

## *Chapter 5*

# **The Impact of An Aging Population**

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Balancing the budget over the next decade is an important goal for the nation in part because later decades threaten even larger budget challenges. The first baby boomers become eligible for early Social Security retirement benefits in 2008 and for Medicare in 2011. As the baby boomers increasingly become eligible for these programs, the federal budget is expected to begin running deficits vastly larger than those projected over the next decade.<sup>1</sup>

Balancing the budget by 2014 will help prepare both the economy as a whole (through higher national saving, which raises our future productivity) and the federal budget (through smaller increases in public debt, which reduce future debt service costs) to meet these challenges. Merely balancing the budget over the next decade, however, is not enough. Both Social Security and Medicare face long-term deficits. The sooner both are placed on a solid long-term footing, the better it will be both for the federal budget and for program beneficiaries. Both programs are a major source of long-term budget imbalance, and early action will allow changes to be implemented gradually and spare everyone the burden of abrupt tax increases or benefit cuts. Delay carries the threat that sudden and dramatic changes in benefits on which people had based their retirement plans may one day be forced on us.

Avoiding abrupt changes to the major retirement programs implies not only that long-term reforms should be enacted as soon as possible, but also that sound long-term reforms will contribute little to balancing the federal budget over the next decade. The fiscal benefits will eventually be enormous, but most will come much later. For example, many Social Security reform plans, reflecting a commitment not to cut benefits of current retirees or older workers, maintain benefits for those fifty-five or older.<sup>2</sup> Those younger than fifty-five in 2004 will not become eligible for Social Security retirement benefits until after 2011 and will receive only about 5 percent of the total retirement benefits paid between 2005 and 2014.

The potential contribution to budget balance over the next decade from a long-term reform that, as we believe proper, exempts retirees and near retirees is therefore small.

In any case, the focus of this book is how to eliminate the deficit in the unified budget over the next decade. It will not address the much larger and more complex problems of how to restore long-term financial balance to Social Security and Medicare and whether and how to change their structure. Nor will it address the quite different but equally serious issues in the design of Medicaid, the federal-state program that provides health benefits for the poor. We believe that large-scale modifications in Social Security and Medicare should be designed not to achieve near-term savings, but rather to improve the structure of retirement and health programs for the aged and disabled and to place them on a sound long-term footing. For these reasons, we make no attempt to evaluate or indicate our preferences among alternative long-term Social Security and Medicare reforms.<sup>3</sup> We list several in tables later and indicate the generally small contribution they can make to balancing the unified budget in the next decade.

### **Background on Entitlement Spending**

In 2004, mandatory spending—outlays that do not require an annual congressional appropriation—is projected to total \$1.3 trillion, more than half of all government spending. Of this mandatory spending, about three-fourths will go for the “Big Three”—Social Security, Medicare, and Medicaid.

Spending on these three programs is projected to grow rapidly as the baby boom generation ages—nearly doubling as a share of gross domestic product by 2040. If, as commonly assumed, per capita medical spending continues to outpace growth of per capita GDP even after 2040, the budget shares will keep on growing (table 5-1). Furthermore, both Social Security and one of the two major parts of

*Table 5-1. Projected Social Security, Medicare, and Medicaid Outlays as Percentage of GDP, 2004-60*

<i>Year</i>	<i>Social Security</i>	<i>Medicare</i>	<i>Medicaid</i>	<i>Total</i>
2004	4.3	2.6	1.6	8.5
2010	4.3	3.2	1.8	9.3
2015	4.8	3.5	2.1	10.4
2020	5.4	4.5	2.4 <sup>a</sup>	12.3
2040	6.6	6.7	4.0	17.3
2060	6.8	8.4	5.2	20.5

Source: Congressional Budget Office, “The Budget and Economic Outlook; An Update,” August 2003; and U.S. House of Representatives, Committee on Ways and Means, *2000 Green Book, Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, October 6, 2000.

a. Assumes that Medicaid spending rises at the same rate as projected Medicare outlays.

