 percent of the labor force. In 1996, 95 percent of all job positions were covered by Social Security, and 175 million individuals are fully insured for retirement and survivors benefits. Unlike Social Security, which is compulsory, employers are not required to sponsor pension programs and employees are not required to participate in such programs where available. Fewer than half (44 percent, or 51 million individuals) of workers participated in employer-sponsored pension programs.

Perhaps the most important policy decision made by the members of the 1934 Committee on Economic Security (who designed Social Security) was to follow a social insurance, instead of a public assistance, model for a new Federal retirement income security program. The controversy surrounding these two alternative systems is alive today. It is very much a part of the current debate over whether to means test Social Security benefits or to otherwise target Federal retirement assistance to the most needy.

- **Social insurance**. Social Security is a social insurance system that is characterized by wage-based contributions and benefits. Social insurance conveys a sense of "earned benefits" and thus avoids the potential stigma of welfare or charity. The system creates a social contract among generations: each generation of workers supports retirees with the expectation that when they retire, they, too, will be supported by future workers.

  > Critics argue that social insurance programs are more costly and less efficient than public assistance programs. More resources have to be channeled through the tax system because a greater number of beneficiaries have to be served. Because benefits are "earned" through paid-in contributions, there is a natural tendency to compare amounts paid in to amounts paid out in the form of benefits. If benefit levels or rates of return fall too low, contributors may perceive the system as a bad deal and support for the system among higher paid workers could weaken. Thus those with higher incomes (who paid in the most over their working lives) receive larger nominal dollar benefit payments than those most in need of assistance.

  > Supporters argue that universality is the only way to ensure lasting political support for the program . Some benefits have to go to people who do not need them in order to ensure that people who do need the benefits get them.

- **Public assistance**. A public assistance program provides benefits based on need and is financed by general revenues. Public assistance avoids regressive payroll taxes. Because it is not tied to contributions, there are no implied commitments to pay specific benefits. The system is more flexible and easier to change. Public assistance programs are smaller programs.

  > Proponents of public assistance programs argue that needs-based programs are more efficient because they concentrate on a defined population of beneficiaries and fewer resources are churned through the tax system.

> Opponents of public assistance programs claim that welfare programs lack sufficient popular support and are most vulnerable to budget cuts. This impedes government's ability to provide adequate benefits to those most in need. Administration of needs-based programs can be burdensome and expensive. In addition, means-tested programs create disincentives to work and save for individuals at the margins of eligibility.

Income Redistribution through Social Security

In addition to providing retirement income, Social Security is designed to redistribute income.

- **Replacement rates** are progressive. A low-wage earner retiring at age 65 in 1996 received a beginning Social Security retirement benefit equal to 58 percent of pre-retirement income. An average wage earner received 43 percent, and a maximum wage earner received 24 percent of pre-retirement taxable earnings. In 2030, scheduled replacement rates are 56 percent, 42 percent, and 28 percent. [10]

- However, in absolute terms, Social Security is **regressive within generations**. Higher income participants receive higher benefit payments than lower income participants. Maximum wage earners who retire at age 65 in 1997 can expect to receive average benefits of $15,955. Retiring low-wage earners can expect 57 percent less, or $6,810.

- Because higher wage earners receive larger nominal dollar benefit payments, they receive a disproportionate share (relative to their numbers) of aggregate Social Security benefit payments. Based on median per capita Social Security benefits, the lowest quintile of elderly units age 65 or above received about 10 percent of aggregate benefits, whereas the top quintile received about 28 percent.[11]

- Life expectancies differ among subgroups of the population. Individuals with higher incomes enjoy longer life expectancies than those with lower incomes. Furthermore, people with higher incomes tend to have higher levels of educational attainment and, therefore, spend fewer years paying payroll taxes. If variances in life expectancy and in years in school are taken into account, Social Security is even more regressive within generations.

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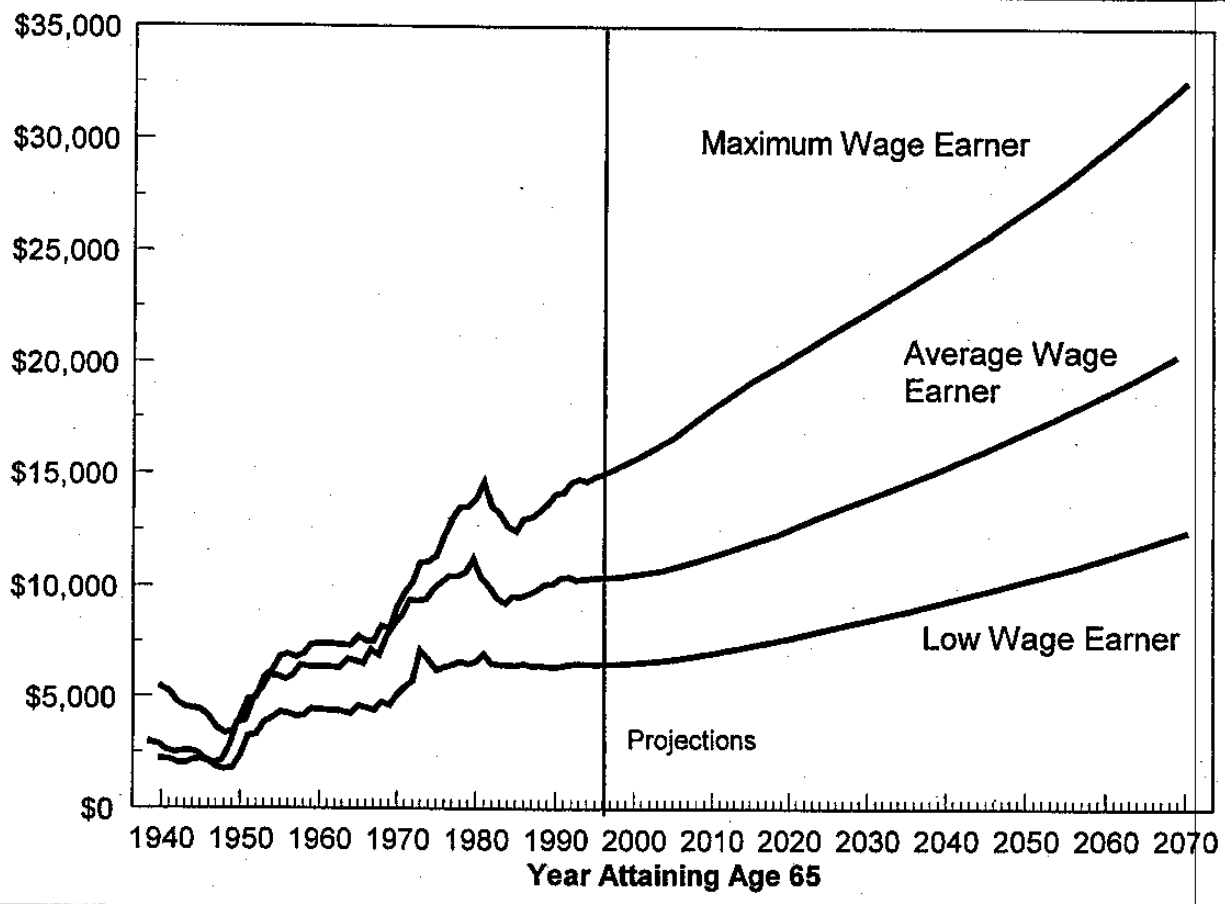
[10] "Low" wage earners are defined as those earning 45 percent of the average wage. "Maximum" wage earners are defined as those who have always earned the maximum wage subject to payroll taxes.
[11] CRFB calculations based on SSA data for 1994.

Figure 6.2
Social Security Retirement Benefits Payable at Normal Retirement Age
(In 1996 constant dollars)



SOURCE: SSA unpublished tables and Board of Trustees of the OASDI Trust Funds (1996).

- Because of survivor, dependent, and spousal benefits, married, one-earner couples fare better than both single wage earners and married, dual worker couples.

Social Security redistributes from the **young to the old**. Each new generation of workers has faced higher payroll taxes for longer periods of their working lives than the preceding generation.

An Intergenerational Perspective

Under a pay-as-you-go system, the younger, working age population provides the resources to finance benefits for the older, retired generation. Workers, in their own turn, will eventually retire and collect benefits financed by succeeding generations of workers.

The first retirees get back far more in benefits than they ever contributed in taxes. Later retirees, just by virtue of having paid taxes longer, will never get the same type of return. Until 1982, each new cohort of retirees did better than previous cohorts. Lifetime benefits expanded faster than lifetime taxes. Two factors combined to make this possible.

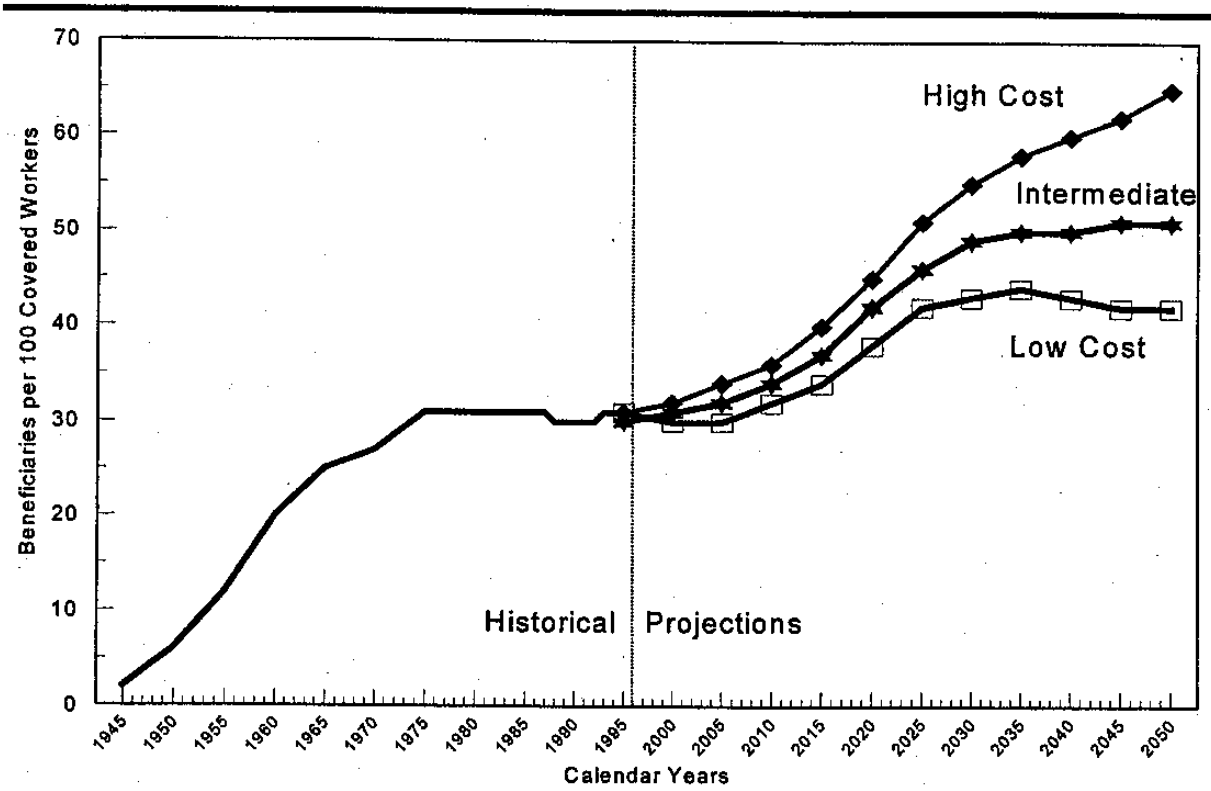
- When Social Security began, there were few retirees collecting Social Security benefits and many workers paying taxes. Tax rates were correspondingly low but were sufficient to support retirees and to build up a balance in the trust fund account.

- The number of participating (taxpaying) workers grew as coverage expanded to more of the workforce and more workers (the baby boomers and women) entered the labor market. In addition, payroll taxes have increased two ways: the level of wage income subject to taxation (the taxable wage base) has increased, and tax rates have risen.

Since the creation of Social Security, the ratio of beneficiaries to workers has increased steadily. The baby boom was followed by a baby bust; most women now work; almost all of the workforce is covered by FICA taxes, leaving no untapped sources for new taxpaying participants. As baby boomers retire, the ratio of beneficiaries to taxpaying workers will increase further even under SSA's most optimistic projections. (See Figure 6.3).

How well individual workers fare under Social Security and Medicare depends on payroll taxes contributed over an entire career relative to benefits collected. Three approaches to analyzing the treatment of participants are described below. Each of these provides a perspective on the treatment of different generations.

Figure 6.3
Social Security (OASDI): Comparison of Beneficiaries to Covered Workers



SOURCE: Board of Trustees of the OASDI Trust Funds (1997).

Payback Times

The Congressional Research Service (CRS) looks at the number of years it takes to recover, in the form of benefits, taxes paid into the Old Age and Survivors Insurance (OASI) program.[12] Once taxes, plus imputed interest, have been recovered, subsequent benefits represent windfall gains in excess of contributions. This approach is easy to understand, but it does not measure the size of individual gains or losses. (See Table 6.1).

[12] Kollmann (1996).

Beginning in 1996, some workers will not live long enough to recover the taxes paid into the system, plus imputed interest.[13] (If differences in life expectancy by income are taken into account, minimum wage earners could experience somewhat less favorable payback times, while the situation of maximum earners could be slightly more favorable.)

Table 6.1
Payback Times, Workers Retiring at Age 65

	Remaining Life Expectancy at Age 65		Number of Years to Recover Taxes plus Interest		
Year of Retirement	Male	Female	Minimum Earner	Average Earner	Maximum Earner
1940	11.9	13.4	less than 0.1	0.2	0.4
1960	12.9	15.9	0.7	1.1	1.4
1980	14.0	18.4	2.2	2.8	3.1
1996	15.5	19.2	9.9	14.3	19.5
2005	16.0	19.5	13.9	20.4	28.4
2015	16.4	19.8	15.4	23.2	35.8
2025	16.8	20.2	14.6	23.3	42.0
Note: Payback times including taxation of benefits: 2025	16.8	20.2	24.5	42.5	15.5

SOURCE: Payback times are from CRS (1996). Life expectancy data are from Board of Trustees of the OASDI Trust Funds (1997).

[13] The results shown in Table 6.1 reflect the following assumptions (see CRS report for results using alternative assumptions):

Retirement portion of the payroll taxes. The table shows payback times for the retirement portion only. The CRS excludes disability insurance (DI) from its analysis because workers receive the benefit of insurance coverage at the time they pay taxes. Similarly, the portion of tax that pays for survivors insurance could be excluded because active workers realize an immediate benefit from insurance coverage. (It is included in the table's payback calculations.) If excluded, payback times would be shorter.

Combined employer-employee taxes. The table shows the time it takes to recover employer and employee taxes. Most economists believe that employer-paid payroll taxes come out of compensation that the employee otherwise could have received in the form of wages.

Interest rates. The table assumes rates on long-term U. S. Treasury bonds. Payback times vary depending on imputed interest rates, or the rate that the worker would have earned if the amount paid in taxes had been invested, instead, in an interest-earning instrument. The higher the assumed interest rate, the longer the payback time.

Lifetime Rates of Return

Lifetime rates of return provide a convenient, but not altogether adequate, perspective on Social Security. Rates of return are derived by using streams of taxes paid into the system and benefits received from the system upon retirement. These rates of return can be used to compare outcomes across generations of retirees. Rates of return also can be compared to rates of return from alternative investments to determine if the individual could have been "better off" if the amount paid in taxes had been invested elsewhere.

- The rate of return analysis shows, as expected, that people who retired soon after Social Security began providing benefits achieved phenomenal rates of return on their contributions because they contributed little in taxes and collected benefits for many years.

- As the system matured, rates of return have decreased. Some single wage earners retiring today can expect less than 2 percent real returns—that is, less than the long term growth rate in the overall economy. Rates of return will get progressively worse for future cohorts of retirees. (See Table 6.2).

Table 6.2
Real Lifetime Rates of Return: OASI
(In percents)

Year Cohort Turns 65	Single Males			Single Females			One-Earner Couples			Two-Earner Couples		
	Low	Average	High	Low	Average	High	Low	Average	High	Low	Low/ Average	Average/ High
1940	145.4	114.5	84.4	147.7	123.0	86.2	169.2	135.1	101.7	146.6	126.7	95.1
1960	13.1	11.0	8.4	14.5	12.6	9.8	17.0	14.6	11.9	14.2	13.0	10.3
1980	5.3	4.2	3.8	6.4	5.5	4.9	9.2	7.7	6.9	6.9	6.2	5.0
1995	2.8	1.8	1.0	3.7	2.9	2.1	5.8	4.8	4.3	3.9	3.5	2.5
2010	2.0	1.1	0.1	2.8	2.1	1.0	4.5	3.6	2.7	2.8	2.5	1.4
2030	1.9	1.0	-0.2	2.6	1.9	0.6	4.2	3.4	2.1	2.6	2.3	1.1
2050	2.1	1.2	-0.0	2.8	2.0	0.8	4.3	3.4	2.2	2.7	2.4	1.2

SOURCE: Steuerle and Bakija (1994).

Like payback times, rates of return do not show how well or how poorly individuals actually fare. Ernest Ackerman retired one day after the Social Security program began in 1937. During his one day in the program, he contributed a nickel in taxes. He received a lump sum payment of 17¢—a 240 percent annual rate of return realized within the space of just a few months. This is a spectacular rate of return, but it hardly represents a significant benefit.

Lifetime Present Value Transfers

Steuerle and Bakija compare lifetime OASI and Medicare tax and premium contributions to benefit payments. Their analysis converts streams of contributions and benefits into 1993 present values.[14] It shows that current retirees will receive substantial windfalls from Medicare and Social Security.

- Assuming there are no changes to the programs, many retired baby boomers (low-income singles and low- and average-income one-earner couples) can still look forward to large gains.

- High income boomer singles and couples face large negative net transfers but will still receive significant benefits. (See Table 6.3) (Although other research shows that health care utilization, adjusted for age and health status, rises with income, Steuerle and Bakija assume the same value of Medicare benefits for all income categories, adjusting for sex and family status.)[15]

Table 6.3
Lifetime Combined OASI and Medicare Net Transfers
(In thousands of 1993 constant dollars)

Year Cohort Turns 65	Single Males			Single Females			One-Earner Couples			Two-Earner Couples		
	Low	Average	High	Low	Average	High	Low	Average	High	Low	Low/ Average	Average/ High
1980	56.5	61.5	62.2	97.5	118.2	129.0	174.8	224.4	255.1	165.6	196.3	204.5
1995	64.3	35.2	-19.8	110.6	93.2	47.0	227.6	249.2	238.7	191.2	195.8	118.2
2010	78.3	10.3	-165.0	133.5	77.7	-86.6	299.6	289.6	186.2	228.0	196.5	-29.1
2030	88.5	-37.2	-451.8	158.8	45.4	-361.0	390.6	335.1	32.1	262.2	175.9	-350.6

SOURCE: Steuerle and Bakija (1994).

[14] Steuerle and Bakija (1994).

[15] For more on the relationship between income and health care utilization, see chapter 7.

- Two-earner couples fare better. They will receive lifetime benefits worth almost $1 million in present value terms ($921 thousand)—equal to 72 percent of lifetime contributions.

- In 2030, single high income males will receive lifetime benefits worth $400 thousand in present value terms—equal to 47 percent of lifetime contributions.

Intragenerational Issues

The greater presence of women and of racial and ethnic minorities makes today's workforce far more diverse than the working population of the 1930s. The labor force of the future will be even more diverse. Social Security was designed for a largely homogeneous population. It may prove less capable of addressing the needs of a diverse population.

Social Security benefits are based on earnings and work history. As long as disparities in earnings, stability of employment, and health status exist between men and women and among racial and ethnic groups, subgroups within the population will not achieve parity in nominal Social Security benefit levels. Whatever their cause, inequities in wage levels between men and women or Whites, African Americans, and other racial and ethnic groups will be perpetuated through the Social Security benefit formula.

In addition, differences in life expectancies and family structures will result in differential lifetime benefits. Those who live longer will collect benefits longer. Married workers and workers with children receive higher benefits than single and childless workers. One-earner couples receive higher benefits than two-earner couples with the same family income and payroll tax contribution history.

Social Security Benefits and Race[16]

Elderly African Americans and Hispanics are less likely to receive Social Security income than elderly Whites, and the average benefits they receive are lower. (See Table 6.4.) These differences help to explain why poverty rates for elderly African Americans and Hispanics are more than 2.5 times higher than for elderly Whites.

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[15] For more on the relationship between income and health care utilization, see chapter 7.
[16] Data from Grad (1996).

Table 6.4
Average Monthly Benefits by Type, Sex and Race

	Average Monthly Benefits (in dollars)						Ratio of Average Monthly Benefits		
	1960		1973		1995		1960	1973	1995
	White	African American & Other*	White	African American	White	African American	African American & Other to White	African American to White	African American to White
Retired Workers	75.00	58.00	169.20	134.70	731.80	607.30	0.77	0.80	0.83
Men	83.00	65.40	185.60	149.70	824.70	669.20	0.79	0.81	0.81
Women	60.60	46.60	148.50	116.60	629.60	547.80	0.77	0.79	0.87
Disabled Workers	90.80	79.00	187.30	159.10	700.90	622.90	0.87	0.85	0.89
Men	94.30	82.40	200.10	172.00	786.80	676.90	0.87	0.86	0.86
Women	78.60	63.20	156.90	130.10	559.70	546.30	0.80	0.83	0.97

SOURCE: Thompson (1975); SSA (1996).

* For 1960, data are available for only African American and other races combined. African Americans made up 95 percent of the category "African American and Other" in 1973.

- In 1994, 92 percent of White seniors received Social Security benefits compared with 86 percent of elderly African Americans and 80 percent of Hispanic seniors.

- However, elderly African Americans and Hispanics who receive Social Security depend on it for a larger share of their income than do Whites. In 1994, Social Security provided more than three-quarters of the income of African American and Hispanic aged units who received benefits, but under two-thirds of the income of White aged units. Social Security was the sole source of income for 32 percent of African American and 31 percent of Hispanic aged units, compared with 14 percent of White elderly units.

- African American and Hispanic beneficiaries receive lower average Social Security benefits than White seniors. While the ratio of Black benefits to White benefits has increased modestly since 1960, most of the improvement can be attributed to a growing wage parity among women workers that translate into smaller disparities in Social Security retirement benefits.

> A 1975 study attributed racial differences in benefits to lower lifetime covered earnings and fewer years in covered employment.[17]

> The 1995 data indicate that although African American women workers receive lower benefits than African American men, their mean benefits have improved relative to those of White women.

> For African American men, there appears to have been little progress toward greater parity with White men in Social Security retirement benefits over the last 35 years.

Women Workers and Social Security

Women's greater participation in the labor force increases their Social Security benefits. Because auxiliary benefits are provided to spouses and dependents, Social Security provides inequitable treatment based on marital status.

- Women are a growing share of covered workers. In 1993, women were 46 percent of participants, up from 28 percent in 1937.

- During the same period, the gap in median annual earnings between men and women decreased from 49 percent to 34 percent.

- Sixty-two percent of women beneficiaries ages 62 or older were entitled to receive benefits based on their participation in the program as workers, up from 43 percent in 1960.

- In 1995, women who were entitled to retirement benefits on the basis of their own work history qualified for average annual benefits of $7,612—11 percent higher than the average benefit of $6,882 received by women who were only entitled to spousal benefits. Dually entitled women (women who qualify for benefits based on their own employment history as well as their marital status) had the highest average benefits ($7,907) because their husbands were more likely to have been high wage earners.

- Although unmarried women have always worked in greater numbers than married women, most married women, including married women with young children, are now in the paid labor force. Nevertheless, Social Security's spousal and survivor benefits provide one-earner couples with greater benefits than two-earner couples with the same wage and tax contributions history. Women who worked may not receive higher benefits as a result of their work history and tax contributions than

[17] Thompson (1975).

they receive based on their husbands' eligibility.[18] Once they are widowed, women who worked may end up with lower benefits than the surviving wife who never worked. (See Table 6.5).

- In 1994, the poverty rate among widows ages 65 and above was 22 percent, compared with 5 percent for married elderly couples. Table 6.5 helps to explain why. A widow's Social Security benefits may be half the level of the couple's Social Security income when the husband was alive. In addition, the husband's employer-sponsored pension benefits may have stopped with his death. (To avoid this situation, most defined benefit plans provide a joint and survivors' annuity option.)

Caregivers earn smaller benefits than continuous workers. Many women do not work in covered employment or they have shorter work and lower earnings histories because they are the primary caregivers for children and aging parents. Social Security benefits are based on earnings averaged over 35 years. Time spent working part-time or out of the paid labor force altogether reduces retirement benefits. Shortening the averaging period or dropping out years with no earnings would help address this problem, but would also increase Social Security's cost. It is not clear that women with the lowest incomes would be helped by this type of change.

Among women age 65 and above, separated or divorced women have the highest poverty rates.[19] Approximately 13 percent of elderly women are divorced or separated. Twenty-nine percent of these women were poor in 1992. Because they were married, these women may have shorter work histories and lower lifetime earnings than women who never married. They often lack any financial support from their former spouses or their estates, and they also may not have been married long enough to qualify for Social Security spousal benefits from their former marriages.

The poverty rate for elderly women who never married is about the same as for widows (21 percent). Their Social Security benefits are based solely on their work histories. They are more likely to have higher average lifetime earnings and longer work histories than married women.

[18] Spouses are eligible for the larger of their own earned benefit or 50 percent of the primary wage earner's benefit. When the primary wage earner dies, the surviving spouse receives the larger of 100 percent of her or his own earned benefit or the benefit of the deceased spouse.

[19] As long as her marriage lasted 10 years, a divorced woman is eligible for the same spousal and survivor benefits (based on her ex-husband's benefits) as a married woman.

Table 6.5
Social Security Couple's, Spousal, and Survivor's Benefits

	Average Monthly Lifetime Earnings	Wife's Spousal Benefits*			Wife's Survivors Benefits*	
		As Spouse	As Worker	Couple's Benefit	Amount	As percentage of Couple's Benefit
Couple A						
• Husband	$1,000			$564		
• Wife	0	$282	$0	282	$564	67%
Total	$1,000			$846		
Couple B						
• Husband	$667			$458		
• Wife	333	$229	$299	299	$458	62%
Total	$1,000			$757		
Couple C						
• Husband	$500			$404		
• Wife	500	$404	$404	404	$404	50%
Total	$1,000			$808		

SOURCE: Trout (1994).

* Spousal and survivors benefits available to husband or wife. Example presumes that the husband is the primary (higher) wage earner because only 15 percent of women earn more than their husbands during their lifetimes and because women have longer life expectancies than men.

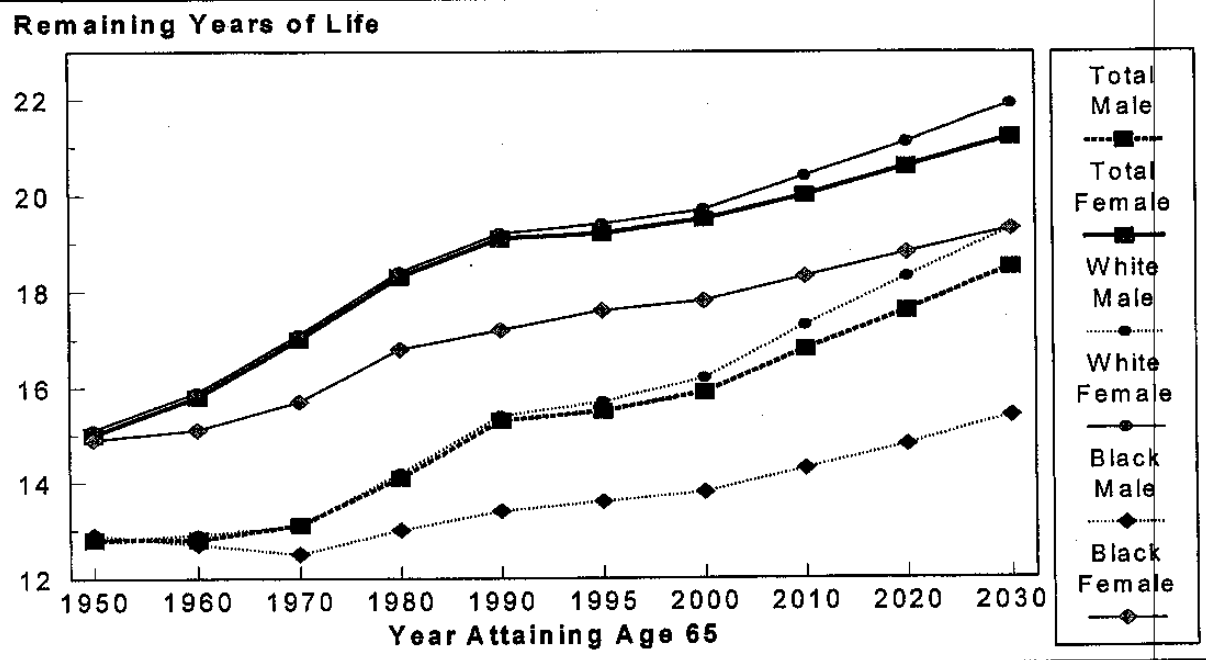
Social Security and Life Expectancies

Because Social Security (and Medicare) benefits are annuitized, individuals who live longer receive greater lifetime benefits.

Life expectancies differ between men and women and between African Americans and Whites. (See Figure 6.4). Research shows that socioeconomic differences (e.g., income, education, and occupational disparities) largely explain racial differences in health status and life expectancy.[20] Controlling for family income alone can eliminate as much as half or more of the African Americans' higher risk of death relative to their White counterparts.[21]

[20] Iams and McCoy (1991).
[21] See Preston and Taubman (1994).

Figure 6.4
Life Expectancy at Age 65 by Sex and Race



SOURCE: Bureau of the Census (1996).

Lower income persons have shorter life expectancies than persons with higher incomes.[22] (See Table 6.6).

The Social Security Administration has undertaken little research on the progressivity of lifetime benefits. It has done even less on the effect of differences on lifetime benefits for different socioeconomic groups. Given the significant differences in life expectancies for lower income populations, Social Security's benefit structure, when coupled with payroll tax financing, may result in unintended, and possibly perverse, income redistribution. More research and more complete data collection are required to understand better Social Security's lifetime economic effects for subgroups of the population. Such research would enhance greatly the policy making community's understanding of how different groups would be affected by changes to the program.

[22] Although it is possible that a reverse causality problem exists (i.e., that incomes are low because health problems that lead to shorter life expectancies also cause lower incomes), Duleep (1995) finds a higher probability of death for men with lower incomes even when controlling for health status.

Table 6.6
Estimated Remaining Life Expectancy at Age 25

Family Income (In 1990 dollars)	Remaining Life Expectancy (In years)		Percentage difference from Overall Average Life Expectancy	
	Men	Women	Men	Women
Less than $5,000	43.6	53.7	-12.8%	-5.8%
$5,000–9,999	46.1	56.0	-7.8%	-1.8%
$10,000–14,999	48.7	56.6	-2.6%	-0.7%
$15,000–19,999	50.8	56.9	+1.6%	-0.2%
$20,000–24.999	51.5	57.9	+3.0%	+1.6%
$25,000–49,999	52.4	57.8	+4.8%	+1.4%
$50,000 or more	53.6	58.0	+7.2%	+1.8%
Overall average	50.0	57.0	0.0%	0.0%

Source: Rogot, Sorlie, and Johnson (1992) quoted by Steuerle and Bakija (1994).

Paying for Social Security

Social Security has always faced financial difficulties. In the 1930s, Social Security's creators worried about the projected doubling of older adults by 1980. In response to initial projections that showed large future imbalances, President Roosevelt said:

> *It is almost dishonest to build up an accumulated deficit for the Congress of the United States to meet in 1980. We can't do that. We can't sell the United States short in 1980 any more than in 1935.*[23]

Despite FDR's original intentions that Social Security be "actuarially" sound, annual Social Security trustees' reports have repeatedly projected eventual trust fund insolvency. The reports have forecast sharply rising costs as a percentage of payroll, particularly since automatic cost of living adjustments were added during the 1970s. (See Figure 6.5).

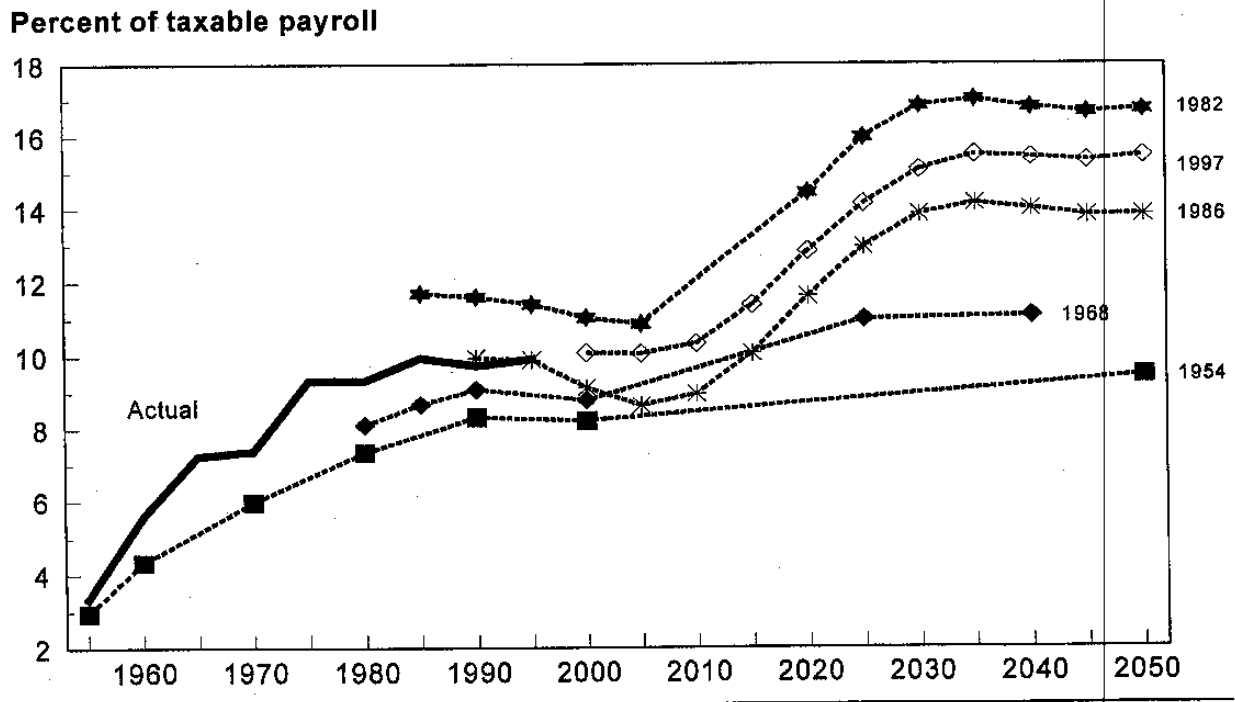
In 1942, Social Security was running a surplus and accumulating balances in the trust fund account. Nevertheless, the second annual trustees' report warned of serious financial problems by 1980. The trustees assumed that the imbalance could be addressed easily as they indicate:

[23] Schlesinger (1958).

