An Aging Society and the Federal Deficit

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THE CONFLICT BETWEEN THE GROWING NEEDS OF an aging society and a federal budget which cannot afford its current commitments has become one of the nation's most difficult government policy dilemmas. Assistance for the elderly—through Social Security, Medicare, and other programs—is already the federal government's largest fiscal responsibility. In 1985 these programs will require nearly half of all domestic program spending—an estimated $256 billion. The future costs of these commitments will rise rapidly well into the next century, accounting—with national defense and interest costs—for virtually all of the spending increases in the projected $200 to $300 billion deficits (Congressional Budget Office 1984a; U.S. Senate. Special Committee on Aging 1984a). Decisions about the nation's assistance to the elderly—and about reaffirmation, reform, and/or retrenchment of these commitments—will thus be central to the coming budget debates.

Government social insurance programs now provide the core of income and economic security for most of the nation's elderly. As a result, the aged are very much at risk from potential reductions in government assistance, and a substantial minority of the elderly, almost totally dependent on Social Security and other government

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programs, are particularly vulnerable to budget cutbacks. The elderly's future financial security is also jeopardized by the absence of effective government policies for dealing with health care costs and the impending bankruptcy of the Medicare hospital insurance fund.

Over the past half century, the enactment of federal legislation for Social Security, Medicare and Medicaid, private pensions, and other legislation has had profound effects on the lives of the elderly and of the under-65 population. Most of the population can now look forward to 10 to 20 years of retirement with standards of living comparable to their working years. In turn, the economic independence of the aged (largely supported by taxes from the working population) has allowed younger generations to plan for their own needs and given women greater freedom to enter the workforce. Redesigning these government policies and programs will thus require consideration of how proposed changes will affect both the nonelderly and elderly populations.

The prospect of federal benefit cutbacks for the aged is particularly troublesome in light of dramatic future increases in the elderly population (and in its highest need subgroups) as the post–World War II "baby boom" generation starts to retire in about 20 years. To the extent that government assistance cannot keep pace with these needs, new arrangements will be needed for private savings and pensions to make up the difference. Indeed, it is today's younger adult population which has most at stake in impending budget decisions, for such choices will influence tax burdens during their working lives, their savings opportunities and health care costs, their personal responsibilities for aged relatives, their inheritances—and their own benefits in retirement.

The following two sections provide overviews of America's aging society and the political economy of the budget situation. Subsequent sections discuss rising health care costs and Medicare's financial crisis (which now pose the greatest economic threats to the elderly) and the major tax, pension, and savings provisions on which future retirees will increasingly need to rely in an era of limited federal resources. These issues will increasingly dominate federal decision-making well into the next century.

Overview of an Aging Society

Projections of population characteristics, income, and asset trends provide a broad picture of how American society is likely to change

as its population ages over the next several decades. Several of these developments have already begun to influence federal policy debates.

Demography

The nation's aged have been increasing for most of this century, both in numbers and as a share of the population. In 1900 about 3 million persons, 4 percent of the population, were over 65; today, 28 million persons, 12 percent of the population, are over 65. The number of aged will increase rather slowly during the next several decades, e.g., to 35 million (13 percent) by 2000. Nevertheless, by 2025—with the aging of the post–World War II babies—the number of aged will more than double to 59 million (a 20 percent population share). By 2050, 67 million persons will be over age 65, 22 percent of the population (U.S. Department of Commerce. Bureau of the Census 1982).

The projected increase in the aged population also means that the "dependency" or "support" ratio—the number of aged persons per working population aged 19 to 64—will rise sharply. Today the aged/working ratio is about 20 percent. By 2025 it will be 33 percent—more than 60 percent higher. By 2050 the ratio will be 38 percent (U.S. Senate. Special Committee on Aging 1984b).

A third forseeable development, also adding to the resources needed by the elderly population in the coming decades, will be a particularly rapid rise of the very old population which is most dependent on government assistance. The number of persons over age 85 will increase from 2.2 million in 1980 to 7 million in 2020—and to over 16 million in 2050. This very old population uses 77 percent more Medicare benefits per capita than the 65 to 69 age group—and incurs fourteen times more nursing home costs per capita than the younger elderly (Torrey 1984). More than 70 percent of this age group will be women, many of them widowed, living alone, and probably with little income except for Social Security.

Income

The economic status of the nation's elderly has improved dramatically over the past several decades, both in overall terms—and in relation to the under-65 population. From 1950 to 1982 the real median income per capita of the aged doubled. By 1982 the median income

of the 9.6 million families headed by aged persons was $16,118—95 percent of the amount for nonaged families, compared to 77 percent of the median (adjusted for family size) as recently as 1970. The proportion of the aged living below the poverty level was also lowered dramatically, from one of every three aged persons in 1959 to 14.6 percent in 1982—virtually the same as for the under-65 population (U.S. Department of Commerce 1984). By 1982, the Census Bureau estimates that the median after-tax income of aged households, adjusted for family size, exceeded that of younger families (U.S. Department of Commerce. Bureau of the Census 1983).