Medicare—hospital insurance, or part A—are financed through dedicated taxes that, over the long term, are projected to be insufficient to pay for all benefits promised under current law.

### *Social Security*

Social Security is now running a sizable cash-flow surplus—more than \$164 billion in 2004. The excess of revenues over outlays for benefits and administration is projected to grow until it reaches almost \$334 billion in inflation-adjusted dollars in 2015. Revenues include payroll taxes, now 12.4 percent of earnings up to a ceiling (\$87,900 in 2004), most of the income tax collections on Social Security benefits, and interest on accumulated reserves. Pension costs will rise fast as the baby boomers become eligible for retirement benefits. Projections indicate that these revenues and accumulated reserves—now \$1.5 trillion—will be sufficient to pay for currently legislated benefits through 2042. The same projections indicate that earmarked revenues will cover 95 percent of promised Social Security benefits over the next fifty years and 88 percent over the next seventy-five years.<sup>4</sup>

### *Medicare*

Medicare hospital insurance (HI, or part A) is also running cash-flow surpluses—\$24 billion in 2004. Benefits, which include inpatient hospital care, skilled nursing facility care, home health care, and hospice care, are financed by a payroll tax of 2.9 percent of all earnings and part of income tax collections on Social Security benefits received by the upper-income elderly and disabled. These surpluses are projected to grow and remain around \$35 billion for the next decade. Accumulated surpluses are projected to cover all currently promised benefits through 2026.

The long-term deficit in HI is proportionately much larger than that in Social Security. Dedicated revenues and accumulated reserves are projected to cover only 71 percent of promised benefits over the next fifty years and 58 percent over the next seventy-five years. The Medicare projections are subject to more uncertainty than are those for Social Security. Both are subject to demographic and economic contingencies, but Medicare projections also depend sensitively on growth of *per capita* health care costs.

Medicare supplemental medical insurance (SMI, or part B) covers doctors' services, a few outpatient drugs and vaccines, durable medical equipment, and certain other services. Premiums paid by Medicare eligibles cover about one-fourth of program costs, and general revenues cover most of the rest. Under legislation enacted in 2003, premiums will be increased for upper-income enrollees, starting in 2007. The same legislation expands coverage of out-patient drugs starting in 2006. The cost of SMI, already a sizable current drain on the budget, is projected to grow rapidly. Outlays net of premiums paid by enrollees are projected to rise from \$95 billion in 2004 to \$163 billion in 2012. In addition, the drug

benefits and other changes in Medicare will absorb \$58 billion in general revenues in 2012 and more in succeeding years.

Medicare expenditures are expected to rise even faster than pension costs because outlays will be driven not only by the growing ranks of beneficiaries, but also by per capita medical costs that are projected to increase faster than per capita income.

### *Medicaid*

Medicaid pays for acute and long-term care for the poor—elderly and nonelderly—and for premiums, deductibles, and cost sharing under Medicare for people enrolled in both programs. Because most middle-class Americans have few savings apart from Social Security and home equity, many quickly exhaust their assets and become eligible for Medicaid when old and forced to enter nursing homes. Medicaid accounts for more than 40 percent of all nursing home and home health payments. In recent years, Medicaid outlays have risen much faster than Medicare spending. The recent recession has simultaneously inflated Medicaid rolls and forced states to cut back on services and eligibility to hold down costs. Over the long term, Medicaid costs could rise faster or slower than Medicare outlays. The exact pace will depend not only on the number of aged and disabled (as do Medicare outlays) but also on changes in the proportion of the population that is in poverty and on state policies.<sup>5</sup>

Clearly, in the case of all three programs, specific long-term estimates matter little because it is impossible accurately to project economic and demographic conditions and health technology decades into the future. But these projections leave little doubt that Social Security faces a long-term deficit, probably of modest size and manageable if tackled soon, but increasingly difficult to handle if action is long delayed. The projections also show that Medicare hospital insurance faces a huge and challenging deficit and that supplemental medical insurance, the new prescription drug benefits, and Medicaid will impose increasing burdens on general revenues.

