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Entitlements: Not Just a Health Care Problem

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Entitlements: Not Just a Health Care Problem

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I. INTRODUCTION

A new consensus on entitlement reform has developed in Washington: rising per-capita health care spending is the only real crisis besetting the government's entitlement programs, while America's aging population and Social Security play minor roles at best. Some cite this view to shift the policy emphasis from entitlement cost control to the restructuring of the U.S. health sector, including private health care.¹ But this new consensus is flawed. Using standard accounting practices and including all major government entitlement programs, population aging will play an equal role with health care cost growth over the next seventy-five years and a significantly larger role than health spending over the next few decades. While rising health care spending is indeed a pressing issue, discounting population aging leaves out half of the problem and ignores half of the potential solutions.

Spending on the government's three main entitlement programs—Social Security, Medicare, and Medicaid—is projected to rise significantly

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1. Henry Aaron, *There is No Entitlement Crisis*, BROOKINGS, Mar. 12, 2009, http://www.brookings.edu/opinions/2009/0223_entitlements_aaron.aspx?rssid=social+security.

in coming decades.² If left unaddressed, these increases put the government's budget and the American economy at risk.

Rising entitlement spending comes from two main sources: increases in the number of individuals receiving benefits and increases in the average spending per-person. Entitlement costs rise relative to the size of the economy if the increase in beneficiaries is larger than the increase in working-age individuals (due to population aging) or if per-person health care spending grows at a rate in excess of the rate of the economy's growth (referred to as "excess cost growth").³

Population aging originates predominantly from falling fertility, which reduces the number of new workers, and from rising life expectancies, which increase the number of beneficiaries. Health care cost growth generally arises from improvements in technology (which make valuable but expensive new treatments available), increases in incomes (which allow individuals to spend more on health care), and a declining share of total health costs paid out of pocket (which reduces patients' incentives to shop wisely). From 1975 through 2005, health care spending grew an average of 2.1 percentage points faster than the economy as a whole.⁴ When either population aging or excess health care cost growth is positive, the share of GDP devoted to financing entitlements will rise. Together, population aging and excess cost growth account for most of the projected spending increases in Social Security, Medicare, and Medicaid.⁵

For years, popular discussion of entitlement issues focused on population aging.⁶ This was in part because aging is easy to understand—visions of a gray wave of baby boomers plays well in the press—and in part because health care costs actually shrank relative to GDP during the mid-to-late 1990s.⁷ Baby boomer retirements and rising life expectancy meant more seniors collecting benefits, while lower birth rates left fewer new workers to support Social Security, Medicare, and Medicaid.

2. See generally OFFICE OF MGMT. AND BUDGET, A NEW ERA OF RESPONSIBILITY: RENEWING AMERICA'S PROMISE (2009), available at http://www.whitehouse.gov/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf.

3. CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 14 (2007), available at www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf.

4. *Id.* at 8.

5. Lester Feder & Ellen-Marie Whelan, *Entitlement Reform Means Fixing the Broader Health System*, CTR. FOR AM. PROGRESS, Feb. 20, 2009, available at http://www.americanprogress.org/issues/2009/02/entitlement_brief.html; see also CONG. BUDGET OFFICE, *supra* note 3, at 14.

