Entitlements and the Federal Budget: Facts, Folklore, and Future*

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DEFICIT REDUCTION HAS OCCUPIED A CENTRAL place on the political agenda for two decades. Over that time, the view that the growth and persistence of federal deficits is due to spending for "entitlements" has come to prevail. While entitlements have become more visible, several factors cause them to remain the subject of widespread myth, exaggeration, and error: sustained attacks on entitlement programs by deficit reduction advocates; media stories about government largesse benefiting the affluent elderly; misinformation or oversimplification by the media and opinion leaders about entitlements; a profound antigovernment mood; and an impending fiscal crisis.

These misunderstandings influence the climate of public opinion in which the budget debate occurs and thus influence the zone of acceptable policy change. In this article, I will begin to separate myth and misconception from fact about entitlements and their role in the budget deficit. In the next section, I will discuss the recent historical context for the current debate, following that with an introduction of basic defini-

*The views expressed here do not necessarily reflect those of the American Association of Retired Persons.

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tions and distinctions. I then will discuss common perceptions about entitlements and explore these perceptions more thoroughly, concluding with an outline of principles and suggestions for options to solve the short- and long-term deficit problems.

Recent History

Deficit reduction has been a policy priority for almost 20 years. As early as 1976, the $74 billion deficit in that fiscal year (FY) budget surpassed 4 percent of the gross domestic product (GDP), a record then for peacetime. But economic conditions and the fiscal policies of the Reagan and Bush Administrations resulted in a new phenomenon: annual deficits averaging over $200 billion per year from FYs 1982 to 1992. After a brief four-year decline during FYs 1993–96, deficits are projected to increase in nominal dollars again in FY 1997 and beyond. The economic policy significance of the deficit is its direct connection to national saving and its indirect influence on long-term economic growth. The sharp decline in national saving since the 1980s resulted in large measure from federal deficits that absorbed an increasing percentage of net private saving, reaching as high as 80 percent (see fig. 1).

In recent years, the deficit has frequently been attributed to increases in entitlement spending. Entitlement authority is defined[1] as authority "to make payments (including loans and grants), the budget authority for which is not provided for in advance by appropriations Acts, to any person or government if, under the provisions of the law containing such authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by such law" (U.S. Senate 1990). Entitlements, which now constitute over 50 percent of federal spending, incite controversy, not only because of their large size and steady growth, but also because they occupy a privileged status in the budgetary process. They do not undergo the scrutiny of the annual appropriations process, and, because their authorizing legislation directly results in spending, they have a stronger claim over budgetary resources than do discretionary programs. Because some entitlement programs—most notably Social Security, federal retirement programs, and Supplemental Security Income (SSI)—have automatic cost-of-

[1]Congressional Budget Reform Act, §401 (c)(2)(C) (1974).

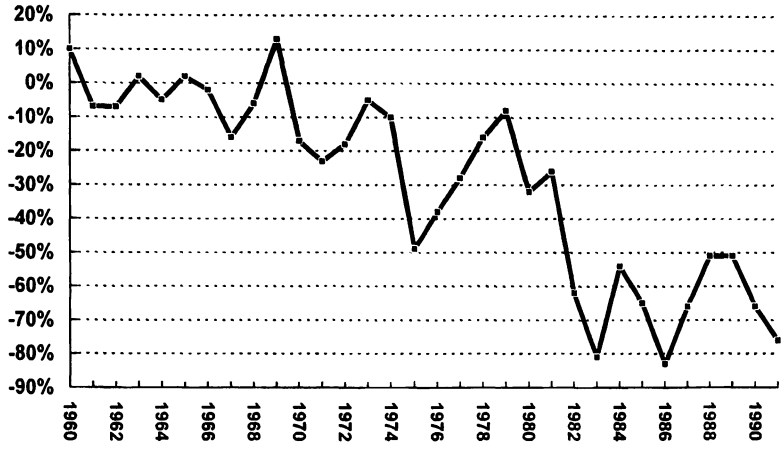

FIG. 1. Federal deficit as percentage of net private savings, 1960 to 1991. *Source:* Council of Economic Advisors (1995).

living adjustments (COLAs) built into them, their spending falls even further outside the reach of the "normal" legislative spending process—that is, the authorization and appropriations committees—which now governs only one-quarter of federal spending.

The provisions of the Budget Enforcement Act of 1990 place entitlement spending and taxes in the same "pay-as-you-go" (PAYGO) category of the budget, which means that any legislative action affecting this portion of the budget that would widen the deficit would require offsetting measures in order to be deficit-neutral. This potentially exposes entitlement spending to greater budgetary scrutiny if legislative action were to cause some entitlements to increase or taxes to be lowered; but if the budget deficit were widened by economic change that caused entitlement spending to rise, there is no requirement for offsetting action.

While the debate of the past two years has made people more aware of entitlements as an issue, like the health care reform debate of 1994, it has illuminated little and obscured much, including the meaning of the term "entitlement."

Types of Entitlements

"Entitlement" has evolved from a term of art in the budget process to a rhetorical device, and some definitional clarification is called for. There

is value in differentiating among types of spending entitlements because the differences are critical and lead to fundamental policy disagreements. It is also useful to recognize the comparably privileged position accorded to government benefits offered through the tax code and to compare their effects with those of spending entitlements.

Spending Entitlements

Most of the federal budget today—approximately 55 percent—consists of spending that is mandatory under current law, which means that federal funds are automatically available without a congressional appropriation. Mandatory spending consists mostly of entitlement authority, which was defined earlier, and spending for prior year obligations, deposit insurance, and numerous small trust funds. Some would also include interest payments on the debt. Entitlements represent legally enforceable statutory rights, either of individuals or of governments. A recent General Accounting Office (GAO) report identified over 400 federal mandatory accounts (most of them small), with most of the dollars providing either income security or health entitlement benefits (U.S. General Accounting Office 1994a). In the broad category of "entitlements and other mandatory spending" set forth by the Congressional Budget Office (1995b), the top ten entitlements account for nearly 95 percent of all entitlement spending, and the top three (Social Security, Medicare, and Medicaid) account for over 70 percent (see table 1).

Some entitlements are "means tested," in that they impose limits on the amount of income or assets that applicants may have in order to be eligible for benefits. This category includes Aid to Families with Dependent Children (AFDC), Medicaid, food stamps, the Earned Income Tax Credit (EITC), and Supplemental Security Income (SSI), among others. Other entitlements are "non-means-tested," which means they are available regardless of income, as long as one satisfies the other eligibility criteria. Social Security, Medicare, unemployment compensation, federal retirement, and agricultural price supports are non-means-tested. They are often referred to as "middle-class entitlements" because the absence of a means test results in benefits going to people in all income classes.

Means-tested entitlements accounted for $191 billion in total federal outlays in FY 1994, just under one-quarter of all entitlement spending

TABLE 1
Ten Largest Spending Entitlements, FY 1995

Program	Amount of federal outlays ($billions)	Percentage of entitlement outlays	Cumulative percentage of outlays
Social Security	333	39.8	39.8
Medicare	178	21.3	61.1
Medicaid	89	10.7	71.8
Civil service retirement	43	5.1	76.9
Military retirement	28	3.4	80.3
Food stamp program	26	3.1	83.4
Supplemental Security Income	24	2.9	86.3
Unemployment compensation	21	2.5	88.8
Veterans compensation	20	2.4	91.2
Family support	18	2.2	93.4
Earned Income Tax Credit	15	1.8	95.2

Source: Congressional Budget Office (1995b).

and about 13 percent of total federal spending. Non-means-tested entitlements totaled $644 billion, or about three-fourths of all entitlement spending and about 42 percent of total federal outlays.

The very definition of entitlements has been politicized in the debate over the budget, becoming synonymous in some people's view with means-tested "welfare" benefits. Confusion over the meaning of the term "entitlements" has even led some defenders and beneficiaries to argue (incorrectly) that Social Security and Medicare are not entitlements because beneficiaries contributed to those programs and have "earned" the benefits. Sometimes the mischaracterization is more subtle. Consider, for example, the following question from a survey conducted for the American Hospital Association in January, 1995: "Are Social Security and Medicare entitlement programs, or do people get benefits that their taxes have already paid for?" (American Hospital Association 1995).