### **Entitlement Reform and the Federal Budget**

Social Security, Medicare, and Medicaid comprise a large and growing part of the budget. To exclude them entirely from the effort to restore fiscal balance would make achieving that goal all the more difficult. In addition, as emphasized above, long-term reform should ideally be enacted soon to spread the burden of addressing the long-term funding problems confronting both Social Security and Medicare hospital insurance.

At the same time, it makes little sense to base big changes in the nation's core retirement programs on short-term budget savings rather than on long-term structural considerations. Congress has

never been willing to enact large abrupt cuts in either Social Security or Medicare. Sound policy as well as politics explains this reticence.

Congress has, however, made small benefit cuts with little notice, and we propose some below. For example, in 1983, Congress cut Social Security benefits to help deal with a current cash-flow deficit and a projected long-term deficit. Congress enacted an immediate implicit benefit reduction of less than 2 percent, but it delayed implementing a much larger long-term benefit cut (raising the age at which benefits can be claimed) for seventeen years and then spread the ensuing cuts over two six-year periods, one from 2000 through 2005 and one from 2017 through 2022. Thus, Congress allowed nearly four decades from enactment until full implementation. This degree of gradualism underscores the caution with which Congress has handled benefit changes within the key retirement programs. By contrast, tax increases or general revenue transfers can be implemented with less notice because they mostly affect workers who are better positioned than retirees to adapt to such policy changes.

*Social Security Reform*

Despite the constraints imposed by the bipartisan and sensible agreement to phase in slowly any significant benefit changes to Social Security, Social Security can contribute to the goal of eliminating the deficit in the unified budget over the next decade. Below, we describe three changes—two plans to take into account the costs of increasing life expectancy and one plan to improve inflation adjustments—that would reduce the unified budget deficit significantly over the next decade. All three changes are consistent with a variety of long-term reforms in Social Security. Table 5-2 shows how such changes would affect federal expenditures in 2014.

Offsetting Increasing Life Expectancy. The lifetime value of Social Security old age benefits is the expected value of benefits from the age of claiming until death. As life expectancy increases, the generosity—and cost—of the system automatically increases. One way to hold down costs is to reduce annual benefits to offset the increased duration of benefit payment as life expectancy increases.<sup>6</sup>

Table 5-2. *Proposed Savings from Reforms in Social Security in 2014*

*Billions of dollars*

<i>Reform</i>	<i>Saving</i>
Accelerate increase in full benefits age to offset costs of increasing life expectancy	1.4
Adjust benefit formula to offset half the costs of increasing life expectancy	<1.0
Improve adjustment for inflation	17.0
<b>Total</b>	<b>19</b>

Source: Authors' estimates.

Congress took a step in this direction in 1983 when it increased from sixty-five to sixty-seven the age at which “full” benefits are paid. (Benefits are actuarially raised or lowered if workers claim benefits after or before the “full” benefits age.) The first of these increases—from age sixty-five to sixty-six—will be complete in 2005. The second step—from sixty-six to sixty-seven—is not scheduled to begin until 2017. Several reform plans have proposed accelerating this shift, which is ultimately equivalent to a benefit cut of about 7 percent for those who will be affected by the change in timing.

The Social Security Commission appointed by President Bush in 2001 recognized that benefit cuts for those soon to retire are neither politically acceptable nor sound policy. Specifically, the commission proposed no cuts in retirement benefits promised under current law for any worker aged fifty-five or older. Because the age of initial eligibility is sixty-two, the commission stance amounts to a refusal to endorse benefit cuts affecting workers within seven years of initial eligibility. Accepting that phase-in period, one could accelerate the benefit cuts enacted in 1983 and now scheduled to begin in 2017; these reductions could instead begin in seven years—that is, in 2012. In other words, the full benefit age could begin increasing again in 2012 rather than 2017. Accelerating this increase would contribute savings in the period 2005-14 of \$2.4 billion (\$1.4 billion in 2014).

