DEMOGRAPHIC TIDAL WAVES AND OTHER MYTHS: SOCIAL SECURITY AND MEDICARE

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In this article based on his Elder Law Journal Lecture*, presented March 1, 2001, at the University of Illinois College of Law, Mr. Weisbrot dispels the myths that Social*

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Security is headed for serious financial troubles and that Medicare is unsustainable as it currently exists. The author approaches these two issues by exploring demographic change and the effect that the myths have had on policy discussions of these and other issues. Privatization of Social Security, he believes, would not bring security, but increased risk to future generations of senior citizens. By using the official figures accepted by all parties to the debate—the annual report of Social Security's Trustees—he discusses how the program will be stable well into the future. Mr. Weisbrot also reminds us that Social Security is a social insurance program, and should be treated as such. Medicare has fallen prey to rising health care costs, and Mr. Weisbrot explores the real reasons behind these increases. He then discusses the problems with privatization of Medicare, and puts forth the economic and societal advantages of a universal system where the government is the sole insurer.

I. Introduction

There is a widespread belief among almost all sectors of society that Social Security is headed for serious financial troubles, and is in need of a major overhaul. The persistence of this particular belief provides one of the most compelling examples of how politics, powerful interest groups, and pervasive intellectual sloppiness on the part of those who inform the public can, in some cases, cause policy debates to take place under completely false premises.

This outcome would be bad enough, from a public policy point of view, even if only Social Security were affected by it. Social Security is the nation's largest anti-poverty program, with its payments keeping about half the nation's elderly above the poverty line.[1] For about two-thirds of the senior citizens, these payments make up the majority of their income; for the poorest sixteen percent, it is their only source of income.[2] It also provides more life insurance than the entire private life insurance industry, as well as payments to millions of disabled workers and their dependents.[3]

As proposals for partial privatization and benefit cuts have moved up the political agenda, the risk to future generations of senior citizens has increased. But the debate surrounding Social Security and demographic change has had consequences that extend far beyond the program itself. Medicare is also falsely portrayed as facing grave

1. *See* DEAN BAKER & MARK WEISBROT, SOCIAL SECURITY: THE PHONY CRISIS 12 (1999).
2. *See id.*
3. *See id.* at 13.

demographic threats to its solvency, and is currently threatened by attempts at further privatization. The myth of a "demographic time bomb" has also served to shift the focus of health care reform to Medicare (the public sector), whereas the private sector has been the source of our most important problems: unsustainable inflation in medical costs, and the lack of health insurance for forty-three million Americans.[4] At the same time, the myths surrounding Social Security make it difficult to apply the most valuable lessons from America's most successful social insurance program to the problem of health care reform—where they are badly needed.

This article examines some of the myths surrounding Social Security, demographic change, and Medicare and explores how these myths have affected policy discussions of these and other issues. It is clear that there is a pressing need for a more honest debate in these areas if we are to avoid regressive changes in the Social Security system, enact health care reform where it is needed, and perhaps even to pursue reasonable fiscal policies by the federal government.

II. Social Security's Troubles: The Making of a Myth

According to the numbers accepted by all experts, Social Security is financially rock-solid for the foreseeable future.[5] Yet two-thirds of the public has become convinced that it is headed for disaster. They do not even believe that they will receive their promised benefits from the program—an event that has about the same probability as the United States government not being around when they retire.

The fiction of Social Security's "looming insolvency" has shown remarkable persistence.[6] It is repeated almost daily in various forms—and not merely by its sworn enemies, the libertarians and "market fundamentalists." Leading journalists, editorial writers, economists, and most amazingly, even those who claim to support the program wholeheartedly have contributed to the confusion.

Keep in mind that this is not a debate about counter-insurgency wars in far away places, or other foreign interventions that are generally the subject of widespread deception. Myths that do not affect most Americans directly, in the absence of a military draft, can have a

4. *See id.* at 15.
5. *See id.*
6. Richard W. Stevenson, *Debate Starts Over Budgets Without Deficits*, N.Y. TIMES, Jan. 5, 1998, at A16.

long shelf life. This is about a domestic program that pays benefits to forty-five million people—one out of every six human beings in this country.

The perpetuation of this myth is all the more remarkable when one considers how little investigation or training is required to refute it. Anyone with a computer and a modem can go to www.ssa.gov (the Social Security Administration's web site) and look at the numbers for herself. A handful of journalists have actually done this, but their occasional portals to the truth have been buried under a mudslide of disinformation.

The actual story is fairly simple: The program is projected to pay all benefits for the next thirty-seven years, without any changes at all. Now that is a very long time; it is difficult to think of any other program or institution that can make any similar claim. And contrary to popular misconception, the retirement of the baby boomers—which starts in 2008 and extends to 2031—will be accommodated without any shortfall whatsoever.[7]

Economists cannot even forecast the federal government budget surplus or deficit one year out, within a margin of eighty percent. So a reasonable person might conclude that a thirty-seven-year window is enough.

But Social Security's Trustees, for reasons that may not be entirely innocent, publish projections for a seventy-five-year period.[8] On the basis of these projections into the science-fiction future, it is possible to show a shortfall.[9] And this projected shortfall, which for all its predictive power might just as well be read from Tarot cards, provides the entire intellectual foundation for the idea that Social Security needs to be "fixed."