Because of the cumulative growth in benefit payments, any long-term deficiency in the finances of the program would be apparent well in advance, and, therefore, could be met, without serious shock or disturbance, by moderate changes in the financial provisions. [24]

- Additional revenues were raised through higher tax rates and taxable earnings levels. But benefits were also broadened. By 1983, the Social Security Trust Fund account did not have sufficient resources with which to pay benefits. A special commission headed by Alan Greenspan[25] worked to design measures to shore up Social Security's finances and to prepare for the baby boomers' retirement. Subsequent legislation attempted to return to the original goal of building up trust fund account balances, thereby providing explicit commitments of future Federal revenues to meet future liabilities.

Figure 6.5 Estimated and Actual OASI Costs
(In percentage of taxable payroll)



SOURCE: Board of Trustees of the OASDI Trust Funds (1954, 1968, 1982, 1986, 1997).

Note: Figures for 1954 and 1968 projections do not include administrative costs, whereas figures for 1982 and later projections do. However, administrative costs represent only a few percentage points of the costs, and thus a minuscule amount off the total payroll. Thus the trend lines are still comparable for all practical purposes.

[24] Board of Trustees of the OASI Trust Fund (1942).

- The reforms increased revenues and reduced benefit costs. They included higher payroll taxes, a gradual increase in the normal retirement age from 65 to 67 beginning in 2003, the partial taxation of benefits for higher income beneficiaries, and coverage of new Federal workers under Social Security instead of under the separate Federal retirement program.

- Although the 1983 reforms lowered future projected costs as a percentage of taxable payroll, the 1997 projections show that about half of that progress has vanished. The actuarial deficit immediate prior to the reforms was 2.09 percent of taxable payroll. Estimated deficits have exceeded this level since 1994.

The Economics of Trust Fund Balances

By running Social Security operating surpluses, the Greenspan Commission intended to increase national savings. This would occur if the Federal government's budget surplus was larger (or its deficit smaller) than otherwise planned, assuming there would be no changes in private savings to offset Federal policy.[26] In theory:

- If the Federal government reduced outstanding public debt (in the case of a budget surplus) or borrowed less (in the case of lower than otherwise occurring deficits), additional funds would become available in the capital markets.

- Market interest rates would fall. Lower interest rates would facilitate investment, increase productive capacity, and raise the rate of economic growth.

- By the time the trust funds are needed to finance retirement benefits, the economy would be larger and the Federal government would have less outstanding debt. Both conditions would make it easier to raise sufficient funds to pay promised Social Security benefits, either through borrowing from the public or by raising taxes.

The Commission and subsequent legislation intended partially to "advance" fund Social Security, thus earmarking an explicit share of future economic resources for Social Security benefits. Under the 1983 reforms, higher payroll taxes meant current workers would have less income to consume. Their higher payroll taxes would produce Social Security operating surpluses that would lower Federal deficits and slow the accumulation of Federal debt (increase Federal savings). Lower Federal public borrowing needs would free up funds for private investment and encourage growth of the capital stock. As a result, future Federal budgets would have lower debt servicing (interest) costs and be better able to support higher benefit costs. The future economy would be better able to provide the resources needed to redeem

[25] Alan Greenspan was Chairman of the Council of Economic Advisers in the Ford Administration. He is currently the Chairman of the Board of Governors of the Federal Reserve System.

[26] See Hambor for a more complete discussion of the economic issues related to trust fund surpluses (1987).

Treasury securities held by the trust fund that would help pay for Social Security benefits.

Was the 1983 Commission's decision to build up trust fund balances the right one? It is not possible to know whether budget deficits would have been higher in the absence of Social Security operating surpluses. The budget was not in balance in 1983. It has not been balanced since 1969. Many analysts suspect that the surpluses have offset non–Social Security deficits, keeping consolidated deficits within a politically acceptable level, and thereby allowing policy makers to spend more on non–Social Security programs without raising other taxes. If so, the trust fund buildup has not accomplished what the Commission intended for the future economy.

- If Social Security surpluses are financing non–Social Security spending, non–Social Security taxes are lower than the levels otherwise necessary and, on an after-tax basis, income for current workers is higher than it should be given the level of government services consumed.

- When the trust fund account balances are needed to finance Social Security benefits, the cost will be borne entirely by future workers. Future workers will not have the advantage of a larger, more productive economy. Even with the trust fund buildup, the system is still pay-as-you-go.

Fixing Social Security

Social Security reform proposals only focus on reforming Social Security. They do not attempt to address wider economic issues and generally ignore the impact of proposed changes on the rest of the budget and the larger economy. To the extent that reforms would reduce the size of future liabilities, they have the potential to increase net national savings, although that outcome is not guaranteed.

Any proposal to address Social Security's long-term financing problems allocates more resources toward retirement, cuts the level of publicly funded retirement income support, or both. Some options assign a greater role to the Federal government for raising and allocating retirement incomes. Others would promote a larger individual, or private, role. Whatever the approach, all proposals must address the question of how to pay for the promises already made to people in the system. These promised to current retirees and workers constitute huge unfunded liabilities.

Some cohorts are going to have to pay twice.

- Incremental reform proposals largely would maintain Social Security's current pay-as-you-go financing and benefit structure. Reform costs would be allocated among workers and retirees through some combination of benefit decreases and revenue increases. Because benefit levels are indexed to current wage rates and then

subsequently adjusted for inflation and because the proportion of retirees to workers has increased, workers pay payroll taxes higher than retirees did when they were working. From a "money's worth" perspective, each new cohort of workers ends up worse off than previous cohorts, even if the current benefit structure is maintained. Cutting future benefits and increasing payroll taxes worsens the money's worth calculation. It implicitly means that workers end up paying again— through even higher taxes and lower retirement benefits.

- Major structural reforms involve partial or full movement towards a pre-funded system. Under a system of advance funding, workers would have to support benefits for current retirees and workers who are too close to retirement to move to a pre-funded system, and they would have to pre-fund their own benefits through investments in private securities. A pre-funded system would make costs explicit. It would recognize the unfunded costs of the old pay-as-you-go system and it would identify costs for the advance-funded system. To make these cost less burdensome, most structural reform proposals would institute benefit reductions and tax increases similar to those contained in incremental reform proposals. These changes would reduce the cost of the old program as it phases out.

Beyond financial and economic considerations, reforming Social Security raises significant political concerns. Supporters of the current universal, pay-as-you-go system fear that moving towards more individual responsibility, through measures like mandatory savings accounts or means-testing, will diminish popular support for Social Security. In essence, they believe the cure would be worse than the disease. Proponents of structural reforms argue that the current system is so fundamentally flawed that it cannot be maintained. They argue that because support for the system will dissipate anyway as younger cohorts recognize the system's flaws, now is the time to begin the transition to an individualized, pre-funded system.

Increasing Resources Available for Retirement

No matter what the approach, the level of resources devoted to retirement incomes will have to increase. Policy makers have only two direct means to increase retirement incomes: explicit or implicit tax increases; or incentives to encourage greater voluntary private retirement savings.

- **Payroll tax increases**. According to the 1997 Social Security Trustees' Report, a 2.23 percent increase in payroll taxes would put Social Security into "actuarial" balance for the next 75 years.[27] If the additional revenues are not used to expand non-Social Security spending, a payroll tax increase could have beneficial economic effects. (See the earlier discussion about the economic impact of trust fund balances). Payroll tax increases would reduce workers' current incomes, and,

[27] Additional payroll tax increases would be needed each year to keep the system in balance for the next 75-year period. That is because the change of the valuation period adds a new, expensive 75th year and drops a year when benefit costs are relatively cheaper.

therefore, their current consumption, in exchange for future publicly financed retirement incomes.

Tax increases lower Social Security rates of return and net transfers. Tax increases hit younger workers the hardest because they pay higher taxes for longer periods. Current retirees and older workers bear little of the additional tax burden. To spread costs more widely, policy makers could raise the ceiling on taxable earnings (affecting higher wage earners), subject a greater portion of Social Security benefits to income tax (affecting retirees), or finance some or all benefits with broader based income taxes (affecting higher income workers and retirees).

- **Mandatory savings.** Some proposals would require individuals to save a minimum amount of their wage or salary income for retirement. Mandatory savings would be in addition to taxes required to continue benefits for current retirees. Withdrawal of mandatory retirement savings would be restricted to retirement purposes only. Mandatory savings accounts would lower workers' current disposable income in exchange for higher future retirement income. Like Social Security payroll taxes, mandatory savings would base retirement income on wage history, but retirement income also would depend on individual investment returns. Thus mandatory savings proposals would transfer economic risk from general taxpayers to individual retirees. To mitigate this risk, policy makers could guarantee minimum rates of return on mandatory savings accounts and place restrictions on how mandatory savings are invested.

  Whether or not a mandatory savings requirement would be reflected as a tax for budget purposes would depend on how the mandate is designed. Regardless of its budgetary treatment, from an economic perspective, a mandated savings requirement would be tantamount to a tax: it would represent a use of the sovereign power of government to direct resources for publicly designated purposes.

  Mandatory savings proposals are most attractive to younger workers with higher incomes. Unlike Social Security payroll taxes, participants would own their mandatory savings accounts. There would be fewer opportunities to redistribute incomes. Participants would be better protected from the political risk that contributions would be diverted to other uses or that their benefits would be reduced by subsequent policy decisions. Lower income, older workers would lose the benefit of inter-and intragenerational transfers. Their retirement incomes would be more closely tied to their lifetime incomes. For this reason, most mandatory savings proposals would supplement retirement saving accounts with "safety net" income support. Such programs would ensure that all retirees receive a minimum level of benefits. In addition, transition provisions would protect current retirees and older workers nearing retirement.

- **Retirement savings incentives.** The Federal government can, and does, encourage individuals to save for retirement by offering tax incentives for retirement savings. These tax provisions allow individuals defer taxation on various levels and forms of retirement savings until they are withdrawn during retirement (when individuals' tax rates presumably will be lower). The largest of these tax incentives excludes from taxation employer contributions to employee pension plans. OMB estimates that this provision cost the Treasury $55 billion in foregone revenues in 1996. (See chapters 3 and 8 for more on the impact of tax policies on retirement savings.)

Reductions in Publicly Financed Retirement Income Support

- **Incremental reductions in benefits.** Benefit reductions lower the cost of Social Security. Like tax increases, benefit reductions erode rates of returns and net transfers. Benefit cuts immediately affect current retirees and older workers (who are less able to accommodate benefit changes). Younger workers will eventually be affected, but they have time to adjust their savings behavior to offset changes.[28] Some benefit reductions, like increases in the retirement eligibility age and changes in the benefit formula, affect only new retirees. Others, like changes in cost-of-living indexing provisions, would affect all retirees.

  The effect of benefit changes on subgroups within the population would not be uniform. Differences in characteristics such as pre-retirement income, life expectancy, and family size and structure would mean that some groups could benefit or suffer disproportionately from changes.

- **Means testing benefits.** Policy makers can reduce Social Security's costs by reducing the number of eligible beneficiaries. Many reform proposals would reduce or eliminate benefits to retirees who have incomes in excess of specific levels. Means testing can be accomplished either by paying benefits, then taxing them back through the normal income tax system, or by only paying benefits to those whose incomes do not exceed established limits. The first option would preserve some of the "earned benefit" character of Social Security. The second would limit the size of the program to those who need assistance, but the process of determining eligibility for benefits would entail additional administrative expenses.

[28] Some analysts argue that because younger workers in particular have little hope of collecting the benefits prescribed under current law, benefit reductions represent more of an acknowledgment of reality than an actual cut in their future Social Security retirement incomes.

Increasing the Rate of Return on Trust Fund Investments

By law, Social Security Trust Fund balances are invested in special, non-marketable U.S. Treasury securities. These investments earn the Treasury "risk free" rate.[29] Many policy makers are dismayed with the relatively low rate earned by the trust fund from these investments. Recent spectacular gains in private equities markets have increased interest in placing surplus payroll taxes in alternative, higher yielding investments.

Based on a historical average, private equities have produced average real returns ***5 percent to 7 percent higher*** than intermediate bonds comparable to Social Security Trust Fund holdings.[30] A higher investment return would provide additional revenues, which could be used to avoid tax increases or benefit reductions. CBO estimates that a 1 percent increase in the rate of return on trust fund assets would equal as much revenue as a 0.5 percent increase in the payroll tax.[31]

From the perspective of the Social Security Trust Fund, investment in private securities appears to be a painless solution. However, this strategy would create no new economic resources, generate no new savings, and promote no greater rates of economic growth. Thus it would not reduce the burden that Social Security places on the economy. Instead, it would withdraw resources from private markets and reallocate them into the Social Security accounts. This would also expose the program to the higher investment risks that go hand in hand with higher rates of return.

- Current Social Security surpluses enable the Federal government to borrow less from the public. If these surpluses were invested in private securities, unless non-Social Security spending was reduced, the Federal government would have to borrow more from the public or raise taxes. In either case, Social Security's private investment would be offset by a reduction in resources in the private markets. The end result is a shift of formerly privately held investments into public accounts.

- Federal investment in private securities would mean that the government would assume significant risks. Critics of this approach question whether the Federal government would be more adept at evaluating and managing risks than the private sector. Proponents of private investment point out that State and local government pension assets are invested in equities and that plan risk can be controlled through regulation.

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[29] The Treasury rate is assumed to be "risk free" in the sense that there is no effective risk of default. The U.S. government, through its sovereign power to levy taxes (and barring short-term political squabbles), has access to sufficient resources to repay its debt obligations. Treasury securities (except for new inflation-indexed securities) do not protect investors from inflation risk.

[30] Zeldes (1995) and Jones (1995).

[31] CBO(1994).

- Many analysts believe it would be naïve to assume that a private investment strategy could be insulated from politics. If trust fund managers had to take into account interests other than those of the beneficiaries (e.g., pressures to invest funds in the districts of powerful politicians), the portfolio would not achieve optimal investment results. Moreover, private sector investment by the Federal government potentially would interfere with private business operations and could effectively lead to nationalization of private industries.

Conclusion

If the objective is to "save" Social Security, solutions are not analytically difficult. All it takes is some combination of revenue increases and benefit reductions. What **is** hard is designing politically viable reforms that balance the need of many elderly individuals for public income support with the need to address serious intra- and intergenerational equity problems.

Social Security successfully allocates additional income to the elderly. In doing so, it improves the standards of living of millions of elderly beneficiaries beyond what they would be able to enjoy on their own. That income comes from the younger working age population who, when they retire, will expect future workers to provide the same sort of income transfer.

From an accounting perspective, raising Social Security payroll taxes or cutting its benefits can bring the system into balance. But, an "actuarially balanced" system really means explicitly committing future taxpayers to the allocation of a sizable share of future Federal revenues to Social Security. Thus focusing on "actuarial balance" is a limited goal that ignores important questions about how to divide individual and public responsibilities within and across generations.

In preparation for the baby boomers' retirement, policy makers could choose to modify and retain Social Security as an essential component of elderly incomes. Or they could replace it with some other publicly sponsored retirement savings or income support program. In either case, the system's future affordability will depend on public and private savings and investment behavior in the intervening years. If the level of savings and investment increases, the economy should be bigger, stronger, and better able to support a larger elderly population.

In short, any real effort to provide more secure retirement income requires a trade-off between current and future consumption. Lower current consumption would increase savings and investment and contribute to a stronger and larger future economy. For workers, lower current consumption means greater personal savings. For retirees, it means reduced Social Security benefits. For the Federal government, it means balancing the budget, even running consolidated budget surpluses. Without these types of changes, Social Security reforms may accomplish accounting changes or

portfolio shifts, but no real change in the aggregate economic burdens passed on to future generations.

Whether or not reform changes aggregate economic conditions, major reform alternatives differ in their distribution of costs, benefits, and economic risks. How individuals fare under these approaches would depend on their income, age, life expectancy, and educational attainment. More research is needed to understand how lifetime incomes for population subgroups would change under alternative approaches.

- Privatization proposals shift, in varying degrees, greater responsibility and economic risk to individuals. These plans would tie benefits more closely to lifetime earnings, but are often supplemented by public income support and insurance programs to provide a floor level of retirement income for low-income workers.

- Incremental Social Security reform proposals share financial responsibility and economic risk across the population, but entail the political risk that future policy makers and voters will change benefit levels.

From an economic perspective, it is clear that the system cannot be sustained indefinitely. The economy will not grow fast enough and there are not going to be enough workers to continue allowing everyone to get more out of the system than he or she put in. From a political perspective, it is difficult to see how changes can be made. Social Security's large unfunded liabilities do not currently qualify as a crisis. The magnitude of the problem ("only 2 percent of payroll") is constantly downplayed. And, although opinion polls indicate popular skepticism about the program's future viability, there is no groundswell of support for reform. It will take large doses of political leadership to help the public understand these issues and why changes are necessary. The longer it takes to begin the process, the more difficult the problems will become.

Chapter 7. Medicare and Medicaid

When Medicare and Medicaid were created in 1965, more than 25 percent of older Americans were poor, more than twice today's level. For their health care, the poor relied on State and local public assistance programs and charitable assistance from community hospitals, clinics and physicians. Although an estimated 70 to 75 percent of the population had surgical and hospitalization coverage provided primarily through their employment, only half of older adults had health insurance coverage. This coverage was both limited and expensive.

The Emergence of Federal Health Care Assistance

Proponents of a new Federal health care program for the elderly wanted a social insurance program that would broaden access to health care, enabling older members of society to benefit from the same standard of care as the younger, privately insured population. Many supporters saw the new health insurance programs as completing Social Security's unfinished mission of providing a secure retirement. Some supporters hoped to begin with universal coverage for the elderly and ultimately to extend it to the entire population.[1] Still others wanted some Federal assistance but feared large government intervention into private health care and insurance markets. They pushed for a means-tested program for the elderly poor.

What emerged was a combination of three approaches: Medicare Hospital Insurance, Medicare Supplemental Medical Insurance, and Medicaid.

Medicare: Universal Health Insurance for Older Americans

Medicare is the third largest Federal program, after Social Security and national defense. It is the largest publicly financed health care program. In addition to financing the health care of people age 65 and older and disabled individuals of any age, it pays for important social benefits such as medical research and education, rural hospitals, and hospitals serving a disproportionate number of poor patients.

- Medicare Part A Hospital Insurance (HI): Near universal hospital insurance coverage based on Social Security's mandatory (payroll tax) contribution system of financing.

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[1] Ball (1995).

- Medicare Part B Supplementary Medical Insurance (SMI): Voluntary coverage for physicians and ambulatory services supported partially by participants' premiums.

Medicaid: Health Insurance for the Low Income Population

Medicaid is jointly funded by the Federal and State governments and administered by the States. It is really four programs: it is the primary source of health insurance for low-income families with children; it pays for acute and long term nursing home and community-based care for elderly individuals who meet income eligiblity criteria; it covers long-term institutional and community-based care for physically and mentally disabled children and adults; and it covers the Medicare premiums and cost-sharing requirements for elderly and disabled individuals who are eligible for both programs ("dually eligible").

Medicaid is a means-tested program. It was created at the same time as Medicare to help low-income elderly who, even with Medicare coverage, would still need financial assistance to cover Medicare premiums, co-payments and deductibles, and long-term nursing home care. Medicaid also consolidated other State–administered, Federal low income health grant programs and extended health care assistance to other segments of the population deemed medically needy.[2]

The Expanding Federal Role in Financing the Nation's Health Care

After the introduction of Federal health care entitlements, health care spending growth rates accelerated. Because health care growth rates exceed the growth of the overall economy, an ever larger share of GDP is devoted to health care. (See Figure 7.1.) Since 1965, aggregate Federal health spending growth rates have exceeded the growth in private spending. As a result, Federal health spending has grown as a share of total health expenditures, whereas the private share has declined. By 1970, five short years after enactment, Medicare and Medicaid (including State payments) paid for 19 percent of all personal health care expenditures.[3] In 1996, the Medicare and Medicaid share had increased to 36 percent.

The Federal role in the nation's health care financing continues to expand. Federal health care programs cover those with the most expensive health care needs—the elderly, the disabled, and the poor. Current proposals are before Congress to reduce the number of uninsured children and to provide coverage to working-age adults who are temporarily unemployed and lack insurance coverage. With the aging of the

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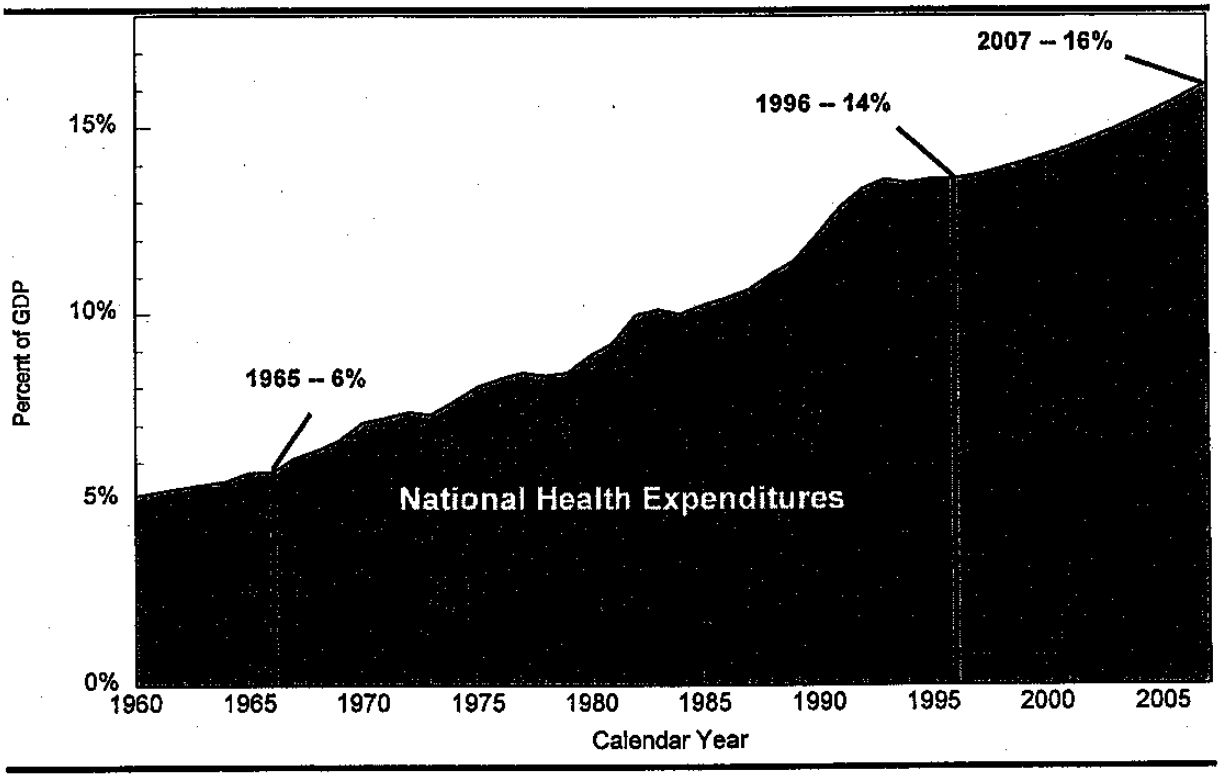
[2] Individuals with high health care costs but whose incomes, while low, are too high to qualify for cash welfare assistance are referred to as "medically needy." These individuals may be required to "spend down" financial resources on medical expenses before they qualify for Medicaid.

[3] Personal health care expenditures do not include public health activities, program and insurance administrative costs, research activities, and the cost of construction. Data from Levit *et al.* (Fall 1996).

population, the Federal share of overall health spending likely will increase even more. This growing Federal responsibility has serious implications for the Federal budget, the overall health care system, and the rest of the economy.

Figure 7.1
Health Care and GDP



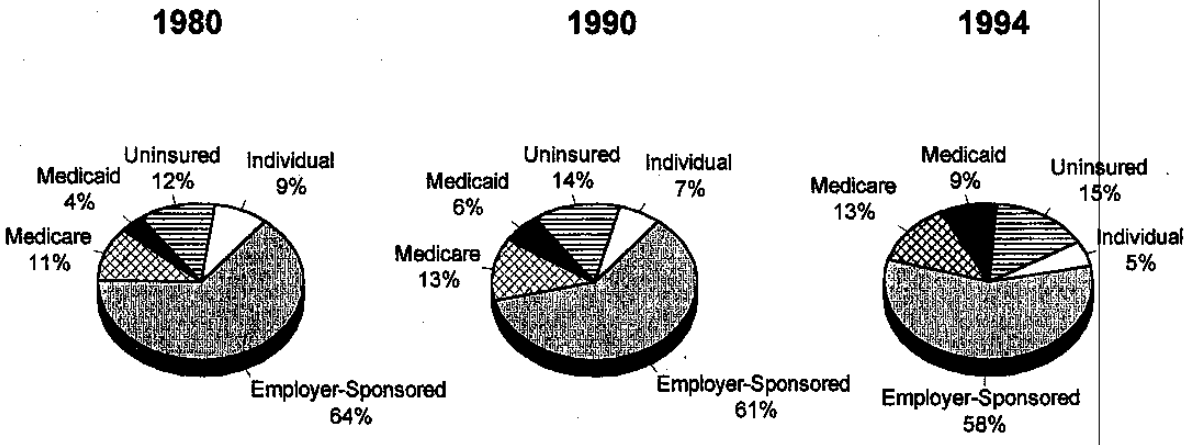
SOURCE: CBO (January 1997).

Medicare and Medicaid are an integral part of the nation's health care financing system. Together, these two programs pay for more than a third of national health expenditures and are the primary source of health insurance for one-fourth of the total population. (See Figure 7.2.)

- Medicare covers 37 million people, including 33 million elderly individuals (96.5 percent of all older adults).

- Medicaid covers 43 million people. Although low-income children are almost half of Medicaid's beneficiaries, a disproportionate share of Medicaid spending (26 percent) goes to the 11 percent of beneficiaries who are age 65 or older.

Figure 7.2
Primary Health Insurance Coverage



SOURCE: HCFA (1996) and EBRI (February 1996).

Issues

Medicare and Medicaid issues are the same as those raised by the overall health care system: cost, quality, and access. Public decision makers must address the costs of publicly financed health care services, how to pay for them, what services to provide, and who should have access to them. Health care choices are particularly difficult. Policy makers have to balance budget constraints against the often compelling needs of individuals seeking assistance. In working through these issues, it is essential that they clearly identify the problem areas they wish to address.

- For example, not all barriers to health care are financial. Studies have shown that the inconvenience involved (e.g., limited clinic or physician office hours) is more likely to deter parents from getting their children immunized than the actual cost.

- Not all individuals in poor health or age 65 and older are in need of publicly financed health care assistance. Some have sufficient income and wealth to assume greater responsibility for their health care expenses.

Projections of health spending show that both national and Federal budget spending for health care will continue to consume larger and larger shares of the economy and of the budget. Left unchecked, health care spending will squeeze out other public and private needs. (See Table 7.1.)

Table 7.1
Health Spending Projections

	1970	1995	2005	2010	2020	2030
National Health Expenditures, % of GDP	7	14	16	22	26	32
Medicare and Medicaid (Federal and State), % of GDP	1	4	6	9	12	14
Medicare and Medicaid (Federal and State) , % of National Health Expenditures	18	33	36	43	44	44
Medicare and Medicaid, % of Federal non-interest outlays*	6	20	27	30	36	44

SOURCES: Except for Medicare and Medicaid as percentages of Federal outlays, the table reflects CBO unpublished data for 1970, CBO March 1997 estimates for 1995 and 2005 and latest Health Care Financing Administration (HCFA) estimates (Fall 1992) for 2010, 2020, and 2030.

* Federal Medicaid spending only. Assumes that discretionary spending grows with inflation after 2007. CBO (March 1997).

- **Since 1970, aggregate Medicare and Medicaid costs have grown faster than aggregate private expenditures**. On a per capita basis, annual Medicare and Medicaid growth rates have generally been slower than per capita growth rates for private insurance. Since the early 1990s, the rate of growth in overall health care expenditures has been moderating. However, private insurers have been much more successful at controlling per capita cost increases than Medicare and Medicaid.

- **If current policies continue, Medicare and Medicaid will cause Federal deficits to explode**. Medicare and Medicaid each are growing faster than the Federal revenues available to support them. There are growing numbers of beneficiaries, and costs per beneficiary are rising. Controlling the cost of Medicare and Medicaid will require greater efficiency and may mean changes in eligibility, coverage, or both.

- **Coverage provided by Medicare and Medicaid is not as good as most private health insurance policies.** Gaps in coverage and high cost-sharing requirements may prevent beneficiaries from obtaining needed health care services.

- **Demand for long-term care assistance will grow as the population ages.** High real growth rates for home health and nursing home care for older Medicare and Medicaid beneficiaries are evidence of a large demand for financial assistance for long-term care. Because most employers do not sponsor long-term care insurance, and most people do not purchase insurance individually, the majority of elderly have insufficient means to pay for long-term care needs. Medicare long-term care assistance is limited. Medicaid does cover these costs, and it has become the largest third party payer for long-term care. The lack of adequate private financing creates incentives for older individuals to transfer their assets or take other actions to qualify for Medicaid assistance.

- **Despite a large and growing public role in health care financing, almost 40 million people, including 10 million children, currently lack health insurance.** Medicare covers the elderly. Medicaid covers many of the poor. Working-age adults who do not obtain group health insurance coverage through their employers often cannot afford individual coverage.

  > Individuals with fewer skills and lower educational attainment are most likely to be uninsured. Young adults, members of racial minority groups, and people of Hispanic origin are disproportionately uninsured.

  > The uninsured tend to have lower incomes, but only 28 percent have incomes below the poverty level. Two-fifths of the uninsured have family incomes of at least twice the official poverty rate.[4]

  > Only 15 percent of the uninsured live in families in which the family head does not work. Over half live in families where the family head works full time, all year.

- **Medicare and Medicaid reform must be coordinated with whatever changes are enacted to reform the overall health care system.** Medicare and Medicaid spending represents one out of every three health care dollars. Through its policies the Federal government exercises tremendous purchasing clout. Changes in policies could have serious repercussions for the financing and delivery of services throughout the health care system. Thus Federal Medicare and Medicaid policies can effect the practice of medicine, enhancing or derailing improvements taking place in privately financed health care.

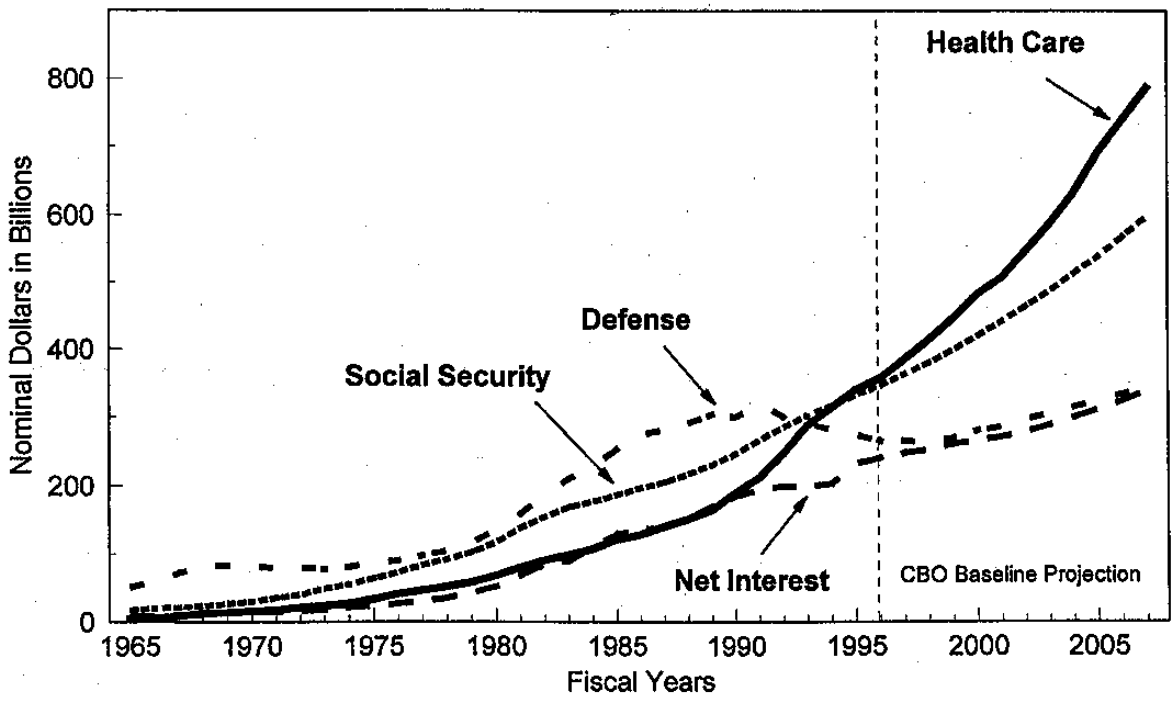
- **Publicly and privately financed health care are inextricably linked.** Sick people will still need care whether or not Federal programs cover their costs. Instead of reducing overall health spending, cutting Federal health spending may shift costs to State and local or private budgets. In addition, Medicare and Medicaid budget cuts could have unforeseen effects on graduate medical education, rural and inner city hospitals, and other parts of the health delivery system.

[4] In 1995, the poverty level was $15,569 for a family of four and $7,963 for a single, nonelderly person.