Behind these averages, major subgroups of the elderly continue to find retirement a period of financial worry and insecurity. Such financial status differentials after age 65 reflect a lifetime of differences in economic opportunities and rewards. Minorities and women, for example, tend to face relatively poor economic conditions; in 1982 the median income for white males aged 65 to 69 was $11,900, and black males averaged $5,900—while white women had $5,700 per capita incomes and black women $3,900. Similarly, aged persons living alone (predominantly widowed or divorced women) had substantially worse economic circumstances than households. In 1982 the 8.4 million elderly who were not living with family members had incomes which were only 66 percent of similar individuals under age 65—with no progress in their relative standing since 1950. A significant number of the aged, while no longer officially classified as poor, were not affluent; some 23 percent of the aged had incomes below 125 percent of poverty in 1982.

The Social Security program has been the major factor in the remarkable economic progress of the retired population—and is particularly important in assuring a minimal standard of living for the most dependent part of the population. Twenty percent of the elderly depend on Social Security for virtually all (over 90 percent) of their retirement income—and half of the elderly receive 50 percent or more of their income from Social Security checks. Overall, Social Security is the largest single source of income (33 percent) for the nation's elderly—and has been increasingly important in recent years. Such trends partly reflect the opportunities for earlier retirement which Social Security benefits have made possible. As a result, work income has been a declining source of income for the elderly—falling from 46 percent of family income in 1970 to a 32 percent share in 1980.

Assets (15 to 18 percent) and other pensions (12 to 14 percent) have provided a much smaller and relatively flat contribution to economic well-being.

These trends highlight several issues which confront the nation in budget decisions about redesign of programs for the elderly.

First, the economic "comparability" of the aged and nonaged has become a central issue in the political debates about reducing government benefits for the elderly. Such comparisons lead to questions about appropriate tax burdens on the under-65 working population to support more affluent retirees, particularly when such retirees are retiring earlier from full-time work, working less in retirement, and living longer.

Congress has already reacted very sharply to these emerging issues in Social Security financing legislation: half of all Social Security benefits (previously tax-free) were made taxable for individuals with incomes over $25,000, and couples with incomes over $32,000. This reform ventured into what was previously considered one of the most politically untouchable issues in American politics—the "means-testing" of Social Security benefits. To preserve Social Security's solvency and counteract trends of rising benefits for early retirees, the retirement age will be gradually raised from 65 to 67, early retirement reductions were raised from 20 percent to 30 percent, and earnings offsets were reduced. As well, first steps were taken to limit the annual Social Security inflation adjustment to the lower of the Consumer Price Index increases or of average wages to assure that benefits for the retired do not increase more rapidly than the economic welfare of those who pay the taxes for the benefits.

Such "comparability" reforms promise to become even more important in the longer term. The income levels established for taxing Social Security benefits, for example, were not indexed for future price rises. Over the next few decades, most Social Security benefits will thus become taxable income. Indeed, this provision alone is so important that it accounts for nearly one-third of the long-run financing provided by the Social Security compromises. As well, projected rises in the numbers of elderly and dependency/support ratios will increase tax burdens on the under-65 population—and raise the issue of whether benefits now written into law would be honored in light of the forseeable intergenerational tensions between the post–World War II "baby boom" generation, their children, and grandchildren. Objections

to the large share of health costs used by the elderly have already surfaced in "duty to die" speeches; such arguments will likely become more prominent as tax increases must be considered to finance Medicare's enormous deficits and as health benefits exceed Social Security payments in the next century. Indeed, various proposals for means-relating Medicare, such as income tax surcharges for the elderly and higher premiums, have already been advanced for the coming budget debates (U.S. House of Representatives. Committee on Ways and Means 1984).

A new social consensus built on economic "comparability" of the elderly and nonelderly would suggest that the aged bear no greater (and no less) of a share in the budget reductions than other population groups. Nevertheless, such even-handedness seems unlikely. In view of the major budget share of assistance for the elderly, proposals to address "structural deficits," "entitlements," and "balanced" tax vs. spending and domestic vs. defense reforms almost inevitably involve disproportionate reductions in programs for the elderly. In light of already-enacted cutbacks, the past trend of rising real retirement incomes—which was built mostly on increasing Social Security benefits faster than inflation in the 1970s—has already been reversed for many of the elderly. And future rises in health costs will add to the financial burdens of the elderly. Realistically, the major issues facing government decision makers seem to be how far government-supported living standards of the elderly will be cut back (or allowed to erode) from assurance of rough equality between the aged and nonaged toward poverty-level or other means-tested support.

These developments will make it far more difficult to meet the rapidly increasing needs of the most vulnerable and dependent aged—particularly the very old. Nevertheless, major increases in health and long-term care spending must be anticipated for these groups, and future policy reforms must take into account the fact that, even if government benefits are cut broadly, spending for these groups must be allowed to rise. In particular, across-the-board policies, such as freezes on Social Security cost-of-living adjustments and increases in Medicare cost-sharing, will be increasingly damaging unless offset by benefit improvements and greater uniformity in programs such as Medicaid and Supplemental Security Income (SSI) for the lower income population. As well, since these high-dependency groups can be foreseen—they are predominantly those with lower incomes during their

working years, particularly women and minorities—early preventive policies for improving their economic circumstances prior to age 65 may also be of benefit, e.g., education, job training, nondiscrimination provisions, and better private savings and pension plan arrangements. Future public policies will increasingly need to consider adequacy of assistance for these most dependent groups, as well as comparability between the aged and nonaged and means-testing.