However, even this projected shortfall over the seventy-five-year period is not anything that a rational person would be worried about. It is well under one percent of our national income. Because the United States' national income grows by more than that *each year*, any burden on future generations would be minimal. In other words, forty years down the road, people making fifty percent more than the current average—in real terms, adjusted for inflation—might have to

7. *See* 2000 SSA ANN. REP. BOARD TRUSTEES FED. OLD-AGE & SURVIVORS INS. & DISABILITY INS. TR. FUNDS 3 [hereinafter SSA ANN. REP.].
8. *See id.*
9. *See id.* at 179, tbl.III.B2.

pay one or two percent more of their income than is currently paid in taxes. Only the most fanatical opponents of taxation or government spending would see this as a problem.

It must be emphasized and repeated, because there is so much confusion on this issue, that this is not a debate about whose numbers or projections are accurate. All the preceding numbers are the numbers that *everyone* in the debate is using. These are the projections of Social Security's trustees. Some economists and actuaries have argued that these projections are overly pessimistic: after all, they are based on the economy growing at about half the rate that it grew over the last seventy-five years. But this is a side issue. The main point is that even if we accept these projections, there is no "there" there.

When a politician or journalist says that Social Security needs to be "fixed" because it is headed for insolvency, this is not exactly an outright lie. It has approximately the same truth content as President Clinton's famous utterance: "I never had sexual relations with that woman." Under certain definitions of the words "sexual relations," this could be considered a true statement. (In fact, the Journal of the American Medical Association, at the height of President Clinton's troubles, published an article based on survey data showing that a majority of college students did not consider oral sex to be "sex."[10] The AMA took this opportunity to fire the editor). Similarly, if we define an easily remediable shortfall that is at least thirty-seven years away and may never materialize as a "problem," then Social Security does need to be "fixed."

President Clinton's statement was ultimately rejected as false and misleading, however irrelevant it might have been. His license to practice law was suspended for five years for saying it under oath. But the everyday misrepresentations of the world's largest retirement system are generally accepted at face value, and repeated endlessly until they have become a truism.

How did Social Security's opponents ever manage to convince the public that they should be worried about something so far-fetched and exaggerated, an eventuality that is contradicted even by their own numbers? This is quite a trick—in fact it is a collection of tricks. For example, we are informed that the population of elderly will double

10. *See* Stephanie A. Sanders & June Machover Reinisch, *Would You Say You Had Sex If . . . ?*, 281 JAMA 275, 275–77 (1999).

over the next thirty-five years.[11] While we now have about 3.4 workers paying Social Security taxes for every beneficiary currently drawing a check, by 2035 this will be reduced to a ratio of approximately 2:1.[12]

This is true enough, but it has no more value than a corporate balance sheet that shows only the expenditure side of the balance sheet. Few investors would sell their stock on the basis of such a one-sided appraisal, yet much of the press is willing to haul Social Security into bankruptcy court without ever asking to see the revenue side of the ledger.

When the program's revenue is taken into account, the demographic time bomb turns out to be a dud. It could hardly be otherwise—after all, the nation raised the baby boom generation—the seventy-six million Americans born between 1946 and 1964—and put them through school in their childhood and adolescence. How hard could it be to support them in their old age, with an economy five or six times as large as the one that sustained them in their youth?[13]

Because productivity and therefore income per person grow each year, the future will provide more than enough income to retire the baby-boomers with hardly a dent in the rest of the population's rising standard of living.[14] Demographic change is slow, even when compared to slow economic growth. The politicians, pundits, and policy wonks that like to pretend otherwise cannot deny this when they are confronted with the facts because they are all using the same numbers.

Many people are skeptical when they are told that the average real wage forty years from now is projected to be fifty percent higher, and that any additional taxes that might be necessary to meet Social Security's obligations will therefore be very small by comparison. The reason for their doubt is understandable: over the last twenty-seven years, the median wage—that received by the majority of the labor force—has not grown at all, after adjusting for inflation.[15] But the *average* has indeed grown, and in fact income per person has grown by

11. *See* 2000 SSA ANN. REP., *supra* note 7, at 147, tbl.II.H1.
12. *See id*. at 22, fig. I.G2.
13. *See* Richard C. Leone, *Why Boomers Don't Spell Bust*, AM. PROSPECT, Jan.–Feb. 1997, at 69–70.
14. *See* BAKER & WEISBROT, *supra* note 1, at 48.
15. *See id.* at 147.

more than seventy percent since 1973.[16] What has happened is that, unprecedented in modern American economic history, the gains from growth have gone entirely to the upper half—and mostly to a much smaller group—of the income distribution.[17]

Now there is a long-term economic trend that most people have good reason to fear. If this were to continue for another generation or two, the polarization of income and wealth in the United States would reach explosive proportions. It is one of the greatest public relations feats of the twentieth century to have repackaged the class warfare that has been unleashed on the majority of Americans as an intergenerational conflict.

Four years ago, Peter Peterson wrote a cover article about Social Security for the *Atlantic Monthly*.[18] Peterson is an investment banker and former Secretary of Commerce in the Nixon administration, whose Concord Coalition has waged an unrelenting campaign since 1992 to cut spending on Social Security.[19] The article, which was grossly misleading and inaccurate, was then parlayed into a book, *Will America Grow Up Before It Grows Old? How the Coming Social Security Crisis Threatens You, Your Family, and Your Country*, published by Random House in 1996.[20]

Peterson conjures up nightmarish visions of gray-haired hordes—"A Nation of Floridas,"[21] in the author's words—jetting around the world on their senior citizens' travel discounts,[22] sponging off of the hard work of the generations beneath them,[23] and squandering our precious national savings.[24] He implores his compatriots with Calvinist urgency to do something about Social Security before these

16. *See* 2001 COUNCIL OF ECON. ADVISERS ECON. REP. PRESIDENT 276, 316 tbls.B2, B35 (2001), *available at* http://www.access.gpo.gov/usbudget/fy2002/erp.html/erp1.