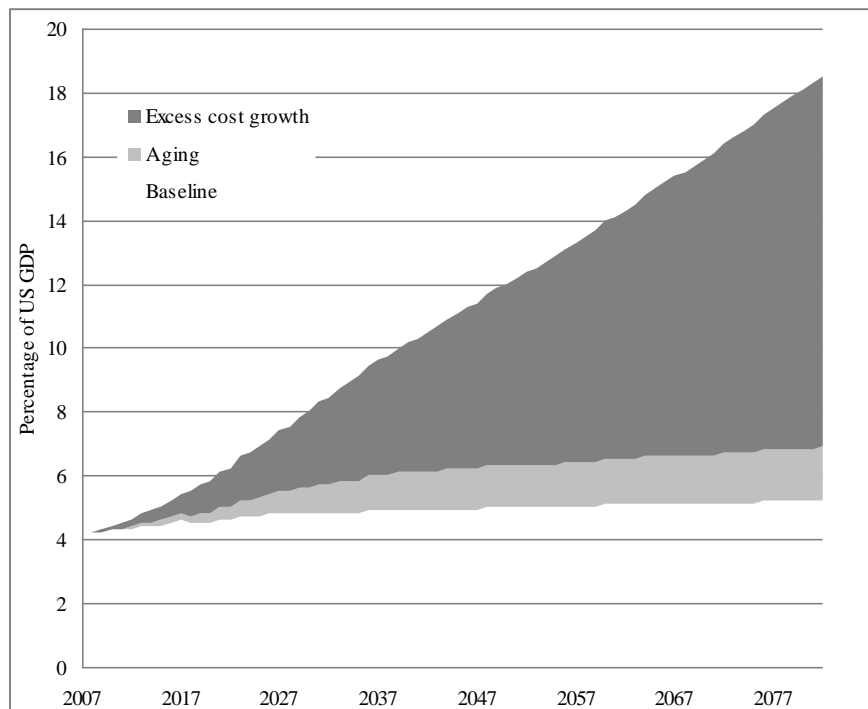
6. See generally Rita L. DiSimone, *Bipartisan Commission on Entitlement and Tax Reform*, 58(2) SOC. SEC. BULL. (Summer 1995), available at <http://www.ssa.gov/policy/docs/ssb/v58n2/v58n2p74.pdf>.

7. Ginsburg et al., *Tracking Health Care Costs*, 25(6) HEALTH AFF. 486–95 (Nov./Dec. 2006); see also CONG. BUDGET OFFICE, *supra* note 3, at 6 (discussing how private sector health spending fell from 8.7% of GDP in 1993 to 8.3% in 1996).

II. THE NEW CONSENSUS

Recently, views on entitlements have changed. The new consensus on entitlement costs was driven by a November 2007 report from the Congressional Budget Office (CBO).⁸ The CBO reported that 88% of the projected growth of Medicare and Medicaid costs over the next seventy-five years stems not from an aging population putting more citizens on the rolls, but from rising per-capita health care costs.⁹ Figure 1, which replicates a chart printed in the CBO report, shows the growth in Medicare and Medicaid costs from their current baseline amount and gives a compelling illustration of the report's conclusions, showing that almost nine out of every ten dollars in extra entitlement costs derives from rising per-capita health care spending.¹⁰

Figure 1¹¹



8. CONG. BUDGET OFFICE, *supra* note 3, at 8.

9. *Id.*

10. *Id.* at 14.

11. *Id.* at 22.

In other words, population aging and excess health care cost growth are not equal partners in driving entitlement costs.

Seizing on this, *New York Times* columnist Paul Krugman wrote that “the whole Beltway obsession with the fiscal burden of an aging population is misguided” and characterized then-Senator Barack Obama as a “sucker” for calling Social Security’s funding status a “crisis.”¹² Brookings Institution senior fellow Henry Aaron, perhaps the leading proponent of the new consensus, flatly stated that “[t]here is no entitlement crisis other than health care”¹³ and went on to say that “if the nation reforms health care delivery and financing, it will have solved the budget problems so misleadingly characterized as a general ‘entitlement crisis.’”¹⁴ The New America Foundation’s Mark Schmitt says the new view “demolishes” concerns that an aging population will lead to fiscal doom.¹⁵

Unfortunately, the new consensus has not spurred policymakers to restrain Medicare and Medicaid costs. Budget experts Neil Howe and Richard Jackson were the first to raise concerns about the policy implications of this new view.¹⁶ Writing for the Concord Coalition, they said that the new consensus “has all the hallmarks of classic bait-and-switch.”¹⁷ The new consensus claims that only fixing Medicare and Medicaid can close the fiscal gap, but doing so requires restructuring *all* health care provision—both public and private.¹⁸ But economy-wide health reform would increase costs for a long period before any savings were generated, in part because most comprehensive health care reform proposals make expanding insurance coverage a higher priority than holding the line on overall costs.¹⁹ During the interim, entitlement costs would only worsen.

12. Paul Krugman, *Played for a Sucker*, N.Y. TIMES, Nov. 16, 2007, at A33.

13. Henry J. Aaron, *Chronic Deficit: Entitlement Crisis? or Health Financing Problem?*, AGENDA FOR SHARED PROSPERITY, Apr. 12, 2007, at 9, available at <http://www.sharedprosperity.org/av/070412/20070412-aaron.ppt>.