The answer, in this case, is yes to both. The neutral use of "entitlement" as a term of budgetary art has nevertheless in some cases been supplanted by a new, value-laden usage meaning "unearned benefit."

Entitlements are sometimes defined too loosely. A 1992 paper, "Controlling Entitlements," defined "federal benefits" (presumably meaning entitlement benefits) as "all federal payments that do not represent

compensation for goods and services" (Howe 1992). A recent critique of entitlements defined them as "any public sector payments, received by a person or a household, that do not represent contractual compensation for goods or services" (Peterson 1993, 99). These similar definitions resemble the classic economic concept of "transfer payments," which encompasses many entitlements but also includes some programs that are not entitlements, such as housing subsidies; furthermore, transfer payments exclude large, third-party payments that clearly are entitlements—namely, spending for Medicare and Medicaid, which constitutes compensation for services.

Too often such observers treat entitlements as an undifferentiated aggregate. In this article, the term "entitlements" is defined as in the Congressional Budget Act. However, for convenience in some of the aggregate expenditure analysis, I use the Congressional Budget Office (CBO) category of "Entitlements and Other Mandatory Spending" (Congressional Budget Office 1995b), which includes a relatively small percentage of mandatory spending items that are not entitlements, such as repayment of loans or loan guarantees, payments to foreign governments, and dozens of small trust and revolving funds.

Tax Expenditures as Entitlements

Tax preferences like deductions, exclusions from income, credits, or preferential tax rates—known as "tax expenditures"—are sometimes considered to be entitlements because they are available automatically to anyone who qualifies and "applies" for them by filing their tax returns (U.S. House of Representatives 1994, 675). Provisions like the exclusion of employer-provided health insurance and the mortgage interest deduction have standing legislative authority and result in direct federal subsidies, so they resemble spending entitlements in their conferral of benefits, their degree of protection from congressional control, and their impact on the federal deficit. Tax expenditures, including both individual and corporate provisions, total well over $400 billion per year, which is nearly half the amount of spending entitlements (U.S. General Accounting Office 1994b).

Many conservatives object to the whole concept of tax expenditures because, they argue, its implicit premise is that government has claim to all one's income. However, tax entitlements and spending entitlements are functionally equivalent, as illustrated by the EITC, which is

one of the largest tax entitlements and also one of the largest spending entitlements. The EITC is "refundable," meaning that the taxpayer actually receives a check from the government if the amount of the credit exceeds his tax liability. The tax reduction portion of this program is a tax entitlement, and the refundable credit portion is a spending entitlement, although both have the same effect on the federal budget deficit. Their equivalence was underscored in the legislative action on the 1995 reconciliation bill, when the Republican majority wanted to treat all of the EITC as a spending entitlement, in part to avoid the characterization of reductions in EITC benefits as a tax increase. Of added significance in the budget deficit debate is that tax expenditures are far less visible to the public than spending entitlements, are distributed in a far less progressive manner than spending entitlements, and have been on the sidelines in much of the debate over the deficit.

Common Perceptions about Entitlement Spending

Several propositions regarding entitlements and the deficit seem to have entered the popular wisdom. Because of their influence on the public's perception about entitlements, they deserve much closer scrutiny. Some of them are analyzed below in the light of recent and historical budgetary data.

Entitlement Spending Is Mainly Responsible for Today's Large Deficits

Spending entitlements are frequently cited as the primary cause of growth in the federal deficit. Peterson has written: "The spiraling costs of our middle- and upper-class entitlement programs—[are] the single most important cause of burgeoning budget deficits" (Peterson 1993, 21). Another account says, "Events have proved that the growth of entitlements is indeed the leading cause of the nation's long-term structural deficits" (Howe and Longman 1992, 90). Numerous press accounts have repeated this assertion to the point that it has reached wide acceptance. But this conventional wisdom does not hold up under close scrutiny. Simply put, when deficits grew most rapidly in the past relative to

the economy, entitlement spending was declining as a percentage of the economy.

Spending entitlements grew substantially from $32 billion in 1962 to $835 billion in 1995, an average annual increase of 5.1 percent in 1992 (inflation-adjusted) dollars (Congressional Budget Office 1995b, table E-6). During that period, deficits also grew substantially—by 4.7 percent in real terms—while GDP increased by only about 2.8 percent. The high correlation between the deficit and entitlement spending over time (.93 from 1962 to 1995) might suggest that entitlements are a causal factor. But there is an equally high correlation between defense spending and the deficit (.94) and between net interest payments and the deficit (.92) over the same period, even though defense barely grew in real terms (0.04 percent per year) from 1962 to 1995 while net interest costs grew faster than any other item in the budget (5.9 percent per year). These high correlations reflect trends in total spending that are mostly inflation driven. A more careful look at the empirical evidence is required.

Entitlement spending has gone through at least three distinct phases since the 1960s: rapid growth from the early 1960s to 1975, stabilization from 1975 to 1991, and a resumption of growth after 1991. Some of the growth spurts in entitlements were due to their cyclical sensitivity: they increase during recessions and contract during recoveries and expansions. Certain trough years of past business cycles, such as 1974–75, 1980–82, and 1991, correspond to years of peak or rapid entitlement growth relative to GDP. From the early 1960s through 1975, as table 2 shows, entitlements grew faster (8.4 percent in inflation-adjusted terms) than total outlays (4.4 percent) and faster still than GDP (3.3 percent). During this time, entitlements nearly doubled from 5.8 percent of GDP in 1962 to 10.9 percent of GDP in 1975, and went from 30 to 50 percent of federal spending. The creation of several new programs, including Medicare and Medicaid, SSI, the food stamp program, and general revenue sharing (an entitlement for states and localities that was later repealed), along with large increases in the Social Security program, spurred the rapid growth. Recessions in 1969–70 and in 1973–75 also created more claimants for these programs.

From 1975 to 1991, both of which were trough years of the economic cycle, entitlements stabilized relative to GDP (Abramson 1989). During this period, GDP grew by 2.5 percent per year after inflation, entitlement spending by 2.7 percent. Entitlement spending also grew

TABLE 2
Growth Rates in Categories of Budget Outlays for Selected Periods ($1992)

	1962–95	1962–75	1975–91	1991–95	1995–2005
Gross domestic product	2.81	3.31	2.50	2.43	2.23
Total outlays	3.18	4.38	2.87	0.60	1.93
Entitlements	5.07	8.41	2.67	4.13	3.50
Means-tested	6.80	9.66	4.10	5.59	4.69
Medicaid	16.70	29.51	7.23	8.67	6.74
Non-means-tested	4.70	8.20	2.19	2.74	2.94
Social Security	4.81	4.74	3.21	2.74	2.01
Medicare	9.35	13.40	7.53	8.62	6.18
Total entitlements, less health	3.86	7.31	1.59	2.05	1.86
Net interest	5.92	5.01	7.77	1.70	−0.18
Income tax revenue	2.91	3.21	2.61	3.19	2.38

Source: Congressional Budget Office (1995b).

more slowly than most other categories of spending. Between 1975 and 1991, entitlement spending went from 10.9 to 11.2 percent of GDP, and dropped from 49.5 to 47.9 percent of federal outlays. This restraint resulted from a series of events, including the development of the reconciliation process under the Congressional Budget Act, restraint in the creation of new entitlements, the repeal of general revenue sharing, change in the political climate during the Reagan Administration, reforms to Social Security in 1983, and administrative actions in holding down the number of beneficiaries (Abramson 1989). The end of a deep recession in 1975 and the indexing of certain entitlements, including Social Security and SSI, also helped stabilize entitlement spending relative to GDP.

In contrast to entitlements, which grew from the 1960s to 1975 and then stabilized, federal deficits grew steadily since the 1960s, averaging less than 1 percent in the 1960s, doubling to 2.1 percent in the 1970s, doubling again to 4.1 percent in the 1980s, stabilizing somewhat at 4.4 percent from 1990 to 1993, and then declining to under 2 percent (projected) by 1996. With the advent of the Reagan Administration fiscal policies in the early 1980s, deficits in excess of 4 percent of GDP occurred annually. This is precisely the time when entitlement spending was *slowing* relative to the economy and relative to growth in other federal outlays.