17. *See* BAKER & WEISBROT, *supra* note 1, at 147.

18. *See* Peter Peterson, *Will America Grow Up Before It Grows Old?*, ATLANTIC MONTHLY, May 1996, at 55.

19. *See* The Concord Coalition, *The Honorable Peter G. Peterson, President; The Concord Coalition*, *at* http://www.concordcoalition.org/home/petersonbio.html (last visited Feb. 12, 2001).

20. *See* PETER G. PETERSON, WILL AMERICA GROW UP BEFORE IT GROWS OLD? HOW THE COMING SOCIAL SECURITY CRISIS THREATENS YOU, YOUR FAMILY, AND YOUR COUNTRY (1996).

21. *Id.* at 15.

22. *See generally id*. at 31–49.

23. *See generally id.*

24. *See generally id.* at 73–110.

bloated entitlements for the elderly bring America's economic growth to a grinding halt.[25]

Paul Krugman, professor of economics at MIT and winner of the profession's prestigious John Bates Clark award,[26] took the bait. He wrote a glowing review as the cover article of the *New York Times* Book Review. "The budgetary effects of this demographic tidal wave are straightforward to compute, but so huge as to defy comprehension," wrote Krugman.[27] Unfortunately, he did not do any of the computation. Krugman later admitted that he had "gone overboard in supporting Peter Peterson's position on entitlements and demographics . . . I broke my own rule that you should always check an argument both with a back-of-the envelope calculation and by consulting with the real experts, no matter how plausible and reasonable its author sounds."[28]

That, as they say, is how rumors get started. Few people ever saw Krugman's *mea culpa*, which was published in an obscure exchange by the on-line magazine *Slate*; whereas his review in the *Times* lent academic credibility to a book that, had it been submitted as a term paper in an undergraduate economics course, might have earned its author a failing grade.

III. Social Security Politics: Budget Surpluses, Lockboxes, and Privatization

Other circumstances have conspired to make 2000 the first year that a Presidential candidate would actually dare to run on a program of partially dismantling Social Security. Ever since Barry Goldwater's crushing defeat in 1964, conservatives had taken the lesson that this program was too popular to attack; even after the New Right captured the Republican Party and the presidency sixteen years later, Ronald Reagan had no inclination to touch the "third rail" of American politics. But the unprecedented run-up of stock market prices in the 1990s made the Right increasingly bolder, while at the same time most of the liberals who would be expected to debunk the myth that Social Secu-

25. *See generally id.* at 155–207.
26. *See* MIT Tech Talk, *Krugman Is Awarded John Bates Clark Medal*, at http://web.mit.edu/newsoffice/tt/1992/mar04/25842.html (last visited Feb. 12, 2001).
27. Paul Krugman, *Demographics and Destiny*, N.Y. TIMES, Oct. 20, 1996, § 7, at 12.
28. Paul Krugman, *Who's the Real Economist?*, at http://slate.msn.com/dialogues/96-11-05/Dialogues.asp (Nov. 11, 1996).

rity is headed for insolvency have failed to do so. To the contrary, President Clinton, who was perfectly honest about Social Security's finances when he ran for the office in 1992, had a change of heart six years later when he was looking for a legacy other than impeachment. It was then that he decided it was time to "save Social Security for the twenty-first century."[29]

The Democrats soon discovered that Social Security was an issue that could help win elections, especially after polls showed that voters trusted them more than Republicans to "save" the program.[30] So they were not about to tell the world that the whole problem was a scam invented by the Right. They also used it to beat back Republican proposals for tax cuts, arguing, completely disingenuously, that such tax cuts would put Social Security in danger. Here is another glowing example of how the rules of arithmetic or accounting can be suspended, with few objections from the press, when the leadership of both parties concurs. Before long each party was accusing the other of trying to "raid" the Social Security trust fund for its own purposes.[31]

This is, of course, nonsensical. The Social Security trust fund is accumulating a surplus each year because it is taking in more revenue than it pays out in benefits.[32] It invests this surplus in U.S. Treasury securities.[33] To say that it has been "raided" when the federal government spends the money that it borrowed is like saying you have lost your money when you buy a government bond, and the government uses the money it borrowed from you to build a highway. You are still holding the bond, and will be repaid both principal and interest. It does not matter whether the government spends your money on education or health care, or a tax cut. The same is true for the Social Security trust fund, and this embarrassingly silly bi-partisan pretense to the contrary has simply reinforced the right's portrayal of Social Security as a huge "Ponzi scheme" that has stolen taxpayers' contributions and used it for other purposes.

Then came the concept of the "lockbox." When the Saturday Night Live actor who played Al Gore in the show's version of the Presidential debates was asked to sum up his campaign in one word,

29. *See* WEISBROT & BAKER, *supra* note 1, at 149.

30. *See* Alison Mitchell, *Republicans Are Seizing the Democrats' Banner on Social Security*, N.Y. TIMES, Apr. 16, 1999, at A22.

31. *See id.*

32. *See* 2000 SSA ANN. REP., *supra* note 7, at 179.

33. *See id*. at 47.

he said: "lockbox." Perhaps it is because the concept itself is so silly that comedians had so much fun with it. The idea is that Social Security's surplus funds be set aside from all other revenues, so that they are not spent on anything else.[34] Of course this is impossible because, as noted above, these funds are required by law to be loaned to the U.S. Treasury.[35] What the "lockbox" means in practice is that Social Security's surplus revenues—so long as the government is running a surplus in the rest of the budget, as it is now—must be used to pay off the national debt.