Medicare, Medicaid, and the Federal Budget

During the last three decades, health care has grown more rapidly than other segments of the economy, rising from 6 percent of GDP in 1965 to 14 percent in 1996. Over this period, the Federal government's share of national health expenditures has grown almost three-fold—from 12 percent of total health care expenditures to 34 percent.[5] Since 1965, Medicare and Medicaid coverage has expanded. These programs now cover more health care services and include more people with expensive needs. The Federal government currently spends a greater share of its budget on health care than any other type of spending, including national defense. Today, one out of every five Federal program dollars is spent by Medicare or Medicaid. (See Figure 7.3 and Table 7.2.)

Figure 7.3
Federal Outlays: Major Program Categories



Source: CRFB based on OMB(1997) and CBO (January 1997).

[5] These percentages do not include health insurance premiums paid by the Federal government on behalf of Federal employees. Those amounts are included under private insurance with other employer-paid health insurance benefits.

Table 7.2
Private and Public Personal Health Expenditures
Average Annual Growth Rates
(In percentages)

	1970–74	1975–79	1980–84	1985–89	1990–95	1970–95
Private insurance	14%	17%	14%	12%	8%	13%
Federal government						
Medicare	14	19	17	9	11	14
Medicaid	23	15	10	12	17	15
Total: Medicare/Medicaid	16	17	15	10	12	14
State Medicaid	21	15	13	9	12	14
Total Medicaid	15	17	16	9	11	14

SOURCE: CRFB calculations based on CBO unpublished data (1997).

Medicare and Medicaid growth rates tend to move with overall growth rates in health spending. On an aggregate basis, Medicare and Medicaid have grown at faster rates than health spending in the private sector. On a per capita basis, until recently, Medicare and Medicaid growth rates have been slower than the growth in spending by private health insurance. (See Figures 7.4 and 7.5.)

- Higher aggregate growth rates reflect growing numbers of beneficiaries and higher per capita costs.

- Medicare and Medicaid serve populations with higher than average costs— the elderly, the disabled (including those with end-stage renal disease) and the poor.

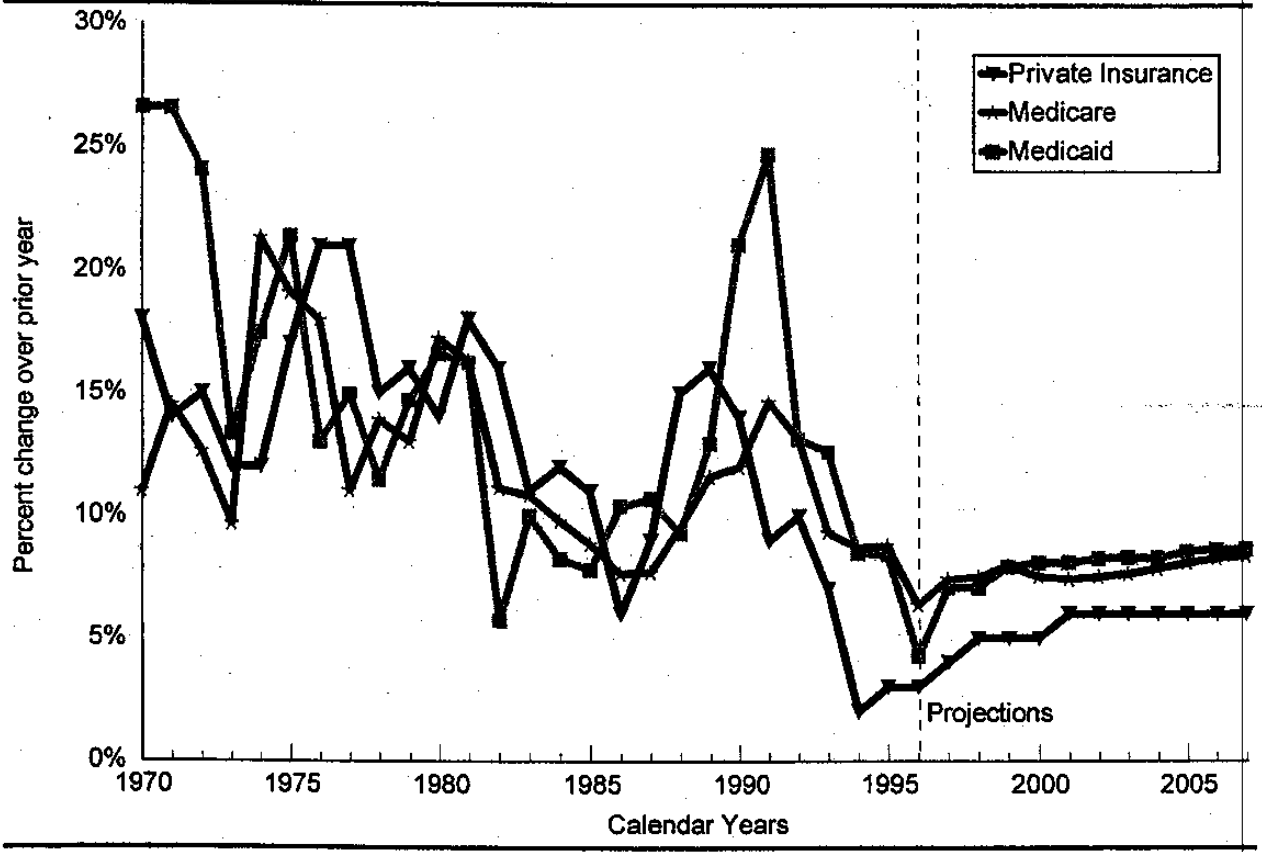
  > CBO estimates that the aging of the population accounted for 5 percent of the increase in overall per capita health care costs between 1965 and 1990.[6] Because average, per capita health care expenditures are 3.5 times greater for individuals age 65 and above than for younger adults (ages 19–64), Medicare and Medicaid costs are particularly sensitive to the number and age of older people. Ninety percent of Medicare enrollees are age 65 or older.

  > A growing percentage of older Medicare enrollees are age 85 or older. On average, the old old are twice as costly as the young old. Only 11 percent of Medicaid's beneficiaries are age 65 or over, but they are the most costly.

[6] CBO (1992).

> Since 1992, private health care costs have increased far more slowly than Medicare's costs. HCFA estimates that differences in coverage, Medicare enrollment growth, and physician incentive payments explained 52 percent of the 1994 difference in per enrollee costs relative to private insurance. Not accounting for these factors, Medicare per enrollee costs were 5.7 percent higher than private insurance. On an adjusted basis, average Medicare costs were 2 percent higher.[7]

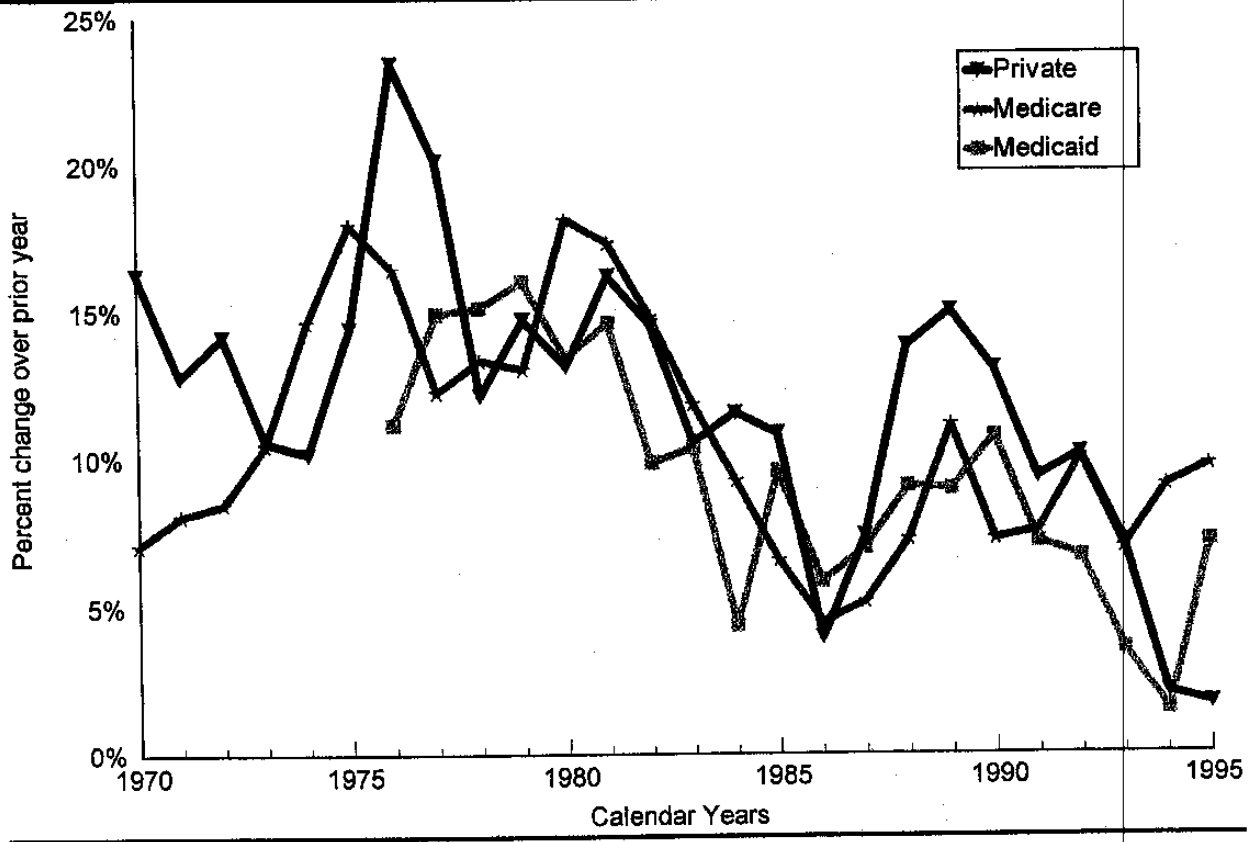
Figure 7.4
Growth in Aggregate Health Spending



SOURCE: CRFB based on HCFA Statistical Supplement (1996).

[7] Levit *et al.* (Summer 1996).

Figure 7.5
Growth in Per Capita Health Spending



SOURCE: CRFB based on unpublished HCFA table (1997) and HCFA Statistical Supplement (1996).

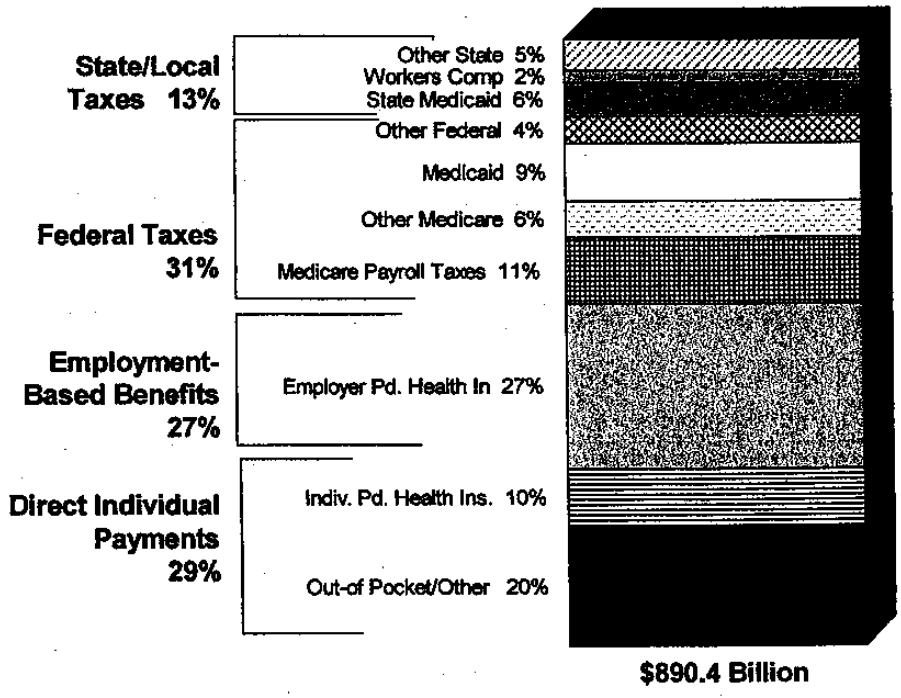
As Federal programs, Medicare and Medicaid cannot adapt as quickly as the private sector to changing conditions and trends. Although private employers have bargained hard to keep insurance costs down and private insurers have rapidly moved into managed care arrangements, the Federal government moves more slowly. It takes time to build Congressional approval to change Federal programs. In the absence of political consensus, cost-saving changes are difficult to achieve.

- Medicare and Medicaid help assure that financing will be available to pay for expensive new technology and services. One of the reasons health care costs have increased so rapidly is that sufficient public and private financing has been available to support advances in medicine and greater intensity of care. Health care services available today are quite different from those delivered 30 years ago. Public financing for the heaviest users of health care services has helped to generate both supply and demand for ever more costly needs.

- Medicare and Medicaid pay for certain "social" benefits in addition to the health care costs of beneficiaries. Medicare and Medicaid support hospitals serving disproportionate numbers of low income patients. Medicare supports rural hospitals and graduate medical education.

Since the creation of Medicare and Medicaid, the Federal role in financing health care has expanded dramatically. In 1965, before Medicare and Medicaid were implemented, health care supplies and services financed by Federal tax revenues were $3 billion, or 9 percent of the total. By 1994, the Federal share was $275 billion, 31 percent of the total.[8] (See Figure 7.6.)

Figure 7.6
Paying for Health Care
Health Services and Supplies, 1994



SOURCE: CRFB based on Cowan *et. al.* (Summer 1996).

Although rates of cost growth for both Medicare and Medicaid have abated in recent years, most analysts do not expect that these lower growth rates will continue. Although greater use of managed care has helped to slow growth rates throughout the system, there is no assurance that these savings will continue. Consumers are beginning to rebel against strict controls over the choice of providers. Providers

[8] CRFB calculations based on HCFA data. Amounts include Medicare spending financed by HI payroll taxes.

increasingly are organizing into practice groups that are more capable of negotiating better fees from payers. Even if welcome trends in slower cost growth continue, Federal spending for these two health care entitlement programs will increase substantially as the elderly live longer and as a the number of people age 65 and older increases.

Medicare

Medicare is in a financial crisis. In 1996, the Federal government spent $70 billion more for Medicare benefits and administrative expenses than it collected in payroll taxes and premiums. According to the 1997 trustees' report, the HI Trust Fund will not have sufficient resources to pay all of its bills in early 2001.[9] Because general revenues make up for any shortfall in premiums and other income, the SMI Trust Fund is not in danger of insolvency. Nevertheless, the trustees "... note with great concern the past and projected rapid growth in the cost of the program" and conclude "(p)rompt, effective, and decisive action is necessary."[10]

Current efforts by policy makers to extend the life of the HI Trust Fund another 10 years do not address the long-term issues. Congress and the President likely will agree to a package of incremental changes as part of the 1998 budget reconciliation bill. These will transfer payment for home health services, the most rapidly increasing Medicare services, from HI to SMI, restrict growth in payments to health care providers, and keep SMI premiums from decreasing as a share of total program costs after 1998. (The Senate would also even means-test SMI premiums and increase the Medicare eligibility age in conformance with already enacted Social Security age increases.) Because the growth in spending will still exceed growth in revenues, the HI Trust Fund will become insolvent before the oldest baby boomers reach age 65.

Cutting Medicare benefits may help Medicare's financing, but may simply shift costs to Medicaid and the private sector. Increases in Medicare co-pays, deductibles, and premiums increase Medicaid payments for dually-eligible beneficiaries. Higher Medicaid costs drive up State Medicaid spending. Medicare benefit reductions and other changes, including raising the Medicare eligibility age, would increase the costs of private retiree health insurance coverage and could lead more employers to drop retiree coverage.

Medicare provides incomplete and uneven access to services. Medicare leaves large gaps in coverage. It does not cover prescription drugs or long-term care, and it requires significant beneficiary cost-sharing, which hits low-income elderly the hardest.

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[9] Board of Trustees of the HI Trust Fund (1997).
[10] Board of Trustees of the SMI Trust Fund (1997).

Although Medicare provides near universal coverage for the elderly, use of services varies by income, sex, race and ethnicity, and geographic location.

Medicare's Chronic Financing Problem

Currently, Medicare spending equals 15 percent of the Federal program outlays and 3 percent of GDP. In 2030, under intermediate economic and demographic assumptions and despite optimistic cost assumptions, Medicare will consume 29 percent of Federal program-related outlays and surpass 7 percent of GDP.[11] (See Table 7.3.)

Table 7.3
Medicare Disbursements as a Share of GDP
(In percentages)

	1997	2010	2030	2050
HI	1.73	2.43	4.01	4.63
SMI	0.94	1.80	3.13	3.17
Total Medicare	2.66	4.23	7.14	7.80

SOURCE: Board of Trustees of the Federal HI Trust Fund (1997).

Insolvency of the HI Trust Fund is now only four fiscal years away. Impending insolvency is sufficient to move Medicare to "crisis" status on the political agenda. However, Medicare's financial problems are far greater than the rapidly depleting HI Trust Fund.

- **CBO estimates that Medicare benefits will grow an average of 8.8 percent a year through 2007**, 2.9 percent above the projected level attributable to nominal GDP (4.7%) and beneficiary (1.2%) growth.

- **To achieve long-term actuarial balance, HI payroll taxes would have to increase from the current 2.9 percent to 7.2 percent.**[12] Just balancing the HI Trust Fund for another 25 years (through 2021) requires a payroll tax increase of 2 percent—70 percent more than the current tax.

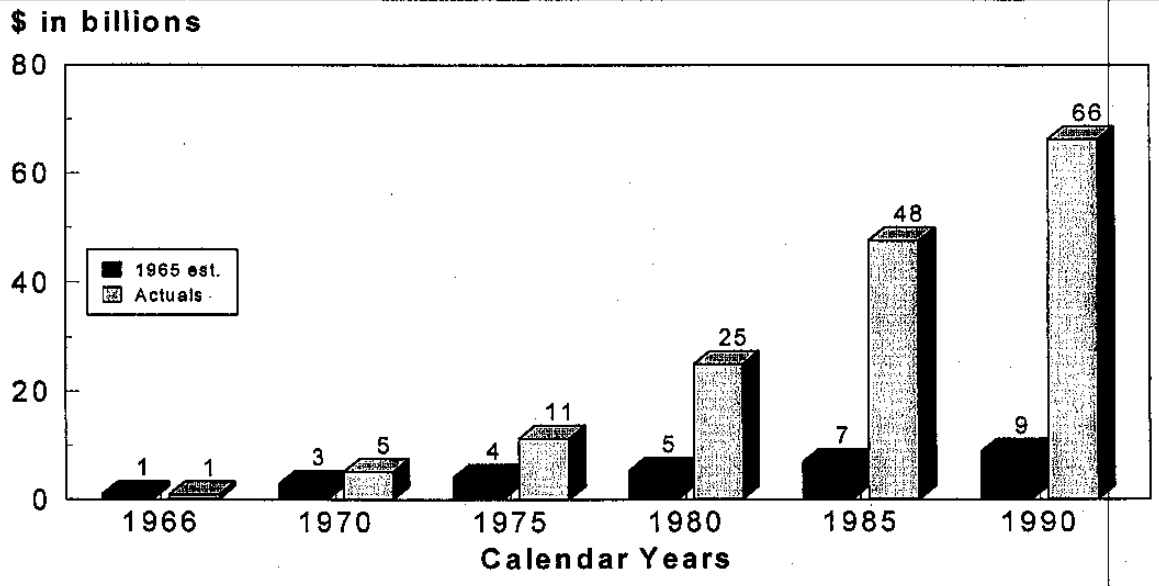
[11] For example, the Trustees project that SMI growth rates will decline to the rate of GDP growth because continuing with historical and current growth rates would result in a program of "implausible" size "given other demands on those (GDP) resources." The projections also assume that 25 years from now, HI costs will only increase at the same rate as average hourly earnings

[12] Board of Trustees of the HI Trust Fund (1997).

- **Aggregate Medicare HI expenditures will exceed the growth in taxable payroll by 2 percent to 3 percent through 2020**, indicating that current law income will be "grossly inadequate" to support the program.[13] Because the revenue base is not expanding as fast as expenditures, the burden of paying for Medicare is getting heavier.

These are not new problems. Impending trust fund insolvency, rapidly growing costs, and financial instability have characterized Medicare from its inception. Initial 1965 estimates by the House Ways and Means Committee indicated that total HI benefit costs would increase an average of 7.7 percent per year between 1967 and 1990. Instead, actual benefit costs increased an average of 17 percent per year.[14] (See Figure 7.7.) By 1970, annual costs were increasing 20 percent. The HCFA Chief Actuary was projecting annual deficits beginning that year, rising to over $20 billion a year in 1995. He estimated that the payroll tax would have to be doubled immediately to correct the actuarial imbalance.[15]

Figure 7.7
1965 Hospital Insurance Cost Projections and Actual Costs



SOURCE: O'Sullivan and Graves (1993).

[13] Board of Trustees of the HI Trust Fund (1997).
[14] O'Sullivan and Graves (1993).
[15] Meyers and Hsiao (1970).

Sources of Medicare Cost Growth

Medicare costs have grown rapidly due to three factors.

- **Beneficiaries:** Medicare serves high cost populations—the elderly and the disabled. The number of Medicare beneficiaries has increased an average of 2.4 percent a year since 1966 and a greater percentage of them are older.

  > In 1995, 45 percent of enrollees were age 75 or older, compared with 37 percent in 1966. The percentage of enrollees age 85 or above grew from 8 percent in 1980 to more than 10 percent in 1994. On average, Medicare enrollees age 85 and over cost twice as much as enrollees ages 65 to 70.

- **Inadequate incentives for providers to control costs**. In 1965, Medicare was modeled after the prevailing retrospective reimbursement payment system used by private health insurers. Instead of encouraging health care providers to control the cost or the volume of services delivered, this system created incentives to increase the volume and cost of services delivered. Successive Federal efforts to control the growth in provider payments have helped but have been only partially successful. They have reduced growth rates for inpatient hospital and physician services, but they have not accommodated changes in medical practice and site of service delivery. Consequently, costs have shifted to post–acute care service providers (e.g., home health, skilled nursing, outpatient, and hospice care), the fastest growing segments of Medicare. Proposals to shift payment for post-acute care services to a prospective basis are currently before Congress and are expected to be enacted in the near future.

- **Absence of incentives for beneficiaries to seek cost-effective care**. Because Medicare covers about 86 percent of eligible services and half of all health care expenses, most Medicare beneficiaries have supplemental coverage, either through private Medigap or employer-sponsored insurance or through Medicaid, to pay deductibles and coinsurance requirements.[16] (Eleven percent of elderly beneficiaries lack supplemental coverage.) Because their direct out-of-pocket exposure to health care costs is limited, beneficiaries frequently lack incentives to consume only cost-effective care. Although 75 percent of insured workers are now enrolled in some form of managed care, some 85 percent of Medicare beneficiaries remain in more expensive fee-for-service care.

[16] Co-pays and deductibles only. Does not include Part B premiums. HCFA (1996).

Controlling Medicare Costs

By the mid-1970s, it became evident that Medicare costs were out of control. Average inpatient hospital charges per day grew from $44 to $145 between 1966 and 1975—an average of 23 percent per year.[17]

Throughout the 1970s and 1980s and continuing into the 1990s, legislative and regulatory efforts to restrain Medicare cost growth have focused on limiting provider payments through price and volume controls. In addition, Medicare has shifted from retroactive to prospective reimbursements for many, but not all, services. First hospitals, then physicians, were subjected to payment restraints because "that's where the money is."

Hospital inpatient and physician services costs are now a smaller share of total Medicare payments, whereas outpatient and home health services have grown. (See Figure 7.8.) Average annual growth rates for two periods, 1967–1983 and 1983–1994 are compared next.

- Overall growth in Medicare costs declined from 17 percent to 10 percent a year.

- Growth in inpatient hospital payments declined from 17 percent to 7 percent. Physician and other medical services growth rates declined from 16 percent a year to 10 percent. Outpatient services grew more slowly (13 percent a year post-1983 compared with 32 percent pre-1983), but at a faster rate than inpatient hospital and physician services payments.

- Cost containment imposed on inpatient hospital care has fueled strong growth rates for post–acute care services. One-fourth of Medicare patients use post–acute care services within 30 days of hospital discharge.

  > **Skilled nursing facility (SNF) payment growth increased from 3 percent to 27 percent a year**. Because SNF coverage was restricted until 1987, most of this growth came after 1987. Recent growth reflects higher levels of patient services, as well as higher admissions as a result of shorter hospital stays.

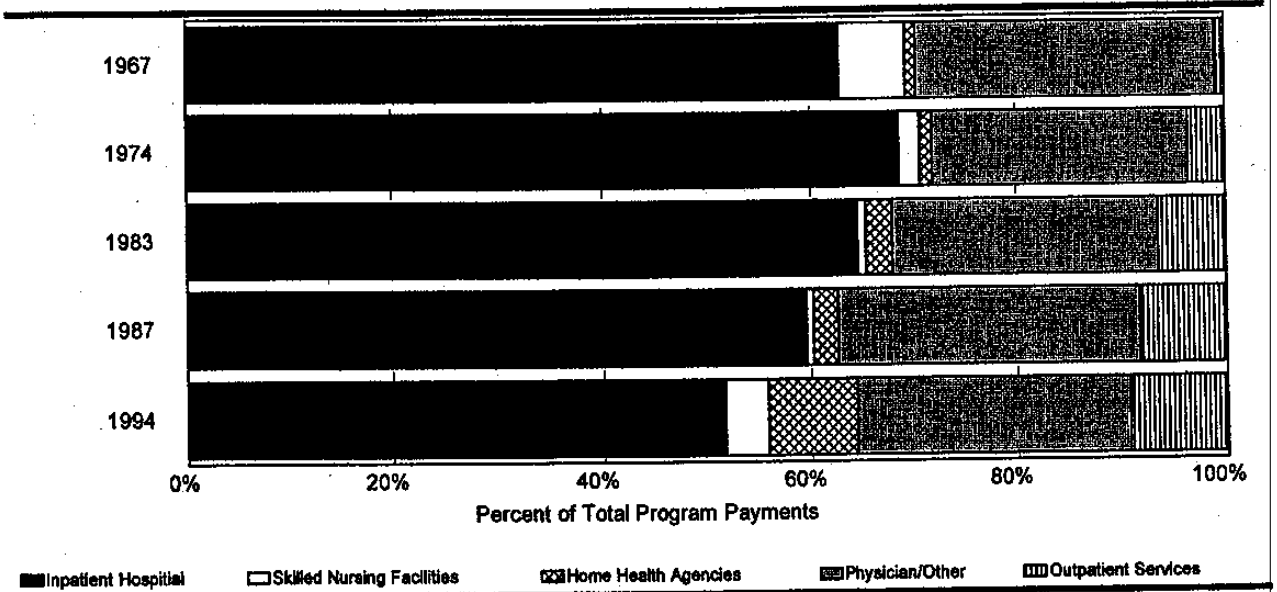
  > **Home health care is the fastest growing segment of Medicare.** Average annual growth rates for SMI home health agency services payments increased from 3 percent (pre-1983) to 17 percent (since 1983). HI home health payments declined slightly from 28 percent to 22 percent per year.

- Although inpatient hospitals and physicians receive prospective payments, skilled nursing facilities, home health agencies, rehabilitation and long-term care hospitals receive cost-based reimbursements. Because controls over the volume and the

[17] SSA (1996).

cost of services delivered are inadequate, costs have grown as much as 30 percent a year. As the number of Medicare beneficiaries grows and their needs for post-acute care and long-term care increase, Medicare spending for these types of services can be expected to increase.

Figure 7.8
Medicare Payments by Type of Coverage



SOURCE: HCFA (1996).

Access

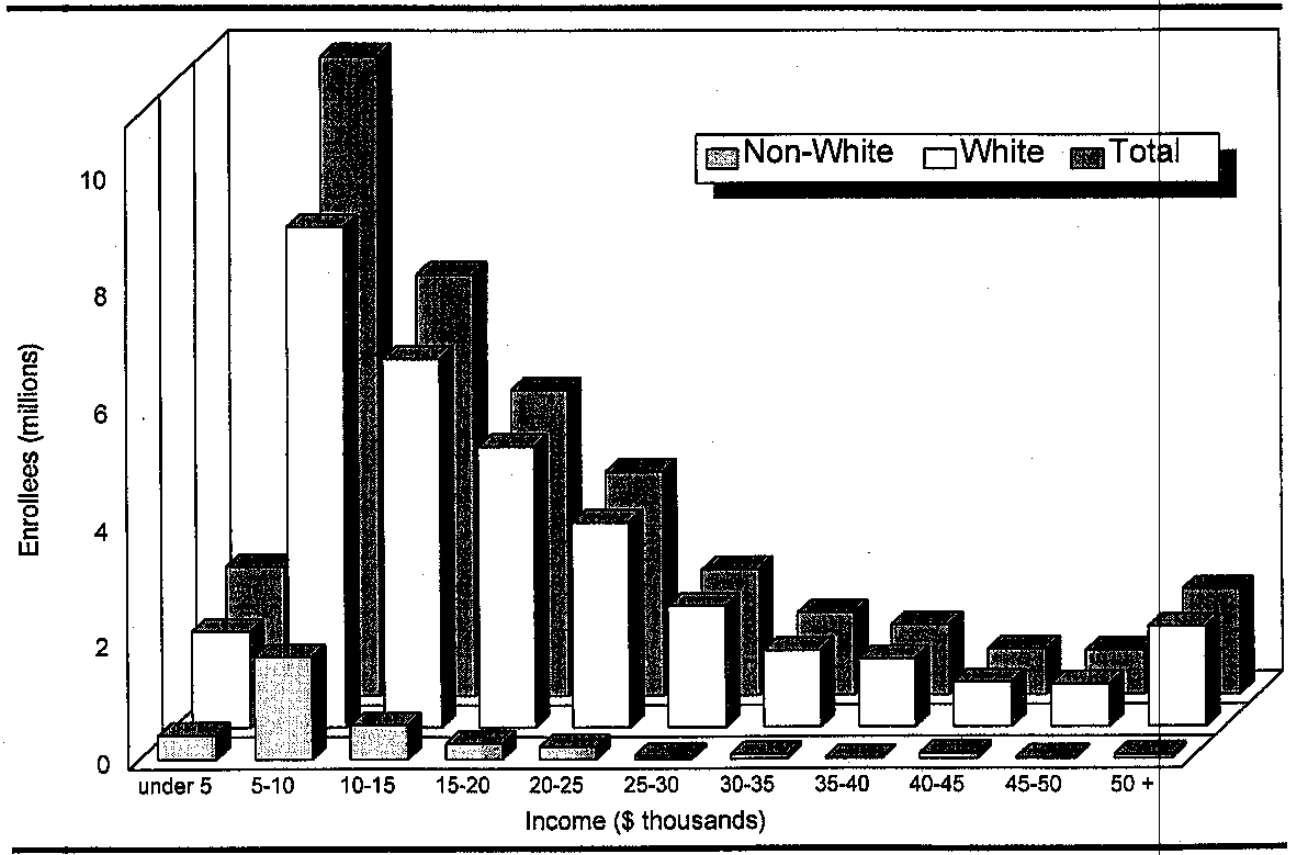
Medicare provides almost all seniors with health insurance coverage. But it is limited to acute care and does not cover all health-related expenses of the older adults. In terms of the actuarial value of benefits, Medicare has been ranked in the bottom 10 percent of health plans. Medicare does not cover prescription drugs and dental care, both of which are commonly included in private employment-based health insurance plans.[18] Neither Medicare nor private insurers cover long-term care. Because seniors are more likely to need long-term care, they are more affected by the absence of coverage than the working-age population.

[18] On the other hand, Medicare does cover hospice care, end-stage renal disease, and more post-acute care services than private insurance.

Beneficiaries pay for an estimated 30 percent of their acute care services through premiums, co-pays, deductibles, and payment for non-covered services.[19] Although Medicaid pays for the cost-sharing requirements of the poorest elderly, and Medigap and employer-subsidized retiree insurance help a sizable portion of the Medicare population (75 percent in 1994), 11 percent of Medicare beneficiaries face large out-of-pocket expenses.

Cost-sharing liabilities are designed to create incentives for beneficiaries and providers to restrict the volume of care used. However, cost sharing requirements do not deter more affluent beneficiaries from using services and may discourage lower income individuals from seeking even necessary care. Four out of five Medicare enrollees have incomes of $30,000 or less; 35 percent have incomes of $10,000 or less. (See Figure 7.9.)

Figure 7.9
Medicare Enrollees by Income, 1993



SOURCE: CRFB based on unpublished HCFA tables (1997).

[19] Moon (1996).