Further evidence of a statistical nature shows a divergence in the growth paths of the total deficit and total entitlement spending as a percentage of GDP. Regressing the deficit as a percentage of GDP against time for the periods from 1962 to 1975 and 1975 to 1991 yields regression coefficients that are nearly identical for both time periods (.094 for 1962–75 and .085 for 1976–91), indicating a roughly constant deficit trend line of nearly 1 percent of GDP per decade. Regressing entitlement spending as a percentage of GDP against time yields a coefficient of .37 for 1962–75 but a negative slope (−.03) for 1975–91 (see table 3). In other words, entitlements grew by .37 percent of GDP per year from 1962 to 1975—faster than the deficit—but they did not grow at all—in fact they declined—relative to GDP from 1975 to 1991 when the deficit continued to grow. Entitlements do not appear to have caused the rapid deficit growth in the latter period.

In the period since 1991, the pattern has reversed again. Deficits have declined relative to GDP from 4.8 percent in 1991 to 2.3 percent in 1995, while entitlements have gone from 11.2 to 11.9 percent of GDP and from 47.9 to 55 percent of federal outlays. Projecting beyond 1995, deficits increase after 1996 relative to GDP if discretionary spending increases with inflation. Entitlements are projected to grow from 12.0 to 13.6 percent of GDP and from 55 to 64 percent of outlays by 2005 (Congressional Budget Office 1995a). This growth of entitlements relative to GDP and to budget outlays is entirely attributable to health spending. Nonhealth entitlement spending is projected to grow at an annual average of only 1.9 percent per year from 1995 to 2005, compared with 2.2 percent growth in real GDP, and is projected to decline from 8.1 percent of GDP in 1995 to 8.0 percent by 2005. However,

TABLE 3
Comparison of Growth in Deficits and Entitlements as Percentage of GDP

Time period	Deficit as percentage of GDP	Entitlements as percentage of GDP
1962–75	0.093 (1.32)[a]	0.366 (7.94)
1975–91	0.085 (1.27)	−0.029 (−0.85)
1962–91	0.152 (6.21)	0.223 (9.46)

[a] *T*-values are in parentheses.
Source: Analysis of data from Congressional Budget Office (1995b).

both Medicare and Medicaid are projected to grow between 9 and 10 percent per year in nominal dollars, and between 6 and 7 percent after inflation for the next decade. This rate is slightly slower than their growth rates in the previous 20 years, but much faster than other entitlement programs. A case can be made for future deficits being the result of rapid growth in entitlement spending, but it is health care spending, not entitlement spending generally, that is responsible.

Public Sector Programs Are Driving up Health Care Costs

Many observers have correctly pointed to the two major health entitlements—Medicare and Medicaid—as the primary sources of short-term budget pressures. Together the two giant health entitlements will rise from 3.9 to 5.5 percent of GDP by 2005, while *nonhealth* entitlements rise by 0.3 percent of GDP and total outlays *other than* Medicare and Medicaid shrink by 0.8 percent of GDP.

Critics of entitlements have concluded that controlling "government-sponsored" health spending directly will solve the health care cost problem. They cite as evidence that Medicare costs grew faster than private health insurance costs from 1991 to 1993. Some observers have concluded that the disparity in growth rates of total private and public health insurance costs is due to the more substantial penetration of managed care in the private health insurance market. About 50 percent of privately insured patients are in managed care plans, compared with only about 9 percent of Medicare beneficiaries and about 23 percent of Medicaid beneficiaries (Christensen 1995).

These observations oversimplify a more complicated reality. One reason for recent higher spending in public programs is that public and private insurance *enrollments* have been moving in opposite directions. Medicare and Medicaid enrollments are growing, and private insurance coverage is shrinking. The number of persons with Medicare and Medicaid coverage increased from 59.7 million in 1991 to 64.6 million in 1993 (Employee Benefits Research Institute 1995)—an 8.2 percent increase. During that period, the number of persons with employer-provided private health insurance coverage fell from 150 million to 147.4 million, a 1.7 percent decline (Employee Benefits Research Institute 1995). Because net enrollment in public and private health

insurance has moved in opposite directions since 1990, it is important to measure cost on a per enrollee basis. When this is done, the growth rates of private and public health insurance converge. Medicare spending per enrollee grew more slowly in 1991 than private health insurance, and the differences between private and Medicare spending rates for 1992 and 1993 were cut by more than half (Moon and Zuckerman 1995).

Furthermore, benefit coverage of private health insurance plans and Medicare differs. Most private plans cover prescription drugs—Medicare does not. Medicare provides coverage for skilled nursing care, which private insurance typically does not. Private insurance plans change over time, whereas Medicare's structure of benefits, deductibles, and coinsurance have remained stable over time. In the private health insurance market, reductions in cost may be due to shifts by enrollees to lower-cost plans, increases in deductibles and coinsurance, or decreases in benefits. Without controlling for these variations, comparisons between private insurance and Medicare are flawed (Moon and Zuckerman 1995).

When these differences are controlled somewhat by comparing only core services provided by both Medicare and private insurance, Medicare costs prove to grow more slowly than private sector costs in every year since 1985 except 1993, when private health insurance grew by 7.1 percent and Medicare by 7.4 percent (Moon and Zuckerman 1995).

A comparable pattern occurs with the Medicaid program. Between 1975 and 1990, Medicaid per enrollee expenditures grew at an annual average rate of 11 percent (before inflation) compared with 12.8 percent for private health insurance per enrollee costs. This pattern also obtained for every 5-year subperiod. Medicaid grew even more slowly than Medicare during this period (Christensen 1992).

Non-Means-Tested Spending Has Grown Faster than Means-Tested Spending

A third common proposition about entitlement spending is that the fastest growth has occurred mainly among the so-called middle-class entitlements, such as Medicare, Social Security, federal retirement, unemployment compensation, and agricultural price supports. To be sure, dollar increases in non-means-tested entitlements have been larger because they are more than three times the size of mean-tested programs. In percentage change terms, however, non-means-tested entitlements

have grown more slowly than means-tested programs for various periods over the past 30 years. Table 2 compares real (inflation-adjusted) average annual growth rates of selected budget items, including means-tested and non-means-tested entitlements, for the three distinct periods of entitlement growth discussed earlier and for the next ten years. Average annual growth (adjusted for inflation) in means-tested entitlements has exceeded that for non-means-tested programs in every period, and is projected to continue doing so in the future.

A more substantively meaningful breakdown of entitlements into retirement, health, safety net, and other programs (table 4; fig. 2) highlights the one entitlement area where the fastest growth has occurred and where the only future growth (relative to the economy) occurs: health care. Since 1975, nonhealth entitlements taken together have grown more slowly than the overall economy.

A corollary perception is that non-means-tested programs have been spared the budget knife. Social Security and Medicare are thought to be politically sacrosanct because they largely benefit older Americans who vote more regularly than other groups (Peterson and Howe 1988, 44). Social Security, the untouchable "third rail" of American politics, has generally been protected from explicit deficit reduction legislation (with the exception of OBRA 1993, in which taxes on benefits were increased for about one-eighth of beneficiaries). However, Social Security benefits for both current and future beneficiaries were cut in the 1983 Social Security amendments (Zedlewski 1988). COLAs were frozen for six

TABLE 4
Real Growth Rates of Various Categories of Entitlement Spending ($1992)

Category of entitlement	1962–95	1962–75	1975–91	1991–95	1995–2005
Retirement	4.9	8.1	3.0	2.4	1.9
Health	9.7	14.5	7.4	9.4	6.4
"Safety net"	3.6	6.6	1.1	3.8	2.5
Other	0.3	6.2	−3.8	−5.5	1.3
All nonhealth entitlements	3.9	7.3	1.6	2.1	1.9
All entitlements	5.1	8.4	2.7	4.1	3.5
Gross domestic product	2.8	3.3	2.5	2.4	2.2

Source: Congressional Budget Office (1995b).