In other words, the "lockbox" commits the government to using the projected $2.5 trillion of surplus Social Security revenues over the next ten years to paying down the national debt. This does not affect Social Security's finances one way or the other: the Social Security Trust Fund still holds the bonds for the surplus funds that it lent to the government, regardless of whether these funds have been used to pay off bondholders and reduce the national debt, or spent for other purposes.

The result of this particular deception in the Social Security debate is that both parties are currently committed to a very conservative fiscal policy: using most of the projected budget surpluses to pay down the national debt. The Clinton administration went even further, arguing that the entire national debt held by the public should be paid off over the next twelve years. If this plan were followed, it would be difficult, if not impossible, for the federal government to play a significant positive role in resolving any major domestic problems, such as poverty, education, or health care reform.

On the other side of the ledger, the benefits to the United States economy of paying down the national debt are so small as to be within measurement error. This is true even if it is assumed that the debt reduction lowers interest rates, leading to increased investment, and therefore a higher growth rate. Extrapolating from the models used by the Congressional Budget Office to estimate the effect of debt reduction, paying off the entire national debt held by the public would result in a GDP that is about one percent larger, twelve years from now, than it would otherwise have been.

With regard to the option of simply telling the truth about Social Security, the liberal think tanks tend to follow the Democratic leader-

34. *See id.*
35. *See* 2000 SSA ANN. REP., *supra* note 7, at 47.

ship, and they both take advice from their professional pollsters and focus-group managers. The latter have counseled for several years that the truth about Social Security is not marketable, because too many people believe the program to be financially shaky. And the liberal foundations have spent almost nothing to defend Social Security, while their conservative counterparts have slathered millions on the program's detractors.

"You could be staring at 130 million new accounts," said William Shipman of State Street Global Advisors, a division of State Street Bank, one of the contributors to pro-privatization research institutes.[36] Wall Street has wisely kept a low profile but is salivating at the prospect of a privatization plan that would allow even a fraction of Social Security's $470 billion in annual payroll taxes to pass through its hands.

Supporters of privatization have appealed to the growing numbers of Americans who hold stocks, arguing that they could get a better deal if they could invest their money in private accounts. There are a number of problems with this argument. First, the authors of the various privatization plans assume that stocks will earn a seven percent real rate of return in the future, as they have in the past.[37] My colleague and coauthor Dean Baker was the first to show that this is inconsistent with the Trustees' (and all other) growth projections, given that we are starting with stock prices that are about twice their historic level relative to corporate earnings. Baker's analysis was replicated last year by Peter Diamond of MIT,[38] and to date no economist has been able to produce a set of projections that would show how a seven percent rate of return could be achieved, given their assumptions.

The reasoning is fairly straightforward: while all kinds of speculative bubbles can persist in the short run, over the long run the value of stocks must be proportional to the earnings of the underlying assets. This means that stock prices cannot forever grow faster than earnings. But earnings (profits) over the long run do not grow faster than the economy. Therefore stock prices can be expected, over the long run, to grow at about the same rate as the economy. The Trustees project economic growth of 1.7 percent over their seventy-five-

36. *See* Trudy Lieberman, *Social Insecurity: The Campaign to Take the System Private*, NATION, Jan. 27, 1997, at 11.
37. *See* PETER A. DIAMOND, WHAT STOCK MARKET RETURNS TO EXPECT FOR THE FUTURE 4–5 (Ctr. for Retirement Research Issue Brief No. 2, 1999).
38. *See id.*

year planning period.[39] Adding in the average dividend payout (currently less than two percent), the total projected real return on stocks is about 3.7 percent.

The second problem with the argument for privatization is that Social Security provides much more than retirement income. It also provides $12 trillion worth of life insurance for spouses and survivors, more than that furnished by the entire life insurance industry, as well as disability insurance for workers and their families. When the insurance value of these benefits is taken into account, Social Security is still the best deal around—especially when one considers that it provides an inflation-proof, guaranteed annual payment from the time of retirement for the rest of the beneficiary's life.[40]

But most importantly, Social Security is not a 401(k) account. It is *social* insurance, which is based on a different ethic—a solidaristic one—and a different conception of the relation between the individual and society. Most of us will eventually grow old, and will either before or during that time, experience health problems or reduced capacity for work. It is therefore in our collective self-interest to provide for these eventualities and risks. Individuals can contribute when we are relatively young, healthy, and working, and collect benefits when they are not. Some will draw a luckier number in the genetic lottery or inherit wealth or even be more successful or healthy or live longer by virtue of their own efforts or wisdom; but this is no reason to deny the necessities of life to anyone else, any more than anyone would want local fire departments to ignore calls from the poor, or even from those whose fires were caused by their own carelessness.

Despite the political resurgence of a market-driven ethic in the last two decades, the majority sentiment is probably still closer to the solidaristic ethic embodied in the principles of social insurance. At the very least, this is true for the areas that social insurance has typically covered: protection against the reduced earnings potential and hardships of old age, sickness, disability, and unemployment. For these reasons, and from the efforts of thousands of activists throughout the country, Social Security will probably emerge unscathed from this latest and most threatening assault of its sixty-five-year existence.

39. *See* 2000 SSA ANN. REP., *supra* note 7, at 11, tbl.I.E1.
40. See Dean Baker, *The Full Returns from Social Security*, A CENTURY FOUND./ECON. POL'Y INST. REP., (The Century Found., New York, N.Y.) 1998.