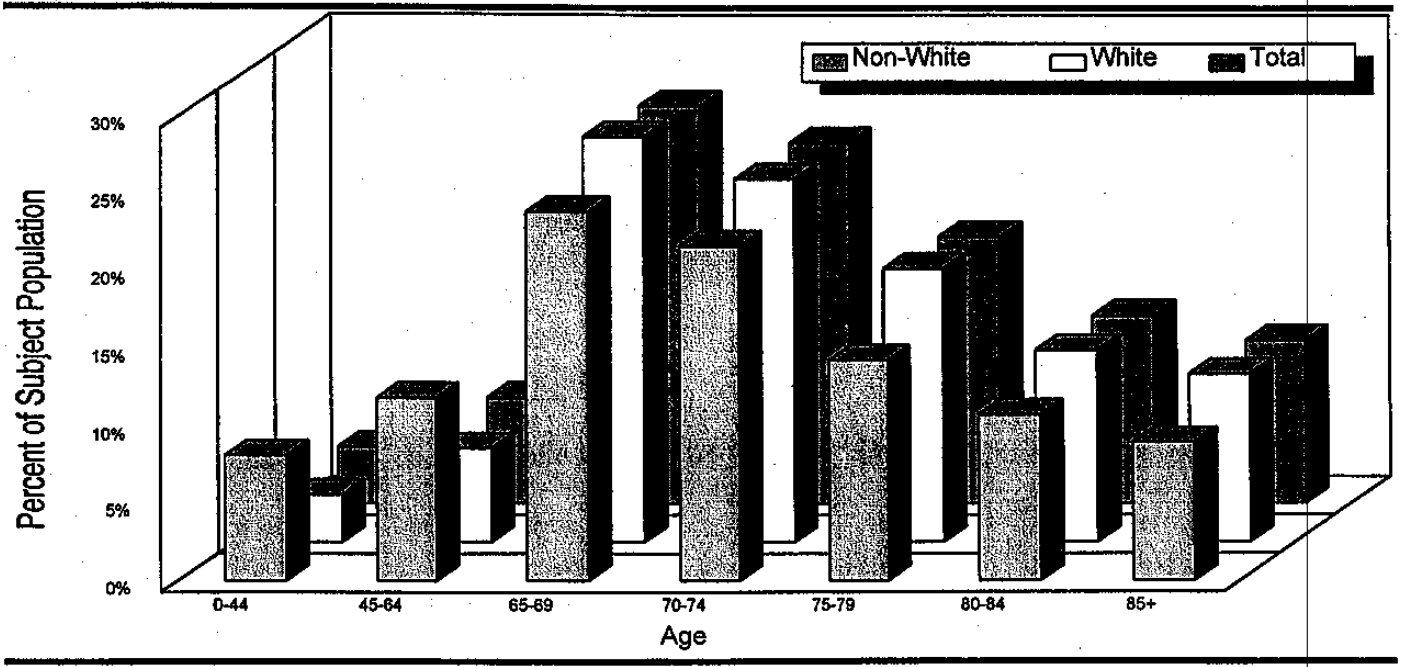
Health care spending increases with income if health status is held constant.[20] Research on use of services by Medicare beneficiaries indicates that age-adjusted use of services varies not only by income, but also by race.[21] Although factors other than race and income (e.g., level of education, cultural differences, and behavioral patterns) may help explain differential use of services, this research indicates that barriers to care may persist despite Medicare's universal coverage.

- Higher income beneficiaries are more likely to use primary care and preventive services than those with lower incomes. Physician visits, mammography rates, and influenza immunizations all increase with income.

- Although use of primary and preventive services by African American beneficiaries increases with income, use of these services is lower than for White beneficiaries with comparable incomes.

- African American and lower income White beneficiaries have greater hospitalization rates. They also have higher mortality rates. Data on the use of specific procedures indicate that these groups may be more at risk because of poorer management of chronic diseases.

Figure 7.10
Medicare Enrollees by Age; 1993



SOURCE: CRFB based on unpublished HCFA tables (1997).

[20] Peden and Freeland (1995). Also see research cited by Moon (1996).
[21] Gornick *et. al.* (1996).

- Disparities in health status can be observed through the age composition of White and non-White Medicare enrollees. People of color have higher disability rates and fewer live to age 85. (See Figure 7.10.)

Medicare data indicate that per capita spending for non-White beneficiaries is higher than for White beneficiaries at comparable ages except 85 and above. (See Table 7.4.)

Table 7.4
Average Medicare Per Capita Spending, 1993

	All Enrollees	White	All Non-White	African American
Total	$3,497	$3,406	$3,846	$4,044
Sex				
• Male	3,665	3,637	3,846	3,726
• Female	3,372	3,234	4,308	4,280
Age				
• 0–64	3,566	2,787	5,562	5,298
• 65–74	2,606	2,413	3,766	3,607
• 75–84	3,503	3,490	3,833	3,626
• 85 +	4,491	4,568	3,906	4,154

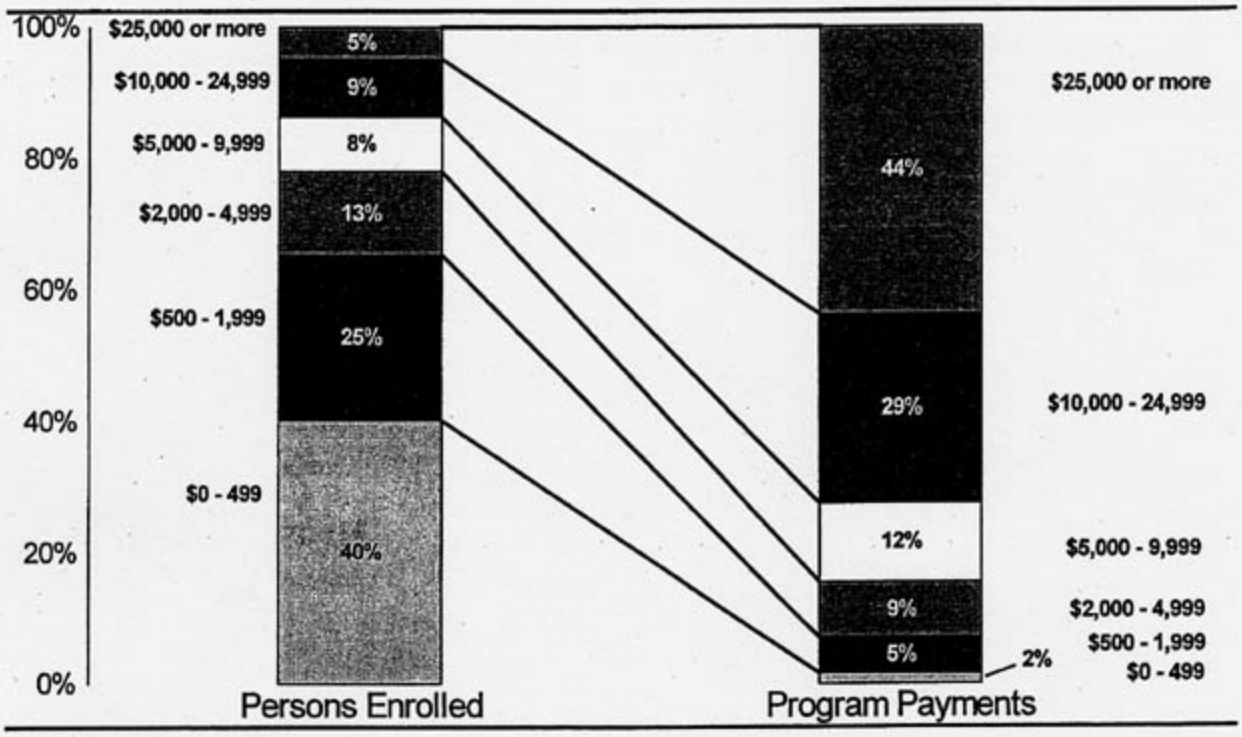
SOURCE: HCFA unpublished tables (1997).

Health spending is concentrated on a small number of individuals. Most people, including most elderly people, are healthy most of the time. Like all health other care expenditures, Medicare expenditures are highly concentrated. More than 80 percent of Medicare enrollees used covered services in 1994, but the most expensive 4 percent of beneficiaries accounted for 44 percent of total Medicare payments.[22] The 6.4 percent of persons who were served under Medicare in 1994 and who died during the year accounted for 20.6 percent of program payments.[23] (See Figure 7.11.)

Income and health status are related. Lower income people generally are in poorer health than more affluent people of the same age. (People in poor health status also tend to have lower incomes because health problems interfere with their ability to earn higher incomes.) Medicare enables lower income elderly to use health services. Relative to more affluent elderly, they tend to need more acute care services, which are more costly than preventive care. This means that they incur expensive end-of-life care at an earlier age than their more affluent counterparts.

[22] HCFA, Table 16, (1996).
[23] *Ibid.* Table 17.

Figure 7.11
Distribution of Medicare Enrollees and Program Payments, 1994



SOURCE: HCFA (1996).

Lifetime health expenditures differ among individuals because of a variety of individual factors. Average annual Medicare expenditures vary by age, race, sex, and income. As discussed earlier, life expectancy differs among subgroups of the population based on identifiable characteristics such as sex, educational attainment, income, and race. What is uncertain is whether significant disparities in lifetime Medicare benefits exist among socioeconomic groups. Additional research is needed to learn more about the lifetime expenditures and the insurance value of Medicare to population subgroups. If it turns out that relative to more affluent beneficiaries, low-income individuals receive lower lifetime benefits in exchange for their lifetime payroll taxes, policy makers may wish to consider converting to less regressive forms of financing.

Medicare Reform Options

The current public debate over Medicare tends to focus on short-term fixes that would extend the life of the HI Trust Fund for five to seven years beyond 2001. Despite acknowledgment from both the President and the Republican leadership of the Congress that more fundamental reform will be needed before the baby boom generation retires, neither side has advanced any proposals. The reason is that any

longer term reform is likely to generate widespread political controversy, not only among the elderly population, health care providers, and private insurers, but also among the general population.

Structural reform of Medicare has to weigh continued public support for those segments of the population that otherwise could not afford health care against the financial burden that taxpayer support entails. Essentially, fundamental reform proposals establish the role and scope of Federal and individual responsibilities, define the set of beneficiaries and benefits to which they are entitled, and decide how to distribute the cost of the program through the tax system. Because Medicare currently does not cover some essential costs (e.g., long-term care and, in fee-for-service Medicare, prescription drugs), fundamental reform likely will have to achieve sufficient cost reductions to allow some benefit expansion.

Establishing the Role and Scope of Federal and Individual Responsibilities

Medicare reform options range from complete privatization to complete socialization.

- With complete privatization, each family could be fully responsible for members' health care costs. Family income and savings would finance expenditures, using whatever private insurance vehicles are available and affordable. Absent Medicare, families would have to save in anticipation of whatever end-of-life medical expenditures they could not cover through private insurance. Senator Phil Gramm (R-Texas) plans to introduce legislation that would replace HI payroll taxes with mandatory savings. These funds would be available to meet health care expenses once individuals reach age 65.

- With complete socialization, health care would be delivered directly by the Federal government (similar to the Veterans' Administration medical system) and financed through taxes.

- In between the two extremes lie several options that would combine adjustment of current Medicare eligibility criteria and benefits with alternative financing arrangements.

  > Incremental reforms would continue to tinker with provider payment formulas, beneficiary cost sharing and premium payments, and coverage.

  > A premium subsidy system would provide assistance to help beneficiaries purchase a government-defined package of coverage. Private intermediaries could bid competitively for shares of this business, or the Federal government could negotiate with intermediaries to provide coverage.

  > A defined contribution (voucher) approach would provide risk-adjusted assistance that beneficiaries could use to purchase coverage from a regulated,

private market. Because individuals would have a "shopping" incentive, they might be able to obtain better coverage than under the current system.

> A "stop loss" approach would limit the Federal government's role to insuring against catastrophic costs while providing tax deductions or tax advantages (e.g., medical savings accounts) for deductibles and other out-of-pocket expenditures. Assistance could be provided through Medicaid or a new program to cover the non-catastrophic costs of low-income individuals.

Beneficiaries and Benefits

Options to constrain costs are described next.

- **Limiting the number of beneficiaries**. The number of beneficiaries can be reduced from current levels through changes in eligibility criteria. For example, policy makers could raise the age (currently 65) at which individuals are entitled to receive benefits. This could be justified on the basis of improvements in the health status of older people and their longer life expectancies. However, unless the change is coordinated with retirement policies, raising the eligibility age could create larger numbers of uninsured people as workers retire and lose employer-based coverage. In addition, raising the retirement age could affect adversely those in poorer health or more physically demanding occupations, who might not be able to continue working longer.

- **Means-testing benefits**. Tying the level of assistance to income is another way to limit the number of beneficiaries. Means testing can be achieved by phasing out benefits to individuals with qualifying incomes or by including the value of benefits in taxable income, [24] thereby providing less net assistance to the more affluent. Means testing is an alternative to increasing co-pays, deductibles, and other cost-sharing requirements that hit the sickest beneficiaries hardest. The number of people affected would depend on the income thresholds. Almost one-fourth of elderly married couples and 5 percent of single elderly have incomes in excess of $40,000, the Concord Coalition means-testing threshold.

- **Reductions in coverage**. Because of gaps in Medicare's coverage, most reform proposals do not include direct reductions in Medicare coverage. Instead, through vouchers or premium subsidies, proposals seek to limit costs by limiting the amount of assistance. If the Federal payment is fixed, beneficiaries would bear the risk of costs in excess of those anticipated by the payment level. They would have

[24] Most taxation of benefits proposals would tax the actuarial or insurance value of Medicare coverage, not the actual payment of benefits. This prevents placing the tax burden on only those who use health care and exempting the healthy.

to pay more out of pocket or buy more supplemental insurance if they wanted greater coverage than the Federal subsidy or voucher payment would provide.

- **Reform of provider payments**. Reforming provider payments is another approach to reducing the cost of coverage. Proposals to change the payment system seek to alter provider incentives in ways that reduce the volume and cost of services delivered. Utilizing prospective payment systems and basing reimbursement on episodes of illness are more cost-effective than using virtually open-ended provider-based cost reimbursement arrangements. The downside is that provider payment restrictions could jeopardize patient access to quality care.

- **Managed care**. Only 10 percent of Medicare enrollees are in managed care (HMO, PPO) plans; most are in risk-based plans.[25] Incremental reform proposals would promote greater enrollment in managed care plans and limit the ability of HMO enrollees to switch out of these plans as soon as they got sick. Reform could go further. Instead of paying for more expensive, fee-for-service coverage, benefit levels could be based on the cost of managed care plans. (Beneficiaries could choose to pay more if they wanted to stay in fee-for-service arrangements.) The cost of these benefits should be based on area market conditions for managed care plans and could be set through competitive bidding by participating plans.

- **Increases in cost sharing.** Medicare currently has a complicated system of co-pays and deductibles for various HI and SMI services. Raising these cost-sharing requirements could provide savings. Proposals to increase co-pays and deductibles are designed to provide incentives for patients and providers to be more cost conscious about the use of services. However, increases in cost-sharing liabilities also have the disadvantage of hitting sick beneficiaries, who have to use medical services, the hardest. In practice, most beneficiaries have supplementary insurance or are eligible for Medicaid assistance, limiting the effect of cost-share increases. To ensure some direct effect of cost sharing, some reform proposals would prohibit first dollar supplemental coverage.

- **Increasing premiums**. Beneficiaries originally paid 50 percent of the cost of the Medicare Part B SMI program. Currently, Part B premiums cover 25 percent of costs and are projected to decrease to 8 percent by 2030. Beneficiaries' costs are subsidized regardless of their income levels. Premiums paid by beneficiaries could be raised across the board. Or, more affluent beneficiaries could pay a greater share or all of the cost of coverage. Poorer beneficiaries (up to 120 percent of poverty) would be protected because their premiums are paid for or subsidized by Medicaid.

[25] These plans receive fixed payments for Medicare enrollees and are at risk for the cost of their care. If costs exceed the fixed payment, the plan does not receive higher payments. Thus these plans have incentives to deliver cost-effective care.

Financing Benefits

Two types of taxes pay for Medicare benefits. Hospital and post–acute care services are financed with a 2.9 percent payroll tax. Physician and ambulatory care are financed by general revenues (75 %) and beneficiary premiums (25%). It may have made sense to use separate tax structures for Medicare Part A and Part B in the mid-1960s, when private hospital insurance coverage and physician coverage were separate, but it makes little sense now.

Since Medicare expenditures are growing faster than payroll and growth in the number of elderly exceeds the growth in workers, payroll taxes create recurring financial crises in the Part A HI program. This creates incentives to shift costs from Part A to the Part B SMI program. Combining the two programs and financing elderly health care services from a common source would eliminate the incentives for these accounting gimmicks and would make more sense in a growing managed care environment. It would also facilitate the creation of a single cost-share requirement and simplify administrative requirements.

Medicare beneficiaries pay for almost a quarter of total Medicare-covered expenditures. They pay relatively little for acute- and post–acute care coverage, but one-fourth of the cost of physician and ambulatory services. Those who get sick pay co-insurance and deductibles. Cost-sharing liabilities are therefore skewed. In 1994, 2 percent of beneficiaries incurred 20 percent of cost share liabilities.

There is no analytically correct allocation of responsibility for financing health care for the older adults. As the population ages, health care expenditures are going to continue to outpace the economy's ability to pay for them. Using general revenues to finance these expenditures has the advantage of spreading the cost of the program over a larger tax base. Unlike Social Security, Medicare benefits bear no relationship to payroll tax contributions. Therefore, there seems to be little rationale for continuing to use payroll taxes, which disproportionately burden younger and lower income workers, to finance these benefits.

Medicaid

Like Medicare, Medicaid issues center on access, cost and quality. In addition, Medicaid's joint Federal-State structure triggers questions about each level of government's financial responsibilities and degree of control over the program.

Medicaid's most costly beneficiaries are those who need long-term care—disabled adults and older individuals who are most likely to be age 85 or older. Three-fourths of Medicaid spending on behalf of beneficiaries age 65 and above is for long-term care. The number of Medicaid's elderly beneficiaries is already growing faster than the overall elderly population. As growth in the elderly population accelerates, Medicaid cost pressures will increase dramatically.

- **Medicaid covers one out of eight Americans and one out of four children. Medicaid pays for 40 percent of all births and half of all nursing home care.** [26]

- **Medicaid is the primary source of health insurance for the poor.** [27] Medicaid is the primary insurer for ***almost half*** of the non-elderly poor and 70 percent of the children and adult members of poor and near-poor single-parent families (incomes below 125 percent of the poverty level). Four-fifths of Medicaid beneficiaries have incomes below 150 percent of the poverty level.

- **Not all of the poor are covered by Medicaid.** In 1994, 32 percent of the poor, including 3.5 million children (22 percent of all poor children), remained without health insurance.

  > Only families with dependent children and low-income blind, disabled, and aged individuals qualify for Medicaid. Single adults and childless couples are generally not eligible, no matter how low their incomes.

  > Poor families who receive cash welfare assistance are automatically eligible for Medicaid. Because State income limits for cash welfare assistance are often lower than the official Federal poverty levels, not all of the poor are eligible for Medicaid.

  > Poor families may be eligible for, but not enrolled in Medicaid. Three million of the 10 million uninsured children are eligible for, but not enrolled in, Medicaid.

- **Although more than 70 percent of Medicaid's beneficiaries are low income children and their parents, two-thirds of Medicaid dollars go to adults age or 65 and above and disabled individuals.** (See Figure 7.12.)

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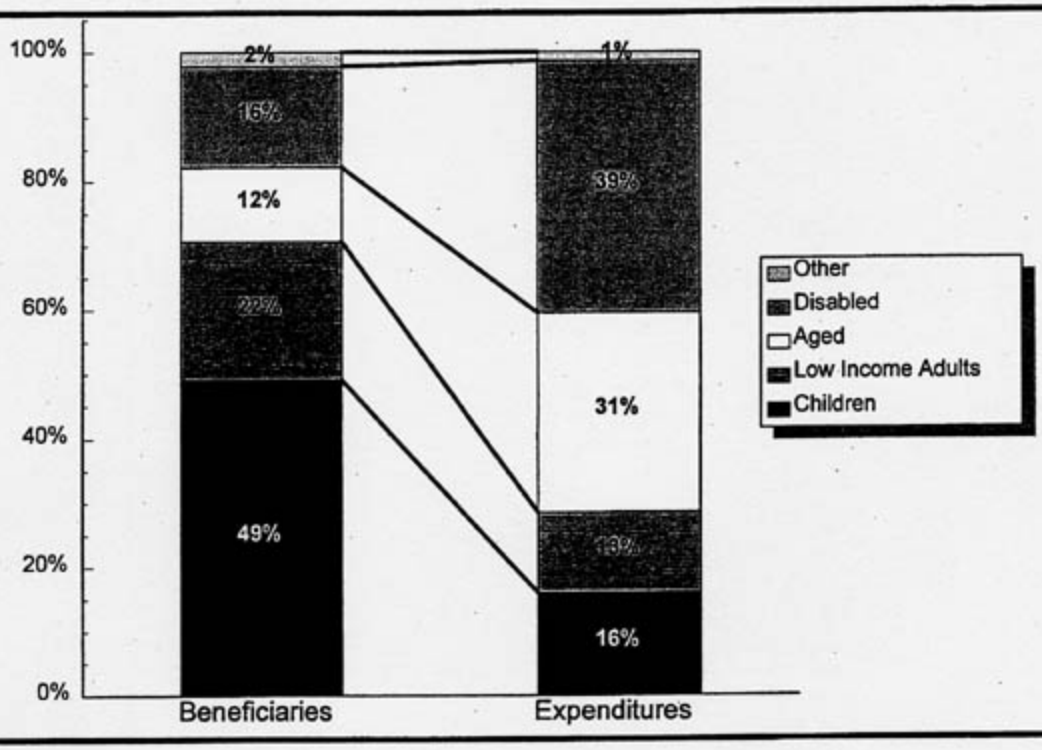
[26] Rowland (1997).

[27] Health insurance coverage data are from EBRI 1995 and 1996 analyses of the Current Population Survey.

Figure 7.12
Distribution of Medicaid Beneficiaries and Expenditures by Eligibility Group, 1994



SOURCE: HCFA (1996).

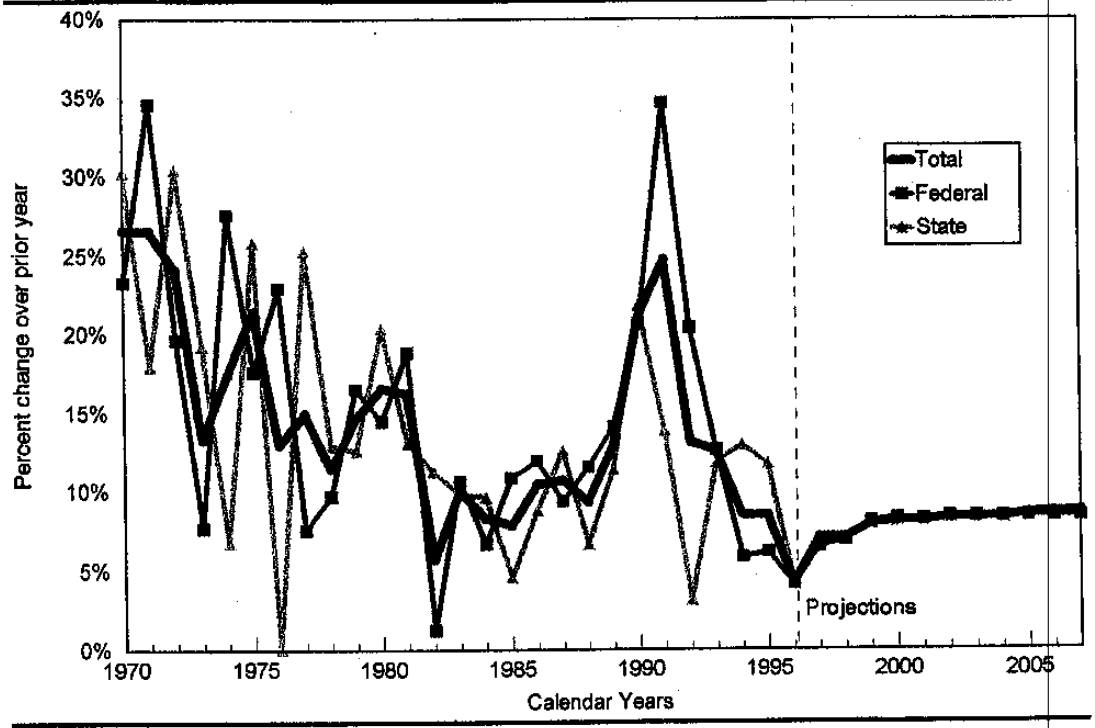
Conflicting policy and fiscal priorities create Federal-State tensions over Medicaid. The Federal government and the States split Medicaid costs, with the Federal government paying 57 percent overall.[28] The Federal government sets broad guidelines and minimum requirements. As long as they meet Federal requirements, States have substantial latitude in program design and administration. Consequently, Medicaid programs differ from State to State. State options, not Federal requirements, account for approximately 60 percent of Medicaid spending.[29]

> From the Federal perspective, the current Medicaid program provides an insufficient ability to control costs because Federal payments are driven by State policies. In addition, States have demonstrated the ability to use Medicaid to qualify for larger Federal payments than their net spending for Medicaid beneficiaries truly warrants.

[28] The Federal share varies by individual state depending on State per capita income, and ranges from 50 to 83 percent of benefit expenditures.
[29] Rowland (1997).

> From the States' perspective, Federal eligibility and coverage mandates deny them needed flexibility to constrain costs and meet State-determined health care priorities. Because the cost of expanded benefits and coverage mandates is shared with the States, Federal policy makers do not have sufficient incentives to control costs.

Figure 7.13
Medicaid: Annual Growth in Aggregate Spending



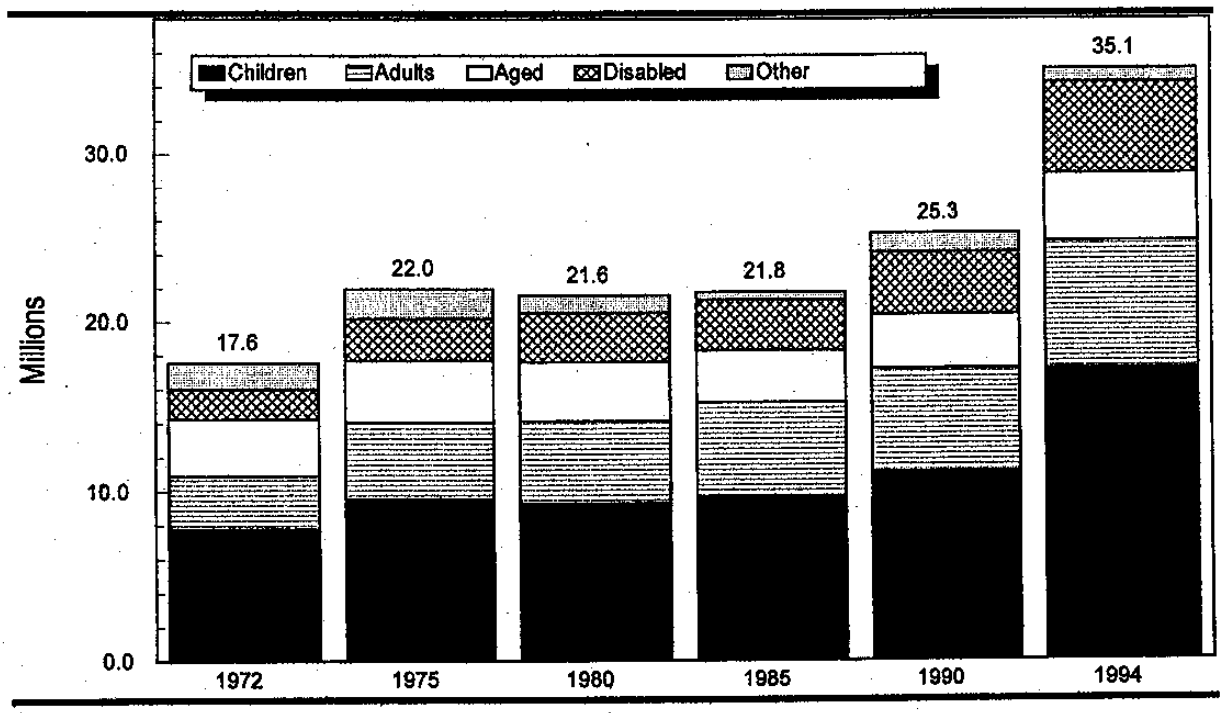
SOURCE: CRFB based on unpublished HCFA tables (1997).

Between 1975 and 1985, Medicaid spending grew in excess of 3 percent a year in inflation-adjusted terms. Between 1988 and 1992, real Medicaid spending exploded, increasing in excess of 12 percent a year. (See Figure 7.13.) While much of Medicaid's cost explosion during this period represented State efforts to boost Federal matching shares, other factors contributed to Medicaid cost growth.

- **Growth in beneficiaries**. Although the number of beneficiaries fluctuates with general economic conditions, most of Medicaid beneficiary growth comes from broadening eligibility provisions. Originally, Medicaid covered children and parents who received welfare (cash assistance) payments under State programs. Eligibility for Medicaid benefits now extends beyond the original cash assistance beneficiary population. In 1975, over three-quarters of Medicaid beneficiaries were cash assistance recipients. This percentage started falling in 1986 and now stands at 60 percent. The number of beneficiaries qualifying under this category

with the state of the economy. For example, the 1990 recession increased the number of people needing public assistance. (See Figure 7.14.)

Figure 7.14
Medicaid Beneficiaries



SOURCE: HCFA (1996).

> Medicaid also covers low-income disabled children and adults and elderly individuals who have high health care costs, but incomes too high to qualify for State cash assistance programs. These "medically needy" groups were not originally eligible for the program.

> Beginning in 1984, the Federal government mandated broader coverage for pregnant women and young children and extended transitional assistance for families moving off of welfare. Medicaid eligibility for poor women and children was no longer limited to receipt of State cash assistance payments. [30]

[30] Unlike Federal poverty standards, State income requirements for cash assistance were not indexed for inflation. As a result, growing numbers of poor women and children lost Medicaid coverage because they did not qualify for cash assistance.

> Welfare reform legislation passed in 1996 decoupled Medicaid benefits from Temporary Assistance for Needy Families—TANF.[31] Decoupling is intended to prevent Medicaid beneficiaries from losing their health care benefits just because they cease to qualify for TANF. The 1996 legislation also tightened eligibility for children and legal immigrants who previously qualified for SSI, and restricted the eligibility of new legal immigrants. The legislation is too recent for researchers to be able to determine its impact, but many Medicaid beneficiaries (other than legal immigrants) are expected to remain eligible for Medicaid based on other eligibility criteria.

- **State efforts to maximize Federal matching payments.** During the late 1980s and early 1990s, States found ways to boost Federal matching payments. The revenue maximizing efforts were at least partially in response to federally mandated eligibility expansions that increased State Medicaid costs. These special financing arrangements were largely curtailed by 1991 and 1993 Federal legislation that tightened up loopholes that made such arrangements possible.

  > Under **provider tax and donation programs,** States taxed hospitals or accepted contributions from them, then paid them back with Medicaid disproportionate share (DSH) payments.[32] Because the State DSH payments qualified for Federal matching payments, States were able to increase Federal Medicaid grants without increasing net State Medicaid spending. Between 1990 and 1992, the number of States with provider tax and donation programs grew from 6 to 39[33] and Federal DSH payments increased 10 times faster than the number of Medicaid beneficiaries.[34]

  > **State intergovernmental transfers** shifted activities (e.g., institutional and community-based services for the developmentally disabled and mentally ill) to Medicaid programs to generate additional Federal matching payments.

- **Service utilization.** The addition of more costly populations (e.g., pregnant women and disabled and elderly individuals with expensive long-term care needs) increased utilization rates and raised per capita spending. Expansion of coverage in the SSI program also extended Medicaid coverage to individuals with AIDS, substance abuse, and other social and medical problems.

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[31] The passage of welfare reform in 1996 replaced Aid to Families with Dependent Children—AFDC—with Temporary Assistance for Needy Families–TANF—to provide income assistance to low-income children and parents. TANF imposes stricter work or job training requirements than AFDC did and limits receipt of benefits to no more than five years. The SSI program provides income assistance to low-income adults who are disabled or age 65 or older.

[32] Disproportionate share payments are designed to compensate hospitals that serve large numbers of poor patients. Although States must meet minimum Federal payment levels, they have the discretion to provide additional payments.

[33] Ku and Coughlin (1995).

[34] CBO (February 1993).

- **Nursing home care.** While the number of elderly Medicaid nursing home patients increased by 7 percent, Medicaid nursing home payments on their behalf increased by 69 percent. This is the result of court decisions forcing higher Medicaid payment rates to hospitals and nursing homes, Federal spousal impoverishment protection legislation, and expanded coverage for community- and home-based care.

Since 1992, the growth in Medicaid spending has moderated from the 1988–92 levels. The economy recovered, special financing arrangements became less attractive, and Federal policy makers failed in health care and, subsequently, Medicaid reform efforts. States began implementing their own Medicaid reforms.

Medicaid from the State Perspective

Medicaid eligibility, benefits, and costs vary considerably across States. First of all, medical costs vary from State to State. Then, each State can opt to cover additional populations and services beyond those required by Federal law and regulation. Because Medicaid coverage, expenditures, and fiscal burdens differ significantly among States, it is very difficult to design reforms that are acceptable to all parties involved.[35]

- In 1994, Medicaid coverage of State low-income (up to 150 percent of poverty) populations ranged from 30 percent in Nevada to 79 percent in Vermont, with a national average of 51 percent.

- Medicaid spending per capita (benefits, only) averaged $3,517 nationwide and ranged from a low of $2,171 in Tennessee to a high of $6,447 in New York.

- Between 1988 and 1994, Medicaid spending per capita (benefits, only) grew an average of 6.8 percent a year. Nineteen States had average annual growth rates below 6 percent; 8 States had growth rates of 10 percent or above.

- State Medicaid spending as a percentage of State revenues (not including Federal transfers) averaged 12 percent across all States and ranged from 4 percent in Utah and Wyoming, to 27 percent in New York and New Hampshire.

Between 1987 and 1995, State Medicaid expenditures increased from 10 percent to 19 percent of all State funds.[36] Medicaid has become the largest component of Federal grant assistance to States.

- In 1995, Medicaid accounted for 42 percent of all Federal aid to States, compared with 14 percent in 1975.

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[35] Data from Liska *et al.* (1996).
[36] National Association of State Budget Officers (April 1996).

- Between 1975 and 1994, total Federal aid to States grew at about the same rate as the overall economy. However, because more than half of the real growth in aid was the result of growth in Medicaid payments, Federal assistance for other types of activities is not keeping pace with the overall growth of the economy. (See Table 7.5.)

Table 7.5
Federal Aid to State and Local Governments
(in 1994 dollars)

	1975	1980	1985	1990	1994	Percentage Change 1975–94
GDP	4,057	4,840	5,594	6,443	6,931	71%
Medicaid	27,910	36,245	38,667	51,844	88,083	216%
Education, Training, Social Services	31,543	38,916	23,447	25,800	34,554	10%
Transportation	15,245	23,296	22,444	21,234	23,133	52%
Family Support	13,713	13,393	12,827	14,024	16,511	20%
Housing, Urban Development	3,447	6,115	8,431	10,984	16,010	364%
Agriculture, State Child Nutrition	3,751	5,755	4,559	5,360	7,254	93%
Other	31,055	38,689	32,316	24,218	32,969	6%
Total	126,664	162,409	142,691	153,464	218,514	73%
Total w/o Medicaid	98,754	126,164	104,024	101,620	130,431	32%

SOURCE: HCFA (1996).