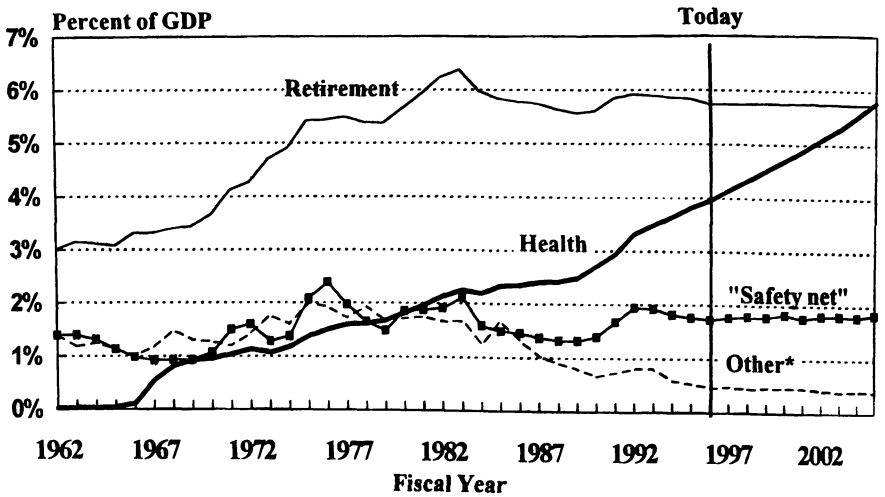

FIG. 2. Entitlement categories as percentage of the GDP, FYs 1962 to 2005. *Other entitlements include agricultural subsidies and veterans benefits. *Source:* Congressional Budget Office (1995b).

months, the "normal" retirement age was raised, benefits were taxed for the first time, and payroll tax increases were accelerated. These cuts contributed to deficit reduction even though their objective was to bring solvency to the Social Security program.

Medicare has been subject to annual reductions since the early 1980s, although those cuts have at times been overstated. The CBO estimated that cumulative budget cuts in the 1980s reduced Medicare spending by about $85 billion compared with baseline projections (Christensen 1991). OBRA 1990 made additional cuts of $43 billion over five years, and OBRA 1993 cut $56 billion more from Medicare over five years.

Still, Medicare spending continued to grow rapidly as a percentage of GDP. Part of the explanation is that some of the cuts in the program were illusory. In budget parlance, a spending cut is a reduction from a baseline that is automatically adjusted for inflation in future years. Some past Medicare cuts have been overstated because they represented cuts from budget baselines that were subsequently allowed to revert to previous growth paths. For example, Medicare cuts in the form of lowered reimbursement rates have the effect of lowering the baseline rate of Medicare growth. When the lowered rates were allowed to expire, the baseline reverted to the former, higher, growth rate. Extending the

lower rates after they expired allowed Congress to claim savings a second time that would have occurred automatically if the reimbursement rates had been made permanent (Cogan, Muris, and Schick 1994).

Non-Means-Tested Entitlements Provide Excessive Benefits to the Affluent

Budget observers often apply the phrase "middle-class entitlement" to non-means-tested programs because eligibility for benefits does not depend on income, and therefore benefits flow to all income classes, not just the needy. Non-means-tested entitlement programs are frequently criticized as subsidies to the wealthy—e.g., even H. Ross Perot qualifies for Social Security. One account claimed that, in 1991, "One half (at least $400 billion) of all entitlements went to households with incomes over $30,000. One quarter (at least $200 billion) went to households with incomes over $50,000" (Howe and Longman 1992, 93). Another source has cited exactly the same percentages (Peterson 1993, 104).

Whether or how much of such benefits *should* be directed to the affluent and whether we can afford these commitments once the baby boomers retire are important policy questions. Strong equity arguments favor means testing, and strong counterarguments insist that the universality and insurance aspects of Social Security have preserved the program. There are plainly ways to reform Social Security for the long term that will maintain universality and will not undermine the social insurance basis of the program. The 1995 Advisory Council on Social Security considered one such option that would not affect benefits drastically but would make the system solvent and stable over at least 75 years.

It is my intent here to deal instead with the narrower empirical question of what percentage of benefits actually go to higher-income people. The reason for focusing on this question is that if the claims are exaggerated, they may undermine popular support for Social Security. Both of the quotes above cite an "unpublished" CBO analysis for their claims. However, a CBO report published in September of 1994 shows that only 37 percent, not 50 percent, of all entitlement benefits in 1991 went to those with incomes over $30,000, and that 17 percent, not one-quarter, went to households with incomes over $50,000 (Congressional Budget Office 1994). Why do these disparities occur?

The distribution of government entitlements by income level is strongly influenced by a number of methodological choices—for example, the unit of analysis (household, family, tax filing unit), the income definition used to classify units, whether adjustments are made to income, whether income is measured before or after transfers or taxes (Menchik 1991), whether it includes in-kind transfers or not, and what data sources are used.

These choices influence how families or individuals are classified in terms of income, and thereby influence the distribution of entitlement benefits by income class. This is illustrated in table 5, which compares the percentage of major spending entitlements received by families whose incomes are above $30,000 and above $50,000, arrayed roughly in order of increasing inclusiveness of the income definition. Current Population Survey (CPS) pretransfer income includes cash income from all sources except government transfers; cash income adds in transfers; expanded income includes AGI (adjusted gross income), tax exempt interest and Social Security benefits not included in AGI; and JCT (Joint Committee on Taxation) income includes AGI, tax exempt interest, untaxed Social Security benefits, workers' compensation, employer-paid Social Security taxes, the insurance value of Medicare, and nontaxable health and life insurance contributions. The percentage of entitlement benefits received by those with incomes above $30,000 ranges widely from 19 percent to 58 percent, and the percentage received by those with incomes above $50,000 ranges from 9 percent to nearly 30 percent. The estimates reported by Howe and Longman (1992) and Peterson (1993) of benefits going to high-income people are high in the sense that they depend on the most inclusive definition of income. By contrast, the CBO estimates fall near the middle of the distribution of estimates shown in table 5.

Table 5 shows that, for most income definitions, the distribution of Social Security is similar to that of total entitlements. This similarity should not come as a surprise because Social Security is 40 percent of all entitlement spending. But table 6 shows that, while Social Security is skewed more toward higher-income people than means-tested programs, it is less skewed toward high-income people than veterans' benefits, military retirement, or civilian retirement benefits. Moreover, it is more progressively distributed than either overall income or government tax benefits. This last comparison suggests that the distribution of tax benefits should be a far greater equity concern than the distribution

TABLE 5
Percentage of Entitlement Benefits Received by Families under $30,000 and above $50,000 Income

Income definition	Distribution above $30,000			Distribution above $50,000		
	Total entitlements	Social Security	Income	Total entitlements	Social Security	Income
CPS pretransfer income (no adjustment)	18.8	19.4	NA	8.5	9.0	NA
CPS pretransfer income (adjusted)[a]	23.2	22.4	81.0	11.1	10.4	62.3
CPS cash income (no adjustment)	32.6	36.6	NA	14.4	7.3	NA
SIPP—cash income (1991)[b]	31.3	30.7	79.3	13.6	12.0	55.4
CPS cash income plus food stamps (1994) (CBO)[c]	36	38	NA	17	NA	NA
CPS cash income (adjusted)[a]	47.5	51.7	81.4	20.9	21.4	60.5
CBO expanded income[a]	41.8	49.1	81.6	18.2	20.7	60.5
SIPP—total income (1991)[b]	46.0	46.5	79.2	18.3	17.0	4.1
JCT expanded income[a]	58.4	66.7	86.9	29.7	32.7	68.4

Note: SIPP total income includes cash income plus values for food stamps, Medicare and Medicaid benefits and Veterans Administration education.
Abbreviations: CBO, Congressional Budget Office; CPS, Current Population Survey; JCT, Joint Committee on Taxation; SIPP, Survey of Income and Program Participation.
Sources: [a]Barents Group LLP individual income tax model. [b]Lewin–VHI, data provided to author. [c]Congressional Budget Office (1994, table 10).