14. Henry J. Aaron, *Budget Crisis, Entitlement Crisis, Health Care Financing Problem—Which Is It?*, 26 HEALTH AFF. 1622, 1624 (2007).

15. Mark Schmitt, *Battle of the Budget Slide Shows*, AM. PROSPECT, June 1, 2008, at 9.

16. Neil Howe & Richard Jackson, *Honey, I Shrunk the Demographics!*, 3(3) FACING FACTS Q. 1, 1 (Dec. 2007), available at <http://www.concordcoalition.org/files/uploaded-pdfs/ff-1220-demographics.pdf>.

17. *Id.*

18. See Aaron, *There is No Entitlement Crisis*, *supra* note 1.

19. Robert Steinbrook, *Health Care Reform in Massachusetts—Expanding Coverage, Escalating Costs*, 358 NEW ENG. J. MED. 2757–60 (2008), available at <http://content.nejm.org/cgi/content/full/358/26/2757>.

III. RUNNING THE NUMBERS

While many have drawn strong conclusions from the CBO figures, these figures do not give a full depiction of the causes of rising entitlement costs. Three important issues stand out. First, while the CBO report caused analysts to reconsider entitlements as a whole, the report's calculations exclude Social Security, the largest government entitlement program and one whose costs are driven almost entirely by population aging.²⁰ This produces an obvious understatement of aging's contribution to the increase in broad entitlement spending and the overall fiscal gap. Thus, the CBO's figures, in isolation, do not say anything regarding the overall entitlement cost problem, though many commentators employed them as if they did.²¹

Second, rising entitlement spending derives from interactions between excess cost growth and population aging.²² For instance, if aging increases spending by 25% while health care inflation increases spending by 35%, total costs will increase by 69%, more than the sum of the two.²³ In the CBO report, these interactions were attributed entirely to per-capita health care spending inflation, not proportionately between the two factors.²⁴ Even though the CBO has since produced corrected figures, the initial impression persists.

Finally, different methods of calculating cost increases can produce different results, as a recent CBO report details. The CBO's calculations used methods that maximize the role of per-capita health cost increases, but equally plausible methods modestly increase population aging's role.²⁵

20. Paul Krugman, *Entitlements on the Back of an Envelope*, NYTIMES.COM, Feb. 23, 2009, <http://krugman.blogs.nytimes.com/2009/02/23/entitlements-on-the-back-of-an-envelope>; see also Schmitt, *supra* note 15, at 9.

21. See Schmitt, *supra* note 15, at 9.

22. CONG. BUDGET OFFICE, *supra* note 3, at 6–7.

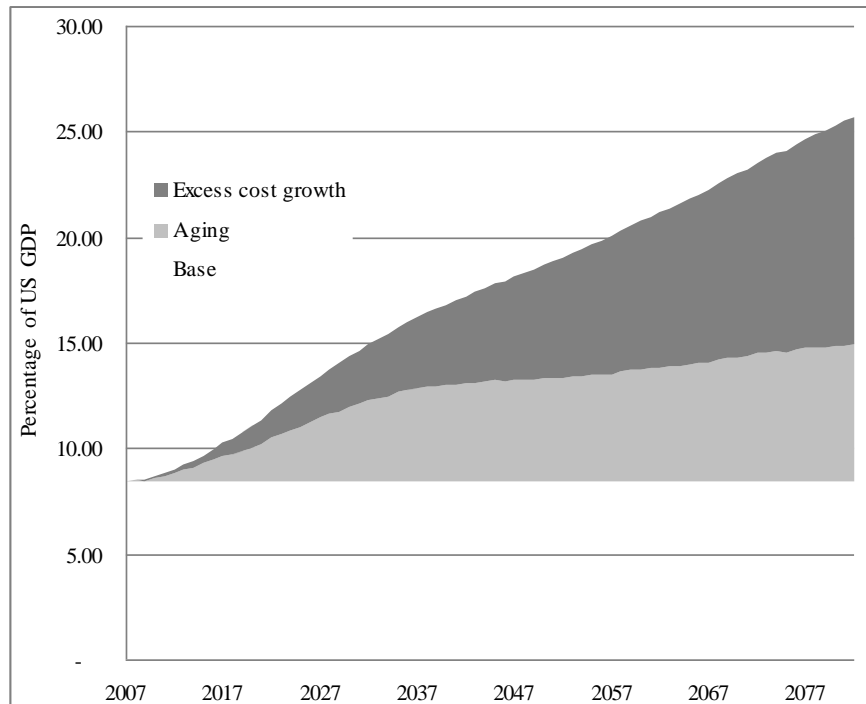
23. More specifically, the effects of aging and excess cost growth are multiplicative. If aging refers to the gross percentage increase due to aging (e.g., 1 + 25%), and excess refers to the gross increase due to excess cost growth, the total increase equals aging × excess. The share attributable to a given factor, inclusive of interactions, can be calculated using logarithms. The aging share, for instance, is equal to $\ln(\text{aging})/\ln(\text{aging} \times \text{excess})$.