IV. Demography as Destiny: The Case of Medicare

After Social Security, Medicare is the second major social insurance program for the elderly, providing some thirty-nine million senior and disabled citizens with health insurance. The coverage is a tremendous help to its beneficiaries but it could be much better.[41] It does not cover, for example, the often bankrupting expenses of long term care for the 6.5 million elderly who need it, nor does it pay for prescription drugs, eyeglasses, hearing aids, dental care, or most preventive care.[42] It thus leaves the average senior citizen spending twenty-two percent of her income on health care.[43] The poor fare even worse, with health care taking thirty percent of their income. But it is not for its incomplete coverage that Medicare has fallen prey to the creative destruction of the entitlement reformers. Rather, the program is widely regarded to be, like Social Security, "unsustainable" in its present form. Demographic change is once again the relentless enemy, which, we are told, will drag everyone—elderly and nonelderly alike—over the cliff when the baby boomers retire.

But for policy analysts and many so-called reformers, the demographic time bomb is the real terror. They often lump Social Security and Medicare together, in an attempt to saddle the former, which is financially sound, with the problems of rising health care costs. The solutions put forth for Medicare are, as in the case of Social Security, a mixture of cuts and privatization, and here the reformers have made much more progress toward their goals.

In 1997, the Senate passed an increase in the age of eligibility from sixty-five to sixty-seven, a move that would have pushed more than 500,000 people aged sixty-five and sixty-six into the ranks of the uninsured.[44] The same bill also provided for significant means testing in the form of steep premiums for upper-income seniors. The bill would have gone into effect in 2002, but it failed to clear the House.[45]

Are we really facing a demographic crisis in the provision of health care for the nation's elderly? And will the further privatization

41. *See* LAWRENCE A. FROLIK & RICHARD A. KAPLAN, ELDER LAW IN A NUTSHELL § 4.5 (2d ed. 1999).

42. *See id.*

43. *See* STEPHANIE MAXWELL ET AL., URBAN INST., GROWTH IN MEDICARE AND OUT-OF-POCKET SPENDING: IMPACT ON VULNERABLE BENEFICIARIES 16 (2000).

44. *See* Timothy A. Waidmann, *Potential Effects of Raising Medicare's Eligibility Age*, HEALTH AFFAIRS, Mar.–Apr. 1998, at 156–62.

45. *See id.* at 156.

of Medicare increase the productivity and efficiency of the health care system, thereby helping to bring its costs under control? The future of health care for Americans, and not only those over sixty-five, may well depend on the answers to these questions.

There are two ways in which health care costs take a bite out of household income: through public spending, which shows up in a household's taxes, and through its own private spending. The latter can take the form of out-of-pocket expenses or the payment of insurance premiums. Even if the premium is paid partially or in full by the employer, economists tend to assume that employees absorb the employer's payment in the form of reduced wages.

In the United States the majority of heath care spending is still private, but not by much: the public sector, which includes Medicare and Medicaid, accounted for about forty-seven percent in 1996.[46] Medicare itself makes up about eight percent of total health care spending.[47] Most of the policy debate, especially in recent years, has concentrated on how to contain public sector medical spending. The focus on Medicare, in particular, has enabled policymakers to implicate demographic changes as the dominant threat to containing health care costs. But this emphasis on both the public sector and the elderly is extremely misleading.

In the first place, the cost of medical care paid by the federal government is overwhelmingly determined in private markets. For example, from 1980–98, private health care spending per capita increased at an average annual rate of 7.5 percent; for Medicare spending per beneficiary it was 8.4 percent.[48] It is therefore the failure to contain the costs of private health care spending that threatens Medicare's long-term viability. To have obscured this causality is another remarkable public relations feat of the entitlement-cutters.

One way to sort out the effect of health care inflation from that of demographic changes is to make separate projections of future household income under different assumptions about these trends. For example, household income can be projected under the assumption that health care spending rises only as a result of the aging of the population and per capita GDP growth. A scenario can also be projected in

46. *See* Katharine R. Levit, *National Health Spending Trends in 1996*, HEALTH AFFAIRS, Jan.–Feb. 1998, at 42.
47. *See id.* at 43.
48. HEALTH CARE FIN. ADMIN., STATE HEALTH CARE EXPENDITURES, *available at* http://www.hefa.gov/stats/nhe-oact/tables/tl.htm (last visited Feb. 13, 2001).

which the age composition of the population remains the same. When these types of projections are made, the effect of population aging, including the baby boomers' retirement, is significant but not very threatening: the reduction in the average family's after-tax income in 2030, attributable to demographic changes, is about six percent, still leaving the average family with an after-tax income that is more than thirty percent higher, in real terms, than it is today.[49] Thus the demographic changes alone still allow for a healthy growth of after-tax income, even while increasing taxes to finance the retirement and health care of the baby boom generation.