TABLE 6
Distribution of Social Security Benefits Compared with All Other Entitlements[a]

Income class ($000)	Social Security	Veterans benefits	Civil Service retirement	Military retirement	Means-tested entitlements	Tax expenditures[b]	Distribution of income
<0	1.2	2.0	0.3	0.6	1.4	0.1	0.02
0–5	1.1	6.4	0.03	0.1	35.0	11.7	0.2
5–10	5.3	7.1	0.4	0.8	19.5	3.9	1.2
10–20	18.6	15.9	4.4	3.2	24.4	6.1	5.8
20–30	24.8	18.0	15.3	6.2	10.5	8.0	10.3
30–50	28.4	26.5	33.6	24.7	7.2	15.2	21.4
50–75	11.6	13.0	28.0	24.6	1.6	16.3	22.3
75–100	3.9	5.2	7.4	14.6	0.4	12.5	10.6
>100	5.2	6.0	10.7	25.1	0.1	26.3	28.1

[a]Using expanded income definition.
[b]Tax expenditure estimates include exclusion of employer-provided health insurance, exclusion of Social Security contributions, mortgage interest deduction, deductions for charitable contributions, deductions for state and local taxes paid, and the capital gains preferential rate. Amounts of health insurance are imputed.
Source: Barents Group LLP Individual Income Tax Model.

of spending entitlements. Figures 3 and 4 compare the cumulative distribution of six large tax entitlements with the cumulative distribution of eleven of the largest spending entitlements, by income class.

Using the expanded measure of income, figures 3 and 4 show that about 48 percent of all federal spending entitlement dollars go to families with incomes above $30,000, while 70 percent of tax entitlement dollars go to families above $30,000 income. About 21 percent of spending entitlements go to those families with incomes in excess of $50,000, compared with 55 percent of tax entitlements going to families above $50,000, and over 30 percent to those with incomes in excess of $100,000. The most regressive entitlements are those in the tax code.

Reforming Entitlement Spending

Even if entitlements, as I argued earlier, were not the source of the deficit problems of the past 15 years, they will almost inevitably have to be part of a solution because the two largest entitlements—Social Security and Medicare—must undergo reform to become solvent: Social Security for the long run and Medicare for both near and long term. Achieving those results will reduce both the current deficit and the long-term deficit that will occur with the retirement of the baby boomers. How large a role Social Security and Medicare will play in reducing the immediate deficit problem will depend on the deficit goal, the time period established for reaching the goal, the contribution extracted from discretionary spending, and the role (if any) played by new tax revenues.

Principles for Dealing with the Deficit

Deficit reduction and entitlement reform should follow some basic guiding principles. First, achieving a sustained downward deficit trajectory is more important to the long-term health of the economy than an arbitrary deficit elimination date such as 2002. While the latter approach may not necessarily damage the economy—indeed some estimates suggest it will be beneficial (Congressional Budget Office 1995c; U.S. General Accounting Office 1995; Meyer 1995)—it presents more downside economic risks than a gradual but sustained ratcheting down

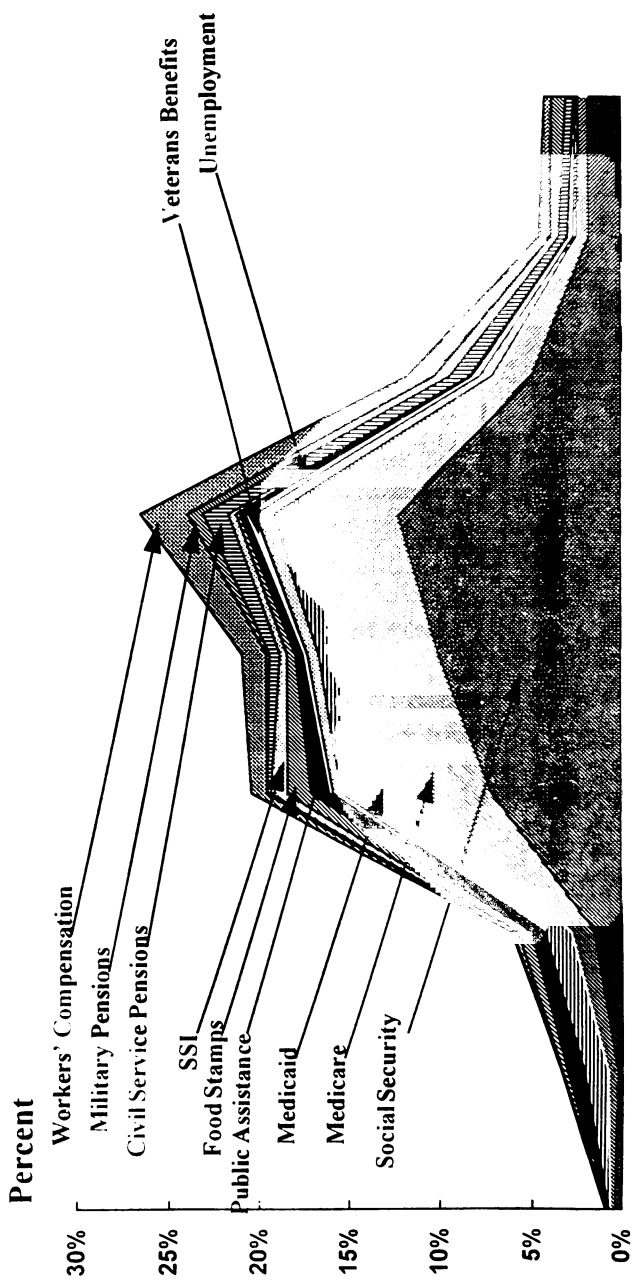

FIG. 3. Distribution of federal entitlement spending by income class, 1996. *Source:* Barents Group LLP individual income tax model.

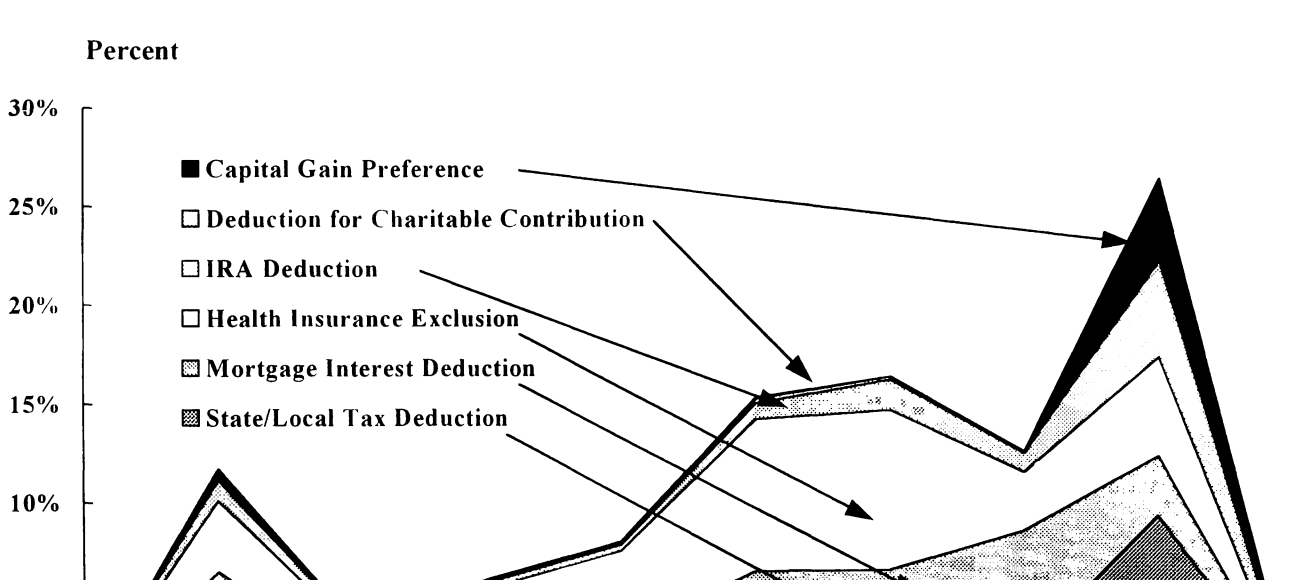

FIG. 4. Distribution of selected federal tax expenditures by income class, 1996. Health insurance premiums are imputed in the model. *Source:* Barents Group LLP individual income tax model.

of the deficit. For example, any deficit reduction strategy must anticipate the likelihood of recession that will automatically widen the deficit and require a postponement of the zero deficit goal. A zero deficit at full employment would be a more sensible policy goal than a zero deficit without regard to the economic cycle. Deficit elimination may prove to be politically unattainable without the discipline (for the Congress) and the symbol (for the public) of a fixed and unambiguous balanced budget deadline. It will be difficult politically to sustain budget discipline without a clear and definite target. But an arbitrary deadline that is adhered to despite recession could damage the economy, and one that is not met because of economic recession might further undermine the confidence of people in their political institutions.