Because of rising Medicaid burdens, States have sought and been granted waivers of Federal service coverage requirements. These waivers are being used to develop new strategies for controlling Medicaid costs while preserving and expanding coverage and eligibility.

- Research and demonstration waivers allow States to test alternative approaches to delivering services and expanding coverage.

- Freedom of choice waivers allow States to require Medicaid recipients to obtain service from State-designated providers.

- Home and community-based service waivers allow States to provide services to individuals who would otherwise have to be institutionalized.

Balancing Federal and State Roles and Responsibilities

Federal efforts to expand Medicaid coverage and improve its quality impinge directly on States' choices and their ability to manage costs. Not surprisingly, States seek greater flexibility and protection from Federal coverage mandates. From the Federal perspective, greater flexibility is a two-edged sword: it allows States to experiment with potentially less expensive and more inclusive delivery systems, but it reduces Federal control over State spending and could generate higher Federal costs.

The ongoing public debate over Medicaid focuses primarily on how to balance conflicting State and Federal interests.

- States seek greater control over eligibility and service requirements and provider payment arrangements. At the same time, they seek a stable source of Federal funding, with protection against fluctuations in State economic conditions that could result in unaffordable beneficiary growth.

- The Federal government requires protection against State-driven cost growth, including the potential for States to shift costs to the Federal budget, as well as assurance that Federal funds are used to meet their intended objectives.

Reformers have proposed three approaches to address these needs:

- **Block grants** would provide States with payments that would grow at rates representing each State's change in beneficiaries and health care costs. The total amount of Federal funding would be adjusted by a predetermined inflation factor (e.g. GDP growth plus some increment). State grant allocations would be formula-driven based on each State's changes relative to a base year. States would have the flexibility to use the funds for broad categories of eligible activities. The existing individual entitlement for benefits would be eliminated. "Maintenance of effort" requirements would guard against States reducing or eliminating State funding low income health.

  Supporters argue that block grants would provide States with the maximum level of flexibility while limiting Federal spending to fixed levels. Opponents argue that block grants provide insufficient protection against economic fluctuations. In a State downturn, the number of people in need of assistance would increase, but under a block grant, the State would not receive additional Federal funding to cover all needy individuals. This would increase State spending at a time it could least afford it or would result in denial of benefits. In the latter instance, local governments would be stuck with the costs of caring for a greater number of uninsured individuals. In addition, opponents fear that despite maintenance of effort requirements, State financial commitment for low income health care would diminish, reducing the overall level of public health care assistance for the poor.

- **Capitated payments** would provide each State with a payment based on per capita costs and number of beneficiaries in defined eligibility categories. The annual growth of the per capita payment would be limited to a predetermined factor set below the current annual Medicaid growth rate. An individual entitlement for benefits would be maintained, but States would have far greater discretion over the administration of the program. Total Federal spending and State grants would fluctuate with the number of beneficiaries.

  Supporters of capitated payments argue that the approach protects States from fluctuations in the number of beneficiaries while constraining Federal costs. Opponents argue that capitated payments saddle the Federal government with too much of the burden of past and future State policies. If payments are based on State expenditures, the allocation formula would lock in current differentials. States that have been less effective at controlling costs, or that have opted for more expensive coverage, would have more room to control costs. States that have low cost programs or that have been more aggressive about containing costs would have smaller margins in which to manage their programs

- **Redefining Federal-State responsibilities**. Traditionally, States have assumed responsibility for their low-income populations whereas the Federal government has taken over support for the elderly and the disabled populations (through Social Security, SSI, Medicare, Medicaid and other programs). Some have suggested that States assume full financial responsibility for low income children and adults while the Federal government assumes responsibility for the Medicaid disabled and elderly populations.

  Medicaid spending on behalf of the elderly and disabled beneficiaries represents two-thirds of Medicaid benefit payments and 57 percent of total Medicaid spending. Initially, the Federal government and the States would be responsible for about the same level of funding as they are now. However, because long-term care costs grow faster than the acute care costs of low-income children and adults and because the potential demand for long-term care assistance is so great, the Federal government would bear full responsibility for large future costs associated with the aging population.

  Consolidation of Medicare and Medicaid benefits for the elderly and the disabled beneficiaries would provide an opportunity to rationalize assistance to these groups, simplifying administrative operations and possibly making Medicaid benefits more accessible to eligible Medicare beneficiaries. However, without strict means testing, a merger could lead to the Federal government's incurring long-term care expenses of the Medicare population, the costs of which would be prohibitive.

Conclusion

Popular attitudes toward both public and private spending for health care tend to differ from perspectives on other types of spending. The public debate over whether defense or education spending should go up or down seeks to establish relative priorities. Because public resources are limited (as are private ones), policy makers have the responsibility of protecting the interests of taxpayers. If, however, they talk of setting priorities for health spending, they are accused of endorsing rationing, that is, proposing to deny someone access to health care.

In health care, controlling costs often means reducing access to care. Ideally, cost containment eliminates only unnecessary care. Unfortunately, health care providers do not always know in advance what is unnecessary. Patients and their families may have different definitions of "unnecessary" than other parties (e.g., managed care organizations).

Most Americans are healthy. This means collectively we can afford to pay for the minority of Americans who have very costly medical needs. We pay taxes to assist the elderly and the poor with their health care expenses through Medicare and Medicaid. We pay for everyone else and protect ourselves and our families through health insurance premiums.

Although it is very likely that baby boomers will enjoy healthier, as well as longer, retirements, it is also likely that health care spending will increase. As boomers grew up, they benefited from one modern medical miracle after another. They have high expectations that modern science and technology can prolong life and cure disease. On the other hand, boomers exhibit more openness to less expensive forms of treatment and greater acceptance of managed care delivery systems. They expect to participate more fully in care decisions, which, studies show, tends to reduce expenditures. It is not certain what influence this generation will exert on health care expenditures.

The question is, who should pay for these looming health care needs? A healthier population provides societal benefits. Healthier older people can contribute longer to the economy and society. Boomers are financing the health care of current retirees. Should they also pay for their own future health care needs? Or should future generations of workers be expected to foot the bill? What can current beneficiaries contribute?

Although the health care needs of an aging population raise different issues than concerns about income support, the same economic issues apply. However these costs are allocated across generations, future age-related expenditures will be more manageable if the economy is bigger and more resources are available to share.

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Chapter 8. Tax Policies and the Aging of the Population

Economic resources are redirected to government use through the tax system. Although the primary function of the tax system is to finance government, tax policies are also used to accomplish economic and social policy goals. Basic differences in core political beliefs readily surface in the debate about the tax system. That is because the tax system determines who pays the government's bills and how big that bill will be.

Because the fundamental tax reform proposals currently receiving the most public attention are consumption based, this chapter focuses primarily on consumption taxes. Other approaches are possible, notably major overhaul of the current income-based system. Some of these would achieve many of the changes as proposed consumption based systems. In the short term, narrower proposals to broaden incentives or close loopholes under the existing system more likely will be adopted. Some of these proposals, such as expanded individual retirement accounts (IRAs) and capital gains tax reductions, seek to provide greater savings and investment incentives and would complement other retirement income policies.

Tax laws are very complex. It is very difficult to understand who ultimately benefits or loses from tax law changes. That is part of the reason for public distrust of and frustration with the current system. No one is sure if they are really paying only their fair share. Equity and fairness, therefore, are major concerns, particularly since the slowdown in economic growth in the mid-1970s.

Economic issues have risen to the forefront. The public debate about tax policy has focused on changes to the tax system that would enhance economic performance and stronger growth.[1] From a macroeconomic perspective, fundamental reform seems likely to provide modest gains. However, because the distributional effects of fundamental reforms can be significant, policy makers should coordinate changes in tax policies with the policies designed to address the aging of the population.

- **Fundamental tax reform could play an essential role in increasing retirement savings.**

  > To the extent that tax policy promotes savings in general, and retirement savings in particular, it can increase resources available for investment, promote capital accumulation, and offset many of the effects of a slower growing labor force and a larger retired population. If, however, tax reform

[1] For discussions of these economic issues, see *The Economics of Fundamental Tax Reform,* edited by Henry J. Aaron and William G. Gale (1996), from which this chapter draws heavily.

results in lower Federal revenues and this lower revenue level is not offset by lower spending, the Federal budget deficit will increase and many of the promised economic benefits are unlikely to be realized.

> Simultaneous consideration of tax policy and the reform of Federal spending programs permits policy makers wider policy alternatives. Tax reform should complement adjustment to entitlements and other programs. Conversely, Federal programs could be designed to offset some of the potentially adverse social policy effects of tax reform.

- **Fundamental reform of tax policy, like entitlement reform, involves tradeoffs between competing objectives**. A broad-based and flat rate system would be more economically efficient than one with multiple rates and preferences. However, many would argue that a broad-based flat rate system would not be optimal system from a social policy or a political perspective. Tax reform would affect the old, young, rich and poor differently. Easing unwanted distributional changes would offset potential gains in aggregate economic growth and efficiency.

  > Fundamental tax reform involving a flatter rate structure would benefit the wealthy more than the poor. Under either an income or a consumption-based system, the flat rate would be lower than the current top marginal rate. Because most proposals would eliminate the earned income tax credit (EITC), low income taxpayers would face higher tax burdens.

  > Consumption taxes would increase tax burdens for the retirees because they consume greater shares of their incomes.

- **Serious transition issues would arise during a change from the current system to a fundamentally different one.** The value of savings, assets, investments, and liabilities accumulated prior to the change could be affected. Reform proponents are challenged by the need to address these transition issues fairly and pragmatically while at least partially preserving the overall objectives and benefits of reform.

- **Assessing the impact of policy changes over lifetimes rather than on an annual basis provides important perspectives.** Because of intertemporal effects on work, savings, and consumption, changes in tax burden look different when viewed from a lifetime perspective than when viewed at a single period. Annual incomes and tax burdens fluctuate from year to year, but generally increase throughout active working years and decrease in retirement. Once implemented, consumption taxes may increase taxation during retirement in exchange for reduced tax burdens on amounts saved during active working years. Although the tax burden of retirees would be higher, the lifetime tax burden of individuals may not change substantially.

- **It is not possible to project how the economy would perform if fundamental tax reform were enacted, let alone coordinated with complementary fiscal policy changes on the scale this project endorses.** Given the fact that economists disagree over how to make the economy grow faster, it is not surprising that they have not agreed on which tax reform, if any, would be best.

  > Tax reform proponents argue that the "right" changes would boost savings, investment, productivity, and entrepreneurship. Critics question whether such economic gains would outweigh resulting social, political, and administrative costs. While showing potentially positive effects, so far neither empirical studies of the impact of past tax policy changes nor the theoretical research indicate that fundamental tax reform alone will solve our long-term economic problems.

  > Skeptics, on the other hand, have dismissed likely benefits of public policy changes, at best, as inconsequential, and, at worst, as potentially harmful. They argue that other factors, such as changes in technology, are far more influential to the economy's growth over the long term.

Basic Elements of Tax Reform

The designers of tax reform proposals face the need to balance economic principles and policy objectives with societal values and political interests.

- Economic efficiency requires that individuals be able to achieve maximum well-being through the exercise of free choice. If the tax system prevents individuals from maximizing their well-being, overall economic performance will be sub-optimal. An intrusive tax system, whether one with high rates or a plethora of provisions designed to encourage some behaviors and discourage others, makes the overall economy less efficient.

- The current tax system promotes other policy objectives, notably the redistribution of income. The system is progressive: taxes as a percentage of income increase as income increases. This principle presumes a need to narrow income inequality and to redistribute from those with higher incomes to those with lower incomes. The tax system also promotes numerous other policy objectives, ranging from homeownership to retirement savings and charitable giving. (See appendix 4 for a description of the largest tax expenditures.)

- The system reflects societal values regarding fairness and equity. The principal of individual equity seeks to preserve some relationship between the amount of taxes paid and the level of benefits received. Under the concept of horizontal equity, people believe that individuals in similar circumstances should be treated equally by the tax system. These principles often conflict with economic and policy

objectives. For example, the policy objective of income redistribution is achieved through a progressive rate structure. This system taxes higher income individuals more heavily without any explicit increase in the level of benefits provided. Similarly, exempting income from taxation because of its source (e.g., Social Security, tax-exempt bond interest) permits individuals with the same pre-tax incomes to be taxed differently.

Tax reformers juggle three interrelated variables in their efforts to design a system that reconciles these conflicting concepts.

- **Taxable base.** The base determines what, and therefore who, is taxed. The alternatives are income, wages, consumption, and property or wealth. Our current Federal system has components based on all of these: income taxes, FICA (payroll) taxes; excise taxes, for example, on gasoline, alcohol and tobacco; and estate taxes.

- **Exemptions from the taxable base.** The taxable base can be narrowed by exclusions, exemptions, deductions, credits, and allowances. The provisions channel behavior by permitting individuals to engage in some activities without being taxed. For example, the exclusion of some retirement savings contributions and earnings (employer pension plans and individual retirement accounts) favor this type of savings over other non-tax advantaged savings.

- **Tax rate**. The tax rate can be proportional or "flat" (the same rate no matter what the level of base activity taxed), progressive (increase as the level of taxed activity increases), or regressive (decrease as the level of taxed activity increases). Gasoline taxes are proportional, income taxes have a progressive rate structure, and Social Security payroll taxes are regressive because they do not tax non-wage income or income above the level of maximum taxable earnings.

Policy makers can opt for simplicity (a broader, more inclusive, base, fewer exemptions, and a lower rate) or complexity (a narrower, more restrictive, base, more exemptions, and a higher rate). Simpler systems are easier to comply with and to enforce. Complex systems are more difficult to administer and are easier to evade. Either approach can be designed to raise a defined level of revenue, but simple math dictates that for any given revenue target, the narrower the base, the higher the rates.

Tax Reform and the Aging of the Population

The aging of the population makes concerns about slowing rates of economic growth more pronounced. In the interest of economic efficiency, the last major Federal tax reform (enacted in 1986) sought to clean up the system. It broadened the tax base by eliminating numerous special provisions and tax breaks and lowered maximum rates for individuals and corporations.

Today, rather than continue to fix up the current system, most major reform proposals (see descriptions in the next section) would change the tax system fundamentally. They are designed largely to promote economic growth by creating incentives (or decreasing disincentives) to save, thereby reducing current consumption in favor of higher future consumption. Although this goal of stronger economic growth is consistent with the needs of an aging society, the various reform proposals could affect the financial resources of retirees in ways that mitigate or aggravate future requirements for publicly financed financial assistance for retirees.

Payroll Taxes and the Aging Population

The designers of Social Security decided to finance benefits with payroll taxes in order to establish a link between work and retirement benefits. However, the program was set-up as a defined benefit, not a defined contribution plan. Benefits levels are not established based upon the amount an individual contributes over his or her lifetime in the form of payroll taxes. Indexing benefits to the growth in real wages and cost-of-living adjustments for benefits meant that retirees, until recently, could expect to recoup their contributions (including their employers' shares), plus interest. Because of the progressive replacement rates, many retirees received far more than they contributed. A combination of factors (maturing pay-as-you-go system, increasing benefit levels, slowing growth in the labor force) means that current workers no longer can expect to recoup their contributions. Thus, despite the popular perception that Social Security is a pension program, the fact that it is an income redistribution program, not only within, but also across, age cohorts is becoming increasingly apparent.

Financing income redistribution to older members of society through payroll taxes may result in younger, working age individuals paying for the benefits of elderly individuals who are financially better off than they. The flat payroll rate affects low-income wage earners more than high-income earners, and new cohorts of workers face higher lifetime tax burdens than earlier cohorts.

As the population ages, more beneficiaries receiving more and more generous benefits increases the cost to workers. In 1950, OASDI cost of slightly more than 1 percent or taxable payroll. In 1997, OASDI/HI together cost 15 percent of taxable payroll. Under intermediate assumptions, OASDI/HI benefits will cost 26 percent of taxable payroll in 2030. Clearly, other sources of revenue will have to be found to finance benefits, benefits will have to be drastically reduced, or policymakers will need to combine new revenues with benefit reductions. As these changes in Social Security and Medicare payroll taxes are considered, they will have to be coordinated with whatever other tax policy changes are implemented to help ensure that revenue, equity, and efficiency goals are achieved across the tax system.

Consumption Taxes and the Elderly

From a lifetime tax and welfare perspective, consumption taxes would increase burdens for the lifetime poor and decrease burdens for the lifetime rich.[2] Looking at the generational effects, consumption taxes would benefit those who are currently young at the expense of those who are currently old. Consumption taxes would increase elderly tax burdens in four ways.

- Elderly retirees have lower incomes. Lower income families would face higher tax burdens under a consumption tax because the proportion of consumption to income rises as income decreases. (Conversely, those with higher incomes would face lower tax burdens.)

- They would be taxed on consumption financed by accumulated (old) savings and assets.[3] Although consumption taxes favor new savings, old savings and assets that originally did not receive preferential treatment could be taxed twice—once when saved or acquired, and once when consumed. Those who are affluent or frugal enough to avoid dissaving could avoid this tax on capital.

- The change to a consumption tax would affect prices in ways that would disproportionately affect the elderly. For example, by removing its tax advantage, a consumption tax would increase the cost of homeownership—more than three-fourths of all elderly households own their own homes. In addition, consumption taxes would increase the price of labor intensive services (e.g., health care, financial services) that are used more heavily by older adults.

- The elderly would lose the preferential tax treatment provided under current law.[4] These benefits are provided regardless of income. As with any tax expenditure, this favorable tax treatment raises the effective tax burden of those who don't benefit from the special provisions—in this case, the non-elderly.

These types of impacts can be at least partially offset by:

- Taxing "necessary" consumption (e.g., food, health care, housing) at lower rates or by exempting altogether these items from taxation ("zero" rating). These exemptions would benefit those with high as well as low incomes.

- Allowing "transitional" treatment of old savings. This would require people to identify "old" assets separately from "new" assets, creating cumbersome

[2] Fullerton and Rogers (1996).

[3] Note that under existing tax law, the capital gains tax similarly taxes savings when assets are converted into consumption.

[4] Special elderly tax provisions include full or partial exemption of Social Security income, an extra exemption for those ages 65 and older, and an exemption from capital gains tax on the sale of a primary residence after age 55.

administrative burdens and ample opportunity for evasion. As a result of the exemptions or transition provisions, higher tax rates would have to be imposed to raise the same level of revenue. This would spread the cost over all consumers.

It is not obvious that all such changes in tax burdens would be entirely undesirable. Just because the elderly as a group have lower incomes than other age groups, many elderly, even some-low income elderly, are not poor.

Fundamental Tax Reform Proposals

Major fundamental tax reform proposals include:

- **Value Added Tax** (VAT): A VAT taxes the value added (gross revenues less purchases from other business) at each stage of production, distribution, and sale of a good or service. The final sales price includes the accumulated effects of the tax, but the tax is collected at each point along the production cycle. VATs are used widely throughout the world.

- **National Retail Sales Tax:** Congressman Bill Archer and Senator Richard Lugar have proposed a national sales tax to replace the individual and corporate income tax. The tax would be collected at the point of sale. A 15 percent sales tax rate would generate the same level of revenue as the Federal income tax if all goods and services were taxed.[5] If spending for education, food consumed at home, health care, housing, and financial and professional services were exempted from the base, the rate would rise to 30 percent.

- **Flat Tax**: Congressman Richard Armey and Senator Richard Shelby have proposed a flat tax. As with the VAT, businesses would be able to deduct all purchases from other businesses, plus employee wage and pension contributions. Individuals would be taxed on earnings and pension income above a specific level ($31,400 for a family of four) to add progressivity to the system. Income from savings (interest, dividends, capital gains) would be exempt. The proposal would eliminate current itemized deductions (mortgage interest, State and local taxes, etc.) and the EITC. It would include employer-sponsored health insurance in the taxable base. A 21 percent rate would be required to replace the current income tax revenues.

- **Unlimited Savings Allowance (USA) Tax:** The USA tax proposed by Senator Pete Domenici and retired Senator Sam Nunn would tax consumption through an 11 percent VAT for businesses, including employee compensation and interest expense, with a credit for employers' share of payroll taxes. A personal consumption tax would be levied in three graduated rates. Initially, rates would be

[5] Aaron and Gale (1996).

19 percent, 27 percent, and 40 percent. These rates would fall to 9 percent, 19 percent, and 40 percent after three years. Effective rates would be lower because of the family allowance exemptions ($4,400 for single filers and $7,400 for joint returns) and a refundable credit for the employee share of payroll taxes. This system would allow an unlimited deduction for net savings (with an exemption for consumption financed by old wealth of $50,000 or less) and would continue deductions for mortgage interest, charitable contributions, alimony, and tuition (up to a specific limit).

- **Fundamental Income Tax Reform**: President Bush proposed a Comprehensive Business Income Tax (CBIT) that would have integrated corporate and individual income taxes. It would have eliminated the double taxation of some forms of income by denying the deductibility of both interest and dividend payments at the business level and exempting such payments from tax at the investor level.

- **Incremental Income Tax Reform**: Congressman Richard Gephardt's proposal would preserve the existing tax system structure, with further base broadening and lower rates. The plan proposes little change to corporate taxation. For individuals, this proposal would end many current deductions, including deductions for pension contributions, State and local taxes, and charitable contributions, but retain the EITC. It would include employer-sponsored health insurance in taxable income. Income would be taxed at five graduated rates—10 percent, 20 percent, 28 percent, 32 percent, and 34 percent—compared to the five current rates—15 percent, 28 percent, 31 percent, 36 percent, and 39.6 percent.

Economic Effects of Fundamental Tax Reform Proposals

In general, the economic research indicates that the benefits of fundamental tax change are not likely to be as great as proponents hope. Decisions to save, invest, work more hours, or retire are affected by changes in tax laws, but the aggregate economic effects appear modest. Tax policy changes may, however, have significant distributional impacts, with varying effects on different types of taxpayers.

In addition, moving to a pure consumption or pure income tax system would not reap the full measure of change. The current tax system is layered with special provisions and is a hybrid of income and consumption bases. Some income is not taxed (income from employer-sponsored fringe benefits, owner-occupied housing, tax-exempt bonds, etc.) Some income is already treated the way it would be under a consumption tax (e.g., tax-deferred pension and IRA savings). Finally, political realities will require transition provisions. These provisions would be designed to cushion the impact of any changes and, consequently, would reduce its effects.

The research indicates several broad conclusions.

- **Broad-based, flatter taxes increase efficiency.** A flatter, more neutral, broad-based tax (whether income, wage or consumption based) is likely to increase overall economic welfare and efficiency relative to the current income tax system because it reduces distortions in behavior. Overall efficiency gains, expressed as increases in lifetime income, however, are modest (1 percent or less).[6] Efficiency can even decrease depending on assumptions about preferences for leisure versus work and willingness to trade off lower consumption when young for higher consumption when old.

- **Building in progressivity and transition provisions sacrifices gains in economic efficiency.** Because efforts to make the system more progressive or to ease transition require higher rates to maintain revenue neutrality, they reduce efficiency gains. A VAT or national sales tax appears to produce larger efficiency gains than an Armey-Shelby flat tax or the USA tax, both of which include provisions to introduce progressivity. The transition provisions in the USA tax and the transition provisions added to the Armey-Shelby flat tax result in modest efficiency losses.[7]

- **At best, any long-term increases in net savings are likely to be modest**—in the range of 0.5 percent of GDP, according to one recent study.[8] Although proponents argue that switching to a consumption-based tax system would increase savings, neither the theoretical nor the empirical research concludes that large permanent changes would occur.[9] Part of the reason is that much personal savings already receives consumption tax treatment. A change that favors all savings may induce shifts from currently tax-advantaged retirement savings to other forms of savings with no net increase in total savings. It is possible that the savings rate could actually decline depending on how sensitive savers are to changes in returns.

- **Output per capita could eventually show noticeable improvement.** According to one study, long-term productivity would increase from 2 percent (under the proposed USA tax) to 9 percent (under a VAT or national sales tax), reflecting increased savings, gradual capital accumulation, and larger labor supply.[10] Because these improvements would accumulate very gradually over many years, annual improvements would be quite small (i.e., 0.2 percent per year). Nearer term effects (within 2 to 10 years) would be far more modest and possibly even be negative. Productivity gains would be reduced by transition provisions and progressive structures. Moreover, most economists think that these growth effects

[6] Fullerton and Rogers, especially Table 9-5 (1996).
[7] Auerbach (1996).
[8] Engen and Gale (1996).
[9] Auerbach (1996) estimates initial increases in savings of 1 percent to 2 percent and permanent changes ranging from a decrease of 1 percent (VAT or national sales tax) to 0.8 percent increase (Armey-Shelby flat tax) assuming no transitions provisions for old savings. Bosworth and Burtless (1992) concluded that savings behavior is not especially responsive to lower after-tax returns.
[10] Assumes adjustment costs and an open economy. Auerbach (1996).

would not be permanent. Once the improvements phased-in, the economy would settle back into its long-term growth rate from the new, higher, base level.

- **Capital accumulation is likely to be gradual.** Empirical analyses of the early 1980s tax changes do not find large short-term increases in aggregate investment. However, the effect of the changes could have been dwarfed by the effects of rising deficits and real interest rates that accompanied the tax cut.[11]

- **Labor supply is likely to show some increases, mostly for high income workers, under either a flat tax or a consumption tax.** Generally, changes in tax rates produce what economists call substitution and income effects. For example, a lower tax rate alters the labor-leisure trade-off by increasing the rewards for working, making leisure more expensive. This is a substitution effect. But a lower tax rate also means that an individual can earn the same amount of income in fewer work hours. This is an income effect. Whether or not the labor supply grows depends on how these two offsetting effects play out. Within the population, labor supply responses to tax changes would vary.

  > Men are less likely to change their work hours than women. Single women who are heads of households are less likely to change their work hours than married women, particularly from high income families, who tend to have more discretion to work or not.

  > However, individuals may need to work more if their tax burdens increase. Under either a flat tax or a consumption tax, low income individuals would face higher lifetime tax rates; high income individuals would face lower rates. This means low income workers have to increase hours of work to earn the same after-tax income, whereas high income workers could decrease hours. Other factors also would affect labor supply response. For low income workers, working more hours may not be worthwhile because of they would pay a higher tax rate and lose the benefit of the EITC, which is proposed by most fundamental reform plans. For high income individuals, both the negative effect of a consumption tax on accumulated (old) wealth and the increased after-tax income from work could result in a greater willingness to work.

- **Retirement.** Retirement decisions would be affected in two ways.

  > Without transition provisions, a consumption tax would reduce the value of accumulated wealth. This could encourage people nearing retirement to work longer to offset the loss in wealth.

  > Both a flat tax and a consumption tax would increase incentives to save but eliminate the preferential treatment of retirement saving relative to other forms of saving. Without early withdrawal penalties and tax advantages, individual

[11] Bosworth and Burtless (1992).

and employer-sponsored retirement savings are likely to decrease. Reduced retirement savings and lower pension coverage could induce people to work longer or produce lower retirement incomes.

Fundamental Tax Reform and Employer-Sponsored Benefits

Under a pure flat tax or consumption tax, tax preferences for employer-sponsored pension, health insurance, and other benefits would be eliminated. These benefits are really part of employee compensation and under a broad-based, flat rate system would be taxed as income. Although removing the tax preference would put these forms of compensation on equal footing with wage and salary income, it would also result in less coverage.

- For example, CBO estimates that repealing the tax subsidy could increase the average price of insurance by 35 percent and reduce insurance coverage by 16 percent to 26 percent.[12]

- Although employees could avoid taxation by participating in employer-sponsored pension plans, pension savings would not be more advantageous than other forms of savings. As a result, the amount of savings allocated to retirement could decrease as other types of savings increased.

Other Tax Proposals

As discussed in chapter 3, while tax-advantaged retirement savings incentives do little to increase net personal savings, they do appear to increase retirement savings. Many individual tax reform proposals seek to encourage additional retirement savings. These include:

- **Expanded IRAs**: Under current law, single individuals and couples who are not covered by employer-sponsored retirement plans can make tax-deductible contributions to IRAs. The annual amount they can contribute is restricted and tax deductibility is only available if incomes do not exceed specific ceilings. Assets accumulate on a tax-free until retirement. Savings are taxed when withdrawn. Proposals to expand IRAs seek to increase retirement savings by loosening IRA restrictions. They would increase the amount that can be contributed, increase the availability tax-deductible contributions, or both.

- **Back-end loaded IRAs.** Back-end loaded IRAs would permit individuals to contribute after-tax dollars and to accumulate tax free earnings until retirement. Because contributions would not be granted favorable tax treatment at the front

[12] CBO (1994).

end, no taxes would be imposed when savings were withdrawn. Unlike regular IRAs, which shift the timing of taxation, back-end loaded IRAs would allow accumulated earnings to avoid taxation. Although it would provide powerful incentives to save, the down-side of back-end loaded IRAs is that they would be very costly to the Treasury. (Back-end loaded IRAs are so named because all the costs to the Treasury would come at the back end.)

- **Kiddie IRAs.** The Congressional Republican majority and the President are poised to grant child tax credits. Instead, some groups like the Concord Coalition and AARP suggest that families be granted a tax credit if they contribute to IRAs for their children. Unlike the proposed child tax credits, which will largely be used for current consumption, the kiddie IRAs would permit tax-free savings from an early age and would be available to meet eventual retirement needs. (Savings eventually would be taxed when withdrawn during retirement.)

Conclusion

Although the economic research does not conclude that fundamental tax policy change alone would be sufficient to offset projected slowdowns in productivity and growth, tax reform objectives are consistent with the needs of an aging population.

- Changes in tax policies that eliminate disincentives to work, save, and invest should be included in any long-term strategy to address the aging of the population.

- However, tax reform would have to be coordinated with changes in budget policy. Fiscal policies that lead to rapidly increasing deficits and debt will negate any positive benefits of tax reform. Similarly, "pro-economic growth" tax policies that contribute to higher Federal deficits and debt would be self-defeating.

- Additional research is necessary to understand the distributional effects of fundamental tax reform. It would be helpful to know more about the effects of changing from the current mix of wage (FICA) and income taxes to the alternative consumption tax proposals. Such research would provide more insight into changes in lifetime tax burdens and lifetime incomes. This would improve the ability of policy makers to weigh the social effects of tax reform with its economic effects.

Chapter 9: Private Pensions and Retiree Health Benefits

Private, employment-based retirement and health benefits are growing components of employee compensation. Between 1960 and 1994, employer spending for benefits grew almost **4 times faster** in real terms than spending for wages and salaries between 1960 and 1994.[1] (See Table 9.1.)

- Aggregate spending for real wages and salaries increased 140 percent, while the spending for benefits increased 530 percent.

- Private pensions and profit sharing plans grew from 1.7 percent of total compensation to 2.2 percent. Total retirement costs, including Social Security, were 8.8 percent of compensation in 1994, compared to 4.8 percent in 1960.

- The largest increase was in employer-paid group health insurance, which increased almost *1,450 percent.* Group health insurance was 6.6 percent of total compensation in 1994, compared with 1 percent in 1960.

- Employers are legally required to pay FICA taxes, State workers' compensation, and unemployment insurance. These payments grew 450 percent.

However, employment-based benefits are not uniformly available to all workers. Low-wage workers are less likely than highly compensated workers to be employed by employers that sponsor retirement and health plans. Employees in small firms are less likely to receive these benefits than employees of larger firms. Unionized employees are more likely to have pension and health benefits than employees who are not covered by collective bargaining agreements. Government workers are more likely to have retirement and health benefits than workers in private industry.

[1] Data from the *EBRI Databook on Employee Benefits* (1995).

Table 9.1
Employer Spending for Compensation

	Constant 1994 Dollars					% chg.
	1960	1970	1980	1990	1994	1960–94
Total compensation	1,483.5	2,359.9	2,957.6	3,732.8	4,002.4	169.8%
Wages/salaries	1,364.0	2,105.0	2,475.9	3,112.2	3,255.9	138.7%
All benefits	118.5	252.7	478.1	620.5	746.5	530.0%
Retirement	71.0	153.8	272.7	295.5	351.5	395.1%
OASDI	28.0	61.8	100.0	155.3	166.1	493.2%
Private pension	24.5	50.0	99.5	56.1	87.7	258.0%
Public	18.5	42.0	73.2	84.0	97.7	428.1%
Health	17.0	55.7	131.3	240.0	305.1	1,694.7%
HI	0.0	8.8	20.9	38.1	40.7	363.6%
Group health	17.0	46.2	109.7	200.2	263.0	1,447.1%
Other	30.5	43.1	74.1	85.0	89.9	194.8%
Unemployment	15.0	14.5	29.5	26.0	30.1	100.7%
Workers comp.	10.0	17.6	34.7	52.2	52.6	426.0%
Legally required*	53.0	102.7	185.1	271.5	289.5	446.2%
Total compensation	100.0%	100.0%	100.0%	100.0%	100.0%	n.a.
Wages/Salaries	91.9%	89.2%	83.7%	83.4%	81.3%	n.a.
All benefits	8.0%	10.7%	16.2%	16.6%	18.7%	n.a.
Retirement	4.8%	6.5%	9.2%	7.9%	8.8%	n.a.
OASDI	1.9%	2.6%	3.4%	4.2%	4.2%	n.a.
Private pension	1.7%	2.1%	3.4%	1.5%	2.2%	n.a.
Public	1.2%	1.8%	2.5%	2.3%	2.4%	n.a.
Health	1.1%	2.4%	4.4%	6.4%	7.6%	n.a.
HI	0.0%	0.4%	0.7%	1.0%	1.0%	n.a.
Group health	1.1%	2.0%	3.7%	5.4%	6.6%	n.a.
Other	2.1%	1.8%	2.5%	2.3%	2.2%	n.a.
Unemployment	1.0%	0.6%	1.0%	0.7%	0.8%	n.a.
Workers comp.	0.7%	0.7%	1.2%	1.4%	1.3%	n.a.
Legally required*	3.6%	4.4%	6.3%	7.3%	7.2%	n.a.

SOURCE: EBRI (1995).

* Legally required benefits are Social Security, Federal and State unemployment, workers' compensation, railroad retirement and supplemental retirement, railroad unemployment.