24. CONG. BUDGET OFFICE, *supra* note 3, at 9.

25. This issue is complex and the effects are smaller than the first two, but it largely deals with the fact that aging and excess cost growth can have effects on GDP (the denominator in the equation), as well as on dollar costs (the numerator). Aging, for instance, tends to reduce GDP because older individuals are generally less productive than younger ones. When combined with excess cost growth, however, this would produce a larger percentage value for excess cost growth—due to the smaller denominator—even if the effect on GDP were wholly due to aging. Again, the effects of these choices are smaller than those of the first two issues. See CONG. BUDGET OFFICE, ECONOMIC AND BUDGET ISSUE BRIEF: ACCOUNTING FOR SOURCES OF PROJECTED GROWTH IN FEDERAL SPENDING ON MEDICARE AND MEDICAID 4 (2008), available at www.cbo.gov/ftpdocs/93xx/doc9316/05-29-SourcesHealthCostGrowth_Brief.pdf.

When all three factors are accounted for, the picture looks very different. Figure 2 shows the contributions of excess health care cost growth and population aging to cost increases in Social Security, Medicare, and Medicaid, attributing to each factor its share of interactive effects.²⁶ As of 2080, per-capita health care spending growth remains the largest contributor to rising projected spending, although its share of the total has declined from nearly nine out of ten dollars to only a little over six.

Figure 2



In the short-to-medium term, however, population aging is the largest driver of overall entitlement spending increases.²⁷ Over the next twenty years, 60% of total entitlement spending increases will stem from population aging.²⁸ It is not until 2045 that per-capita health care spending growth becomes the majority factor.²⁹ Yet, by 2045, entitlement spending—if left unaddressed—would *already*

26. See *infra* Figure 2.

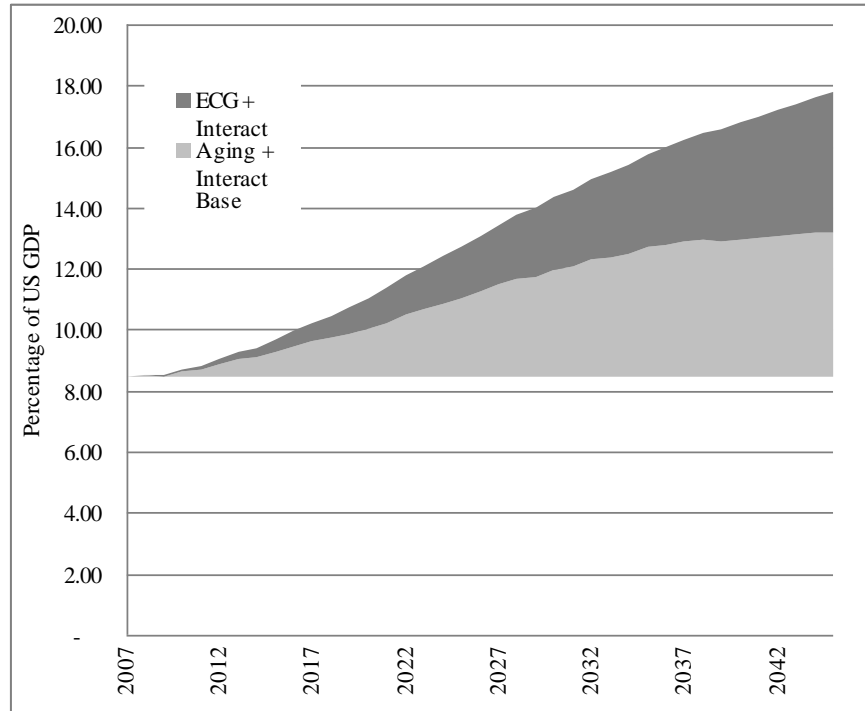
27. *Id.*

28. *Id.*

29. See *infra* Figure 3.

have risen to unsustainable levels. Thus, the larger role of excess cost growth post-2045 is in some ways academic: if the nation has not found a way to address rising entitlement spending before then, the issue will have resolved itself by precipitating a fiscal disaster.

