Backgrounder

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A Guide to Fixing Social Security, Medicare, and Medicaid

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The coming challenge of paying Social Security, Medicare, and Medicaid benefits to 77 million retiring baby boomers will be one of the greatest economic challenges of the 21st century. What Federal Reserve Chairman Ben Bernanke called the "calm before the storm" ended on January 1, 2008, when the first baby boomers became eligible for early Social Security benefits.[1] In three years, they will also become eligible for Medicare.

In the coming decades, the cost of these programs will leap from 8.4 percent of gross domestic product (GDP) to 18.6 percent of GDP—an increase of 10.2 percent of GDP. Without reform, this increased cost would require raising taxes by the current equivalent of $12,072 per household or eliminating every other government program. Funding all of the promised benefits with income taxes would require raising the 35 percent income tax bracket to at least 77 percent and raising the 25 percent tax bracket to at least 55 percent.

Although aware of this coming crisis, Members of Congress have largely ignored it because all of the possible reforms are considered politically risky. Yet delays only increase the pain of the ultimate reforms, which are becoming about $1 trillion more expensive annually. Furthermore, many believe that Americans ages 55 and over should be exempt from any reforms. One-third of all baby boomers have already crossed that threshold, and at 4 million per year, all of them will have crossed it by 2019.

Entitlement reform is more than just an economic issue. Americans need to decide whether they want a

Talking Points

- The first of 77 million baby boomers have begun to collect Social Security and will soon start receiving Medicare and Medicaid benefits.
- The total cost of these entitlement programs will increase from 8.4 percent of GDP to 18.6 percent of GDP by 2050. In comparison, the entire federal budget is 20 percent of GDP.
- To cover these additional costs, Congress would need to raise taxes permanently by the equivalent of $12,072 per household or eliminate every other federal program.
- A first step in reforming the entitlement programs is addressing whether or not entitlement programs should always have the first claim on tax dollars, leaving discretionary programs (e.g., defense, education, and veterans health) to fight over the remaining scraps of the federal budget.

This paper, in its entirety, can be found at:
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future in which older Americans have an automatic claim on one-fifth of the future income of their grandchildren—who will be raising their own children and paying off their home mortgages. Under the current system, retirees will spend one-third of their adult lives in taxpayer-funded retirement while national security, education, health research, and antipoverty programs fight for the few remaining tax dollars.

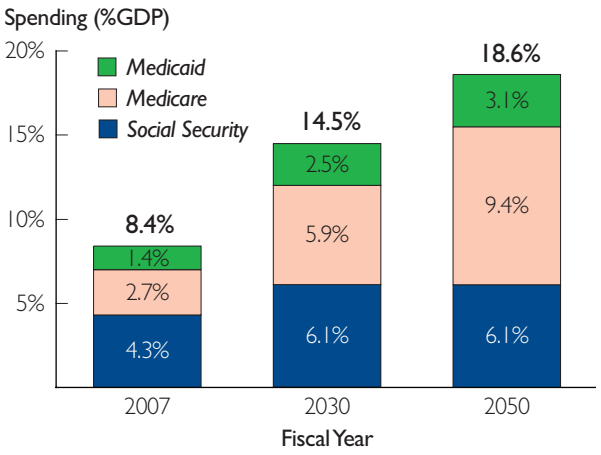
This paper provides an introduction to the coming crisis in Social Security, Medicare, and Medicaid and sets up a framework for the consideration of various reforms.

No Easy Solutions

The Congressional Budget Office (CBO) projects that federal spending on Social Security, Medicare, and Medicaid will leap from 8.4 percent of GDP today to 18.6 percent by 2050.[2] (See Chart 1.) For comparison, the entire federal budget is 20 percent of GDP (18 percent spent on programs and 2 percent on net interest). This massive cost increase will be fueled by the 77 million retiring baby boomers, combined with steep inflation in health care costs and automatic scheduled benefit hikes.

Chart 1 B 2114

Major Entitlements Will Expand to 18.6 Percent of GDP

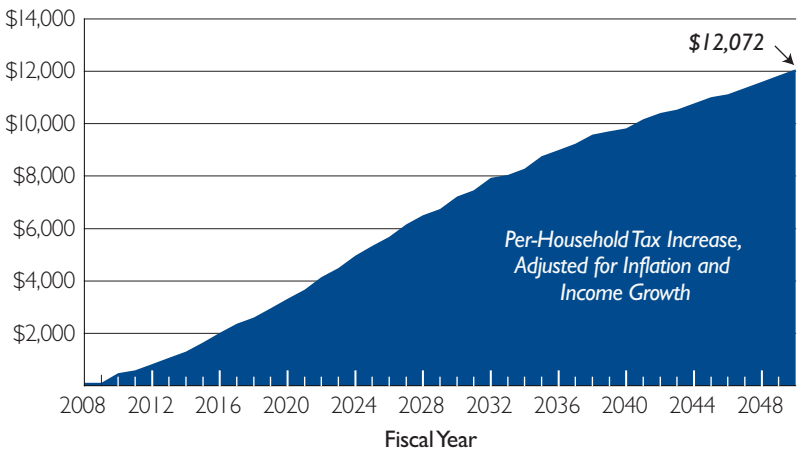


Note: This represents the alternative baseline scenario.