Assets

Although data on assets are less reliable than for incomes, the overall pictures are similar: an elderly population (particularly its most affluent members) now comparing favorably with the under-65 population—lending support to those who wish to reduce retirement benefits—but with many elderly having few resources beyond their residence to offset potential benefit reductions or rising health costs.

In 1979 the average net worth for the 65 to 69 group was about $88,300, significantly higher than for many younger working-age groups, e.g., $74,900 and $65,400 for the 45 to 54 and 35 to 44 populations, respectively. The higher assets reflect not only more earning years, but also the fact that the elderly continue to save throughout their lives (U.S. Department of Health and Human Services 1979).

For most of the elderly, their single greatest asset—about 45 percent of net worth—is their home. More than 70 percent of the aged own their own home—and more than 80 percent no longer owe any mortgage. Going behind the averages, however, most of the elderly have clearly trusted in the adequacy of government social-insurance programs for much of their retirement planning. An in-depth look at 1969 to 1975 retirees, for example, showed their median liquid assets averaged only $3,000 to $3,600, and that nonliquid assets (other than house or vehicle) were held by only one-third of retirees studied (Friedman and Sjogren 1981). Unless society wishes to require retirees to sell their homes to pay living expenses, there now seems to be little room for reducing government assistance without direct impacts on standards of living for most of the elderly.

Nevertheless, future retirees (particularly those with affluent and provident parents) will be increasingly asset-rich. Today's very old have had to contend with the adverse effects of the Depression, while

newer (and future) aged will have benefited from post–World War II prosperity. The 55 to 64 age group, for example, already has substantially higher assets ($108,600 vs. $88,300) than the 65 to 69 age group ahead of them. With recent tax law changes, these trends can be expected to accelerate. These changes raised amounts not subject to federal inheritance taxes from $60,000 (for estates) in 1976 to $325,000 (for estates and gifts combined) in 1984—and future rises to $600,000 are scheduled in 1987. Future generations of the elderly will have their assets increased by such substantial inheritances from the assets of the previous generation—as well as by IRAs, financial deregulation (with higher interest rates), and lowered tax rates of the past three years.

These data and trends raise similar "comparability" issues between working/retired populations as income differences: Should taxes on the under-65 working population be raised to pay Medicare benefits for retirees with $100,000 plus in assets? But the asset-comparison issues will be more difficult to resolve. While income differences and income reporting are commonly used in shaping public policies, even reliable information about United States wealth differentials (which are far more skewed) is very difficult to obtain, and there are no routine reporting systems. Taking assets into consideration is also complicated by the preponderance of housing as an asset for most of the aged, since housing cannot be easily converted to income, and public assistance policies do not currently require sale of homes as a condition for assistance. Nevertheless, it is likely that such trends will lead to greater use of asset "spend down" requirements (now used by a number of states for Medicaid eligibility) and estate tax reforms.

The Political Economy of the Federal Deficit

The Federal budget decisions critical to meeting the needs of an aging society will not be made solely (and perhaps not even primarily) on the basis of the welfare of the elderly. The amounts of income and wealth redistribution to be resolved in the impending federal budget debates—$200 to $300 billion annually, $2 to $3 trillion over just the next decade—are unprecedented in political and economic importance. These issues will engage most of the nation's business and other interest groups, both in intense advocacy for their own causes—

and in alliances to see that adverse spending and tax actions fall in other areas. Social policies for the elderly will be reshaped, at least in part, by such pressures.

Table 1 records that most future federal spending is now committed to national defense and to major health and retirement programs which benefit the elderly. These programs (and interest on the debt) already account for over three-quarters of all federal spending—and over 90 percent of the projected increases. Indeed, the spending commitments for these areas (and tax increases) have already become the central budget issues, particularly as political actors prepare for the post-election period.

The major spending priority confrontations will clearly be between the aged and national defense—what economist Barbara Torrey calls "guns vs. canes." Now that Social Security spending is (at least temporarily) "locked-in" by last year's compromises which preserve its solvency, attention has shifted to Medicare as the major focus for further domestic-spending cuts. In such circumstances, Medicare benefits will be increasingly pitted against the military budget; indeed, major Medicare vs. military floor fights have already occurred for the past two years. This conflict engages the 28 million elderly against the interests of the military-industrial complex (7 percent of the gross national product).

TABLE 1
Federal Budget Projections (Outlays in billions)

	1985	1987	1989
National defense	$263	$331	$419
Retirement programs	225	259	297
(Social Security)	(184)	(211)	(243)
(Federal pensions)	(41)	(48)	(54)
Health programs	97	121	152
(Medicare)	(74)	(94)	(120)
(Medicaid)	(23)	(27)	(32)
Net interest	127	168	219
All other (net)	216	233	255
Total	928	1,112	1,342
Deficit	−195	−248	−326

Source: Congressional Budget Office 1984a.