Figure 3



Aging's role becomes more influential if we express costs in present-value terms, which is standard practice for Social Security and Medicare accounting and for measuring the government's fiscal gap as a whole. Present values tell us, in effect, how much extra cash we would need to have on hand today to finance these programs going into the future. Due to discounting, costs that occur in the near term—when population aging plays a larger role—are given greater weight than costs occurring in following decades.

In present-value terms, over the next seventy-five years, Social Security, Medicare, and Medicaid will cost an additional 5.7% of GDP, and the cost increases will be split almost evenly between population aging and

excess health care cost growth.³⁰ Thus, based on standard accounting practices for government entitlement programs, the claim that excess cost growth in health care is by far the primary driver of overall entitlement cost increases over the next seventy-five years is, at best, vastly overstated.

Moreover, the long-term role played by health care spending depends greatly on the assumed rate of excess cost growth, which is the subject of great speculation. Both the Medicare Trustees and the CBO use relatively simple rules of thumb to project health care cost growth. The Medicare Trustees simply assume that health care spending will grow one percentage point faster than the GDP, known as the “GDP plus 1” rule.³¹ The CBO assumes that health care costs will continue to grow until they begin to reduce real consumption of non-health goods and services.³² From this point, which would occur at the end of the seventy-five-year scoring period, health care would grow only with per-capita GDP.³³ Neither rule is unreasonable, but neither attempts to account for the full range of factors affecting health care spending growth.

One recent analysis in the *Journal of Health Economics*, however, utilized a more comprehensive economic model and concluded that health spending will grow at a considerably slower rate than the CBO projects.³⁴ Economy-wide long-term health expenditures in this model were one-quarter lower than projected by the CBO.³⁵ If true, population aging could remain the predominant entitlement cost driver for the foreseeable future, particularly if measured in present-value terms.

This point highlights the fact that all of the underlying economic and demographic variables are uncertain, making all such projections educated guesswork. Yet historical health care cost growth has generally varied more than demographic factors such as fertility or improvements in life expectancy.³⁶ Moreover, a number of experts believe that the projections

30. Using a nominal discount rate of 5.23%, which is consistent with that used for the CBO's long-term Social Security projections, the total present-value cost increase of 5.66% of GDP can be divided into 2.84% for aging plus interactions, plus 2.82% for excess cost growth plus interactions. See generally CONG. BUDGET OFFICE, THE LONG-TERM BUDGET OUTLOOK (2007), available at <http://cbo.gov/ftpdocs/88xx/doc8877/12-13-LTBO.pdf>.

31. Christine Borger et al., *Projecting Long Term Medical Spending Growth*, 27(1) J. HEALTH ECON. 69, 85 (2008), available at <http://www.mpsge.org/mainpage/MedicalSpending.pdf>.

32. *Id.* at 89.

33. This implies that in an analysis extending beyond seventy-five years, such as an infinite horizon measure, population aging would be the sole cost driver after around 2082.

34. See generally Borger et al., *supra* note 31.

35. *Id.* Total health expenditures economy-wide in 2080 are projected at 35% of GDP versus 41% of GDP by the Medicare Trustees and 48% by the CBO. *Id.* at 89.

36. For instance, in the Social Security Administration's stochastic model of Social Security finances, the coefficient of variation (the standard deviation divided by the mean value) of fertility is roughly 0.12 and of mortality roughly 0.46. A coefficient of variation of excess cost growth derived from a CBO report is roughly 1.05. See generally JULIE TOPOLESKI, CONG. BUDGET OFFICE, TECH.

for fertility and mortality used by Social Security and the CBO may be optimistic with regard to their effects on entitlement financing.³⁷ This is not to say we should not prepare for the worst; indeed, the greater uncertainty regarding health care cost growth is an argument for addressing it sooner rather than later. But it is ironic that while some cite uncertainty regarding future projections as a reason not to enact Social Security reform, uncertainty regarding health care cost growth is far greater.³⁸

Population aging cannot be stopped, so prompt action to bring Social Security, Medicare, and Medicaid into long-term financial balance is necessary. This will require increases in revenues or reductions in outlays, and the sooner these are accomplished, the easier the changes will be for each generation.