Retirement and health benefits emerged as prominent components of employee compensation during World War II. Employer payments for retirement and health benefits provided a means to attract and keep workers during an era of labor shortages, wage controls, and limitations on corporate profits. Clarification of the tax status of employer-sponsored benefits fueled their growth.[2] (See following box.) During the post-War prosperity of the 1950s, 1960s, and 1970s, employer-sponsored benefits expanded. Today, trends in employer-sponsored benefits are mixed.

- The number of workers participating in employer sponsored retirement plans appears to have stabilized at about 45 percent of all civilian workers. It is not expected to increase significantly. Changes in vesting requirements mean that more workers eventually will receive pension payments but, for many workers, the size of these payments will be small. Greater participation in the labor force means that more women will receive pension benefits, but their payments will be affected by lower wages and salary levels, breaks in work history, and spells of part-time work.

- Sixty-four percent of all nonelderly Americans are covered by employment-based health insurance. This is 5 percentage points lower than in 1987. In response to the rising cost of health care, employers have reduced or dropped altogether employee health insurance coverage. Although private health insurance costs are currently growing more slowly than the overall economy, this trend is not expected to continue. As a result, employers will face further pressure to control the cost of health insurance benefits.

- Employer-sponsored retiree health coverage covers individuals until they reach age 65 and become eligible for Medicare. Some private retiree coverage also supplements Medicare after age 65 and is a major source of Medigap insurance. One-third of the elderly currently have employment-based health insurance coverage. In 1993, 39 percent of workers had employment-based retiree health insurance coverage. Most of these workers report that retiree health benefits continue through retirement. However, for 14 percent of these workers, retiree health insurance coverage will only last until they reach age 65 and become eligible for Medicare.

[2] Employer contributions on behalf of employees for retirement and health benefits are deductible expenses for employers and are not taxable income to the employee. Distributions from retirement plans are normally subject to taxation when realized as income by the retired employee. These tax advantages mean that employer benefit contributions are worth an average of $1.30 for every $1.00 in wage and salaries. EBRI (April 1996).

Development of Private Pension System

The American Express Company created the first pension plan in 1875. It covered permanently disabled workers who had been with the company for at least 20 years.[3] Railroads followed suit. By 1905, they had established a dozen formal plans. By the late 1920s, 80 percent of railroad workers had pension coverage.

Pension plan coverage grew in regulated and concentrated industries. In these industries, the plan costs could be passed on through higher prices. By the 1920s, most banking, mining, petroleum, and utility companies and some manufacturers offered plans.

The first trade union retirement benefits were offered in 1905 by the Granite Cutters' International Association. The first benefits were gratuities and depended upon the ability of unions to assess members for sufficient funds. By 1928, about 40 percent of union members belonged to unions that provided some sort of retirement and permanent disability benefits. The tax status of pension trusts, income, and distributions was first established through the Revenue Acts of 1921, 1926, and 1928.

The Great Depression had a devastating effect on these pension plans. Private employers cut back pension benefits, abolished plans, and even terminated payments to retired workers. With so many members out of work, union plans could not raise the funds to pay benefits to retirees. Both industrial and union plans went bankrupt.

In 1934, the Railroad Retirement Act rescued the railroad plans by establishing a public retirement system for railroad employees. In 1935, the Social Security Old Age assistance program established lump sum benefits for elderly retirees. In 1939, the Social Security Act was amended to allow monthly retirement benefits.

World War II and the Growth of Private Pensions and Employer Sponsored Health Insurance

During the tight labor market conditions created by World War II, wage control policies prevented employers from using wages to attract employees. Instead, they could offer compensation in the form of fringe benefits—pensions and health insurance—and deduct the costs from taxable income. The deductibility benefit costs, together with high corporate tax rates, meant that the benefits were financed with resources that otherwise would have gone to the government.

Between 1942 and 1944, more than 4,200 pension plans received Internal Revenue Service approval as tax deductible plans compared with 1,360 plans in the previous 12 years. During the 1950s, the Korean War spurred additional expansion in retirement plans. In the 1960s, coverage expanded through the growth of multi-employer (union) plans. In addition, more workers were covered as employment grew in businesses offering plans.

Employment-based health insurance grew during the 1950, 1960s, and 1970s. Although over half of the nonelderly population has employment-based coverage, coverage rates have been dropping since the early 1980s.

[3] History from Munnell (1982).

Issues

Employment-based retirement and retiree health benefits make important contributions to the financial security of retirees. These benefits are changing in response to economic and demographic shifts as well as changes in employee needs and preferences.

Employment-based retirement and retiree health insurance benefits are often integrated with Social Security and Medicare. That is, the level of benefit provided by employer-sponsored plans coordinates with Social Security and Medicare benefits. Consequently, the total amount of benefits provided by employment-based plans can be affected by changes to Social Security and Medicare. In addition, because employment-based benefit plans and benefits currently enjoy significant tax advantages, changes to the tax system can have major implications for the continued availability of these benefits.

Great number of retirees and longer life expectancies will raise substantially the cost of employment-based benefits. Retirement and retiree health benefits represent large and growing claims against the future incomes of employers. The Financial Accounting Standards Board (FASB) has recognized the significance of these liabilities and requires private employers to disclose unfunded pension and retiree health benefit liabilities in their financial statements. In response to these disclosure requirements, employers are modifying benefit structures to reduce unfunded liabilities.

- A 1990 Financial Accounting Statement (FAS 106) requires employers to record the unfunded expected future cost of retiree health benefits in their financial statements. In response to FAS 106, employers appear to be increasing retiree premiums, co-pays, and deductibles and controlling costs, rather than eliminating coverage entirely. That is because the availability of retiree health benefits facilitates employers' ability to encourage older employees to retire early.

- In addition to FASB financial disclosure requirements,[4] defined benefit pension plans are subject to the Employee Retirement Income Security Act (ERISA) and Internal Revenue Code funding requirements. These plans pay insurance premiums to the Pension Benefit Guaranty Corporation (PBGC). ERISA establishes funding, vesting, and eligibility requirements for single– and multi–employer pension plans. Currently, most defined benefit plans hold more than enough assets to meet current accrued liabilities. Limitations on the tax deductibility of employer contributions constrain defined benefit plans from advance funding benefits current workers are expected to earn through retirement.

[4] FAS 87 and FAS 88, both issued December 1985.

Employment-based benefits affect labor markets in a number of ways.

- Benefits may tie employees to employers, impeding labor force mobility.

- The tax advantages accorded to employment-based benefits increase the value of benefits relative to wages and salaries and distort workers' preferences among forms of compensation. This is particularly true in the case of health insurance, into which many workers have unwittingly channeled greater and greater shares of compensation, and, in the process, helped fuel faster growth in the cost of health services.

- Employees may undervalue benefits because the cost of the benefits are relatively invisible (e.g., defined benefit pension plans, "employers' shares" of health insurance premiums and FICA taxes).

- Finally, because many employees view employer benefit payments as employer contributions instead of as part of compensation, they may not understand that rising benefit costs depress growth in cash wages and salaries.

Some analysts welcome the growth in defined contribution arrangements as breaking down paternalistic employer behavior and enabling employees to exert more control over important elements of their compensation. Others view employment-based benefits as part of employers' responsibility to provide for their employees, many of whom do not have the resources or the knowledge necessary to manage the scale and scope of risks involved, particularly where retirement income and health care needs are concerned. These analysts view the trend towards defined contribution arrangements as a disastrous erosion of workers' security that saddles them with risks they cannot handle and frees employers of important responsibilities towards employees.

In response to a combination of economic conditions, regulatory requirements, and employee preferences, employers increasingly are moving toward defined contribution benefit structures. Defined contribution arrangements have advantages and disadvantages for employers and employees.

- For employers, defined contribution arrangements increase predictability and control over benefit costs. However, these arrangements, particularly portable pension savings, can lessen employees' attachment to their employers.

- For employees, defined contribution pension arrangements show faster, more visible build up of account balances. Employees can take these sums with them when they change employers, either by combining with the new employer's plan or by rolling them over into an IRA. In exchange, employees assume more responsibility for their retirement incomes and are at greater financial risk.

Growth in employer-sponsored pension benefits is taking place through defined contribution plans. In 1975, defined benefit plans were two-thirds of all private retirement plans. In 1993, defined contribution plans were 88 percent of all plans. Larger employers are using defined contribution plans to supplement existing defined benefit plans. Smaller employers are providing retirement benefits only through defined contribution plans. Under defined contribution plans, retirement income levels are dependent on how well individuals manage their retirement savings and how well their investments perform. By contrast, defined benefit plans guarantee specific benefits levels if certain employment requirements are met.

Close to three-quarters of covered employees are in managed care health insurance plans. This represents a complete turnaround from 1989 when three-fourths of workers were covered under fee-for-service plans. Managed care arrangements allow employers to purchase coverage at set (and often negotiated) prices, passing financial risk for health care usage along to insurers or providers. Under these plans, employees do not have the open-ended access to services once available under cost-reimbursement, fee-for-service plans. They are at risk for higher out-of-pocket expenses if they go outside of the available provider network, or need or want additional coverage.

Employers have to satisfy the needs and preferences of baby boomers who are reaching the age where concerns about retirement income and health insurance coverage are increasingly important. At the same time, employers have to increase their attractiveness to a smaller pool of younger workers who are less concerned about retirement incomes and more focused on immediate income requirements.

Employer-Sponsored Pension Benefits

In 1993, 51 million workers, 44 percent of all civilian workers, participated in employer- or union-sponsored retirement plans, compared with only 25 percent in 1950. Participation rates peaked in 1974 at 47 percent of civilian workers, but have remained stable since 1983. (See Table 9.2.)

The importance of private pension and annuity payments to current retirees varies. In 1994, for those receiving payments, private pension and annuity payments averaged $4,735. For the bottom 20 percent of elderly units in terms of total money income, private pensions and annuities averaged less than $1,200 in 1994, compared with $5,400 from Social Security. For the top quintile, pensions and annuities averaged $10,100, compared to $13, 300 from Social Security.[5]

[5] Grad (1994).

Table 9.2
Retirement Plan Trends
(In percentages)

	Sponsorship Rate [a]	Participation Rate [b]	Sponsored Participation Rate [c]	Vesting Rate [d]	Participant Vesting Rate
All civilian workers					
• 1979	56	46	81	24	52
• 1983	52	43	83	24	57
• 1988 [e]	55	42	76	28	68
• 1988 [f]	57	43	75	34	77
• 1993	57	44	76	38	86
Private wage and salary					
• 1979	54	43	79	20	47
• 1983	49	40	80	20	50
• 1988 [e]	51	37	72	24	65
• 1988 [f]	55	39	72	29	73
• 1993	56	41	73	34	84
Public wage and salary					
• 1979	87	77	88	45	59
• 1983	83	73	88	48	65
• 1988 [e]	92	77	83	54	71
• 1988 [f]	92	77	83	66	86
• 1993	89	75	84	67	89
Civilian females					
• 1979	52	38	73	18	46
• 1983	50	38	76	20	52
• 1988 [e]	54	38	70	25	66
• 1988 [f]	57	40	70	30	76
• 1993	58	42	72	36	86
Civilian males					
• 1979	59	51	87	28	55
• 1983	54	47	88	28	60
• 1988 [e]	55	45	81	31	70
• 1988 [f]	58	46	80	36	78
• 1993	56	45	81	39	86

SOURCE: EBRI, Table 3.1 (1995).

[a] Percentage of workers whose employer or union sponsors a plan for employees at the place of employment.
[b] Percentage of workers who responded that they are included in an employment-based plan.
[c] Percentage of workers whose employer or union sponsors a plan who participate in that plan.
[d] Percentage of workers who respond that they are eligible to receive benefits at retirement or to receive a lump sum distribution if they leave employment.
[e] For comparability with earlier data, if employer offered a profit sharing or stock plan, does not count workers as working for an employer where a plan is sponsored by the employer or union. Does not include workers as vested even if they responded that they could receive a lump sum distribution if they left their plan immediately.
[f] For comparability with 1993 data, if employer offered a profit sharing or stock plan, counts workers as working for an employer where a plan is sponsored by the employer or union. Counts workers as vested if they responded that they could receive a lump sum distribution if they left their plan immediately.

More retirees are receiving pension and annuity payments and the amounts of payments are increasing in real terms. However, for many retirees, combined Social Security and private pension benefits do not replace the 60 percent to 70 percent of pre-retirement income financial planners advise is necessary to maintain standards of living, even for employees with 20 to 30 years of service. (See Table 9.3.)

Table 9.3
Private Defined Benefit Plan Replacement Rates, 1993
(As percentage of final earnings)

Final Annual Earnings	Private Pension, Only		Private Pension and Social Security	
	20 Years Service	30 Years Service	20 Years Service	30 Years Service
$15,000	24%	37%	63%	81%
$25,000	21	32	52	72
$35,000	20	30	47	65
$45,000	19	29	44	58
$55,000	19	29	41	53
$65,000	19	29	38	50

SOURCE: EBRI. Table 4.14 (1995).

Pension Plan Sponsorship and Participant Trends

Pension plan sponsorship rates vary by industry and by size of firm. (See Table 9.4.)

- Public employers are the most likely to sponsor retirement plans. Business, personal, and entertainment services have the lowest sponsorship rates.
- Unionized workers were 56 percent more likely to work for employers offering retirement plans.
- Employees in firms with more than 100 employees were 4 times as likely to have access to pension plans than employees in firms with fewer than 25 employees.

Table 9.4
Pension Plans by Industry, 1983 and 1993
(Percentage of workers age 16 and above)

Industry	Employer Sponsorship Rate*		Employee Participation Rate**		Participant Vesting Rate+	
	1983	1993	1983	1993	1983	1993
Federal government	87%	90%	79%	79%	68%	89%
State/Local government	82	89	72	74	64	89
Communications/utilities	86	89	78	78	59	89
Manufacturing–durable	72	77	65	64	55	87
Manufacturing–nondurable	65	68	56	56	52	83
Mining	73	73	67	67	57	90
Finance, insurance, real estate	63	70	48	53	44	87
Professional services	51	63	35	43	46	83
Business, personal, and entertainment services	21	30	15	19	40	83
Wholesale trade	52	57	43	45	51	84
Retail trade	32	42	20	24	40	80
Transportation	54	60	48	47	56	83
Construction	32	35	28	30	50	85

SOURCE: EBRI, Table 3.3 (1995).

* Percent of employees whose employer or union sponsors a plan at the worker's place of employment.
** Percent of employees who are included in an employment-based plan.
\+ Percent of employees who indicate they are eligible to receive benefits at retirement or to receive a lump sum distribution if they leave employment.

Employee participation rates vary by age, sex, length of job tenure, and annual earnings. Retirement plans primarily benefit higher-paid, better-educated employees.

- Participation rates peak among workers ages 41 to 50. Young workers and workers aged 65 and over (who are likely to be partially retired) are less likely to participate.

- Men and women are equally likely to work for firms sponsoring pension plans. In 1988, 43 percent of women and 52 percent of men participated in plans. In 1993, the percentage of women participants increased to 46 percent, while men's participation rate remained the same.

- Both plan sponsorship and participation rates increase with annual earnings. In 1993, 30 percent of workers earning less than $5,000 worked in firms where pension plans were available and only 4 percent participated. 88 percent of workers making $50,000 or more worked for employers where pension plans were available and 83 percent participated in retirement plans.

- 82 percent of workers with 15 years or more in job tenure participated in retirement plans, compared to 38 percent of workers with 1-4 years of job tenure. Although over 40 percent of workers with less than 1 year on the job worked in firms sponsoring pension plans, only 12 percent participated in the plans.

Types of Retirement Plans

Major types of employer-sponsored retirement plans are described below.

- **Defined benefit plans** provide a specified level of benefits after retirement. Most frequently, the level of benefit is based on the number of years of employment and the level of earnings in the last years of employment. In these plans, the employer bears the investment risk—the employee is guaranteed a specific benefit no matter how the invested plan assets perform.

- **Defined contribution plans** are plans in which employers make specified contributions on behalf of employees into investment accounts. These plans include profit-sharing arrangements, employee stock ownership plans (ESOPs) and tax-advantaged salary reduction plans (401(k)s and 403(b)s). In these plans, employees bear the investment risk. Their retirement benefits equal the amount in their accounts at the time they are eligible to retire.

- **Hybrid plans** combine features of defined benefit and defined contribution plans. These plans generally allow employees to accrue benefits based upon defined benefit-type formulas. Vested participants who leave their employers before retirement can receive a lump-sum distribution that can be rolled over into IRAs or into their new employers' plans. Hybrid plans include cash balance, pension equity, target benefit, and age-weighted profit sharing plans.

In 1990, 84 percent of private pension plans were defined contribution plans. This percentage has grown steadily since 1975 when defined contribution plans were 67 percent of all private plans.

- In 1990, the primary plan for 38 percent of active participants (current employees) was a defined contribution plan compared to 13 percent in 1975. Half of all pension plan participants (active, vested, and separated workers, retirees, and

survivors) were covered by defined contribution plans, almost double the percentage in 1975.

- Most of the change in pension plans between 1985 and 1990 occurred in small plans with 2-9 participants; 45 percent of the increase in defined contribution plans was in small plans; 75 percent of the decrease in defined benefit plans was in small plans.

- Government employees and employees in medium and large private firms are more likely than employees in small firms to participate in defined contribution plans.

  > In 1993, 93 percent of full-time State and local government employees were covered by retirement plans. 87 percent were in defined benefit plans.

  > 78 percent of employees in medium and large private firms were covered by retirement plans—72 percent of them were in defined benefit plans.

  > 47 percent of full-time employees of small firms participated in retirement plans—70 percent of them were covered by *defined contribution* plans.

Integration with Social Security

Many defined benefit plans are integrated with Social Security. Under integrated plans, the combined Social Security and plan benefits replace similar levels of pre-retirement earnings for workers of all pay levels. Social Security replaces 58 percent of the earnings of low wage earners and 25 percent of the maximum taxable earnings of high wage earners. Although employers cannot discriminate in favor of highly paid workers, they can take Social Security into account when setting benefit formulas.

- Almost half (48 percent) of employees in medium and large private firms sponsoring retirement benefits have their benefits integrated with Social Security. 60 percent of clerical and sale workers and 59 percent of professional, technical and related employees are in integrated plans.

- The retirement benefits of 90 percent of State and local government employees are not integrated with Social Security. 64 percent of blue collar and service employee were covered by plans that are not integrated with Social Security.

The Impact of Regulation

At least some of the shift away from defined benefit plans has to be attributed to regulation. ERISA sets coverage, funding, and vesting requirements for private plans. The rules for defined benefit plans are more complex than for defined contribution plans. Defined benefit plans are required to pay premiums to the federal Pension Benefit Guaranty Corporation (PBGC) for insurance guaranteeing employee retirement benefits. Finally, FASB rules require defined benefit plans to disclose unfunded liabilities.

Salary Reduction Plans

Salary reduction plans, such as 401(k)s and 403(b)s, are used both to supplement defined benefit plans and as primary plans. These plans allow participants to save a portion of income while deferring taxation on that income until the time it is withdrawn.

- Almost one-fourth of all civilian workers participated in a salary reduction plan in 1993, an increase of 10 percentage points in 5 years.
- 401(k) plans have grown dramatically. Forty-six percent of all active participants in retirement plans contributed to a 401(k) in 1990. Fourteen percent of all private retirement plans included a salary reduction component.
- In 1993, salary reduction plans served as the primary retirement plan for 17 percent of total workers, up from 7.5 percent in 1988.
- On average, employees contributed 7 percent of earnings to salary reduction plans in 1993.

Employer matching contributions to salary reduction plans have a dramatic impact on employee participation rates.

- In 1993, 51 percent of plan sponsors offered matching contributions. 62 percent of employees participated in plans where matching contributions were available. Only 20 percent of employees participated in plans where no matching contribution were offered.

Financial Condition of Retirement Plans

In the first quarter of 1996, the assets of pension plans totaled $5.5 trillion. IRAs and Keogh assets added another $1.2 billion, for a total for all retirement plans of $6.7 trillion. [6]

[6] EBRI Fact Sheet (October 1996).

- Eighty-five percent of large (1,000 participants or more) private defined benefit plans report sufficient assets to meet all accrued plan liabilities.[7]

- By contrast, the Federal government retirement funds are seriously underfunded—that is, insufficient resources have been identified to pay for projected future benefits. In 1992, the unfunded liability of the Civil Service Retirement System and the Federal Employees Retirement System totaled $870 billion. To amortize this liability over 40 years, Federal employee and agency contributions would have to be increased 29 percent of payroll on top of the 36 percent currently contributed.

- The Military Retirement System is in even worse shape. The unfunded liability was $627 billion in 1992. To fund this liability over the next 40 years, contribution rates would have to be increased 59 percent of payroll, which together with the 67 percent actually contributed, would total 126 percent of military pay.

In 1993, estimated employer contributions to all retirement plans was $53 billion.

> The contributions of most private employers (63 percent) totaled 3 percent or less of payroll. The average employer contribution was 2.9 percent, compare to 3.6 percent in 1990.

> Public employers contributed an average of 16.1 percent of payroll in 1993, compared to 16.5 percent in 1990.

Employment-Based Retiree Health Insurance Benefits

Retiree health insurance coverage began following World War II, expanding at the same time as active employee coverage. Because there were few retirees relative to the number of active workers, initial retiree health insurance costs were low. The creation of Medicare permitted employers to reduce the costs of retiree health insurance by integrating their plans with Medicare. Now, the ratio of retirees to active workers is growing, retirees are living longer, and health care is more expensive. FAS 106 requires employers to disclose unfunded retiree health costs and reflect them in their financial statements. These liabilities have a negative impact on net income and retained earnings. As a result, employers face growing pressure to reduce unfunded retiree health insurance liabilities and to control the cost of retiree health benefits.

From the perspective of retirees, retiree health benefits have become an important source of supplementary (Medigap) coverage, helping to cover costs that Medicare does not cover. Employment-based plans enable retirees to continue receiving the same level of coverage they enjoyed as active workers.

[7] This level of sufficiency does not include anticipated liabilities from the continued employment of the current workforce.

Retiree health benefits are also important to active employees. Retiree health insurance allows employees to retire early. A 1993 poll found that 61 percent of respondents would keep working until they became eligible for Medicare if their employers did not provide retiree health insurance coverage.[8] Almost half of the survey's respondents said that they planned to retire early, at an average age lower than 61. The academic research indicates that individuals are more likely to retire early if retiree health insurance is available.

Health benefits are regulated under ERISA, but requirements are far less strict than they are for pension plans. Employers are not subject to vesting and funding requirements as they are with retirement plans. If employers have reserved the right to modify health benefits (and virtually all have), they are able to do so. So far, the courts have allowed employers to change, even terminate existing health benefit plans

The future cost of retiree health benefits is substantial. GAO estimated that private employer FAS 106 liabilities were $412 billion in 1993.[9] In the face of these substantial costs, employers are modifying their retiree benefit plans. Although surveys indicate some employers are eliminating coverage, most are reducing their liabilities through other means. These include increasing the cost of coverage to retirees through premium increases and higher co-pays and deductibles. Some employers are providing fixed contributions towards coverage, leaving the beneficiary to pick up the remaining costs. Providing coverage through HMOs also reduces employers' unfunded liabilities and provides them with better control over costs.

Despite FAS 106, the data so far indicate that the percentage of individuals age 65 and above with employment-based health insurance coverage has stayed around 33 percent since 1988. The number of employees expecting retiree coverage has also remained around 40 percent.[10] However, these data only reflect conditions through 1993. Although FAS 106 required companies to begin reporting the expected effects of the new rule in 1991, large corporations did not have to include unfunded retiree health liabilities on their balance sheets until 1993 and smaller companies had until 1995 to comply. Without more recent data, it is difficult to tell what effect FAS 106 is having on retiree health coverage.

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[8] EBRI/Gallup poll cited in EBRI Issue Brief No. 184 (April 1997).

[9] GAO (1993).

[10] Availability of retiree health insurance coverage follows the same general patterns as other benefits. High wage earning individuals are more likely than low-wage workers to work for employers who offer retiree health insurance coverage. Employees in larger firms are more likely to have retiree health insurance coverage, as are employees in manufacturing and other industries that generally offer good benefits.

Conclusion

As the labor force ages, retirement, health, and retiree health benefits are becoming increasingly costly and are growing as shares of total compensation, reducing the amounts that otherwise would be available for wages and salaries. Employers will have to manage competing pressures for different forms of compensation.

From an economic perspective, employer sponsorship provides an administratively efficient way for employees to save and invest to meet future retirement income and health care needs and to purchase health insurance. Employers have more knowledge and skills to manage retirement savings. Because they represent the pooled purchasing power of their employees, they are able to negotiate better rates from insurers and health care providers.

Workers could perform these tasks individually. However, administrative costs would be higher and investment outcomes likely would suffer. Some policy experts believe that greater individual control over these forms of compensation would not be all bad. For example, employees might not choose to consume so much of their compensation in the form of health benefits. However, given current low personal savings rates, many policy experts fear that giving workers more control over amounts currently going into retirement plans would be a mistake. They believe that workers would be unlikely to preserve as much of their compensation for retirement as under the current benefit structure. Many of these experts propose mandatory savings requirements to direct greater portions of employee compensation into retirement savings.

From the perspective of employers, benefits are necessary to attract and keep the right workers. Because worker preferences differ, the value of benefits varies among workers. While younger workers are less interested in retirement-related and health benefits, these benefits are of major concern to older workers. Boomer-age workers may have welcomed defined contribution pension plans that allowed them early access to funds to finance, for example, college educations for their children. As boomers age, they may be more interested in more certain retirement incomes Employers have to structure benefits in ways that respond to changing preferences while simultaneously controlling costs.

In addition, the employee benefit system is subject to changes in public policies. Potential reforms of Social Security, Medicare, Medicaid, and the tax system could have major impacts on employment-based retirement and health benefits. Reforms that shift costs to employers, could improve the financial condition of Federal programs, but reduce the availability and coverage of privately-sponsored benefits. This is especially true for health benefit plans, which employers can terminate more easily than retirement plans. If employment-based benefits are cut back, there will be greater pressure for publicly-financed support.

Chapter 10. Baby Boomers

The post–World War II baby boomers were born between 1946 and 1964. Today, they number 78 million—almost 30 percent of the total population. The oldest boomers turned 50 in 1996. The boomers will begin turning 66—the normal retirement age—in 2012, 15 short years from now. Many boomers will retire sooner, some as soon as 2001.[1]

How boomers will fare in retirement depends on a number of factors—some are within their control, but many are not. Boomers can exert at least some control over how much they save, how long they keep working, and how healthy their lifestyles are. The performance of the overall economy, the return on assets (especially housing), the availability of public income and health care assistance, and the changing demographic composition of the population are clearly outside their individual control.

What standard should we use to assess boomers retirement incomes? Many studies compare projections of boomers' standards of living in retirement with the standards of living of their retired parents. These studies conclude **retired boomers generally will do as well as, if not better than, their parents**. However, some segments of the boomer population—women, African Americans and Hispanics, low-wage earners, singles, and people who do not own their own homes are more at risk and may actually end up worse off than their parents.

To project boomers' retirement incomes, many studies compare the financial condition of middle age boomers with their parents at the same age.[2] They conclude that because boomers are generally doing better in middle age than their parents did at the same age, they will do at least as well in retirement. On average, boomers have higher incomes, more educational attainment, and better access to private pensions. Because education and income are strongly correlated to better health, boomers are likely to live healthier, as well as longer, lives.

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[1] The 1983 amendments to the Social Security Act raised the "normal retirement age" for Social Security to 67. This increase will be phased-in gradually. In 2003, the Social Security normal retirement age will be increased to 65, plus 2 months. It will reach 66 in 2009. No increases are projected between 2009 and 2020. Then it will increase gradually, reaching 67 in 2027.

[2] See CBO, *Baby Boomers in Retirement: An Early Perspective* (September 1993), CED, *Who Will Pay for Your Retirement? The Looming Crisis* (1995), EBRI, *Baby Boomers in Retirement* (1994), John Sabelhaus and Joyce Manchester, "Baby Boomers and Their Parents: How Does Their Economic Well-Being Compare in Middle Age?", *The Journal of Human Resources* (Fall 1995), and summary of other research contained in the *Final Report* of the Social Security Advisory Council, Technical Panel on Trends and Issues in Retirement Saving (1995).

Comparing middle-age baby boomers with their parents at the same age and extrapolating from that to estimate the financial circumstance of boomers in retirement provides only a limited perspective. Boomer parents largely were able to achieve their current standards of living through a run of economic good luck, not through diligent saving. They were in the labor force during years of strong economic growth, rising wages, and expanding benefits. In retirement, they receive large windfall gains through Social Security and Medicare financed through transfers from an expanding workforce. They are the beneficiaries of gains in real estate and financial assets.

Boomers are unlikely to experience the same good fortune. Future economic conditions will not be as favorable. Future Social Security and Medicare transfers will not be as generous. Moreover, matching the standards of living of current retirees implies no real improvements in retirement living standards despite the real economic growth projected to occur between now and the time of boomers' retirements.

A 1994 AARP study projects boomers' income in 2030.[3] It, too, concludes that boomers will do at least as well as their parents. This study looks at existing trends in private pensions and models retirement incomes under two sets of economic assumptions to provide a range of possible outcomes. Both sets of assumptions produce median incomes for boomers at least comparable to median elderly incomes today.

The research on boomers includes a big caveat: that Social Security, Medicare, and tax policy stay the same. The studies recognize that this is a very big **"if."** Projections of current fiscal and budget policies clearly show that they are not sustainable. No one knows how boomers will respond to changes. Increases in taxes and reductions in public benefits will affect boomers' pre-retirement incomes, their ability to accumulate wealth and, ultimately, their standards of living in retirement.

Boomers are a diverse group. Those who are well-educated and have higher incomes are likely to posses sufficient resources and knowledge to secure comfortable retirements. Others will not do as well.

- Higher divorce rates among boomers and fewer children mean weaker informal support networks and less access to familial financial support than their parents have. This affects women more than men because women's earnings and pension coverage lag behind men's.

- Low-wage boomers have not seen the same kind of improvements in income as other groups. They are less likely to see large improvements in their future incomes and to receive adequate private pension benefits. Unmarried boomers, particularly women with children, also face more difficult prospects.

[3] Study by Lewin-VHI for AARP (1994).

- Education has a positive influence on health and income. Less educated boomers are more likely to be in poorer health and suffer more chronic and potentially disabling health conditions. Their educational attainment and health status adversely affect their lifetime incomes. Their ability to continue working and their quality of life in retirement may be impaired.

To compensate for eventual changes in public policy, all boomers will need to increase retirement savings. While a majority of workers report that they have begun saving for retirement (including participation in 401(k)s and IRAs), only a third of them have tried to estimate how much they will need to maintain their standards of living. Not surprisingly, most boomers are not saving enough.

Determinants of Baby Boomers' Retirement Incomes

Income during retirement comes from four sources: accumulated wealth (particularly home equity), public programs (Social Security, Medicare, and Medicaid), pension and other retirement savings, and, increasingly, continued earning from employment.

Income and Wealth

Baby boomers have higher median incomes than their parents did at the same age. Older boomers, who have been in the workforce longer, have done better than younger boomers. Women of all age categories have higher incomes than their mothers. Improvements in income during working years allow higher retirement savings. (See Table 10.1.)

Table 10.1
Median Incomes of Persons by Age
(In 1995 constant dollars)

	Men			Women		
Year	25–34	35–44	45–54	25–34	35–44	45–54
1950	$17,216	$18,920	$16,886	$7,878	$7,605	$7,221
1960	23,200	26,157	24,506	8,303	9,622	9,941
1995	23,609	31,420	35,586	15,557	17,397	17,723

SOURCE: CRFB tabulations of data from Bureau of the Census (September 1996(a)).

Average real earnings are projected to rise 15 percent by 2010 and 37 percent by 2030 (the period during which boomers reach retirement age) under the Social Security intermediate assumptions.[4] This growth in real income could permit boomers to increase their retirement savings.

Boomers generally have more wealth than their parents did at the same age. As with other age groups, including retirees, their single biggest asset is home equity. For boomer age groups, home equity constitutes 45 to 50 percent of net worth. (See Table 10.2.)

Table 10.2
Household Wealth in 1962 and 1989
(In 1989 constant dollars)

	Ages 25 to 34		Ages 35 to 44	
	1962	1989	1962	1989
All Households				
Median wealth	$6,100	$9,000	$29,300	$54,200
Median non-housing wealth	2,400	4,200	12,200	17,400
Unmarried Head of Household				
Median wealth	400	1,800	6,300	16,700
Median non-housing wealth	300	1,100	1,900	4,000
Married Head of Household				
Median wealth	7,900	17,300	36,500	70,100
Median non-housing wealth	3,200	7,800	15,800	23,400

SOURCE: CBO tabulations of 1962 and 1989 Survey of Consumer Finances (September 1993).

Buying a house can be viewed as a form of retirement savings, particularly if people are willing to sell their houses after they retire. **Studies are mixed, but some researchers predict that the basic laws of supply and demand will drive real housing prices down precipitously when boomers sell their homes.**[5]

- Consequently, counting on home equity for a large portion of retirement wealth is risky. Many economists believe that housing will not be as good of an investment for boomers as it was for their parents. The boom in housing prices in the 1970s and early 1980s was fueled by a combination of demand, inflation, tax policy, and speculation that is unlikely to be repeated.

[4] 1997 SSA intermediate assumptions. These projections assume 2 percent real growth in GDP through 2006, declining to 1.4 percent by 2030, real annual wage growth of 0.8 percent to 1 percent, and stable interest, inflation, and unemployment rates.

[5] See the Final Report of the Social Security Advisory Council Technical Panel(1996) and McFadden (1994).

Although boomers are wealthier than their parents were at the same age, these levels of wealth are not sufficient to support boomers for very long. In a recent Public Agenda survey, 38 percent of baby boomers reported retirement savings less than $10,000.[6] Boomers are unlikely to duplicate the same level of capital gains, particularly in housing, experienced by their parents prior to retirement. Nor are future income transfers through Social Security and Medicare likely to be as generous.

Social Security, Medicare, and Other Public Programs

Assuming no changes in current policy, the SSA projects benefits in 2030 that, in real terms, are significantly higher than benefits paid in 1996.

- New retirees who consistently earned low wages (45 percent of the average) would receive a beginning annual benefit of $7,473 (in 1997 dollars), a 28 percent increase above the 1997 level. This benefit would replace 56 percent of pre-retirement taxable earnings.