> The effect of rising health care costs, however, based on past rates of increase, is much greater. The average family would see its after-tax, after-health care income reduced by 14%, as compared to a scenario in which health care costs were brought under control. This would wipe out most of the income gains that would accrue to households from three decades of economic growth. Moreover, most of this reduction—about two-thirds—would not come from increasing taxes for Medicare or Medicaid, but from increased costs of private sector medical care. Again, this illustrates that the problem so commonly attributed to entitlement spending is in fact a problem of cost control in the private health care sector.
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> But even the foregoing analysis overstates the effect of an aging population on health care spending, because it assumes that such spending increases directly with the proportion of elderly in the population. In other words, total health care spending is projected by applying the current cost of health care for elderly and nonelderly citizens to a population that contains a higher proportion of elderly. But this is an extrapolation from micro- to macrodata that does not necessarily reflect the real world. It may be that as a country's population ages, other measures are taken to reduce spending on the nonelderly population or to increase the productivity or efficiency of the health care system as a whole.
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> This appears to be the case in other developed countries. In fact, the almost total lack of a relationship between the aging of the population and total health care spending is striking, not only for cross-sectional comparisons between countries in a given year but also in terms of the growth of health care spending in each country over time.[50]

Table 1 lists the percent of GDP spent on health care for eighteen OECD countries, including the United States,[51] and the percentage of the population over sixty-five. There is no obvious relationship be-

49. *See* BAKER & WEISBROT, *supra* note 1, at 2.
50. *Id.* at 56–57.
51. *See id.* at 58.

tween the age of the population and health care spending.[52] In Sweden, for example, 17.7 percent of its population is over sixty-five—a proportion that the U.S. is not expected to reach for another twenty-five years. Yet Sweden spends only 7.2 percent of its income on health care, or about half of what the U.S. spends. A number of other countries with older populations also spend less than the average (8 percent for the group): Austria, Italy, Norway, and Britain also spend less than the average (8.1 percent for the group). Figure 1 shows this lack of relationship in a scatter plot.[53]

The growth of health care spending also appears to be unrelated to the aging of the population over time. This can be seen in Figure 2. This graph plots the increase, in percentage points, in the share of GDP devoted to health care spending as a function of the rate of growth of the elderly population. It is clear that countries who experience a faster growth in their proportion of senior citizens do not necessarily increase their health care spending, as a proportion of their income, any faster than other countries whose population is aging at a slower pace.[54]

These trends do not mean, however, that the aging of the population has no effect on per capita health care costs. Clearly there must be some effect: in the United States, for example, health care spending on the average senior citizen is about four times the average for the rest of the population.[55] But the rate at which the population grows is rather slow compared with all the changes in other variables that have caused health care spending to grow fairly rapidly as a share of GDP in recent decades. To look at it from the other side, it is plausible that differences in cost control measures are important enough to swamp the effect of demographics.

52. *See* Thomas E. Getzen, *Population Aging and the Growth of Health Expenditures*, 47 J. GERONTOLOGY S98, S102 (1992).

53. *See* BAKER & WEISBROT, *supra* note 1, at 59.

54. Getzen has shown both of these relationships for the years 1960–88. He also found that the age composition of the population was not significant in explaining the differences in health care spending across countries, when per capita income was included in the regression. The same was true when the dependent variable was the rate of growth of health care expenditures, regressed against the growth of the elderly population. *See* Getzen, *supra* note 54, at S102.

55. *See* BAKER & WEISBROT, *supra* note 1, at 58–59; *see also* D.R. Waldo et al., *Health Care Financing Trend: Health Expenditures by Age Group 1977 to 1987*, HEALTH CARE FINANCING REV. 116–20 (1989).

Some have argued that the most expensive effects of aging are yet to come, as life expectancy increases and people spend a larger proportion of their lives in need of expensive medical intervention. Indeed, projections of longevity on Medicare spending typically assume that rates of disability and the need for health care remain the same for the various age groups as life spans increase.[56] That is, they assume that the medical needs of a typical seventy year old will be the same thirty years from now, when people are living much longer, as they are today. But recent research has indicated that as people live longer lives, they may also live healthier lives, and the onset of disability is postponed and compressed into fewer years at the end of life.[57]

In the major debates over public policy, however, demography is still destiny, and "entitlements for the elderly" are the problem that threatens to drive the nation to economic ruin. In this simplified world, we are told that there are only two measures that can save us: serious cuts in those entitlements, or increasing the efficiency of the health care system through continuing privatization.

V. Medicare and Health Care Reform

The growth of managed care both inside and outside of Medicare (as well as Medicaid) illustrates the dangers of relying on market forces, and especially private insurance, as an agent of health care reform. In fact the very principles by which private insurance operates are in direct conflict with any attempt to provide universal health care for all citizens.

The goal of private insurers is not only to enroll those with the lowest risk, as in the case of Medicare HMOs, but to fragment the risk pool in a way that allows them to charge a premium that will exceed the expected health care costs of any particular risk group. Higher premiums will be charged for those who are older or who have preexisting conditions or other health risks. If individuals had to purchase their own insurance throughout their lifetime, they would typically

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56. *See* James Lubitz et al., *Longevity and Medicare Expenditures*, 332 NEW ENG. J. MED. 999, 999–1000 (1995).

57. *See, e.g.*, James F. Fries, *The Compression of Morbidity: Near or Far?*, 67 MILBANK Q. 208–31 (1989); Kenneth G. Manton et al., *Chronic Disability Trends in Elderly United States Populations: 1982–1994*, 94 NAT'L ACAD. SCI. USA 2593 (1997); Anthony J. Vita et al., *Aging, Health Risks, and Cumulative Disability*, 338 NEW ENG. J. MED. 1035 (1998).

face low premiums when they were young and healthy and find insurance unaffordable as they aged or developed health problems.

Even at the level of employer-based insurance, insurers use "experience rating" to determine the premiums for a particular employer, meaning that the premium is based on prior experience with health care costs at the company. This practice has led to serious problems at small firms, where the smaller number of workers means that premiums may vary considerably and be priced out of reach for a company whose employees have incurred higher-than-usual medical costs.