Second, deficit reduction should combine both spending and revenue changes. Every deficit reduction measure enacted in the past 15 years combined significant revenue increases and spending cuts. Non-social-insurance revenues are now about 2 percent of GDP below their FY 1962–81 average levels, and restoring the general revenue base to its pre-1982 share of GDP should be one of the steps toward balancing revenues and outlays. Such a change would itself eliminate all of the projected $144 billion 1996 deficit. While the Congress and the President continue to advocate net tax cuts, not tax increases, the public seems more willing to forgo tax cuts in order to pursue deficit reduction. The FY 1996 budget reconciliation bill actually included increased tax revenues, mostly from low-income working families through changes in the EITC and from closing some corporate loopholes, but the middle- and upper-income tax cuts far offset them. Responsible and fair deficit reduction should include additional revenues raised in a progressive way.

Third, entitlement reform should start with health care, which is the only area of entitlement spending growing faster than the economy. But simply reducing federal health care spending does not itself qualify as entitlement or health care reform. Medicare does not offer a rich benefits package as it is: it lacks outpatient prescription drug coverage, does not have adequate mental health coverage, requires a high deductible for inpatient hospital services (although the deductible for physician services is low and has not been increased since 1991), and has no out-of-pocket cap. There are arguments to be made for improving benefits. Over three-fourths of all beneficiaries have a form of private supplementary health insurance to cover some of these costs, and over half of those with incomes below $5,000 have private insurance (Chulis, Eppig, and

Poisal 1995). Cost-containment approaches, like the extension of managed care or a defined contribution approach to the Medicare budget, might prove effective if a better method of risk adjustment were developed to offset adverse selection. Purchasing health insurance in the private market would be difficult to impossible for most elderly persons. Estimates of what a policy like Medicare would cost a person aged 65 to 74 in the private market at today's private insurance rates range from $6,400 to $8,500 (Actuarial Research Corporation 1994; Wyatt Company, December 19, 1994: personal communication re Medical premium estimates), whereas Medicare beneficiaries aged 65 to 74 now cost the federal government on average less than $3,000 in reimbursements per enrollee (U. S. House of Representatives 1994, table 5-30). Medicare benefit cuts should take place in the context of broader reform of the entire health care system, because such cuts have serious implications for coverage and quality of care. While many are now touting the savings achieved by the private market to reduce the rate of growth of health costs, it may have come at the expense of restrictions on coverage, cost of coverage, or even loss of coverage. Almost 40 million nonelderly persons are uninsured today, compared with about 33.6 million in 1988 (Employee Benefits Research Institute 1996). Structural change of the entire system will be needed to reduce costs while extending coverage to the uninsured.

Fourth, the long-term solvency of Social Security and Medicare deserves to be addressed outside the context of deficit reduction, even though reforms to those two programs will have a direct impact on the longer-term deficit picture. One reason for treating them separately is that their long-term financing problems are driven by the demographics of the baby boom generation's retirement. The ten-year deficit outlook is an increase from $164 billion in FY 1995 to $144 billion in 1996 to $376 billion in FY 2005 under current law (i.e., if discretionary spending caps are not extended beyond 1998). This projection is substantially more sanguine than the CBO's projection, which, as recently as August of 1995 forecast a deficit of $340 billion for 2002 and of $462 billion by 2005 if discretionary caps were not extended beyond 1998. The primary cause of this deficit spurt is health care costs. Under a current policy scenario, between 1996 and 2002 Medicare and Medicaid are projected to rise by $203 billion out of a total mandatory spending rise of $410 billion, while net interest outlays increase by $71 billion, and discretionary spending is $81 billion higher by 2002 than in 1996 in

nominal terms. After 2005, budget pressures of an even larger order of magnitude begin to build, driven by health costs plus demographic pressures from the retirement of the baby boomers. These pressures require reform of both Social Security and Medicare. Social Security is the easier case to solve because the problem is more easily defined, the solutions are more obvious, there is experience in dealing with similar situations in the past, and there is a longer lead time to address the problem in a comprehensive and deliberate way. Health care (Medicare and Medicaid) presents a far more explosive and vexing budget problem because the solutions are not as obvious, there is greater interdependence between these programs and the private health insurance system, the future cost is even greater than Social Security, and there is less time to address the problem.

Finally, if entitlement benefits are reduced, those with the lowest incomes should be protected. Protected does not necessarily mean experiencing no benefit cuts—e.g., the public assistance recipient may be better off with smaller benefits if he or she has a paycheck that more than offsets the benefit loss. But the case of welfare reform, one of the keystones of the Congressional deficit plan, illustrates that true reform actually may cost more rather than less, if it is to mean substituting jobs for welfare. The same is true of health care reform—if it does not sacrifice coverage, as proposals to cap or block grant the Medicaid program would do, by disentitling current beneficiaries of a program that even now does not reach all the poor.

Social Security

There are good reasons for addressing Social Security solvency separately and on a different schedule from the budget deficit problem. At present, Social Security actually reduces the deficit because of its $70 billion annual surplus. On the expenditure side, program costs are growing at only the same rate as the economy—about 5 percent per year in nominal terms. But the long-term scenario is bleak unless remedial actions are taken relatively soon to address future insolvency. Reductions in benefits should be phased in gradually so as to limit disruption to those already retired or close to retirement. In any event, of the standard set of Social Security policy parameters, two would affect both current and future beneficiaries: COLA reductions and greater taxation of Social

Security benefits. Changes in the retirement age, the benefit formula, or the payroll tax would only affect future beneficiaries, either now as workers or later as beneficiaries. Of all the available options, reductions in COLAs would be most harmful to low-income beneficiaries of the program.

Furthermore, on the revenue side, raising payroll taxes today cannot, under current policy, prefund the retirement benefits of those retiring in the next century so long as the annual Social Security surplus must be invested in government securities. Social Security is still a pay-as-you-go system, and any additional revenues raised today not needed to pay current benefits would simply increase today's Old Age, Survivors, and Disability Insurance (OASDI) trust fund balances, which would in turn be loaned to the Treasury, at interest, and used to finance today's general budget deficit. If one views Social Security as separate from the rest of the budget, there is little point in increasing Social Security payroll taxes until the revenues are needed to pay benefits, unless the revenues could be invested in nongovernment securities or stocks. The latter measure, however, would effectively end the ability of the government to borrow from the trust funds. But from the government- and economy-wide standpoint, many would argue that even if higher payroll tax revenues merely created larger Social Security trust fund reserves to be borrowed, more private capital is thereby "freed up" to promote greater private investment and a larger future economy from which to finance future Social Security benefits. This issue would become moot, however, if the Social Security program were reformed to permit private investment of trust fund reserves, something considered by the Quadrennial Advisory Council (see below). If that were to happen, the privately invested funds would not be available for deficit reduction.

Of the standard policy options to reform Social Security, two have fairly compelling rationales—changing the tax treatment of Social Security benefits and changing the age at which full retirement benefits can be received. On the tax side, Social Security benefits should be fully (i.e., above the amounts contributed) subject to tax for all beneficiaries, just as all other income is taxed. Currently, only if total incomes exceed thresholds of $25,000 or $32,000 are benefits taxed at all. Eliminating these thresholds and taxing benefits in excess of contributions, just as pensions are taxed, would equal about .40 percent of payroll and would eliminate about 19 percent of the actuarial deficit in Social Security (Bipartisan Commission on Entitlement and Federal Tax Reform 1995).