Another way to respond to increasing longevity would be to adjust the benefit formula each year to offset at least part of the cost-increasing effects of rises in life expectancy. Starting such adjustments in 2012, as proposed in a recent Brookings volume, *Saving Social Security*, would produce negligible savings between 2005 and 2014—less than \$500 million—but would save far more in the future than would a one-time increase in the full benefits age to sixty-seven because the benefit formula would be adjusted continually as life expectancy increases over time.<sup>7</sup>

Improving Inflation Adjustments. For more than three decades, both political parties have endorsed the principle that Social Security benefits should be fully protected from inflation. To achieve that goal, benefits have, since 1972, been automatically adjusted to keep pace with the consumer price index (CPI). Analysis has revealed that the CPI somewhat overstates growth of the cost of living for the population as a whole.<sup>8</sup> The Bureau of Labor Statistics has created an alternative price index, C-CPI-U, which more accurately measures the cost of living. Federal Reserve Board Chairman Alan Greenspan, among others, has proposed using this alternative measure to index Social Security.

Such a change would reduce benefits for retirees and near-retirees but could nonetheless be justified by the generally accepted principle that real purchasing power of currently payable benefits should be maintained. Switching to the C-CPI-U would reduce Social Security benefit costs an estimated \$70 billion cumulatively from 2005 through 2014 (\$17 billion in 2014). (It could also increase personal

income tax collections by an estimated \$83 billion from 2005 through 2014, \$18 billion in 2014, and reduce other public spending by several billion dollars more.)

Although some critics oppose this change on the ground that the elderly have different spending patterns from those of the general population, that the real purchasing power of retirement benefits should increase over time with rising productivity, and that the change imposes the largest relative burdens on those who live the longest, several technical adjustments made recently to the official CPI have reduced measured inflation without eliciting opposition. Switching to a more accurate price index should be no more objectionable than correcting the current index.

Restoring Long-Term Balance of the Current System. In table 5-3 we list several proposals advanced in recent years either to change the long-term structure of Social Security or to close projected long-term Social Security deficits. Most would somewhat reduce Social Security spending or increase revenues. All would retain primary reliance on a defined-benefit pension system.<sup>9</sup> Several would have large long-term effects, but none reduces spending much over the next decade.

Table 5-3. *Elements of Long-term Plan to Restore Financial Balance to Social Security*  
*Billions of dollars*

<i>Element</i>	<i>2005-14</i>	<i>2014</i>
<b><i>Benefit changes</i></b>		
Adjust benefit formula to offset half the costs of increasing life expectancy, starting in 2012	<1	<1
Accelerate increase in full benefits age (from age 66 to 67) from 2017-22 to 2012-17	2	2
Reduce benefits as a share of average earnings for workers with earnings exceeding \$64,000, starting in 2012	<1	<1
Extend period over which average earnings are computed to establish initial benefits from 35 to 38 years, starting in 2008	2	1
<b><i>Revenue changes</i></b>		
Increase earnings base to include 90 percent of all earnings; for further explanation, see chapter 6	470	53
Cover newly hired state employees, starting in 2008	55	14
Impose a 3 percent payroll tax (“legacy tax”) on all earnings over the Social Security earning ceiling to cover the cost of benefits paid to past and current beneficiaries in excess of the value of their and their employers’ payroll taxes, starting in 2005	296	38
Raise the payroll tax by 0.3 percent each on workers and employers (from a total of 12.4 percent to 13 percent) in 2005	358	44
Treat Social Security benefits like private pension benefits for tax purposes by including in income subject to personal income tax all Social Security benefits in excess of employees’ payroll taxes	185	40

Source: Authors’ estimates.

Many of these proposed changes are controversial, and no consensus has yet emerged on whether or how to close the projected financial deficit within the current system. Should such a consensus develop soon, these proposals could also help close a small part of the unified budget deficit over the next decade. Most of the spending reductions or revenue increases would nonetheless occur outside the ten-year budget window that frames all of the proposals presented in this book.