The private market thus does not really provide a mechanism by which people can insure against the costs associated with health problems in the distant or even intermediate future.[58] There is a growing fear among consumer advocates that this problem will worsen as insurers take advantage of more advanced methods for estimating risk—for example, DNA screening. One of the purposes of social insurance is to resolve these problems. It allows (and in most cases compels) people to pay when they are young and healthy for insurance that they are much more likely to use when they are older. At the same time, the pooling of risk across the entire population makes that insurance equally affordable to everyone without regard to risk status.

Medicare was created, in part, for these reasons, and the opening of Medicare to the operation of private insurance, through managed care, has introduced a different and antagonistic set of principles. As noted above, insurers have an enormous incentive to "cherry pick" the lower risk patients. But even aside from that problem, there is a deliberate fragmentation of the risk pool in the proliferating variety of choices now offered to the elderly: competing HMO's, preferred provider organizations, provider-sponsored organizations, and different fee-for-service options.

The options now available to senior citizens are so complex that those charged with administering the system have found that "even well-educated beneficiaries have difficulty understanding them all." With some forty percent of senior citizens having "very limited ability to read and use printed materials,"[59] it is difficult to see how this neo-

58. *See, e.g.*, DAVID M. CUTLER & BRIGETTE C. MADRIAN, LABOR MARKET RESPONSES TO RISING HEALTH INSURANCE COSTS: EVIDENCE ON HOURS WORKED (Nat'l Bureau of Econ. Research Working Paper No. 5525, 1996).

59. Robert Pear, *New Health Plans Due for Elderly*, N.Y. TIMES, June 10, 1998, at A1.

classical fascination with tailoring insurance policies to individual preferences is going to produce a net gain for anyone.

More important, these measures illustrate the futility, and indeed destructiveness of trying to contain health care inflation by reducing demand at the level of the individual patient. The savings as are achieved are generally not worth the cost, in terms of further reducing access to needed care, or adding administrative waste to the system.

These are the two great problems of the American health care system: lack of access, and waste. They are also its distinguishing irrationalities as compared to other developed countries. The United States has forty-three million people without health insurance, and yet it spends a larger share of income than any country in the world on health care. At nearly 14.2 percent GDP, U.S. health care spending is in a league of its own: the average for the other OECD countries shown in Table 1 is 8.1 percent. From 1960 to 1995, U.S. health care spending as a share of GDP rose from 5.0 percent to 14.2 percent of GDP, an increase of 9.2 percentage points. This compares to an average of 4.5 percentage points for the other developed countries.[60]

The United States also ranks twenty-third out of twenty-nine industrialized countries in infant mortality, and is in the bottom third for life expectancy.[61] The U.S. ranking has been falling steadily for decades, and it can be expected to decline further due to recent developments such as welfare reform, significant cost-shifting from employers to employees, declining employer-based coverage,[62] and the increasing restrictiveness of managed care.

At the same time our health care system is saddled with enormous administrative costs.[63] A General Accounting Office study in 1991 estimated that we could save about eleven percent of total health care costs, or $110 billion today, by switching to a single-payer social insurance system like Canada's.[64] Other estimates have put the potential savings considerably higher.[65] The number of administrative per-

60. *See supra* table 1.
61. *See* BAKER & WEISBROT, *supra* note 1, at 65; EMPLOYEE BENEFIT RESEARCH INST., ISSUE BRIEF NO. 185, TRENDS IN HEALTH INS. COVERAGE (1997).
62. *See* BAKER & WEISBROT, *supra* note 1, at 65.
63. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, CANADIAN HEALTH INSURANCE: LESSONS FOR THE UNITED STATES 47 (1991).
64. *See id*.
65. *See* Steffie Woolhandler et al., *Administrative Costs in U.S. Hospitals*, 329 NEW ENG. J. MED. 400, 400–03 (1993).

sonnel in our health care system has grown by 2000 percent since 1970, and the nonclinical share of health care spending also seems to be rising with the shift to managed care.[66] While the average HMO takes about fourteen percent of premiums for overhead and profits, some of the largest and most successful are in the range of twenty to twenty-six percent.[67] The problems of access, medical care inflation, and administrative waste are clearly related. The superiority of social insurance in reducing administrative expenses is well known to economists and health policy analysts. In Canada, administrative costs for the national health care system are about 0.9 percent,[68] similar to the U.S. Social Security system, and for Medicare they are about 2 percent.[69]

Among the developed countries discussed above that have been much more successful at containing health care inflation, all provide for universal care or something close to it. The experience of European health care systems indicates that the most successful cost-saving measures have been supply-side interventions that are difficult to achieve outside of a universal system.[70] The most important of these is global budgeting, which sets a limit on spending by hospitals or other subsectors of the system.[71] Reducing excess hospital beds (the U.S. has about a third too many), and controlling the price of health supplies and the payment of professionals are also easier to accomplish within a universal system. The same is true for efficiency gains that can be achieved by substituting primary and outpatient care for inpatient care.[72]

Health economists and other analysts have often emphasized the role of new technologies in accelerating health care inflation.[73] For many of these analysts, the problem is that these high-tech procedures

66. *See* BAKER & WEISBROT, *supra* note 1, at 65.
67. *See id*.
68. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 65, at 62–63.
69. This figure is not directly comparable to the administrative costs for HMOs, because the latter incur some medical administrative costs not resulting from insurance. However, adjusting for these differences would still leave Medicare with a small fraction of the administrative costs of the private sector.
70. *See generally* Richard B. Saltman & Josep Figueras, *Analyzing the Evidence on European Health Care Reforms* (Mar.–Apr. 1998), *available at* http://web.lexis-nexis.com/universe/printdoc.
71. *See id.*
72. *See id.*
73. *See* Burton A. Weisbrod, *The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment*, 29 J. ECON. LITERATURE 523, 527 (1991).