Since the revenue from taxing up to 85 percent of benefits above $34,000 (for singles) and above $44,000 (for couples) now goes to the Hospital Insurance (HI) trust fund, redirecting all the revenue from fully taxing benefits to OASDI would worsen the actuarial deficit in the HI trust fund.

With respect to the age of retirement, the average worker is paying into Social Security for five fewer years and receiving benefits for three to five more years than when the system was established. By 2030, the retirement period of the average worker will be about half that of his work life (Bosworth 1995), as compared with roughly one-quarter of the work life of the average worker back in 1940. This long-term trend continues into the future, and calls for some restoration of the relation between time in the workforce and time in retirement. Eliminating the ten-year hiatus (between 2012 and 2022) that exists in the current scheduled increase in the normal age of retirement from 65 to 67, and increasing the normal age to 68 would be a relatively modest change, given changes in life expectancy. For this change to have any impact on program cost, however, benefits would have to be actuarially adjusted for those who retire at the earliest age of eligibility (age 62) or those who retire late.

Raising the retirement age to 68 and taxing benefits fully would not by themselves be sufficient to make Social Security solvent. They would together equal less than 1 percent of payroll, compared with a shortfall of 2.17 percent of payroll. However, two other important policy considerations may fundamentally alter the Social Security financing picture: changes in the Consumer Price Index (CPI) and changes in the investment policies of the Social Security trust funds.

It is now believed by many analysts that the CPI, as currently measured, overestimates the true rate of inflation. The Federal Reserve Board chair has suggested that the overestimate is as high as 1.5 percentage points (Greenspan 1995), and the Congressional Budget Office has estimated it at somewhere between 0.2 and 0.8 percentage points (Congressional Budget Office 1994; O'Neill 1995). A panel of five renowned economists established by the Senate leadership reached the conclusion, on the basis of existing studies, that the range of possible overstatement was 0.7 to 2.0 percentage points, with the best estimate at about 1.0 percent per year (U.S. Senate, Committee on Finance 1995).

Permanent changes in the CPI can dramatically affect Social Security and the deficit, depending on the size of the change. The CBO has

estimated that a 0.5 percentage point change in the CPI (the middle of CBO's range of the CPI overestimate) would result in a reduction of $67 billion in the deficit over five years, $26 billion of which would come from Social Security and nearly $24 billion of which would come from additional tax revenue (O'Neill 1995). The Kerrey–Danforth Commission estimated that reducing the CPI by 0.5 percentage points per year would be equal to 0.7 percent of payroll, nearly one-third of the 2.17 percent of payroll solvency goal. The 1995 budget reconciliation bill contained a 0.2 percentage point adjustment in the CPI, reflecting the rebenchmarking of the CPI that will occur in 1998 based on the Consumer Expenditure Surveys (CES) conducted from 1993 to 1995. However, further reductions in the CPI were considered in negotiations over a budget agreement. Technical changes implemented by the Bureau of Labor Statistics in 1995 to correct for bias in the introduction of new goods into the CES were estimated by BLS Commissioner Katherine Abraham to reduce the CPI by an additional .1 to .2 percentage points, and future changes will reduce it up to another .3 percentage points beginning in 1997. If Congress were to anticipate such a change in prices, it would make more sense to incorporate it in the baseline, thus reducing baseline deficits and the amounts of legislated changes needed. While a legislated adjustment to the CPI that is not based on careful empirical analysis cannot be defended from a policy perspective, it would have a profound effect on Social Security financing and the overall deficit.

Another important change to Social Security would be investment of the trust fund reserves in private securities. This change would alter the calculus of both the budget deficit and the Social Security trust fund balance. The Quadrennial Advisory Council of the Social Security system has considered one plan dedicating over one-third of trust fund reserves to private investment as well as a plan that would create private Social Security individual retirement accounts (IRAs) for individuals. The private investment option could yield a significantly higher return for the trust funds over the amount currently received from federal treasury securities, the magnitude depending in part upon how much of the fund is invested (Bosworth 1995). One Quadrennial Council proposal, offered by Robert Ball, would invest up to 40 percent of trust fund reserves in private securities, which he estimated would increase overall yield to the trust funds from 2.3 to 3.8 percent. However, as noted above, if the funds were invested privately, they would not be available to reduce the deficit, and thus the deficit to be financed would

be larger. It would also be possible to prefund some Social Security obligations and provide a more substantive justification for the segregation of the Social Security trust funds.

The Solvency and Individual Return model developed by Lee Cohen of AARP in 1995 can be used to demonstrate the potency of CPI and private investment changes: Consider that an increase in the retirement age to 68 and full taxation of benefits would achieve less than 50 percent of solvency, whereas combining these with a reduction of 0.5 percentage points in the CPI and private investment of only the incremental Social Security reserves resulting from these reforms (assuming a 1 percent greater rate of return) would make Social Security solvent for well beyond 75 years. A simulation using the Barents Group individual income tax model estimates that full taxation of benefits and the .05 CPI change together would reduce the deficit by about $70 billion in 2002 if the changes were enacted in 1996.

Medicare

Although Social Security is still the larger program, Medicare presents a more daunting challenge. First, although Social Security remains solvent for 35 more years, the reserves of the Medicare Part A (HI) trust fund are exhausted under current law by 2001. Although insolvency has threatened frequently in the past (Moon 1993; Moon and Mulvey 1996; O'Sullivan 1995), it will be necessary to act soon to shore up Part A again, if for no other reason than to maintain public confidence that the program will continue to provide benefits to older and disabled Americans. The most fundamental problem, however, is that an effective solution to the problem of systemwide cost containment has eluded analysts and policy makers.

Medicare has pioneered some important cost containment reforms, such as diagnosis-related groups (DRGs) for hospital reimbursement, volume performance standards (VPS's), and the Resource Based Relative Value Scale (RBRVS) for physician reimbursement. In addition, the ratcheting down of Medicare hospital reimbursement rates in the1980s created a large disparity between what hospitals were paid by privately insured patients and Medicare-insured patients. Similarly, lowering physician reimbursment created disparities between private insurance, Medicare, and Medicaid reimbursement. Currently, Medicare pays 59 percent

of private rates and Medicaid now pays physicians 48 percent of private rates (Physician Payment Review Commission 1994). Fee differentials have already created access problems in Medicaid (Kellermann 1994), a situation that is likely to be true of Medicare in some regions of the country.

Existing reimbursement disparities have affected provider behavior, shifting costs to privately insured patients, whom providers charge more to compensate for lower reimbursements received from treating Medicare and Medicaid patients. However, since the late 1980s, annual increases in private insurance costs per enrollee have gradually been cut in half, from 10.9 percent in 1988 to 5.4 percent in 1994 (Health Care Financing Administration 1995). While it is not clear whether these cost reductions are primarily the result of better control over utilization, fewer insured persons, higher cost-sharing payments by enrollees, or reduced benefit packages (Moon and Zuckerman 1995), tightening of controls on private sector costs makes it more difficult for Medicare providers to shift costs to private patients; as a result, it may become even more difficult for Medicare beneficiaries to obtain access to physicians.

Some strong advocates of managed care may see it as a panacea for containing costs in the federal health entitlements. Managed care was an important feature of the Health Security Act and figures prominently in both congressional and administration balanced budget proposals. A report by the CBO suggests that if all insured people were in group or staff HMOs, spending on insured services (if spending mirrors reduced utilization) would be nearly 17 percent lower for all sources of insurance, and about 20 percent lower for Medicare (Congressional Budget Office 1995a). If only the 70 percent of the population who live in areas populous enough to support group or staff or other equally effective HMOs were enrolled, insured spending would be lower by nearly 12 percent, and total national health spending would be more than 8 percent lower, according to the CBO. This would require that 100 percent of persons with access to HMOs enroll in them, a highly unlikely outcome.