A longer term look at the federal budget makes clear the enormous financial consequences involved in budget decisions on health and retirement programs—both for the elderly and for those who wish to claim these resource "entitlements" for other purposes. Such a projection, by John Palmer and Barbara Torrey, shows that the rising costs of retirement and health programs will claim a rapidly increasing share both of the gross national product (GNP) and the federal budget (Palmer and Torrey 1983). Assuming other federal domestic programs remain a constant share of the GNP, Torrey and Palmer project that current commitments to the elderly will alone increase federal spending from 24 percent of the GNP to 29 percent—a 25 percent increase—by 2040. While retirement programs will grow more slowly than the GNP for the next several decades (until the post–World War II babies retire) the health programs—driven by rising costs—continue rapidly to increase their claim on the nation's resources and the federal budget. The federal revenues needed for long-run balancing of the budget will require tax increases from 19 percent of the GNP currently to a 29 percent share—more than a 50 percent increase.

Economic status in retirement in many ways reflects opportunities and rewards over a person's working life. The full impact of budget decisions on an aging society will thus include both the changes in assistance to retirees and changes in taxes and spending for the under-65 population during their working lives. Tax and spending changes over the past few years have widened the nation's income and wealth differentials—and, if persistent, these changes will have cumulative effects for future aged populations.

Congressional Budget Office estimates show that the 1981–1983 budget changes have primarily favored upper income groups (Congressional Budget Office 1984b). In 1985 the net result of these changes will produce economic losses of $440 for households with incomes under $10,000—and gains of $3,540 for households with $40,000 to $80,000 income, and $8,390 for households with incomes over $80,000. At the same time, recession and budget changes have caused the population officially classified as poor to rise from 24.5 million in 1978 to 34.4 million in 1982. Unemployment, which can wipe out years of family savings, has been the worst since the Depression. Such developments suggest more of the future elderly may be heavily dependent on federal assistance, while others will be "IRA millionaires" at taxpayer expense. If such changes are ratified and enlarged, both

the adequacy of minimum benefits and means-testing of higher income persons will be issues of increasing long-term importance.

Faced with the difficult policy and political decisions posed by these conflicts, Congress may choose to make successive "down payments" and try to live with still-major deficits, at least for a number of years. Such developments would not be neutral with respect to future funding for the elderly—rising interest costs from continued high deficits would make it increasingly unlikely that current commitments can be maintained.

Health Financing Issues

The major economic risk for the elderly over the next several decades is from rising health care costs, which both raise current out-of-pocket expenses faster than their incomes and threaten massive future Medicare benefit cuts. The elderly now depend on government programs (primarily Medicare and Medicaid) to finance about 64 percent of their health costs. While rising hospital and physician costs are implicated in Medicare's financial crises, inadequate Medicaid funding for long-term care will present an increasingly serious problem as the post–World War II generation retires.

Medicare

Even after three years of budget cuts, Medicare's hospital insurance (HI) and supplementary medical insurance (SMI) funds, which will cost $74 billion in 1985 and are still rising at 16 percent per year, will require massive funding increases or spending cuts over the next twenty years. The hospital insurance trust fund, financed by payroll taxes from the working population, is projected to be bankrupt by 1991, with cumulative deficits of over $1 trillion by 2005; under similar assumptions, the physicians insurance (SMI) fund, now financed 75 percent by general revenues and 25 percent by enrollees, will also require rising general revenue appropriations and higher premiums, with cumulative subsidies of over $1.5 trillion for the same period (Federal Hospital Insurance Trust Fund Board of Trustees 1984; Federal Supplementary Medical Insurance Trust Fund Board of Trustees 1984; Etheredge 1983).

Beneficiary Costs. The aged (as well as health providers, taxpayers, and the Defense Department) have a great deal financially at stake in how Congress deals with Medicare's financing needs and health costs. Medicare now pays about 45 percent of the elderly's health bills, and out-of-pocket health costs for the elderly already averaged an estimated $1,187 per aged person in 1981. Medicare's future-funding needs average about $3,500 per year for every elderly person over the next twenty years, $7,000 annually per couple. Medicare's current coverage is particularly inadequate as catastrophic insurance, with no cost-sharing limits for either hospital or physician services. Most of the aged thus buy various private "Medigap" plans to fill in these deficiencies—paying $1.50 or more for every $1.00 of private coverage. Many of the elderly are at high risk from added costs and across-the-board benefit cuts—particularly elderly persons with incomes slightly above the poverty line who do not qualify for Medicaid and cannot afford excessive Medigap costs. Of the 27 million Medicare enrollees, for example, only 3.5 to 4 million have Medicaid coverage.

The past few years have already seen several billion dollars of cost shifts from Medicare to its elderly beneficiaries—higher deductibles for both hospital and physician insurance, as well as higher SMI premiums. Options already proposed for directly raising the elderly's future out-of-pocket costs include: higher cost-sharing, higher premiums, and income tax surcharges. Other proposals include not only high-quality government Medigap insurance (recently proposed by the Social Security Advisory Council), but also various means-testing approaches with improved adequacy (and uniformity) in Medicaid benefits and better integration of the Medicare and Medicaid programs for the elderly.

Reimbursement Reforms. The most consequential Medicare budget issue is whether to seek comprehensive, society-wide solutions to rising health costs or to deal only with government's budget expenses. In the 1970s the nation's political leadership mostly sought comprehensive solutions, such as national health insurance and hospital cost-containment legislation, but without success. In the 1980s Congress has, so far, adopted the Reagan administration proposals for a Medicare-only hospital prospective payment system (and allowed the states broader payment discretion for Medicaid) without addressing rising costs of other payers.