At the same time, government policies could help mitigate the effects of aging. Reduced taxes on labor and improved health and pension policies could keep older Americans working. While labor force participation by older workers has improved in recent years—in part due to a secular increase in participation by females—labor force participation rates for males aged sixty to sixty-four remain lower today than in 1976, despite a life expectancy at age sixty-five that is more than three years longer.³⁹ Immigration, while controversial, can bring younger workers into the economy. For the long-term, research has shown that changes in government policies can potentially increase fertility rates.⁴⁰ Higher birth rates would increase future economic output and broaden the base of working-

PAPER NO. 2004-13, UNCERTAINTY ABOUT PROJECTIONS OF MEDICARE COST GROWTH 1–4 (2004), available at www.cbo.gov/ftpdocs/57xx/doc5770/2004-13.pdf.

37. For instance, the report of the 2007 Technical Panel on Assumptions and Methods to the Social Security Advisory Board concluded that the Social Security Trustees' projections underestimate future improvements in life expectancies and that uncertainty regarding the Trustees' fertility projections should be weighted more toward the likelihood of the United States falling to lower European levels of fertility. See TECHNICAL PANEL ON ASSUMPTIONS AND METHODS, REPORT TO THE SOCIAL SECURITY ADVISORY BOARD 7 (2007), http://socialsecurityadvisoryboard.gov/documents/2007_Technical_Panel_Report.PDF. Both of these factors would tend to increase the share of total costs attributable to population aging.

38. It is often argued that the Social Security Trustees' projections for the program's finances are unduly pessimistic and that a proper course of action would be to wait until shortfalls are more certain before enacting reform. See, e.g., Charles P. Blahous, *Have the Social Security Trustees Been Too Conservative?*, AEI.ORG, Sept. 11, 2007, at 4–5, http://www.aei.org/docLib/20070911_BlahousSocialSecurity.pdf.

39. See Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, available at http://www.bls.gov/cps/cps_over.htm (last visited Aug. 4, 2008).

40. For instance, Joseph Chamie of the United Nations concludes: "Based on national experiences during the past quarter century, it appears that government policies that promote childbearing, reduce the costs of childrearing, facilitate working couples, especially women, encourage greater male involvement in parenting and preferences to couples with children, may be able to influence fertility in an upward direction." Joseph Chamie, Presentation at the Annual Meeting of the Population Association of America: Low Fertility: Can Governments Make a Difference? 11 (Apr. 2, 2004), available at <http://paa2004.princeton.edu/download.asp?submissionId=42278>.

age individuals supporting entitlement programs. None of these policy changes would be easy to implement, but neither would changes to entitlement taxes or benefits.

IV. CONCLUSION

Some claim that health care cost growth is by far the dominant source of projected increases in overall entitlement program costs, using that claim to justify a far-reaching overhaul of both public and private health care provision.⁴¹ However, using standard government accounting approaches incorporating all major entitlement programs, population aging and excess health care cost growth play roughly equal roles in driving future entitlement spending. Over the next several decades, when projections are more accurate and current policy's ability to affect outcomes is at its greatest, population aging will play a larger role than excess health care cost growth. Excess cost growth, in turn, will be the primary cost driver in the long term. While reasonable changes in assumptions or methodology could easily swing the balance of influence in either direction, it is clear that aging does not play the minor role in driving entitlement spending that the purveyors of the new consensus purport. None of this implies an either/or choice: policies to improve health care efficiency and reduce cost growth must be undertaken alongside policies to tackle the challenges of population aging. The recent work of the CBO in exploring health care cost and quality issues in new detail is of great value, but neither task should be taken as an excuse to ignore the direct financing challenges of Social Security, Medicare, and Medicaid.

41. See, e.g., Aaron, *There is No Entitlement Crisis*, *supra* note 1.