Diverting Social Security Revenue to Individual Accounts. President Bush appointed his Social Security Commission to honor his presidential campaign pledge to have such a commission recommend ways to replace Social Security in part with individually owned investment accounts. The commission duly reported, on December 11, 2001, and presented three plans, all of which would have allowed workers to divert a portion of the payroll tax from Social Security to individual investment accounts.

President Bush did not endorse any of these plans. In the current budget situation it is extremely unlikely that he, or the winner of the 2004 election, will—or should—do so, regardless of the long-term strengths or weaknesses of these proposals. The reason is that if implemented, all three plans would greatly aggravate the unified budget deficit not only for the next ten years (table 5-4), but for many years more. They would do so because each would reduce revenues far more than benefits for several decades. By 2040, each plan would have increased the government debt in the hands of the public by more than \$4 trillion (for comparison, debt in the hands of the public at the end of fiscal year 2003 was nearly \$3.8 trillion).

Almost any plan to divert Social Security revenue into individual accounts will add to, not relieve, government deficits over the medium term, as long as it protects benefits for current retirees and those nearing retirement. The reason is that traditional Social Security benefit payments would continue *and* the federal government would also have to find funds to deposit in the newly created, individually owned accounts.

Table 5-4. *Elements of Long-term Plan to Divert Social Security Revenue to Individual Accounts*  
*Billions of dollars*

<i>Element</i>	<i>2005-14</i>	<i>2014</i>
Adjust income ranges to which various replacement rates apply by changes in prices rather than changes in wages for retirees reaching age 62 starting in 2012	2	2
Divert 2 percentage points of the payroll tax from Social Security into individually owned private accounts for workers age 55 or younger, starting in 2005	-1,300	-152

Source: Authors' estimates.

These deposits would either boost spending or divert federal revenue. In either case, they would increase the budget deficit for many years. It would take several decades before cuts in traditional benefits linked to individual accounts would offset the diversion of revenue itself.

### *Medicare and Medicaid Reform*

Will Rogers once reviewed a restaurant by commenting that the food was mediocre and there wasn't enough of it. Much the same can be said of Medicare, with the addition that it is also very expensive. It exposes beneficiaries to high cost-sharing. It does not limit total out-of-pocket costs during serious and extended illnesses. And it does not cover nursing home costs, other than those in a skilled nursing facility immediately following hospitalization.

Although coverage is below the standard of employment-based insurance, Medicare hospital insurance is still projected to cost far more than the taxes earmarked to pay for it. And the costs of supplementary medical insurance (part B), in excess of the 25 percent of program outlays covered by premiums, are projected to claim ever growing shares of general revenues. In brief, even with its inadequate benefits, Medicare is likely to pose massive fiscal challenges.

The shortcomings in Medicare's coverage make it difficult to see how significant reductions in growth of benefits would be politically feasible in the coming years. Indeed, if anything, pressure for expanding the program is likely to increase. The debate on the recently enacted prescription drug bill was a vivid lesson. That bill added well over \$500 billion to the budget deficit over the next decade (including added interest costs) and close to \$2 trillion to the deficit over the succeeding decade.<sup>10</sup> We are persuaded that in evaluating such potential expansions in Medicare, policymakers should always recognize the trade-offs with other areas of the budget. Medicare benefits should not be increased without offsetting spending reductions or tax increases. In other words, the PAYGO principle, which chapter 2 recommends for all mandatory spending, should be applied.

Requiring beneficiaries to shoulder more of the cost of covered services through premiums, deductibles, and other forms of cost-sharing is an option that merits increased scrutiny. Few current Medicare beneficiaries have paid premiums approaching the actuarial value of the benefits they receive.<sup>11</sup> Shifting some of Medicare's costs to patients through increased cost-sharing or higher premiums would reduce long-term budget costs. It is unclear, however, whether such charges would be sufficient to offset any added long-term cost of extending Medicare benefits.

Whatever other structural changes may eventually be made in Medicare, some savings are possible over the next decade through targeted changes, including increased charges on enrollees. Table 5-5 shows how such changes in Medicare would affect federal revenue in 2014.