These Medicare and Medicaid-only policies have proved a short-term expedient for budget restraint, but seem less desirable as long-

term policies for assisting the elderly. As the nation's largest users of health care, the elderly would seem to have most to gain from rapid advances in health technology and availability of health services, e.g., from such emerging (but expensive) technologies as nuclear magnetic resonance (NMR) and positron emission tomography (PET) scanners, artificial organs and joints, and better transplants—and also the most to lose if providers cannot afford to provide services to them. Separate Medicare and Medicaid payment systems thus present the risk that the national health cost "problem" will be solved by rationing of health care for the elderly and low-income population. Other concerns are that if Medicare and Medicaid use their dominant market positions to pay increasingly less than other payers, they will erode the ability of providers to meet the needs of the uninsured and cost-shift to other payers with less market share. Both results "solve" government's problems only by adding billions of dollars to the health costs of others. As well, the new "simplified" diagnosis-related group (DRG) hospital-payment system is rapidly becoming even more complex than the cost-based reimbursement system it was designed to replace, with millions of separate prices and ever more detailed government regulations.

If the nation is to restrain health costs for all payers, rather than just cut government payments for the elderly and poor, there will need to be some agreement on what that course will be. Nevertheless, the frustrated reform attempts of the 1970s suggest that such comprehensive solutions will not come easily, if at all. Indeed, the health sector, $75 billion in 1970, will be $400 billion this year—and probably $700 billion by 1990 (Freeland and Schendler 1984). Thus, it is already several times larger than when reform attempts failed in the 1970s—and has enormous fiscal incentives to protect its prospective growth.

The nation's business community may well be the deciding voice in how our society will restrain health costs for the elderly. In the past, business lobbies have frequently objected (usually as a matter of general philosophy) to government health-sector regulation as a solution to rising health costs. These assessments may be changing, however, with the apparent failures of the Reagan "procompetition" strategies to control costs—and the potential cost-shifting of much of Medicare's multitrillion shortfall to business's bottom line. If business groups advise political leaders that they can contain their own health costs without government assistance, then political leaders are likely

to let them continue to try to do so—and the nation will continue with separate payment arrangements for the elderly and poor.

The Medicare/health cost issue has already been recognized as the major domestic-spending decision facing the next Congress, and new comprehensive proposals and political alliances are being advanced. Senator Kennedy and Representative Gephardt—formerly the leaders of the opposing regulatory and competitive health reform coalitions—have joined forces to sponsor a national health cost-control proposal which would preserve Medicare's hospital insurance solvency (and make major inroads on the physician insurance-financing problem). These proposals avoid the need for Medicare benefit cuts or new taxes and restrain costs for all payers (business and individuals). Their approach, also endorsed by Walter Mondale, builds on state-based health-cost control programs and allows use of both regulation and competitive measures to meet national objectives. The nation's major elderly groups have endorsed the proposal.

An alternative Medicare-only approach has been proposed by the recent Advisory Council on Social Security (1984). The council's recommendations specifically reject any general tax increases on the under-65 population to help pay for the Medicare deficit. Of the $182 billion in new financing and savings proposed over 1985 to 1995, more than 60 percent (over $115 billion) would be cost shifts to the aged. Reduced payments for teaching hospitals would make up about another $40 billion of savings and cost-shifting. Less than 20 percent of the savings would come from provider payment restraints. Despite the very heavy burden of added costs proposed for the elderly (and others)—which illustrate how seriously at risk the aged are in next year's budget debates—the council's proposals would not assure long-term hospital insurance solvency and make few inroads at all on the even larger SMI subsidy requirements.

Long-term Care

While Medicare's financial crises, resulting from rising hospital and physician expenses, are the most immediate threat to the economic well-being of the elderly, major inadequacies in insurance protection for long-term care expenses will become increasingly important for future retirees.

The needs for improved long-term care financing and services will

rise rapidly with the increasing numbers of the most dependent elderly—the aged 85 and over population. Only 1.5 percent of the 65 to 84 age group is in nursing homes. After age 85, however, most of the elderly have chronic, limiting conditions; many are widowed, living alone, and/or have children who themselves may be elderly and limited in the assistance they can provide. Of this 85 and over group, 23 percent are in nursing homes (U.S. Department of Health and Human Services 1984). As a result, the nursing home population is projected to more than double between 1980 and 2010 (from 1.2 million to 2.6 million)—and more than double again (to 5.4 million) by 2050. Since these will be the most dependent aged, most of the costs will be add-ons to public budgets.

Long-term care can be extremely expensive for those who need it—nursing home costs can average over $14,000 per year—and few elderly can feel secure faced with the prospect of such potential expenses. Virtually no private insurance is available against such costs. As a result, more than half of all long-term care benefits are now publicly financed, and many private patients are only able to sustain private payments for a few months until their resources are exhausted.