- New retirees who always earned at or above the ceiling on maximum taxable earnings would receive a beginning benefit of $22,987 (in 1997 dollars), a 44 percent increase above 1997 benefit payments. This would replace 28 percent of pre-retirement taxable earnings.

Although higher than today's benefits, these amounts can hardly be considered overly generous. Even so, they are an overly optimistic projection of what boomers can expect. There is a significant likelihood that these benefit levels will be reduced or other reforms implemented, at least for higher wage earners, before baby boomers retire. Otherwise, Social Security will become insolvent.

Most Americans realize that Social Security and Medicare are in trouble. The EBRI 1996 Retirement Confidence survey reveals that only a fifth of current workers are confident that Social Security will continue to provide benefits of the same value that it offers today, and only a fourth are confident about Medicare's future.[7] Not surprisingly, only 26 percent expect that Social Security will be their most important source of retirement income.

Although Social Security and Medicare are projected to provide benefits for the foreseeable future, the level of benefits they will offer is uncertain. Almost no one is proposing to eliminate public retirement and health care benefits, but most policy makers agree that Social Security and Medicare will have to be reformed. All options would either raise taxes or cut benefits. Sub-groups of boomers will be affected differently.

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[6] Farkas and Johnson (1997).

[7] This survey interviewed 1,000 current workers and retirees ages 25 and over. EBRI (January 1997).

- **Those with longer life expectancies** benefit if tax increases are used to close operating imbalances in Social Security and Medicare. Tax increases permit higher retirement incomes and a larger social insurance program. But higher taxes will disproportionately affect younger workers and may discourage low-wage workers from working altogether.

- Assuming younger generations would never receive the benefits at the levels currently projected, benefit cuts improve equity between generations, encourage more private savings, and may keep workers in the labor force longer. But lower benefits provide less certainty that retirement incomes will be adequate.

- Means-testing benefits would discourage savings and wealth accumulation for workers who are close to the eligibility cutoff limits. Higher income workers, who would no longer qualify for benefits, would have greater reasons to save. Although lower income workers would not be affected directly by a means test, some argue that means testing would erode the broad political support for these programs, eventually leading to their demise.

Pension Coverage and Income

More retired boomers will receive pension benefits in 2030 than current retirees. According to the AARP study, between 77 percent and 82 percent of boomers will receive pension benefits compared with the 50 percent of today's elderly.[8]

- Private pension coverage has grown significantly since 1940. Most of the growth occurred prior to 1970. Coverage now seems to have leveled off at just under half of all civilian workers.

- While it is unlikely that pension coverage will be extended to much more of the workforce, greater shares of covered workers eventually are expected to receive pensions. Changes in pension rules means that participating workers are two-thirds more likely to be vested (entitled to pension benefits) than they were fifteen years ago. [9]

- However, for many boomers, the pension incomes eventually received will be relatively small. These alone will not sustain pre-retirement standards of living.

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[8] AARP study conducted by Lewin-VHI. The lower estimate (77 percent) uses more pessimistic assumptions. The higher estimate (82 percent) uses "middle-of-road" assumptions consistent with 1991 SSA intermediate projections.

[9] Under ERISA, pension plans cannot discriminate against lower paid employees. This provision helped expand pension coverage. ERISA also ended unreasonably long vesting periods that denied pensions to many longtime workers.

Pension coverage among baby boomers is far from universal. (See Table 10.3.)

- Married workers are more likely to receive pension incomes than single workers because even if they are not eligible for benefits, their spouses may be.
- Lower wage, less educated, younger workers in industries characterized by high turnover are far less likely to participate in employer-sponsored pension plans.

Table 10.3
Pension Coverage for Boomers Age 24 to 42, 1988
(In percentages)

	Pension Availability		Pension Coverage		Ratio of Coverage to Availability		Vested: Current or Previous Job	
	Own	Own and/or Spouse	Own	Own and/or Spouse	Own	Own and/or Spouse	Own	Own and/or Spouse
All boomers	46%	61%	43%	57%	92%	94%	26%	38%
Women	42	61	36	58	87	94	22	39
Men	51	60	50	57	97	95	31	37
Early *	49	65	49	66	100	100	33	48
Late **	45	58	38	51	84	88	21	31
African American	46	54	38	45	83	83	25	33
White	47	62	43	59	93	96	26	39
Hispanic	35	47	29	39	82	83	16	25
Education								
0–11 years	23	34	19	31	86	90	11	18
12 years	42	59	40	56	94	96	24	38
13–15 years	50	65	46	61	92	95	27	40
16+ years	63	75	58	70	92	93	37	49
Hours worked/year								
0 hours	16	40	13	36	79	89	6	22
1–500 hours	34	52	23	49	69	93	11	30
501–1,000 hours	48	66	29	58	61	97	16	39
1,001–1,500 hours	55	70	42	62	76	90	n.a.	n.a.
1,500+ hours	67	70	64	72	96	97	24	42
Family Income								
$0–14,999	26	42	22	36	83	86	12	22
$15,000–29,999	44	69	41	66	94	96	23	41
$30,000+	60	82	59	82	98	100	39	62

SOURCE: Tabulations of the May 1988 CPS Pension Supplement by Lewin-VHI for AARP (1994).

* "Early" boomers are defined as born between1946 and1954.
** "Late" boomers are defined as born between1955 and1964.

In the AARP study, using "middle of the road" economic assumptions,[10] Lewin-VHI estimated median boomer pension incomes will be similar to the pension incomes of the current 65+ population. Although more of the retired population in 2030 will receive retirement benefits, one-fourth of the population will receive relatively small benefits (below $3,000). (See Table 10.4.)

Disparities in pension incomes will mirror disparities in earnings. Men do better than women, more highly educated individuals are more likely to earn higher income and receive better pension than those with lower levels of educational attainment. African Americans and those of Hispanic origin will not fare as well as their White counterparts.

Table 10.4
Comparison of Pension Incomes, 1990 and 2030
Persons Age 66 to 84
(In 1990 constant dollars)

	Elderly Individuals in 1990					Baby Boomers in 2030				
	No Pension	$1–2,999	$3,000 –9,999	$10,000 & above	Median Benefit	No Pension	$1–2,999	$3,000 –9,999	$10,000 & above	Median Benefit
All Persons	50%	14%	20%	16%	$6,600	17%	25%	28%	30%	$6,918
Women	54	15	18	12	5,700	21	29	27	24	5,042
Men	45	13	23	20	7,200	14	20	29	37	9,601
Ages 66–75	47	14	21	18	6,900	16	24	28	32	7,502
Ages 76–84	57	16	16	11	3,800	20	26	28	26	6,362
African American	68	10	14	8	5,600	21	29	25	24	5,536
White	49	15	20	16	6,600	17	24	28	30	7,140
Hispanic	72	9	11	8	6,200	16	27	30	28	6,292
Education										
0–11 years	61	16	18	6	4,000	19	29	34	18	5,084
12 years	46	15	22	16	6,400	20	29	27	24	6,243
13–15 years	41	12	21	26	8,800	18	22	28	32	7,031
16+ years	34	9	19	38	11,500	14	19	27	41	9,927

SOURCE: Lewin-VHI tabulations of the May 1988 CPS Pension Supplement and PRISM forecasts. AARP (1994).

[10] These assumptions are comparable to the 1991 Social Security intermediate actuarial assumptions.

Baseline Projections of Boomers Future Are Likely to be Too Optimistic

Most projections of boomers in retirement assume positive economic trends such as continued and steady growth in GDP, productivity, and income and earnings, and stable, moderate inflation, interest, and unemployment rates. Typically, the effect of growing Federal budget deficits and rapidly rising public and private debt are not included.

- The SSA and HCFA actuarial projections of Social Security and Medicare costs rely on more optimistic assumptions than other estimates.

  > SSA mortality assumptions are more optimistic than the ones used by Census and other organizations. If greater numbers of the elderly live to age 85 and above, costs for Social Security and Medicare will be higher than current SSA estimates.

  > HCFA assumes that the rate of growth in Medicare costs will fall to the rate of growth of hourly earnings in 12 years for SMI and in 25 years for HI. Otherwise, Medicare costs would rise to "implausible" shares of GDP.

- CBO projects that GDP growth will drop to 1.8 percent by 2030 without taking into account the feedback effects of growing Federal budget deficits projected under current policies. Economic growth eventually turns negative if the feedback effects of large deficits are incorporated into the estimates.

- The trend toward more defined contribution plans could mean lower pension benefits. Seven out of ten boomers still list defined benefit plans as their primary plans, but the growing prevalence of defined contribution plans over defined benefit plans means that future retirees will depend on defined contribution plans for greater shares of their retirement incomes. Defined contribution plan benefits may be smaller for a variety of reasons.

  > Employers that only offer defined contribution plans tend be smaller, pay lower wages, and provide less generous benefits than firms offering defined benefit plans.

  > Participants bear the investment risk. Compared with professional investment managers, participants who invest their accounts may be risk averse and give up too much yield in exchange for safety. If investment decisions are unwise or if the market falls, defined contribution plan participants have no guarantees of income.

  > In addition, participants have greater opportunities to use plan assets for non-retirement purposes.

- Boomers are no better at preserving lump sum distributions for retirement than other age groups. In 1993, boomers were about equally likely to consume some of their lump sum distributions and to put some of it into a tax-qualified retirement program. Only 20 percent reported that they put the full amount into an IRA or other tax qualified retirement program. Individuals who are closer to retirement are more likely to roll over greater portions of lump sum distributions into other forms of retirement savings. Younger boomers are somewhat more likely than other age groups to use some or all of the funds to purchase a house, start a business, or reduce mortgage or other debt.

Conclusion

Survey results show that Americans are not big savers. Only a fourth are "planners" when it comes to retirement. Two-thirds of baby boomers agree with the statement, "I don't want to worry so much about my retirement that I end up not enjoying my life now." But boomers are not unique. That percentage is about the same as the percentage of younger and older survey respondents. Overall, only 41 percent of Americans report that they save regularly for any purpose.[11]

For the baby boom generation, the relevant question may not be ***when*** they will retire, but ***if*** they will be able to retire. Financial prospects for boomers in retirement are uncertain. Since boomers are not saving adequately on their own, and because Social Security and Medicare benefits are not likely to make up for the lack of private savings, boomers will either have to keep on working or lower their standards of living in retirement. Fortunately, by the time baby boomers reach retirement age, employers may not be able to absorb the loss of human capital represented by boomers leaving the labor force. Unlike today, older workers may be more valued. Because, in general, they will be healthier, they will be able to continue working enough hours to supplement their income. Thus the concept of retirement will come to include extended active and productive lives and retirement security will become a "four-legged stool"—continued employment, private savings, employment-based pensions, and public income and health care assistance.

[11] Farkas and Johnson (1997).

Appendices and References

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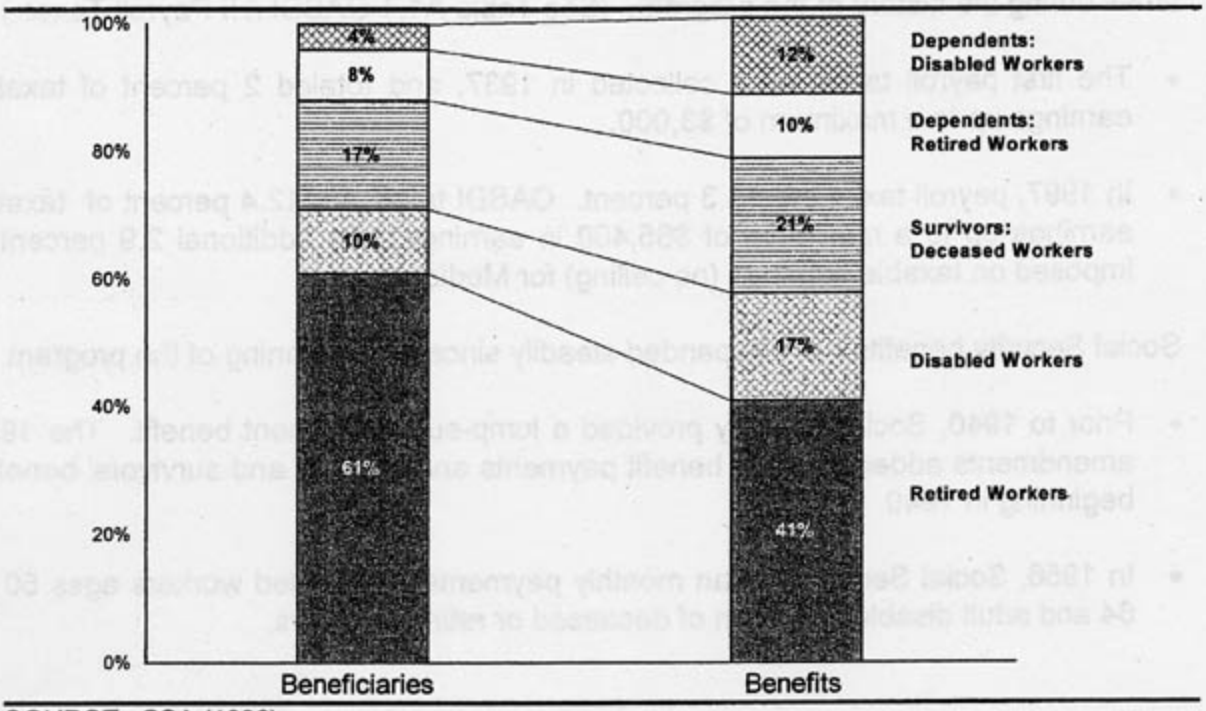
Appendix 1: Social Security

Figure A1.1
OASDI Beneficiaries and Benefits Awarded, 1995



SOURCE: SSA (1996).

The Social Security program (Old Age Survivors and Disability Insurance (See Figure A1.1 OASDI) has three purposes, distinct in principle but intertwined in practice.

- It provides **retirement income** for participating retirees and, under certain conditions, for their spouses and children. This monthly payment increases with the cost of living, providing retirees with protection from inflation. In 1994, retired workers and their dependents received 51 percent of total benefit payments.

- It provides **social insurance** for participating workers against disability and, for the participant's spouse and children, against the disability or death of the primary beneficiary (survivor's insurance). 28 percent of 1994 benefit payments went to disabled workers and their dependents; 21 percent went to the survivors of deceased workers.

- It is designed to **redistribute income** by replacing a higher percentage of the pre-retirement earnings of low-wage workers than of higher wage earners.

How Social Security Works

Social Security is funded through a mandatory contribution divided equally between employees and employers.[1] (Self-employed persons pay the full share.) This **dedicated payroll tax** on the earnings of participating workers has increased many times during the history of the program. (See Table A1.1 OASDI /HI Payroll Taxes.)

- The first payroll taxes were collected in 1937, and totaled 2 percent of taxable earnings up to a maximum of $3,000.

- In 1997, payroll taxes are 15.3 percent. OASDI taxes are 12.4 percent of taxable earnings up to a maximum of $65,400 in earnings. An additional 2.9 percent is imposed on taxable earnings (no ceiling) for Medicare.

Social Security benefits have expanded steadily since the beginning of the program.

- Prior to 1940, Social Security provided a lump-sum retirement benefit. The 1939 amendments added monthly benefit payments and spousal and survivors' benefits beginning in 1940.

- In 1956, Social Security began monthly payments to disabled workers ages 50 to 64 and adult disabled children of deceased or retired workers.

[1] Most economists believe that the full payroll tax is borne by the employee because it comes out of compensation or is passed through to consumers in the form of higher prices.

Table A.1.1
OASDI/HI Payroll Taxes

Year	Annual Maximum Taxable Earnings		Contribution Rate (in percentage)					
			Employees & Employers			Self - employed		
	OASDI	HI	OASDI	HI	Total	OASDI	HI	Total
1937 to 1949	$3,000		1.00		1.00			
1950	3,000		1.50		1.50			
1951 to 1953	3,600		1.50		1.50			2.25
1954	3,600		2.00		2.00			3.00
1955 to 1956	4,200		2.00		2.00			3.00
1957 to 1958	4,200		2.00		2.25			3.38
1959	4,800		2.50		2.50			3.75
1960 to 1961	4,800		3.00		3.00			4.50
1962	4,800		3.13		3.13			4.70
1963 to 1965	4,800		3.63		3.63			5.40
1966	6,600	$6,600	3.85	0.35	4.20	5.80	0.35	6.15
1967	6,600	6,600	3.90	0.50	4.40	5.90	0.50	6.40
1968	7,800	7,800	3.80	0.60	4.40	5.80	0.60	6.40
1969	7,800	7,800	4.20	0.60	4.80	6.30	0.60	6.90
1970	7,800	7,800	4.20	0.60	4.80	6.30	0.60	6.90
1971	7,800	7,800	4.60	0.60	5.20	6.90	0.60	7.50
1972	9,000	9,000	4.60	0.60	5.20	6.90	0.60	7.50
1973	10,800	10,800	4.85	1.00	5.85	7.00	1.00	8.00
1974	13,200	13,200	4.95	0.90	5.85	7.00	0.90	7.90
1975	14,100	14,100	4.95	0.90	5.85	7.00	0.90	7.90
1976	15,300	15,300	4.95	0.90	5.85	7.00	0.90	7.90
1977	16,500	16,500	4.95	0.90	5.85	7.00	0.90	7.90
1978	17,700	17,700	5.05	1.00	6.05	7.10	1.00	8.10
1979	22,900	22,900	5.08	1.05	6.13	7.05	1.05	8.10
1980	25,900	25,900	5.08	1.05	6.13	7.05	1.05	8.10
1981	29,700	29,700	5.35	1.30	6.65	8.00	1.30	9.30
1982	32,400	32,400	5.40	1.30	6.70	8.05	1.30	9.35
1983	35,700	35,700	5.40	1.30	6.70	8.05	1.30	9.35
1984	37,800	37,800	5.70	1.30	7.00	11.40	2.60	14.00
1985	39,600	39,600	5.70	1.35	7.05	11.40	2.70	14.10
1986	42,000	42,000	5.70	1.45	7.15	11.40	2.90	14.30
1987	43,800	43,800	5.70	1.45	7.15	11.40	2.90	14.30
1988	45,000	45,000	6.06	1.45	7.51	12.12	2.90	15.02
1989	48,000	48,000	6.06	1.45	7.51	12.12	2.90	15.02
1990	51,300	51,300	6.20	1.45	7.65	12.40	2.90	15.30
1991	53,400	125,000	6.20	1.45	7.65	12.40	2.90	15.30
1992	55,500	130,200	6.20	1.45	7.65	12.40	2.90	15.30
1993	57,600	135,000	6.20	1.45	7.65	12.40	2.90	15.30
1994	60,600	*	6.20	1.45	7.65	12.40	2.90	15.30

Table A1.2
OASDI/HI Payroll Taxes (continued)

Year	Annual Maximum Taxable Earnings		Contribution Rate (in percent)					
			Employees & Employers			Self employed		
	OASDI	HI	OASDI	HI	Total	OASDI	HI	Total
1995	61,200	*	6.20	1.45	7.65	12.40	2.90	15.30
1996	62,700	*	6.20	1.45	7.65	12.40	2.90	15.30
1997	65,400	*	6.20	1.45	7.65	12.40	2.9	15.30
Future Schedule:								
1998 and later		*	6.20	1.45	7.65	12.50	2.90	15.30

SOURCE: SSA (1996) and Board of Trustee of the OASDI Trust Funds (1997).

*ceiling on earnings subject to HI taxes was repealed by OBRA in 1993.

- In 1960, disability benefits were extended to all workers and their dependents.
- Early retirement benefits at age 62 were first provided for women in 1956 and for men in 1961.

Initially, all workers in "industry and commerce", about 60 percent of the work force, were covered. Today, 95 percent of all jobs are covered. [2] To be eligible for benefits, workers must meet minimum earnings and length of employment requirements in covered positions.

Social Security benefit levels are based on a worker's covered earnings, not contributions. This has allowed individuals to collect more in benefits than they contributed in taxes, even with imputed interest figured in. The benefit formula also provides important protections from erosion of the value of benefits due to inflation and real wage growth.

- First, covered **earnings are indexed** to derive the average indexed monthly earnings (AIME). This adjusts the worker's prior earnings for subsequent real wage growth and inflation. Each new cohort of workers begins with a higher real benefit than succeeding cohorts.

[2] Exclusions include State and local government positions covered by separate retirement systems, Federal employees hired before 1984 covered under a separate Federal retirement system, and workers or self-employed individuals with very low incomes.

- Second, the primary insurance amount (PIA), or basic monthly benefit level, is calculated. Through two "bend points," the formula provides a higher replacement rate at lower wage levels. The replacement rate is 90 percent up to the first bend point ($437 in 1996); 32 percent up to the next bend point ($2,635 in 1996); and 15 percent on all remaining amounts of covered wages. The bend points themselves are also indexed. Otherwise, larger and larger portions of workers' AIME would fall under the lower replacement rates. Average replacement rates produced by the bend points increased between 1940 and 1981, but have declined since then.

- Third, the PIA is adjusted annually for inflation through a cost-of-living adjustment (COLA). COLAs were added in 1974. Previously, benefits were increased on an *ad hoc* basis through periodic legislation. [3]

As a result of these adjustments, monthly average retirement benefits increased by 168 percent in real (inflation-adjusted) terms between 1950 and 1994, from $269 per month (1995 dollars) to $720 per month. [4] As long as real wages continue to grow, each new cohort of beneficiaries can expect higher real benefits. The SSA estimates that benefits for average wage earners who retire in 2030 will be **32 percent** higher in real terms than benefits received by new retirees in 1996.

Covered Workers and Beneficiaries

In 1996, 142 million workers were covered by Social Security. Almost 44 million individuals collected retirement, disability, or survivors benefits. Although the number of covered workers has increased four fold since 1937, the number of beneficiaries is almost 200 times larger. The number of covered workers to beneficiaries has decreased sharply from 41.9 per beneficiary when the program began to 3.2 today. This trend is expected to continue, falling to 2.0 covered workers per beneficiary in 2030, under Social Security's intermediate actuarial assumptions.

[3] The COLA is based on inflation as measured by the consumer price index (CPI). Many economists believe that the CPI overstates inflation in the economy. If so, the Social Security COLA adjustments have overcompensated beneficiaries for inflation and have raised real benefit levels.
[4] SS Statistical Supplement (1996).

Table A.1.3
OASDI Beneficiaries and Average Benefits, December 1995

	Total	White	Black	Other
	Number (in Thousands)			
Total	43,380	37,647	4,432	1,077
• Men	16,580	14,417	1,485	408
• Women	23,060	20,416	2,086	462
• Retired workers	26,671	23,983	2,106	497
• Dependents of retired workers	3,467	3,127	238	89
• Disabled workers	4,187	3,196	750	192
• Dependents of disabled workers	1,675	1,190	361	102
• Survivors of deceased workers	7,379	6,151	978	196
	Average Annual Benefits (in Dollars)			
Retired workers	$8,636	$8,782	$7,288	$7,456
• Men	9,720	9,896	8,030	8,117
• Women	7,456	7,555	6,574	6,564
Disabled workers	8,189	8,411	7,475	7,379
• Men	9,144	9,442	8,123	8,113
• Women	6,666	6,716	6,556	6,248
Survivors				
• Non–disabled widows/widowers	8,162	8,347	6,476	6,641
• Children	5,614	5,996	4,722	4,627

Source: SSA (1996).

Benefit payments mirror differences in wages among men and women and between races. Based on calendar year 1995,

- The plurality (47 percent) of Social Security beneficiaries are White women;
- African American beneficiaries are 8 percent of retired beneficiaries and 18 percent of workers receiving disability benefits;
- White retired workers receive average benefits that are 21 percent higher than those received by retired African American beneficiaries, and 17 percent higher than those received by retired workers of other races. The difference is greater among men than among women.
- On average, men's monthly retirement benefits are 31 percent higher than women's. Men's monthly disability benefits are 38 percent higher than the benefits of disabled women. Non–disabled widows' benefits are 36 percent higher than non–disabled widowers.

Table A1.4 summarizes changes to OASDI since 1935.

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Table A1.4 Summary of OASDI Changes, 1935 to the present

Category of Change	1935–44	1945–54	1955–64	1965–74	1975–84	1985–present
Workers covered	1935: Commerce and industry workers	1946: Merged with Railroad Retirement 1950: Farm and domestic workers 1954: Self employed	1956: Members of uniformed services		1983: New federal employees	1990: State and local government employees not already covered
Credits not based on salary		1946: For WWI veterans		1972: For Japanese-Americans interned during WWI		
Earnings required to earn quarter of coverage	1939: $50 in wage income	1950: $100 in self-employed income	1954: $100 in agricultural wages		1977: $250 in wages and/or self-employed income. Automatic provision	1994: $620, will continue to increase
Disability defined as:		1954: "Inability to engage in substantial gainful activity"		1965: Expected to last at least 12 months 1967: "Inability to engage in substantial gainful work existing in the national economy"		
Period of disability		1954: Continuous period of at least 6 months		1972: At least 5 months		
Calculation of wages and earnings	1939: Average Monthly Wage (AMW) calculated using all earnings after year 1936 and age 22	1950: AMW calculated from year 1950 1954: 4 years may be excluded (5 if worker has 20 QC)	1956: 5 years may be excluded		1977: Switch to system using Average Indexed Monthly Earnings (AIME). Automatic provision for inflation and wage increases	

Category of Change	1935–44	1945–54	1955–64	1965–74	1975–84	1985–present
Primary Insurance Amount (PIA) formula increases	1935 (set originally) 1939	1950, 1952, 1954	1958	1965, 1967, 1969, 1971, 1972 1973: Automatic provision	1977: 1973 automatic provision changed and superseded	1994: See "a" below for 1994 status of PIA
Minimum Primary Insurance Amount (PIA)	1935: $10	1950: $20 1952: $25 1954: $30	1958: $38 1961. $40	1965. $44. 1967. $55. 1971. $70.40 1972. $84.50 1973: Automatic provision	1977: 1973 automatic provision superseded. Non-indexed minimum of $122 set. Indexed "special minimum" created based on years of work	1993: See "b " below for 1993 status of special minimum
Maximum Family Benefit (MFB) increases	1939	1950, 1952, 1954	1958, 1961	1965, 1967, 1969, 1971, 1972. 1973: Automatic provision	1977: 1973 automatic provision superseded, new provision also automatic	1994: See "c" below for 1994 status of MFB
Age of retirement	1935: 65		1956: Early retirement at 62, for women, with actuarial reduction per month under 65 1961: Same for men	1972: Delayed retirement provision	1983: Increased to age 67, will be phased from 2000-2022. Actuarial reduction applies for earlier retiremen	
Age eligible for disability benefits			1956: Ages 50 to 64 1960: All ages under 65		1983: 65 to be replaced with new retirement age under phased in provision, described above	

a. PIA formula now at 90% of first $422 of AIME, plus 32% of AIME $422-$2,545, plus 15% of AIME over $2,545.
b. ~~Special minimum now at $25.27 per month times years of work after 10 years, not to exceed 30 years.~~
c. 150% of first $539 of PIA, plus 272% of PIA $539-$779, plus 175% of PIA above $1,016.

Category of Change	1935–44	1945–4	1955–64	1965–74	1975–84	1985–present
Auxiliaries and survivors eligible for 50% PIA benefits (see "d" below)	1939: Wife, if over 65 Child below age 18, must be student at 16. (see "f" below). *Parent*, if dependent, above 65, and no surviving widow or child eligible	1950: Wife, any age, if caring for eligible child. Dependent husband, if above 65	1955: Child age 18–21 if full-time student. Disabled child, any age. 1956: Wife eligible at age 62 w/ reduction 1961: Dependent husband eligible at age 62 w/ reduction	1965: Divorced, dependent wife, as per still-married wife, if married 20 years 1972: Dependency requirement eliminated for divorced wife	1977: Wife's benefit reduced based on own pension, if any. Dependency requirement eliminated for husband 1983: Husband, any age, if caring for eligible child. Divorced husband, if married 20 years (see "e" below)	
Auxiliaries and survivors eligible for 75% of PIA benefits (see "d" below)	1939: *Widowed mother*, if caring for eligible child. *Widow*, if above 65	1950: *Widowed mother*, if divorced and dependent. *Widower* aged 65 and above, if dependent. *Parent*, if dependent and no surviving widow or child eligible	1956: *Widow*, if 62. *Child*, below age 18, or if student, up to 21. Disabled *child*, any age 1958: For *parent*, no-other-survivor requirement eliminated	1972: Dependency requirement eliminated for divorced *widowed mother*	1977: *Widowed mother's* benefit reduced based on own pension, if any 1983: *Widowed father*, if caring for eligible child under age 18	

d. Auxiliaries and survivors of retired workers as of 1939, disabled workers as of 1958. Where age 65 is mentioned, substitute new retirement age after 2000. Later benefits for a class of auxiliary supersede previous ones. Survivor's relation to insured worker in *italics*.
e. Originally payable by court order; date given is date of legislation.
f. Children also eligible for survivor benefits. 1950 through 1960, additional 25% of PIA divided among survivor's children.

Category of Change	1935–44	1945–54	1955–64	1965–74	1975–84	1985–present
Auxiliaries and survivors eligible for 82½% of PIA benefits (see "d" below,)			1961: *Widow*, if above 62, and *widower*, if dependent. *Parent*, as above – 75% if two parents	1965: *Divorced wife*, dependent, married 20 years 1967: Disabled *widow* or *widower* age 50–62		
Auxiliaries eligible for 100% of PIA benefits (see "d" below,)				1972: *Widow* or *widower* age 65 and over. Eligible for benefits at age 60, reduced per month under 65. Disabled *widow* or *widower* aged 50–59, benefits reduced per month below 60		
Tax policy	1935: Benefits not subject to income tax 1939: No tax deduction for payroll tax				1983: Some self-employment tax is allowed as tax deduction. Some benefits taxable (see "g" below)	1993: Threshold at which benefits become taxable lowered

g. As of 1983, if taxpayer's combined income and 50% of Social Security exceed a threshold, then 50% of the benefit or 50% of the income exceeding the threshold is subject to income tax, whichever isless. A more complex threshold was instituted in 1993, with the total amount of benefit taxable not to exceed 85%.

Category of Change	1935–44	1945–54	1955–64	1965–74	1975–84	1985–present
Earnings test	1935: No covered earnings without full loss of benefit. 1939: $14.99 monthy with no loss of benefits	1950: Above 75 exempt from test. $600 yearr or $50 monthly with no loss 1952: $900 year, $75 monthly 1954: $1,200 year, $80 monthly	1956: Disabled exempt from test 1958: $100 monthly 1960: Reduction scaled by income, instead of full loss of benefit	1965: $1,500 year, $125 monthly 1967: $1,680 year, $140 monthly 1972: Over 72 exempt from test $2,100 year, $175 monthly Automatic provision	1977: New, superseding automatic provision 1981: Over 70 exempt from tes 1983: Scale of reduction decreased	
OASDI payroll tax rates for employees. (see "h" and "I" below)	In 1940: OASI , 1.0%	In 1950: OASI, 1.5%	In 1960: OASI, 2.75% DI, 0.25%	In 1970: OASI, 3.65% DI, 0.55%	In 1980: OASI, 4.52% DI, 0.56%	In 1990: OASI, 5.6% DI, 0.6% (see I)
OASDI payroll tax rate for self-employed. (see "I" below)	None	In 1951: OASI, 2.25%	In 1960: OASI, 4.125% DI, 0.375%.	In 1970: OASI, 5.475% DI, 0.825%	In 1980: OASI, 6.2725% DI, 0.7775%	In 1990: OASI, 11.2%. DI, 1.2% (see J)

h. Employer contributes same amount as employee.
i. Rates shown for a given year are those effective that year. Acts were not passed in all the given years.
j. Current law sets rates after the year 2000 at: Employee, OASI 5.49%, DI 0.71%; Self-employed, OASI 10.98%, DI 1.42%.

Category of Change	1935–44	1945–54	1955–64	1965–74	1975–84	1985–present
Acts financing OASDI from general revenue sources		1947: For cost of military service credits		1966: For cost of transitional insurance for those above 72 1972: For cost of credits for Japanese-American internees during WW II	1983: For taxes that would have been collected on post-1956 military service credits	
Borrowing among trust funds					1981: Borrowing among OASI, DI, HI authorized to 1982 1983: Borrowing authorized to 1987	
Crediting of taxes to trust funds	1935: Credited on a reserve basis 1939: Credited on a daily basis				1983: Estimated receipts per month credited in advance, with interest paid to General Fund	1990: Returned to 1939 Act basis (credited daily)

SOURCE: CRFB based on SSA materials.

Appendix 2: Medicare

The Medicare program provides two types of coverage.

- Medicare Part A, the Hospital Insurance (HI) program, covers inpatient hospital services, care following hospitalization in skilled nursing facilities, home health and hospice care.

- Medicare Part B, Supplemental Medical Insurance (SMI), generally covers 80 percent of physicians and other medical services, including laboratory and other diagnostic tests, x-rays and radiation therapy, ambulance services, and medical devices.

Medicare Financing

Medicare is financed through four sources, which are described next.

- **Payroll taxes**. The HI program is supported by payroll taxes collected from employers and employees. These revenues finance benefits for current retirees. Any surplus revenues are deposited in the HI Trust Fund. In 1966, combined employer and employee payroll taxes were 0.7 percent on wages up to $6,600. Now, the combined tax rate stands at 2.9 percent and there is no ceiling on wages.

- **Participant contributions**

  > *Premiums.* Participants in the SMI program voluntarily contribute premiums for coverage. In 1996, the SMI premium was $510 ($42.50 per month). Initially, these premiums covered half of program costs. Because costs have increased faster than the allowable maximum increase in SMI premiums (the percentage by cost-of-living-adjustments for Social Security cash benefits), premium income has declined as a share of total costs. Current statutory provisions require premiums to cover approximately 25 percent of costs through 1998. The latest SMI Trustees Report estimates that when this provision expires, premiums will decline further, falling to only 8 percent of costs by 2030.