SMI Premiums. When Medicare was enacted in 1965, Congress set the premiums for supplementary medical insurance to cover half of program costs. The other half was to come from general revenues. The principle of automatic adjustments for inflation had not yet been applied to any major government program. (Social Security benefits, as noted, were first automatically indexed to inflation in 1972.) Thus, Medicare premiums were initially fixed and had to be changed by legislation. But Congress failed to raise premiums as fast as program costs grew. In 1972, it limited premium growth to the increase in the consumer price index, which was rising far more slowly than *per capita* SMI costs. Over time, premiums came to cover less than one-fourth of program costs. In the 1980s Congress overrode its own limit on premium increases to hold premiums at one-fourth of total SMI costs and in 1997 set the premium at this level.<sup>12</sup>

Some subsidy of supplemental medical insurance premiums is desirable to encourage the elderly and disabled to enroll in SMI. Deep subsidies for the low-income elderly are justified to spare them from having to divert their meager incomes to pay health insurance premiums. In fact, federal and state governments jointly cover all premiums (and many other Medicare charges as well) for elderly and disabled beneficiaries who qualify for and receive Medicaid. But some premium increase for the majority of current supplementary medical insurance enrollees can be justified as part of a program to restore fiscal balance.

The 2003 bill that introduced drug coverage took a tiny step in this direction by reducing the premium subsidy over five years starting in 2007. For married Medicare enrollees with incomes from \$160,000 to \$200,000 (single enrollees with incomes of \$80,000 to \$100,000), the subsidy would be reduced from 75 percent to 65 percent. The subsidy reduction would be progressively larger as income rises, dropping from 75 percent to 20 percent for couples with annual incomes of \$400,000 or more (single enrollees with incomes of \$200,000 or more). These increases would initially affect only about 3 percent of Medicare beneficiaries (rising to 6 percent when fully implemented).

Table 5-5. *Proposed Savings from Reforms in Medicare and Medicaid in 2014*

<i>Billions of dollars</i>	
<i>Reform</i>	<i>Savings</i>
Increase supplemental medical insurance premium	16
Reform indirect teaching payments	5
Reduce over-payments to managed care plans	5
Reform upper-payment limit	0
Reform and reduce payments to disproportionate share providers	2
<b>Total</b>	<b>28</b>

Source: Authors' estimates and Congressional Budget Office, *Budget Options* (March 2003).

As part of a program to lower the deficit, the premium subsidy could be lowered from 75 percent to 65 percent for all Medicare beneficiaries effective in 2005.<sup>13</sup> If one-third of the additional revenues were used to protect low-income Medicare beneficiaries from the premium increase and to provide aid to states whose Medicaid budgets will skyrocket as baby boomers increasingly become eligible for long-term care, this measure would reduce net spending by \$123 billion during 2005-14 and by \$16 billion in 2014.

Indirect Teaching Payments. Medicare increases payments to teaching hospitals in recognition of extra costs they incur because they are thought to provide more tests and other procedures and to care for particularly sick patients. Some extra compensation for such costs is in order. But the Medicare Payment Advisory Commission has found that the current bonus is roughly twice as large as it should be to compensate teaching hospitals for added costs. Cutting the payments over a three-year period starting in 2005 to half of their levels under law in effect before the drug bill was enacted would lower total Medicare spending by an additional \$40 billion over the period 2005-2014 and \$5 billion in 2014.

Payments to Managed Care. Medicare now pays managed care plans more than the costs it incurs through traditional Medicare. The reimbursement rate is 103 percent of the average cost in each county. Before 1997, managed care plans received 95 percent of the average cost of serving Medicare patients in each county. This rate enabled taxpayers to gain savings that managed care plans were supposed to generate and to capture savings they reaped from enrolling healthier-than-average patients. Currently, managed care plans enroll patients who cost about 16 percent less than the average enrollee. Although a new formula is supposed to adjust payments based on expected costs, the methodology is imperfect and accounts for only a small fraction of potentially predictable cost variation. Because the gain is large, managed care plans are likely to continue to try to attract low-cost patients and there is probably no pricing formula that will prevent them from doing so. Rather than trying to narrow the current unwarranted subsidies to managed care, the 2003 drug bill added to them by increasing payments by nearly \$16 billion from 2005 through 2014 (\$2 billion in 2014). At a minimum, this increase could be rescinded and managed care plans be paid no more than 100 percent of the average cost of treating Medicare patients. These steps would shave an estimated total of \$38 billion from Medicare spending from 2005 through 2014 and \$5 billion in 2014.<sup>14</sup>