The Medicaid program is the major public insurance for the elderly for long-term care—an estimated 43 percent of current expenditures are for nursing home care (Gibson, Waldo, and Levit 1983). Although there is wide variation, most Medicaid plans require near-impoverishment before providing long-term care benefits. Most states provide Medicaid eligibility for the elderly on Supplemental Security Income (SSI) criteria. In 1982 SSI income eligibility cut-offs were $3,412 per year for aged individuals and $5,117 for couples—just 77 percent and 88 percent of the poverty level (U.S. Department of Health and Human Services 1983b). For the elderly, SSI asset tests meant they could keep their homes, household possessions, and a car—but had to exhaust virtually all other assets except for $1,500. Fourteen states (known as "209B" states), however, have adopted even more restrictive policies than national SSI standards. About thirty states have elected to extend coverage to some non-SSI elderly through various "medically needy" and "institutional eligibility" provisions. The patchwork variability of assistance is also reflected in resources: nursing home beds per 1,000 aged are four times greater in high-bed states than in low-bed states, and in expenditures; New York alone accounts for 50 percent of Medicaid's national home health expenditures (U.S. Department of Health and Human Services 1983b).

Reform Directions. The major reason all insurers—federal government, state government, and private insurers—have been extremely reluctant to provide significant protection against long-term care is concern about the costs. These concerns reflect the view that the potential demand for services could become extremely large if they were partly financed by insurance—not only because there may be very high levels of need for the services, but also because of shifting of many services now being provided by relatives to the insurer's expense.

Most reform ideas have thus involved arrangements for managing long-term care services within predetermined budgets. To date most of these developments are still in the early experimental and demonstration phases. One promising idea is a "social" health maintenance organization (HMO) or S/HMO which will provide long-term care to a group of persons for a capitated fee. Recent Medicaid amendments have also allowed states to apply for waivers (Section 2176) to provide home-based or other alternatives to institutional care if this can be done without budget increases. Forty-six states have sought waivers for some groups. A recent Medicaid-administrators task force recommended that long-term care be turned over to the states as a block grant so that the funds could be managed along with other social and health services. Such proposals will find strong advocates in the budget debates to come; it is well recognized that Medicaid long-term care costs will be the "hot potato" of future federal budget costs within the next several decades, and capping the federal expenditures on such expenses will be actively pursued.

Even if the myriad problems of self-financed long-term care insurance can be resolved for the most affluent elderly, the major requirers of long-term care will remain the lowest income, most dependent elderly in the 85 and over group and they will need added public financing—as well as broader service arrangements (S/HMOs and other coordinated health/social service programs). For financing such programs, individualized estate-tax calculations (described later) have the appeal of building in automatic (albeit indirect) "relative responsibility" provisions; if relatives fail to provide needed support services some or all of these costs would be deducted from the inheritance they otherwise would receive. Several states are now moving in this direction through liens on estates or housing to pay for long-term care costs after an individual and surviving spouse have died. In view of federal deficit problems, the elderly will have to look to an enormous expansion of state and local government funding for long-term care.

Veterans Administration. A final budget consideration in long-term care policy will be the future role of the Veterans Administration. By 1990, 60 percent of all males over the age of 65 will be veterans and—since all veterans are legally deemed to be "service disabled" at age 65—entitled to free health care at VA facilities if space is available. If the VA is to meet these needs, it will need substantially to redirect its activities away from hospital care and toward long-term care, with corresponding investment and operating expenses. A recent Congressional Budget Office study (1984c) estimated that VA nursing home demand would rise 73 percent by 1995 and 107 percent by 2000 (assuming extrapolation of current trends), with added costs of $600 million annually (1982 dollars). Such costs could be much higher if private nursing home financing and availability is limited by rising nonveteran demand. The long-term care budget issues will thus involve a reconsideration of whether the nation's commitments to nonservice-disabled veterans should extend to nursing home care, as well as hospital and physician services, after the age of 65. At the same time, the existing VA programs provide opportunities for demonstration of alternative delivery and financing models and for training health professions students in geriatric medicine.

Taxes, Savings, and Pensions

The federal deficit crisis is obviously so severe that benefit retrenchments for the elderly, rather than benefit improvements, must be expected. Such developments will make private savings and pensions increasingly important for assuring adequate retirement income and economic security.

Federal tax policies now shape the nation's pension and retirement savings incentives. Major overhauls of the revenue statutes may be made in the next few years. In this light, the deficiencies in the current arrangements must be reconsidered, particularly inadequate overall levels of personal savings, inadequate assistance for lower income persons, and disproportionate subsidies for the more affluent population.

Tax Policies

Tax policies which are central to the welfare of the elderly are already among the most important features of the federal tax code (Office of Management and Budget 1984). The deferral of taxes on contributions to pension plans (IRAs and Keoghs, for example) is now the largest

of all federal tax expenditures, with an estimated revenue loss of $68 billion in 1985. As well, housing ownership—the major asset of the elderly—has been subsidized by the deductibility of mortgage interest expenses; these revenue losses are the second largest federal tax expenditure, some $25 billion in 1985. Other tax code provisions of special importance to the elderly are the nontaxability of most Social Security income and the double exemption for the elderly, with revenue losses of $13 billion and $2.7 billion in 1985.

Tax changes to encourage private savings have been a major theme of the past few years, reflecting the view that United States economic performance has been held back by undersaving (and thus underinvesting), particularly in business capital. The United States personal savings rate has been the lowest of any industrialized nation—and the adequacy of Social Security, Medicare, and other publicly funded insurance has been implicated in this result. If individuals are assured of adequate incomes and protection for their retirement by public insurance, they have less reason for private savings.