There is an increasing trend toward managed care in Medicare, which, if it accelerates, may help control the costs of Medicare beneficiaries. However, as an illustration of the law of unintended consequences, Medicare actually pays *more* for HMO enrollees (5.7 percent more on average) than it would have paid had they stayed in fee-for-service medicine, because Medicare's capitation payment to HMOs fails to adjust payments (downward) adequately for the better health status of the people

who enroll in HMOs (Brown et al. 1995; Congressional Budget Office 1995a; MaCurdy 1995). Even if the capitation payment were correctly risk adjusted, it is likely that mainly the healthier population would enroll in HMOs, and the sicker and more costly beneficiaries would choose to remain in fee-for-service, making it an increasingly costly component of Medicare and risking a "death spiral" that would ultimately destroy Medicare fee-for-service.

Given that little momentum now exists for comprehensive health care reform, systemwide solutions will probably be deferred, meaning that other budget-driven, short-term changes will have to be adopted to keep Medicare solvent until a consensus develops for broader reform. There are a series of standard changes to Medicare that would improve the program's financial condition, including but not limited to, the following:

1. further reductions in provider reimbursement
2. instituting an income-related Part B premium for high-income people
3. increases in the Part B premium from the present $42.50 per month in 1996 (a decline from $46.10 in 1995 that resulted from the impasse over balanced budget legislation)
4. increases in the Part B deductible from $100, where it has been for five years
5. instituting coinsurance for certain services, such as home health and lab services, for which there is now no coinsurance
6. increases in coinsurance from 20 percent for most services to some higher level

These changes are no more than short-term measures to deal with the immediate budget problem, but such incremental steps should delay the date of insolvency by at least ten years (Moon and Mulvey 1996), buying time until the longer-term demographic problem as it affects health care can be addressed.

Conclusion

The entitlements debate promises to continue well into the future because the demographic imperative of the baby boom's retirement will

continue to drive entitlement spending upward for years to come. As with health care reform, the quality of the debate will depend in large part on the quality of the information that is brought to public attention. Thus far, the entitlements debate has had more than its share of myth and oversimplification, and better information is always needed. Of course, given the tenor of today's political rhetoric, there is no assurance that better information will be used or applied accurately. But the public debate is ultimately influenced by ideas, and so it is critical that those ideas have solid grounding in empirical reality. I have attempted to provide some of that foundation in this article.

References

Abramson, A. 1989. Budgeting for Entitlement Programs in Periods of Expansion and Consolidation. Paper delivered at the annual meeting of the American Political Science Association, Atlanta, Georgia.

Actuarial Research Corporation. 1994. Premiums for Private Insurance That Covers Medicare Benefits. Annandale, Va. (Memorandum, December 20)

American Hospital Association. 1995. *Medicare National Study: Executive Summary.* Washington, D.C.: Public Opinion Strategies/Frederick Schneiders Inc.

Bipartisan Commission on Entitlement and Tax Reform. 1995. *Final Report to the President.* Washington, D.C.

Bosworth, B. 1995. The Social Security Fund: How Big? How Managed? Paper presented at the annual meeting of the National Academy of Social Insurance, January, Washington, D.C.

Brown, R., et al. 1995. Do HMOs Work for Medicare? Evidence from the Medicare Risk Program Evaluation. Paper presented at the American Enterprise Institute Medicare Reform Conference, July 24, Washington, D.C.

Christensen, S. 1991. Growth in Medicare Costs. Washington, D.C. (Memorandum)

———. 1992. Discussion of the Canadian Model in the President's Comprehensive Health Reform Report. Washington, D.C. (Memorandum, February 14)

———. 1995. Managed Care and the Medicare Program. Washington, D.C.: Congressional Budget Office. (Memorandum, April 26)

Chulis, G., F. Eppig, and J. Poisal. 1995. Ownership and Average Premiums for Medicare Supplementary Insurance Policies. *Health Care Financing Review* 17(1):155–62.

Cogan, J., T. Muris, and A. Schick. 1994. *The Budget Puzzle: Understanding Federal Spending.* Stanford, Calif.: Stanford University Press.

Cohen, L. 1995. Solvency and Individual Return Model. Washington, D.C.: American Association of Retired Persons. (Software model)

Congressional Budget Office. 1994. *Reducing Entitlement Spending.* Washington, D.C.

———. 1995a. *The Effects of Managed Care and Managed Competition.* Washington, D.C.

———. 1995b. *The Economic and Budget Outlook: Fiscal Years 1996–2000.* Washington, D.C.

———. 1995c. *An Analysis of the President's Budgetary Proposals for Fiscal Year 1996.* Washington, D.C.

Council of Economic Advisors. 1995. *Economic Report of the President.* Washington, D.C.

Employee Benefits Research Institute. 1995. *Sources of Health Insurance and Characteristics of the Uninsured: Special Report.* Washington, D.C.

———. 1996. *Sources of Health Insurance and Characteristics of the Uninsured: Special Report.* Washington, D.C.

Greenspan, A. 1995. Statement before the Committee on Finance, U.S. Senate, 104th Congress, 1st Session, March 13.

Health Care Financing Administration. 1995. Comparison of Medicare Expenditures per Enrollee and PHI Benefits per Insured Person. Baltimore, Md.: Office of the Actuary. (Photocopy)

Howe, N. 1992. *Controlling Entitlements: The Argument for Comprehensive "Means Testing."* Washington, D.C.: National Taxpayers Union Foundation.

Howe, N., and P. Longman. 1992. The Next New Deal. *Atlantic Monthly* (April).

Kellermann, A. 1994. Access of Medicaid Recipients to Outpatient Care. *New England Journal of Medicine* 330:1426–30.

MaCurdy, T. 1995. Evaluating the Evidence on the Cost-Effectiveness of HMOs in Medicare. Paper presented at the American Enterprise Institute Medicare Reform Conference, July 24, Washington, D.C.

Menchik, P. 1991. The Distribution of Federal Expenditures. *National Tax Journal* 44(3):269–76.

Meyer, L.H., and Associates. 1995. *Special Analysis: Macroeconomic Aspects of the Republican Contract with America.* St. Louis, Mo.

Moon, M. 1993. *Medicare Now and in the Future.* Washington, D.C.: Urban Institute.

Moon, M., and J. Mulvey. 1996. *Entitlements and the Elderly.* Washington, D.C.: Urban Institute.

Moon, M., and S. Zuckerman. 1995. Are Private Insurers Really Controlling Spending Better than Medicare? Paper prepared for the Henry J. Kaiser Family Foundation, Menlo Park, Calif.

O'Neill, J. 1995. Statement before the Committee on Finance, U.S. Senate, 104th Congress, 1st Session, March 13.

O'Sullivan, J. 1995. *Medicare: Financing the Part A Hospital Insurance.* Washington, D.C.: Congressional Research Service.

Peterson, P.G. 1993. *Facing Up: How to Rescue the Economy from Crushing Debt and Restore the American Dream.* New York: Simon and Schuster.

Peterson, P.G., and N. Howe. 1988. *On Borrowed Time.* Washington, D.C.: Institute for Contemporary Studies.

Physician Payment Review Commission. 1994. *Annual Report to Congress.* Washington, D.C.

U.S. General Accounting Office. 1994a. *Issues in Capping Mandatory Spending.* Report to the Chairman, Committee on Government Operations, U.S. House of Representatives. Washington, D.C.

———. 1994b. *Tax Expenditures Deserve More Scrutiny.* Report to the Honorable William J. Coyne, House of Representatives. Washington, D.C.

———. 1995. *The Deficit and the Economy: An Update of Long-Term Simulations.* Report to the chairman of the Committee on the Budget, U.S. Senate, and the chairman of the Committee on the Budget, U.S. House of Representatives. Washington, D.C.

U.S. House of Representatives, Committee on Ways and Means. 1994. *Overview of Entitlement Programs.* Washington, D.C.

U.S. Senate. Committee on the Budget. 1990. *Congressional Budget Act Annotated.* 101st Congress, 2d session. Washington, D.C.

———. Committee on Finance. 1995. *Toward a More Accurate Measure of the Cost of Living.* Interim Report of the Advisory Commission to Study the Consumer Price Index. Washington, D.C.

Zedlewski, S. 1988. The Increasing Fiscal Burden on the Elderly. In *Social Security and Economic Well-Being Across Generations*, ed. J. Gist. Washington, D.C.: American Association of Retired Persons.

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