Upper-Payment Limit. The federal government pays each state a fraction of the state's cost of services provided to Medicaid enrollees. Allowable costs cannot exceed what Medicare would pay them. This ceiling is called the "upper-payment limit." In practice, however, Medicaid's payments are typically

smaller than Medicare's. This difference created an opportunity for states to cook the books to extract more from the federal government. A transaction by Pennsylvania is illustrative. In 2000, twenty counties borrowed \$695.6 million from a bank. They then transferred it to the state Medicaid agency's account in the same bank.<sup>15</sup> The Medicaid agency then made a grant of \$697.1 million (the original amount plus a \$1.5 million fee) to the counties, ostensibly as payment for treating Medicaid patients. The counties used the proceeds to pay off the loan. The state then billed the federal government \$393.3 million—the federal matching share (56.4 percent) of its “outlay” of \$697.1 million—and used this sum for other purposes.

To curb such abuse, Congress authorized and the Department of Health and Human Services imposed regulations that take effect gradually through 2008. Accelerating the effective date to 2006 would reduce spending faster but would have no effect on outlays in 2014 as the new regulations are projected to be fully in effect in our baseline.

DSH Payments. Medicaid provides extra payments to states for services rendered by hospitals that serve a disproportionate share of Medicaid patients (hence the acronym, DSH). A justification for such payments is that hospitals serving many Medicaid patients are likely also to provide disproportionate amounts of uncompensated care to uninsured patients. Thus, payments based on the numbers of Medicaid (and Medicare) patients can help hospitals serve the uninsured without weakening their incentives to collect reimbursements whenever possible.

Although some form of assistance may well be justified, the distribution of assistance under the current DSH program is badly flawed. Current rules permit states to extract large sums with gimmicks similar to those used to exploit the upper-payment limit. Because not all states have used this option, the pattern of DSH payments bears little relation to the problem they are intended to ameliorate. In 1997, for example, DSH payments per Medicaid or uninsured individual ranged from more than \$500 in five states to less than \$10 in eight states. The larger totals come in part from the clever use of payments to providers that the states recover in other ways but that form the basis of claims against the federal government. Some of the funds advance the intended purpose of extending health care to the uninsured, but some—an estimated 40 percent of the \$7 billion annual cost in the late 1990s—flow back to state treasuries as general government support.

Successive administrations of both parties have proposed limits on DSH payments to curb these abuses. Congress has been willing to cap payments, but not to reform the fundamental structure of the program. The stated objectives of the program would be better achieved if the federal government established standards for direct allocation of funds to hospitals and other qualifying facilities that serve poor or uninsured populations. Given states' current fiscal duress, no immediate cutbacks in DSH payments—or any other form of federal assistance to the states—should be made. Starting in 2006,

though, DSH payments could be channeled directly to care-giving facilities and total spending scaled back 20 percent. The net saving would be between \$15 billion and \$20 billion from 2006 through 2014.

**Summary**

Some analysts and elected officials have claimed that serious discussion of budget deficits cannot begin until people acknowledge that spending on “entitlements”—usually defined to include Social Security, Medicare, and Medicaid—must be cut by large amounts. We believe this view is flawed. Well-designed reforms of these entitlement programs will eventually produce large savings and are essential for long-term fiscal balance, but one should not expect substantial budgetary savings over the next decade. On Social Security, for example, the unwillingness to cut pensions for retirees or those soon to retire is bipartisan and close to unanimous. This reticence is well founded. Medicare outlays are unlikely to be cut significantly even in the long run, given justifiable pressure to liberalize a rather parsimonious benefit package.