These recent tax (and regulatory) changes to encourage (and redirect) savings have included personal tax cuts (which reduce attractiveness of tax dodges and deductions), lower corporate taxes (particularly on capital investment) to make savings and investments in business more profitable, deregulation of financial institutions (which raises returns on savings, particularly for small savers), IRA, Keogh, and estate tax liberalizations. The deregulation of financial institutions has also contributed to higher home mortgage interest costs, an outcome which shifts savings from housing to other, more productive assets.

To date, these changes have had disappointing results. Despite the rising expenditures for pensions, IRAs, and Keoghs, the savings rate fell to 4.8 percent in 1983, a 34 year low (Council of Economic Advisers 1984). Some of the potential effects, however, may have been obliterated by the recession, recovery, and higher federal borrowing.

Further tax reforms to encourage private retirement savings could either take the form of general tax system changes or specific reforms in current pension, IRA, and Keogh provisions (discussed in the following sections). A leading option for general tax system overhaul—the consumption (or expenditure) tax— would seem particularly useful for expanding personal savings (Congressional Budget Office 1983). Since income which is saved would be exempt from such a tax (until it is spent), the tax would amount to a much-broadened IRA. If

recent and future tax changes do successfully increase private savings, more of the elderly will be less dependent on government benefits and able to offset future assistance cutbacks.

Pensions and Retirement Savings

The Social Security system was enacted to provide a base-income support level for retirees—with the expectation that individuals would supplement these benefits by their own savings. Private pension arrangements developed rapidly after World War II, encouraged by federal tax subsidies in the form of deferral of taxes on employer contributions (and interest thereon) until benefits were received. These income exclusions provided federal pension subsidies of $56 billion in 1985. Federal regulation of private pension plans, primarily through the Employee Retirement Income Security Act (ERISA) of 1974, is concerned with solvency and other standards but does not mandate pension availability or benefit adequacy.

Despite the high budget costs involved, national efforts to encourage widespread private pension coverage as supplements to Social Security have not been very successful. Since employers are not now required to offer pension plans, only about half the work force has any private pension coverage (President's Commission on Pension Policy 1981). Enrollment growth in pension plans stalled out in the mid-1970s. As well, most plans are not transportable to work for other employers. Public pension systems (including Social Security) now provide approximately 86 percent of all cash retirement benefits—while private-sector pension plans provide only 14 percent of the benefits.

Gaps in private pension coverage will be particularly troublesome for those population groups most in need of Social Security supplements for retirement, including lower wage workers, women, and minorities. Only 13 percent of persons with incomes below $5,000 in 1979 had private pension coverage, compared to 38 percent for those with incomes of $5,000 to $10,000, 59 percent with $10,000 to $15,000, and 72 percent with $15,000 and over incomes. As a result, 25 to 34-year-old workers with incomes over $20,000 received an estimated $3 in tax subsidy for every $1 received by workers in the same age group with incomes below $20,000.

The shortcomings of current pension provisions raise questions which will need to be considered in tax reform debates: How much should

persons in different economic circumstances be expected to save for their own retirement? How much tax subsidy (if any) should be provided for such savings? How can private pensions and savings incentives be redesigned (or redirected) to assist those most in need of them, particularly as federal assistance cuts take hold?

The Congress will have before it a number of proposals for addressing these issues and a national retirement income policy. The President's Advisory Council on Pension Reform (February 1981) has recommended a mandatory Minimum Universal Pension System (MUPS), to which employers would provide at least 3 percent of payroll; these plans would be vested (i.e., employees would become eligible for some benefits after a year), and transportable (i.e., employee benefits would accumulate regardless of job change). MUPS plans could be arranged by an employer or could be handled through the federal government. Such legislation would extend private pension coverage to all persons who do not now have such protection; its major attractions include improving the standard of living for those future retirees who most need Social Security supplements and increased savings. Other pension legislation could standardize provisions for assuring rights of the divorced and widowed to share in or continue pensions of former spouses; such changes would be of particular assistance to elderly women (particularly in the aged 85 and over group) who are the most dependent of the elderly population.

Similar issues—that current retirement tax subsidies are nearly the opposite of the needs for them—arise concerning the future role of IRAs in national retirement income policy and tax reforms. As with employer-paid pensions, higher income persons have much greater gain from IRAs than lower income persons. A $4,000 IRA deduction provides a $2,000 benefit for a couple in the 50 percent tax bracket, but only a $600 benefit for a couple in the 15 percent tax bracket. As well, higher income persons are more likely to have the discretionary funds to take full advantage of IRA provisions than moderate- and low-income persons. Higher income persons thus use IRAs much more than other income groups; Treasury Department data show that 26 percent of persons with a $20,000 to $50,000 income and 55 percent of persons in the $50,000 and over bracket have opened IRA accounts compared to only 5 percent in the under-$20,000 income groups. As well, most IRA investments seem to be transfers from other assets rather than new savings.