are often deployed to the point where they have little or even zero marginal impact on medical outcomes. While this is undoubtedly true to some extent, there is still a question of what to do about it. Once a technology is available, it is difficult to contain its use, especially if that means refusing a potential cure to a patient in need. Here again, the more promising reforms would seem to be on the supply side: that is, the adoption of measures to reduce the development of costly technologies that are of limited value in reducing mortality or disability. In a profit and market-driven health care system, the incentives to develop and apply such technologies are strong. Furthermore, without global budgets for capital expenditures, there is a tendency to over-purchase certain technologies. For example, the United States has about twice as many mammography machines as it needs.[74]

There are demand-side interventions that offer enormous potential savings, although not the kind that are directed at reducing the demand among individuals through such disincentives as cost-sharing. The most promising strategies would seem to be those that reduce medical need through public health and education. This approach would also have much more effect on helping people live longer, healthier lives. About eighty percent of our health care costs currently result from chronic conditions that occur between the age of fifty-five and the end of life,[75] and there is strong evidence that chronic illness and disability during this period are correlated with living standards. For example, those with favorable risk factors—which include higher income and education as well as exercise—have only one-fourth to one-half the amount of disability in the seventh and eighth decades of life.[76] The considerable socioeconomic differences in risk factors associated with earlier onset of disability and chronic illnesses make a strong case for reducing inequalities of income and education, as a matter of public health. No one has yet explored the health effects of current trends toward increasing income inequality continuing over the next few decades, but any such projection would certainly reinforce the argument that growing inequality, rather than

74. *See* Martin L. Brown et al., *Is the Supply of Mammography Machines Outstripping Need and Demand?*, 113 ANNALS INTERNAL MED. 547, 549 (1990) (estimating a 369 percent surplus of supply over usage in 1990).

75. *See, e.g.*, Fries, *supra* note 59, at 208–31. "Some 18 percent of lifetime medical costs, however, occur in the last year of life. In many studies . . . these effects are noted to be further concentrated in the last one or two months of life." *Id.*

76. *See* James S. House et al., *Age, Socioeconomic Status, and Health*, 68 MILBANK Q. 383, 411 (1990).

population aging, poses the greater economic threat to future generations.[77]

Even taking the distribution of income as given, there are numerous efforts that could enhance the quality of life while reducing health care costs. However, these would require a shift of resources to health promotion,[78] and there is little incentive under our present system for investing in the necessary public education and outreach. In theory, HMOs and other managed-care organizations should have a stake in health promotion for their members. But their horizon is too short term, and the turnover of doctors as well as patients is high. It seems that here, too, a universal system—especially one in which the government was the sole insurer—has much more potential, as well as the incentive structure, to accomplish these goals. The recent experience with tobacco legislation illustrates this point. Much of the impetus for this effort came from state governments seeking to recover the Medicaid costs that were incurred as a result of smoking-related illnesses. The curbs on tobacco companies' ability to promote new addictions, and other public health measures that may emerge from this confrontation will have the potential to save millions of people from premature death and avoidable disability.

The establishment of universal social insurance for health care would also have important non-health-related economic benefits. The current attachment of health insurance to employment creates considerable inefficiencies in the labor market. The most obvious is "job-lock," where people remain in jobs that they would otherwise leave, simply for fear of losing their health insurance.[79] The reduction in mobility for married men, for example, has been estimated at twenty-six percent.[80] On the other side of the labor contract, the fixed cost of health insurance for employers predisposes them to increase hours rather than hire more employees.[81] Although this would not necessarily increase unemployment over the long run, it does contribute to widespread overwork and stress on the part of employees, many of whom report, for example, that they would like to have more time to spend with their families.

77. *See id.*
78. *See* Fries, *supra* note 59, at 208–31.
79. *See* Brigette C. Madrian, *Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?*, 109 Q.J. ECON. 27, 27 (1994).
80. *See id.*
81. *See* CUTLER & MADRIAN, *supra* note 60, at 2.

The current debate over entitlements for the elderly has managed to project an Orwellian inversion of reality. On the grounds of efficiency, equity, and cost containment, a universal, single payer social insurance system is the clear winner. We know this not only as a matter of economic logic, but from national and international experience as well. It is also clear from polling data that people want universal health care, and would even be willing to pay higher taxes in order to achieve it.[82] In Medicare we have such a system for the elderly, although its coverage is incomplete.

VI. Conclusion

A rational public discussion would focus on how to expand Medicare's coverage to meet not only the needs of the elderly, but the entire population. Instead we have a debate about how to cut Medicare, and a race to implement increasingly complex and administratively wasteful means of privatizing the insurance that it provides. Moreover, Medicare's problems in cost containment, which are wholly imported from the private sector, are used to project explosive growth not only for Medicare but for the entire federal budget. And finally, with a link no stronger than guilt by association, Social Security is dragged into the swamp of unsustainable entitlement spending.

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82. BAKER & WEISBROT, *supra* note 1, at 68 n.7.

> Some experts have taken the failure of President Clinton's attempt at health care reform in 1994 to mean that more sweeping measures, such as a single-payer social insurance system, are not politically feasible. But the long-run growth of health care costs can not be sustained, so something will have to change. Given that there is still widespread public support for universal health care, it would seem that a social insurance system for health care is more feasible than the continuation of the status quo into the indefinite future.

Id.