> *Cost-share liability.* Medicare beneficiaries also face out-of-pocket costs caused by deductibles, co-insurance payments, and uncovered services (notably prescription drugs). In 1994, the average cost-share liability for Medicare services was $710. For more than 75 percent of those actually served by Medicare, the cost-share liability was under $1,000. Almost 2 percent of those needing medical care faced cost-shares of $5,000 or more, and their cost sharing liability represented 20 percent of the total cost-sharing liability of all beneficiaries. Because use of health care services increases with age, average out-of-pocket expenses are 42 percent higher for the oldest old than for those aged 65–74.[1]

- **General revenues**

  > *Hospital Insurance.* For the last several years, general revenues have been required to make up for the cash shortfall in HI financing. Largely through interest accrued on interest earned on early trust fund balances, the HI Trust Fund built up a peak balance of $133 billion in 1994. Since 1992, however, HI has experienced a cash revenue shortfall as payroll taxes have been insufficient to cover all expenditures. In 1995, HI expenditures exceeded all HI income, and the trust fund balances began to decline. The HI Trust Fund is now projected to be depleted in early 2001.

  > *SMI.* General revenues make up the difference between SMI participant premiums and total costs. There is no statutory limit on the level of general revenues that can be used to support SMI.

- **Taxation of Social Security benefits**. The 1993 Omnibus Budget Reconciliation Act imposes taxes on a greater portion of Social Security benefits for higher income elderly families. This tax revenue ($4 billion in 1995) is credited to the HI Trust Fund.

[1] 1993 HCFA data cited by Moon (1996).

Medicare Beneficiaries

Medicare coverage is nearly universal among the elderly. Beginning in 1973, Medicare coverage was extended to those who receive Social Security disability benefits for two years or more.[2] In addition, coverage was extended to those with end stage renal disease (ESRD). The number of disabled enrollees has grown over twice as fast as the number of aged enrollees. In 1994, disabled enrollees were over 11 percent of total enrollees. Enrollees with ESRD were fewer than 1 percent of the total. (See Table A 2.1).

Table A2.1
Medicare Enrollees
(In thousands)

	Total			Hospital Insurance			SMI		
Year	Total	Aged	Disabled	Total	Aged	Disabled	Total	Aged	Disabled
1966	19,109	19,109	--	19,082	19,082	--	17,736	17,736	--
1976	25,663	23,271	2,392	25,313	22,920	2,392	24,614	22,224	2,168
1986	31,750	28,791	2,959	31,216	28,257	2,595	30,590	27,863	2,727
1994	36,950	32,799	4,151	36,542	32,394	4,148	35,179	31,444	3,735
				Average Annual Growth Rate (percent)					
1966-1994	2.4	1.9	--	2.3	1.9	--	2.5	2.1	--
1973-1994	2.2	2.0	4.3	2.2	2.0	4.2	2.2	2.0	4.2

SOURCE: HCFA (1996).

In 1983, Medicare coverage was extended to Federal workers. This expansion of coverage was really designed to boost revenues. Many Federal workers qualified for coverage anyway as spouses of eligible workers or because they had paid some taxes during stints of employment in non-Federal positions. Similarly, in 1986, all new State and local workers were brought into the program.

[2] To draw Social Security disability benefits, the disability needs to be permanent and total and the worker generally needs to have paid payroll taxes for 20 out of the 40 quarters preceding the disability claim.

Not only is Medicare serving a greater share of the overall population, but the people it serves are getting older. In 1994, 39.2 percent of Medicare enrollees were 75 years or older, compared with 36.2 percent in 1980. Persons using Medicare covered services who are 85 or older cost, on average, 60 percent more than those aged 65-74. Those with ESRD were the most costly Medicare beneficiaries. (See Table A 2.2).

Table A2.2
Medicare Beneficiaries by Demographic Characteristic, 1994

	Share of		Share of Total	Avg. Amount ($) per	
	Enrollees	Persons Served	Program Payments	Enrollee	Person Served
Total	100%	100%	100%	$4,301	$4,871
Sex					
Male	43%	40%	44%	4,453	5,277
Female	57%	60%	56%	4,229	4,597
Age					
Under 65	11%	11%	13%	553	5,706
65-74	50%	46%	38%	3,300	3,955
75-84	29%	31%	35%	5,152	5,396
85 and older	10%	11%	15%	6,267	6,346
Race					
White	87%	88%	84%	4,182	4,680
Black	9%	8%	12%	5,606	6,862
MSA Type					
Urban	76%	74%	78%	4,475	5,157
Rural	24%	25%	22%	3,687	4,129
Medical Status					
Aged	89%	89%	85%	4,121	4,639
Disabled	11%	10%	10%	3,616	4,617
ESRD	1%	1%	6%	36,284	33,745

SOURCE: HCFA (1996).

Medicare spending varies by the beneficiary's sex, race and income. 11 percent of beneficiaries are disabled and under the age of 65. Average spending for aged beneficiaries increases with age. Lower income beneficiaries, who are more likely to be older and in poorer health, cost more than more affluent beneficiaries. (See Table A 2.3).

Table A2.3
Medicare Enrollees and Per Capita Payments, 1993

	Total		White		African American	
	Enrollees: % of Subject Population	Per capita Expenditure ($)	Enrollees: % of Subject Population	Per capita Expenditure ($)	Enrollees: % of Subject Population	Per capita Expenditure ($)
Total	100%	$3,497	100%	$3,406	100%	4,044
Sex	100%	--	100%	--	100%	--
• Male	43	3,665	43	3,637	43	3,726
• Female	57	3.372	57	3,234	57	4,280
Age	100%	--	100%	--	100%	--
• 0-44	4	3,566	3	2,787	8	
• 45-64	7	3,765	6	3,507	13	4,067
• 65-69	26	2,302	26	2,161	24	3,362
• 70-74	23	3,157	24	3,065	23	3,764
• 75-79	17	4,035	18	4,057	14	3,402
• 80-84	12	4,491	14	4,568	10	4,154
• 85+	11	4.937	11	4,873	8	6,470
Income	100%	--	100%	--	100%	--
• less than 5,000	6	4,060	5	4,002	12	4,190
• 5,001-10,000	29	4,163	26	4,018	51	4,595
• 10,001-15,000	19	3,690	19	3,650	17	3,787
• 15,001-20,000	14	3,282	15	3,260	8	3,450
• 20,001-25,000	10	2,873	11	2,887	6	3,204
• 25,001-30,000	6	2,733	6	2,699	2	*
• 30,001-35,000	4	2,870	4	2,966	2	*
• 35,001-40,000	3	3,462	4	3,477	0	*
• 40,001-45,000	2	2,253	2	2,223	0	*
• 45,001-50,000	2	2,797	2	2,887	0	*
• 50,000 +	5	2,226	5	2,273	2	*

* Not available. Insufficient sample size.

SOURCE: CRFB based on HCFA unpublished tables (1997).

Medicare Cost–Containment Efforts

Provider Payment Restrictions

- ***Efforts to restrain hospital costs.*** Hospital cost containment efforts in the mid-1970s took the form of price restraints. First, payments were limited to 120 percent of charges of other similar facilities. Then, in response to Carter Administration proposals to impose price controls, hospitals voluntarily imposed restraints. But, by the early eighties, annual high growth rates returned. In 1983, prospective reimbursement rates replaced after-the-fact reimbursements. The Prospective Payment System (PPS) was fully implemented in 1987. Payments were established based on diagnoses (diagnosis-related groups—DRGs). Since the implementation of PPS, efforts to contain hospital costs have focused on adjusting the DRG payment schedules and limiting the annual formula-driven increases in payment schedules.

- ***Physician payments.*** To overcome initial physician resistance to Medicare (the AMA had opposed the 1965 Act), physician reimbursements were relatively generous and physician care was not restricted. By the eighties, physician payments were growing above 20 percent annually. In 1984 and 1985, physician payments were frozen. Attempts made to reach agreement on how to restrain physician costs during the freeze failed. In 1986, Congress created the Physician Payment Review Commission (PPRC) to find a solution. In 1987, the PPRC proposed a system (resource-based relative value scale–RBRVS) designed to favor primary care over surgery and other "overvalued" services based on the time and complexity involved. The RBRVS and other reforms to restrain the growth in the volume of services and to limit extra billing of patients above the Medicare fee levels were phased in through 1995.

- ***Capitation.*** Beginning in 1985, Medicare began contracting with health maintenance organizations (HMOs) to provide services to enrollees on a pre-paid basis. Between 1986 and 1991, HMO enrollment grew slowly from 5 percent to 6 percent of total enrollees. Since 1991, HMO enrollment has accelerated. As of June 1996, Medicare managed care enrollees were 11.2 percent of total enrollees.

  Managed care contracts provide incentives for providers to become more efficient in their delivery of care. Medicare pays HMOs 95 percent of the average cost of enrollees using a fee-for-service approach. Some studies indicate that HMO enrollees are healthier and, according to one study, use 89 percent of average Medicare services.[3] If so, instead of achieving savings relative to fee-for-service care, Medicare may be overcompensating HMOs. A more recent study indicates

[3] Brown *et. al.* 1993 study cited by Moon, 1996.

more promising cost containment potential for managed care. It shows little difference between Medicare HMO and fee-for-service enrollees except among the disabled, oldest (85 years and above) and dually eligible (Medicare and Medicaid) populations.[4]

Table A2.4 summarized changes to the Medicare program since 1965.

[4] Welch, 1996.

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Table A2.4 Summary of Medicare Changes: 1965 to the present

Category of Change	1965–69	1970–74	1975–79	1980–84	1985–89	1990–present
Workers covered	1965: HI: As per OASDI (commerce, industry, farm, domestic, self-employed, uniformed services). SMI: Coverage voluntary.	1972: SMI: Disabled under 65, and those with kidney disease (see below). Automatic enrollment of HI eligibles.		1982: HI: Federal civilian employees. 1983: HI: Elected and senior appointed Federal officials.		1990: HI: State and local government employees not already covered.
Eligibility requirements	1965: HI: Above 65, and entitled to OASDI or RR *or* 3 quarters of work per year after 1965 before age 65. (See "a" below.) 1967: HI: quarters counted from 1966.	1972: HI: Disabled under 65, and those with kidney disease, entitled to cash benefits. Voluntary coverage (w/ payment of premiums) for those over 65 enrolled in SMI.		1980: HI: Eligibility for, rather than entitlement to, OASDI or RR benefits now required. 1982: HI: Federal workers credited for work prior to 1983.	1987: HI: Standards eased for previously disabled who re-establish DI coverage.	
Covered services	1965: HI: Hospital services up to 90 days per illness. Extended care or home health services to 100 days. SMI: Physician services, outpatient services, some home health, and miscellaneous medical. 1967: HI: Lifetime reserve of additional 60 days.	1972: SMI: Physician services extended.	1977: SMI: Rural health clinics added.	1981, 1982: HI, SMI: Benefits made secondary to certain private insurance. SMI: Standards for physician compensation defined in law.	1987: SMI: Outpatient mental health care covered. 1988: HI: Unlimited hospice care for terminally ill recipients. SMI: 50% of prescription drugs covered, routine mammography. Repealed in 1989.	1990: SMI: Routine mammography screening re-enacted.

SOURCE: CRFB based on HCFA materials.
a. HI: No quarters of work (see OASDI definition) required for those reaching age 65 before 1968.

Category of Change	1965–69	1970–74	1975–79	1980–84	1985–89	1990–present
Reimbursement	1965: HI, SMI: "Reasonable costs of institution (or physician) providing services."			1983: HI: "Prospectively determined amount per discharge based on diagnosis related groups." Phased in. SMI: Inpatient care now covered under HI only. 1984: SMI: Fee schedule for outpatient tests.	1986: SMI: Fee schedule for anesthesia services. 1987: SMI: Fee schedule for radiology. 1989: SMI: Fee schedule for physician services.	
Cost sharing	1965: HI: Inpatient deductible, indexed for health care costs, plus co–insurance. SMI: Deductible, non–indexed, plus co-insurance.	1972: SMI: Deductible raised. Coinsurance for home health services eliminated.		1980: SMI: Deductible for home health services eliminated. 1981: HI: Inpatient deductible raised. SMI: Deductible raised.	1988: HI: Deductible set annually, coinsurance for hospital stay removed. SMI: Ceiling set on total out-of-pocket costs. Repealed in 1989.	1990: SMI: Deductible raised.

Category of Change	1965-69	1970-74	1975-79	1980-84	1985-89	1990-present
HI payroll tax rate, employee (see "b" and "c" below)	In 1966: 0.35%	In 1970: 0.60%	In 1975: 0.90%	In 1980: 1.05%	In 1985: 1.35%	In 1990 and after: 1.45%
HI payroll tax rate, self-employed (see "c") below	In 1966: 0.35%	In 1970: 0.60%	In 1975: 0.90%	In 1980: 1.05%	In 1985: 2.70%	In 1990 and after: 2.90%
HI earnings base	In 1966: $6,600	In 1970: $7,800	In 1975: $14,100	In 1980: $25,900	In 1985: $39,600	In 1990: $51,800 Eliminated in 1994.
SMI premium rate (per month)	In 1966: $3	In 1970: $5.30	In 1975: $6.70	In 1980: $9.60	In 1985: $15.50	In 1990: $28.60

b. Employer contributes same amount as employee.
c. Rates shown for a given year are those effective that year. Acts were not passed in all the given years.

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Appendix 3: Medicaid

Medicaid is a means-tested program that provides three types of health care services to beneficiaries:

- insurance for basic medical services;
- long-term medical and social services for the elderly and disabled;
- programs to assist individuals who are disabled or mentally ill.

Created in 1965, Medicaid replaced Federal matching grants to State payments to health care providers on behalf of public assistance recipients and for "medically needy" low-income elderly. As part of the original policy goal of providing the poor with access to the same standard of care as everyone else, States initially were required to make progress toward "comprehensive" programs by expanding eligibility and benefits. Because of rapidly growing costs, this requirement was repealed in 1972.

Medicaid Financing

Medicaid program and administrative costs are shared by the Federal government and the States. The Federal share (Federal medical assistance percentage—FMAP) ranges from 50 percent to 83 percent of State payments for medical services and varies inversely with State per capita income. The Federal government splits administrative costs 50–50 with the States. From 1975 to 1988, the Federal government's share of Medicaid costs was about 55.5 percent of the total. In the last ten years, the Federal government's share has risen about 2 percentage points to 57.3 percent of the total.

Federal Medicaid payments come exclusively from general revenues. Because States set cash assistance and Medicaid eligibility, Federal spending is driven by State policies. As a result, short of changing the underlying statute, the Federal government lacks the ability to control Medicaid costs directly.

Medicaid Eligibility

Initially, Medicaid was designed to meet the health care needs of recipients of cash assistance programs (AFDC and SSI). In 1975, more than three-quarters of Medicaid beneficiaries were cash assistance recipients. This percentage began to fall in 1986 and now stands at 60 percent. This change represents two shifts in policy.

- Medicaid coverage has been extended to individuals with very costly needs, but whose income and resource levels are too high to qualify for cash assistance. These beneficiaries, who must spend down their resources to specified levels qualify for Medicaid and are known as "*medically needy*."

  > Between 1971 and 1972, individuals receiving treatment in intermediate care facilities for the mentally retarded (ICF/MR) and psychiatric hospitals (beneficiaries belowr age 22) became eligible. Individuals can qualify under the State's medically needy criteria. [1]

  > Coverage has been extended to low-income elderly who do not qualify for SSI but who require nursing home care as long as their incomes do not exceed three times the SSI limits (*300 percent rule*). Changes made in 1987 were designed to protect spouses of institutionalized (nursing home) beneficiaries from impoverishment.

  > Medicaid pays Medicare premiums and cost-shares for elderly and disabled individuals whose incomes are below the poverty level and whose resources are below 200 percent of the SSI limits (Qualified Medicare Beneficiaries).

- In 1984 to 1990, the eligibility of poor children and women for Medicaid assistance was severed from the receipt of cash benefits. Because State AFDC income limits generally are not adjusted for inflation, and Federal poverty standards are, a growing number of Medicaid beneficiaries are falling into the *poverty related* category.

[1] If a disabled child lives at home, the income and resources of the parents are "deemed" to be available for the care of the child. If the child is institutionalized, after 30 days, only the income that parents contribute to the child's support is considered to be available. Waivers can be provided for certain children to permit them to live at home.

> The largest expansion in coverage was prompted by concerns in the 1980's about infant mortality rates. The expansion mandated progressively broader coverage for low-income pregnant women and young children.

> In 1988, coverage was extended on a transitional basis to families moving off of welfare and to two-parent families whose primary wage earner is unemployed.

As a result of the mandatory expansions in coverage, the number of low income children and pregnant women eligible for Medicaid grew rapidly. Low income children now make up 49 percent of all beneficiaries, 5 percentage points more than in 1988. More recently, (1993 - 1994), the growth in the number of disabled beneficiaries has exceeded that of any other eligible group. This appears to reflect increased coverage of AIDS patients, substance abusers, and court-ordered coverage of disabled children.

Over 50 population groups are potentially eligible for Medicaid. States are required to cover most individuals receiving Federal cash assistance. States have the option to cover other low income and medically needy individuals.

- ***Mandatory coverage groups include:***

  > Cash assistance beneficiaries: Families with children receiving Aid to Families with Dependent Children (AFDC) payments; and aged, blind and disabled individuals receiving Supplement Security Income (SSI) payments;

  > Other low-income individuals, including those who are eligible for Medicare for whom Medicaid pays HI and SMI premiums, co-payments, and deductibles; pregnant or postpartum women and children under age 6 with family incomes above the State AFDC limits but below 133 percent of the Federal poverty level; and by 2002, all children under 19 in families with incomes at or below the poverty level.

- ***Optional coverage*** categories include: other aged, blind, or disabled individuals and children up to age 21 whose family incomes and resources, depending on category, do not exceed AFDC or Federal poverty levels; infants and pregnant women whose family incomes are between 133 and 185 percent of poverty; institutionalized individuals whose income and resources do not exceed specified limits; and "medically needy" individuals otherwise eligible but whose incomes and resources fall between Federal limits and higher State limits.

Medicaid spending is concentrated on two high cost groups – the elderly and the disabled.

- In 1994, the elderly represented 12 percent of beneficiaries, but 31 percent of total costs. The disabled individuals were 16 percent of beneficiaries, but 39 percent of costs.

- By contrast, low-income children made up just below half of Medicaid beneficiaries but accounted for only 16 percent of total payments.

Medicaid Services

States are required to meet Federal guidelines governing covered services. In general, coverage for mandatory eligibility groups must be equal to coverage offered optional eligibility groups, and equal coverage must be offered statewide.

States are required to cover basic services, including inpatient and outpatient hospital care; physician, nurse practitioner and nurse midwife services; diagnostic and periodic screening tests for children under 21; laboratory and x-ray services; and home health or nursing facility services for individuals 21 and above.

In the last 20 years, the number of Medicaid beneficiaries increased by 59 percent while total payments increased more than a thousand percent in nominal dollars. Most of this increase was caused by both general and medical price inflation. In real terms, total Medicaid spending increased 178 percent. (See Table A3.1).

Table A3.1
Medicaid Payments: Total and Average Payment per Person, 1975-1994

Calendar Year	Beneficiaries (000)	Total Payments ($ mil.)	Average Payment per Person				
			All Beneficiaries	Low Income Children	Low Income Adults	Aged	Disabled
1975	22,007	$51,559	$2,269	$930	$1,857	$4,917	$5,207
1976	22,815	54,724	2,310	916	1,790	5,079	5,490
1977	22,832	58,708	2,425	921	1,859	5,158	5,945
1978	21,965	59,561	2,549	912	1,793	5,817	6,436
1979	21,520	62,407	2,721	907	1,892	5,992	7,154
1980	21,605	65,498	2,802	870	1,722	6,596	6,801
1981	21,980	69,348	2,880	851	1,686	6,857	7,143
1982	21,603	66,545	2,848	760	1,599	6,938	7,534
1983	21,554	67,302	2,902	776	1,549	6,846	7,514
1984	21,607	67,313	2,831	741	1,423	7,139	7,418
1985	21,814	70,379	2,934	771	1,468	7,860	7,610
1986	22,515	73,134	2,992	841	1,420	7,900	7,701
1987	23,109	77,383	3,070	854	1,574	7,837	7,836
1988	22,907	79,661	3,132	859	1,575	7,992	7,855
1989	23,511	83,428	3,153	909	1,641	8,061	7,913
1990	25,255	91,976	3,239	1,023	1,802	8,472	8,279
1991	27,967	109,130	3,268	1,071	1,846	9,045	8,318
1992	31,150	132,468	3,292	1,088	1,975	8,697	8,494
1993	33,432	138,505	3,220	1,072	1,919	8,647	8,158
1994	35,053	143,265	3,122	1,017	1,810	8,421	7,832
		Average annual rate of growth					
1975–85	-0.1%	3.2%	2.6%	-1.8%	-2.2%	4.9%	4.0%
1985–94	5.0%	8.0%	1.0%	3.3%	2.6%	1.7%	0.6%
1975–94	2.6%	5.7%	1.7%	0.6%	0.0%	3.0%	2.3%
			Total Change				
1975-94	59.3%	177.9%	37.6%	9.4%	-2.5%	71.3%	50.4%

Source: HCFA (1996).

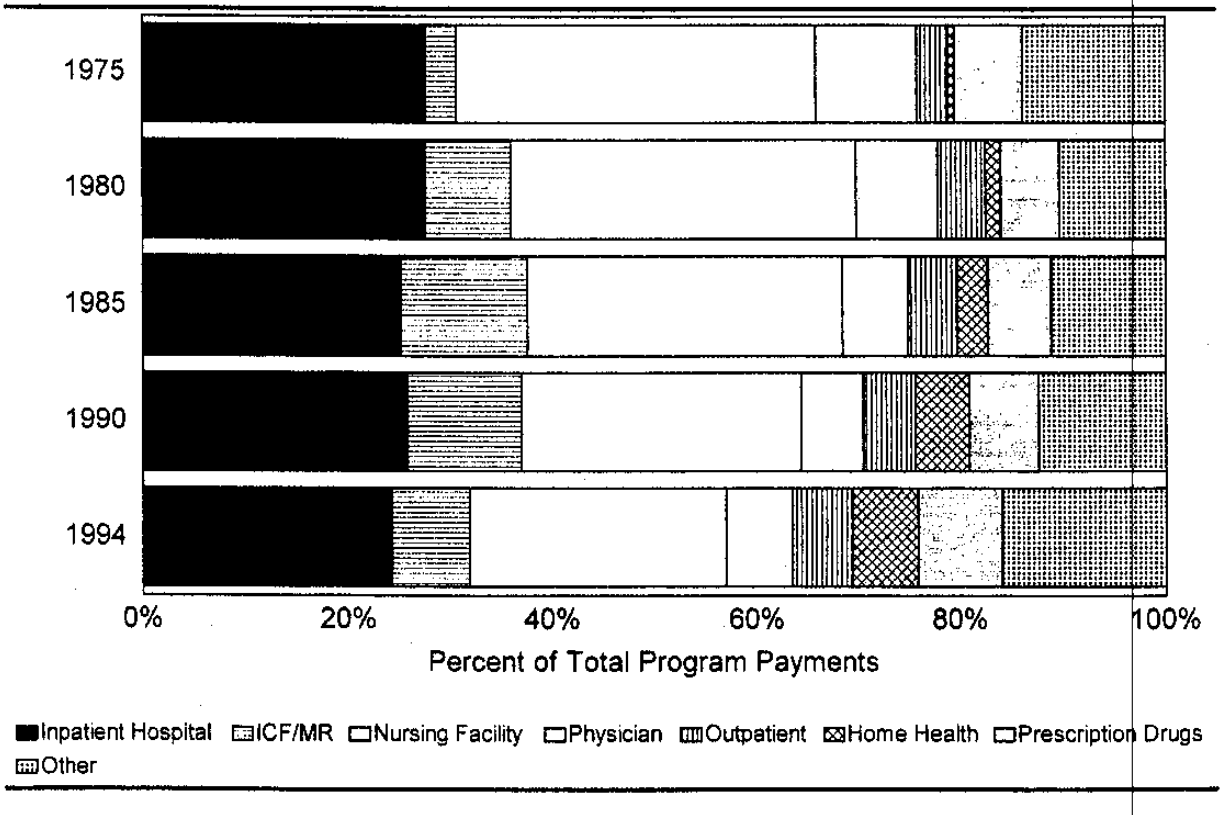
On a per capita basis, real Medicaid spending has increased by 38 percent. This is a little more than half the real growth achieved in the overall economy.

- Growth in real per capita spending for the elderly has been faster than for any other Medicaid eligibility group and has outpaced inflation by an average of 3 percent a year. From 1975 to 1985, spending per elderly person grew almost 5 percent a year in excess of general and medical inflation. Growth has moderated to 1.7 percent since 1985.

- Real per capita spending for low income children and adults has just kept pace with inflation. It actually decreased from 1975 to 1985, but since 1985, it has grown about 3 percent a year.

Since 1975, aggregate payments for inpatient hospital care and physician services have decreased as a share of total payments, while payments for home health, outpatient, and other services (including payments to HMOs) have increased.

Figure A3.1
Medicaid Payments by Type of Service



SOURCE: HCFA (1996).

Long–Term Care

In 1994, Medicaid spending for long term care services delivered through nursing facilities, home health agencies, and intermediate care facilities for the mentally retarded (ICF/MR) accounted for almost 40 percent of Medicaid spending. These providers deliver a broad range of medical, social, personal care, and supportive services to individuals with chronic conditions. On a per capita basis, these services are far more costly than acute care services. (See Table A3.2).

Table A3.2
Medicaid Payments by Eligibility Group and Type of Service
(In dollars)

	Total	Inpatient Hospital	ICF/MR	Nursing Facility	Physician	Outpatient Hospital	Home Health	Prescription Drugs
Total								
1994 per capita payment	3,122	4,510	53,055	16,707	299	387	5,504	367
Avg. annual rate of change (1975-94)	1.7%	0.6%	4.6%	1.2%	-0.5%	3.4%	10.5%	2.3%
Low Income Children								
1994 per capita payment	1,017	3,626	50,391	22,225	199	255	1,021	96
Avg. annual rate of change (1975-94)	0.5%	0.0%	n.a.	n.a.	-1.1%	2.4%	3.0%	0.1%
Low Income Adults								
1994 per capita payment	1,810	3,487	25,549	7,688	424	408	640	181
Avg. annual rate of change (1975-94)	-0.1%	-1.2%	n.a.	n.a.	-0.6%	3.0%	1.4%	-0.7%
Aged								
1994 per capita payment	8,424	2,203	54,557	16,381	205	323	6,814	889
Avg. annual rate of change (1975-94)	2.9%	3.7%	3.5%	1.1%	-0.8%	4.4%	10.8%	3.6%
Disabled								
1994 per capita payment	7,832	8,925	53,308	19,335	470	717	7,289	946
Avg. annual rate of change (1975-94)	2.2%	0.5%	5.0%	1.7%	-1.3%	3.5%	10.3%	3.8%

SOURCE: HCFA (1996).

- Medicaid is the largest third party payer for nursing home care, covering 45 percent of all nursing home costs in 1990.[2]

- The elderly are the primary users of long-term care services. Over 85 percent of all nursing home occupants and over 60 percent of the community-based long-term care population are elderly.

- Three-fourths of Medicaid spending on behalf of the elderly is for long term care (67 percent for nursing home and institutional care; and 8 percent is for community-based home health and personal care services). [3]

- Most elderly beneficiaries qualify for Medicaid as "medically needy" or through the 300 percent rule. In 1994, fewer than half (41 percent) of elderly Medicaid beneficiaries were cash assistance (SSI) recipients. The recent trend is downward: 49 percent of elderly beneficiaries received SSI in 1990. Average Medicaid expenditures per cash assistance elderly beneficiary are 40 percent of average expenditures for non-cash elderly beneficiaries.

- In 1994, the medically needy and non-cash assistance beneficiaries accounted for 85 percent of all Medicaid nursing home and institutional care expenditures and 78 percent of spending for the elderly.

- State studies have estimated 27 to 45 percent of elderly nursing home residents spend down their resources to eventually qualify for Medicaid assistance. [4]

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[2] CRS (1993).
[3] Beneficiary and expenditure data from Liska *et. al.* (1996).
[4] CRS (1993).

Appendix 4: Summary of Major Tax Expenditures

Tax expenditure[1]	Cost in Fiscal Year 1996[2] ($ billions)	Incentives for Taxpayers	Groups Subsidized
Exclusion of investment income from annuities and life insurance	8.7, **0.5**	Purchase annuities and life insurance policies for retirement income and security needs.	retirees, survivors, financial institutions and other corporations selling annuities and insurance policies
Deduction for interest on mortgages for owner-occupied homes	59.2	Purchase home, finance home purchase with a mortgage.	homeowners, housing and construction industry (builders and agencies), financial institutions selling mortgages
Deduction for property tax on owner-occupied homes	14.4	Purchase home, also reduces cost of living in high-property-tax areas.	homeowners, housing and construction industry, local governments financing services through property taxes
Deferral of capital of capital gains on sales of principal residences[3]	15.3	"Move up" by purchasing more expensive home.	homeowners, housing, and construction industry
Exclusion of capital gains on sales of principal residences for persons age 55 and over[4]	5.1	Purchase home *as "retirement savings".*	homeowners, retirees, housing, and construction industry
Maximum 28% tax rate on long-term capital gains	9.1	Invest in assets with long-term yield.	long-term asset owners, those issuing long-term debt (corporations and state or local governments), stockbrokers

[1] Includes only expenditures which cost the government more than $5 billion in fiscal year 1996.
[2] The number in plain type is the amount effectively paid to individuals. The number in bold type, where present, is the amount effectively paid to corporations. These represent direct gains only and do not include the indirect gains by others, such as subsidized industries.
[3] For up to 2 years or until purchase of new home, whichever comes sooner.
[4] Limit of $125,000 to be excluded.

Tax expenditure[5]	Cost in Fiscal Year 1996[6] ($ billions)	Incentives for Taxpayers	Groups Subsidized
Deduction for depreciation of owned buildings in excess of alternative system[7]	3.7, **1.5**	(for small business owners and corporations) Purchase buildings.	Corporations or stockholders, small businesses, construction industry
Deduction for depreciation of equipment in excess of alternative system[7]	5.6, **22.5**	(for small business owners and corporations) Purchase equipment.	Corporations or stockholders, small businesses
Exclusion of capital gains at death	14.0	Leave bequests and inheritances to heirs.	heirs
Deduction for charitable contributions (health, education, all others)	17.4, **1.4**	Donate to private charities, whether cash or goods.	private charities
Exclusion of employer contributions for medical insurance premiums and care	48.4	Accept employer-provided health insurance as compensation, instead of wages or other forms.	taxpayers and employers, health and insurance industries
Exclusion of untaxed Medicare benefits, both HI and SMI	13.2	Enroll in Medicare and use it as primary care provider, if possible, or secondary, if necessary.	Medicare recipients (essentially all elderly), Medigap insurers

[5] Includes only expenditures which cost the government more than $5 billion in fiscal year 1996.
[6] The number in plain type is the amount effectively paid to individuals. The number in bold type, where present, is the amount effectively paid to corporations. These represent direct gains only and do not include the indirect gains by others, such as subsidized industries.
[7] Part of the cost of depreciation of buildings and equipment is covered under standard business expenses; this item represents deductions above and beyond that standard.

Tax expenditure[8]	Cost in Fiscal Year 1996[9] ($ billions)	Incentives for Taxpayers	Groups Subsidized
Net exclusion of pension contributions and earnings	81.9	Accept pension benefits and plans from employers as compensation, save in excluded plans, increase savings.	taxpayers and employers, financial institutions selling and managing pension plans or IRA/Keogh plans
Earned income tax credit	3.6[10]	(for low-income workers)Intended to reduce unintended disincentive to work created by welfare system.	low-income workers (the "working poor")
Exclusion of untaxed Social Security and railroad retirement	23.1	Rely on Social Security as retirement income.	retirees
Exclusion of interest on public purpose state and local government debt	10.3, **4.4**	Invest in state and local bonds.	bondholders, state and local governments
Deduction of nonbusiness state and local government income and personal property taxes	27.5	Reduces cost of living in high-tax states and localities.	taxpayers, state and local governments

SOURCE: CRFB based on OMB (1997(a)).

Notes:

1. Income **excluded** from taxes is not reported to the IRS.
2. Income **exempt** from taxes is reported, but no taxes are paid upon it.
3. Expenses **deducted** from taxes are subtracted, in whole or in part, from income when taxes are calculated.
4. Tax **credits** are counted against taxes that must be paid. (The Earned-Income Tax Credit also involves a cash subsidy.)

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[8] Includes only expenditures which cost the government more than $5 billion in fiscal year 1996.

[9] The number in plain type is the amount effectively paid to individuals. The number in bold type, where present, is the amount effectively paid to corporations. These represent direct gains only and do not include the indirect gains by others, such as subsidized industries.

[10] While the tax expenditure portion of the EITC was under $5 billion, the outlay portion was $19.9 billion in 1996.

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About the Committee for a Responsible Federal Budget

The Committee is a bipartisan, non-profit educational organization committed to educating the public regarding the budget process and issues that have significant fiscal policy impact. The Committee sponsors analysis and research, conducts educational symposia, and prepares and distributes educational materials.

The **Committee** is bipartisan. One-third of the Board Members are elected by Democrats as Democrats. One third are elected by Republicans as Republicans. One third are elected at large without respect to political party affiliation.

Goals

The broad long-range goal is to educate the public on the federal budget process and on the need for discipline and order in making spending and revenue decisions. The immediate, specific goal of the **Committee** is to point out the prospect and consequences of continuing deficits and a national debt that will once again grow faster than the economy, which threaten the budget process and the very fabric of our nation's economic and political life.

What We Do

The **Committee** sponsors symposia on budget and economic issues. We provide speakers from civic, academic, and business groups and hold Congressional Breakfasts for Members of the House and Senate interested in a dialogue on the budget and related issues. **Committee** staff and Board Members write about the budget and related issues for major media outlets, provide background information and educational materials, and help explain the budget and the budget process to many audiences.

In the fall of 1982 the **Committee** launched an ambitious education and outreach program on the problem of the deficit. ***The Exercise in Hard Choices*** is to inform the American people of the nature and magnitude of the deficit and debt problems facing the country and the limited choices available to solve those problems. *The Exercise* is updated every year to reflect the actual choices Congress and the Administration are considering to reduce the Federal deficit and reorder national priorities. The **Committee** provides the Exercise workbook to educational organizations and other interested parties at cost.

The **Committee** is a 501(c)(3) educational organization. All of its activities are funded through tax deductible contributions from individuals, foundations, corporations, and other interested groups. It accepts no government funding.