Such statistics also raise the question of whether current tax policies

for retirement planning overly subsidize the well-to-do, and whether they should be redirected to assist the lower income elderly. Should taxpayers be asked to create "IRA millionaires" when 15 percent of the elderly still live in poverty? Savings by higher income persons could also be fostered by other means—which would reduce rather than add to the federal deficit—such as a consumption tax and by taxing (or otherwise means-testing) Social Security and Medicare benefits. If the IRA concept is retained, a major reform option would be to replace the deduction with a tax credit, e.g., $500 per person, which will provide the same dollar subsidy for every taxpayer regardless of income.

Inheritance Taxes

One of the major social policy issues involved in tax and retirement legislation is the extent to which our society should allow and encourage passage of assets from one generation to another. As noted in the previous discussions, many of the elderly have saved enough to finance shortfalls in government assistance—but most of these savings are tied up in housing and household possessions. Similarly, the amount of an estate which can be passed on without taxes will rise to $600,000 in 1987. Over time, this will mean an even greater level of financial resources for future retirees as they inherit assets which their parents and grandparents have accumulated throughout their lifetimes.

In the coming reconsideration of federal tax policies, estate taxes offer an alternative to income taxation of benefits and other forms of means-testing as a way for the elderly to finance a greater share of their benefits. Taxes on assets which are no longer needed by the deceased elderly are certainly less burdensome than higher income tax burdens or higher Medicare cost-sharing during their lifetimes. One such "pay-as-you-go" proposal, for example, would help meet the Medicare deficit by comparing the amount of Medicare expenses for an individual to the taxes and premiums paid for the deceased's benefits and taxing an estate up to 25 percent of the difference after the death of a surviving spouse (Palmer and Torrey 1983).

Conclusion

For most of the past fifty years, the nation has used an expanding federal role in social insurance as its major public policy tool for

improving the standard of living and security of the elderly. Those efforts have been both highly successful and expensive. The federal budget deficit now requires a reconsideration of what standards of living, health care, and financial security the nation wishes the federal government to assure for future retirees. These questions will be answered primarily through how the political process deals with the nation's currently inadequate policies for slowing health costs and for improving retirement income through private pensions and savings.

References

Advisory Council on Social Security. 1984. *Medicare Benefits and Financing.* Washington.

Congressional Budget Office. 1983. *Revising the Individual Income Tax.* Washington.

———. 1984a. *Baseline Budget Projections for Fiscal Years 1985–1989.* Washington.

———. 1984b. The Combined Effects of Major Changes in Federal Taxes and Spending Programs Since 1981. Washington. (Staff memorandum.)

———. 1984c. *Veterans Administration Health Care: Planning for Future Years.* Washington.

Council of Economic Advisers. 1984. *Economic Report of the President.* Washington.

Etheredge, L. 1983. Estimates for a Medicare Rescue Plan. Report for U.S. Senate. Labor and Human Resources Committee. Washington.

Federal Hospital Insurance Trust Fund Board of Trustees. 1984. *Annual Report.* Washington.

Federal Supplementary Medical Insurance Trust Fund Board of Trustees. 1984. *Annual Report.* Washington.

Freeland, M., and C. Schendler. 1984. Health Spending in the 1980s. *Health Care Financing Review* 5(3):1–68.

Friedman, J., and J. Sjogren. 1981. Assets of the Elderly as They Retire. *Social Security Bulletin* 44(1):16–31.

Gibson, R., D. Waldo, and K. Levit. 1983. National Health Expenditures 1982. *Health Care Financing Review* 5(1):1–32.

Office of Management and Budget. 1984. *Special Analyses. Budget of the United States Government. FY 1985.* Washington.

Palmer, J., and B. Torrey. 1983. Health Care Financing and Pension Programs. Discussion paper for the Urban Institute.

President's Commission on Pension Policy. 1981. *Coming of Age: Toward a National Retirement Income Policy.* Washington.

Torrey, B. 1984. The Visible Costs of the Invisible Aged: Fiscal Implications of the Growth in the Very Old. Paper for the Association for the Advancement of Science.

U.S. Department of Commerce. Bureau of the Census. 1982. Decennial Census of Population 1900–1983 and Projection of the Population of the U.S. 1982–2050. *Current Population Reports.* Series P-25, no. 922. Washington.

———. 1983. Estimating After-tax Money Income Distributions Using Data from the March Current Population Survey. *Current Population Reports.* Series P-23, no. 126. Washington.

———. 1984. *Money Income of Households, Families, and Persons in the United States 1982. Current Population Reports.* Series P-60, no. 142. Washington.

U.S. Department of Health and Human Services. 1979. *Survey of Income and Program Participation.* Second and fifth waves. Washington.

———. 1983a. *Social Security Bulletin, Annual Statistical Supplement 1982.* SSA pub. no. 13-11700. Washington.

———. 1983b. *The Medicare and Medicaid Data Book 1983.* HCFA pub. no. 03156. Washington.

———. 1984. *Health—United States 1983.* PHS pub. no. 84-1232. Washington.

U.S. House of Representatives. Committee on Ways and Means. 1984. *Proceedings of the Conference on the Future of Medicare.* WMCP pub. no. 98-23. Washington.

U.S. Senate. Special Committee on Aging. 1984a. *Older Americans and the Federal Budget: Past, Present, and Future.* Senate report 98-168. Washington.

———. 1984b. *Developments in Aging 1983.* Senate report 98-360. Washington.

———. 1984c. *Medicare and the Health Costs of Older Americans.* Senate report 98-166. Washington.

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