Finally, growth of state revenues slowed or stopped in the recent recession, forcing significant cutbacks in Medicaid coverage. Further curtailments in Medicaid coverage would threaten to destroy the only health coverage available to millions of poor Americans. For that reason, we think that reductions in Medicaid spending beyond what we have outlined in this chapter are undesirable.

**ENDNOTES**

1. Congressional Budget Office, "A 125-Year Picture of the Federal Government's Share of the Economy, 1950 to 2075," Long-Range Fiscal Policy Brief 1, June 14, 2002 (revised July 2002).

2. The Commission to Strengthen Social Security appointed by President George W. Bush recommended that benefits not be changed for current beneficiaries or workers fewer than seven years from eligibility. This standard is also adopted in other recent Social Security reform plans.

3. For our views on reforming Social Security, see Peter A. Diamond and Peter R. Orszag, *Saving Social Security: A Balanced Approach* (Brookings, 2004). For an earlier set of recommendations, see Henry J. Aaron and Robert R. Reischauer, *Countdown to Reform: the Great Social Security Debate* (Century Foundation, 2001). For views on reforming Medicare, see Henry J. Aaron and Robert R. Reischauer, *Modernizing Medicare for the 21st Century* (Century Foundation, forthcoming).

4. Present tax rates would be sufficient to pay 73 percent of scheduled benefits after the trust fund is projected to be exhausted in 2042 and 65 percent of scheduled benefits in 2077.

5. Growth will also depend on legislation. For example, the law adding a drug benefit to Medicare also terminated federal support for Medicaid payments for drugs on behalf of people who are also eligible for Medicare.

6. Increasing the age at which retirement benefits can first be claimed, currently age 62, has virtually no effect on long-term costs. The reason is that monthly benefits are increased for each month that a person defers claiming benefits, up to age 70 when benefits are paid automatically. These adjustments compensate those who delay claiming benefits with a benefit increase that is computed actuarially to approximately offset the reduced period over which benefits will be paid. Increasing the age at which benefits may be claimed would have large effects on budget outlays over the next decade, however, because all of the "front-end" savings from deferred payment would be realized but few of the added costs from increased monthly payments would be incurred. We do not include this change as a means of financing deficit reduction because counting as savings a reduction in current outlays, when there is no reduction in long-term cost, would be dishonest.

7. The plan in *Saving Social Security* offsets roughly half the cost of increases in life expectancy through gradual benefit reductions and roughly half through payroll revenue increases.

8. The Bureau of Labor Statistics has made various adjustments to reduce that bias. The CPI on which Social Security indexation is based, however, has failed to incorporate the fact that when relative prices change, consumers typically shift away from major categories of goods that have become more costly and toward categories of goods that have become less expensive.

9. Chapter 6, which lists changes in tax laws that could contribute to deficit reduction, also includes several tax increases that would help sustain the current surpluses in Social Security. Again, most of the revenue gains occur after 2014.

10. Authors' estimate.

11. This statement will cease to be universally true in the future, as the 2.9 percent payroll tax levied for Medicare hospitalization benefits (part A) has since 1993 applied to all earnings. For a small proportion of high earners, therefore, the actuarial value of taxes will exceed the actuarial value of benefits.

12. Committee on Ways and Means, U.S. House of Representatives, *2000 Green Book, Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, October 6, 2000.

13. In practice, supplemental medical insurance premiums are subtracted automatically from monthly Social Security benefit checks. Most beneficiaries would see these premium increases simply as a cut in cash pensions.

14. Rolling back payments to 95 percent of average cost would lower spending by \$70 billion from 2005 through 2014 and \$11 billion in 2014. So large a cut is probably unjustified, as one motivation for setting the payment at 95 percent of average cost was recognition that managed care plans were enrolling patients with lower-than-average costs, the very problem that risk-adjusted premiums aim to offset, even if they succeed only imperfectly.

15. This example is reported by Andy Schneider and David Rousseau, "Upper Payment Limits: Reality and Illusion in Medicaid Financing," Kaiser Commission Issue Paper, February 2002.