Source: Congressional Budget Office, "The Long-Term Budget Outlook," December 2007, at *www.cbo.gov/ftpdocs/88xx/doc8877/12-13-LTBO.pdf* (February 25, 2008).

Chart 2 B 2114

Bad Option 1: Funding Entitlements with Tax Increases



Source: Heritage Foundation calculations based on data from the Congressional Budget Office.

These costs far exceed what taxpayers will be able to afford. Increasing taxes by 10.2 percent of GDP today would come to $1.394 trillion, or $12,072 per household. (See Chart 2.) It could mean raising income tax rates by at least 120 percent—and probably more because tax increases slow economic growth and dampen new revenues—with additional raises thereafter.[3] Funding all of the promised benefits would require raising the 35 percent income tax bracket to at least 77 percent and the 25 percent tax bracket to at least 55 percent.[3]

1. Ben Bernanke, "Long-Term Fiscal Challenges Facing the United States," testimony before the Committee on the Budget, U.S. Senate, January 18, 2007, at *www.federalreserve.gov/boarddocs/testimony/2007/20070118/default.htm* (February 25, 2008).
2. Congressional Budget Office "The Long-Term Budget Outlook," December 2007, p. 5, at *www.cbo.gov/ftpdocs/88xx/doc8877/12-13-LTBO.pdf* (February 25, 2008). This represents the alternative fiscal scenario.

Regrettably, five common myths undermine the cause for immediate action.

MYTH 1: There is no hurry.

Social Security, Medicare, and Medicaid already absorb 42 percent of the federal budget and are growing by 7 percent annually, making them the largest impediment to balancing the budget. Furthermore, many believe that anyone over age 55 should be exempt from entitlement reforms.

Yet every year, 4 million more baby boomers turn 55, effectively locking in their future benefits (and taxpayer costs) by this standard. By 2019, all 77 million baby boomers will have turned 55,[4] leaving future lawmakers with the unpalatable options of massive, economy-stagnating tax increases, unprecedented program terminations, or the paring back of benefits for those over 55. Tackling reforms immediately will reduce their ultimate costs, spread the burden across more people, and give baby boomers more time to adjust their retirement strategies.

MYTH 2: These budget projections are unreliable.

Projecting economic variables such as growth and inflation rates is difficult, but the impending retirement of 77 million baby boomers is not a vague theoretical projection. The Social Security costs for these future retirees are determined by a set benefit formula. Medicare faces the same demographic realities, and its steep spending projections even assume a sharp slowdown in per capita growth. These same baby boomers will also push up Medicaid spending on long-term care.

MYTH 3: Economic growth will solve the problem.

Revenues associated with higher economic growth would help only marginally. As Federal Reserve Chairman Ben Bernanke has testified:

> Economic growth leads to higher wages and profits and thus increases tax receipts, but higher wages also imply increased Social Security benefits, as those benefits are tied to wages. Higher incomes also tend to increase the demand for medical services so that, indirectly, higher incomes may also increase federal health expenditures.[5]

In short, the same factors that could increase tax revenues would also increase spending.

MYTH 4: Cutting waste and pork is enough.

Although Washington wastes billions of dollars, cuts in federal spending cannot absorb a cost increase of 10.2 percent of GDP. In fact, offsetting this spending hike would require eliminating *every other* federal program by 2049 except interest payments on the federal debt. Non-defense programs would be eliminated by 2030, and defense spending would be eliminated by 2049. (See Chart 3.)

MYTH 5: Letting the 2001 and 2003 tax cuts expire is enough.

The CBO projects that tax revenues will increase from 18.8 percent of GDP to a record 22.8 percent by 2050, but letting the 2001 and 2003 tax cuts expire in 2011 would only nudge revenues up to 23.4 percent by 2050.[6] Thus, losing the tax cuts would close less than 1 percentage point of the 10.2 percent gap.

Even that projection unrealistically assumes that such a large tax increase on families, investors, and businesses would have no negative economic consequences and that Congress would not spend the new revenues elsewhere. Massive new spending, not low tax revenues, is the problem.

All five of these myths distract America and its lawmakers from confronting the difficult but nec-

3. Individual income tax revenues are currently 8.5 percent of GDP. Adding 10.2 percent of GDP represents a 120 percent increase over that original level.
4. Baby boomers are defined as those born between 1946 and 1964.
5. Bernanke, "Long-Term Fiscal Challenges Facing the United States."
6. Calculated using Congressional Budget Office "The Long-Term Budget Outlook," pp. 44–46, at *www.cbo.gov/ftpdocs/88xx/doc8877/12-13-LTBO.pdf* (February 25, 2008), and supplemental data, Figure 1.1 and Figure 5.3, at *www.cbo.gov/ftpdocs/88xx/doc8877/SupplementalData.xls* (February 25, 2008). The 23.4 percent figure assumes that Congress does not adjust the alternative minimum tax threshold. If the Bush tax cuts are made permanent and the AMT is adjusted annually, the CBO's 2050 revenue projections are 19.4 percent of GDP, which is still well above the historical average.

essary entitlement reforms. The continued refusal to modernize Social Security, Medicare, and Medicaid leaves only three options:

1. Massive and economically debilitating tax increases. (See Chart 2.)
2. Elimination of other federal programs. (See Chart 3.)
3. Unprecedented budget deficits. (See Chart 4.)

How Entitlements Hijack the Budget Process

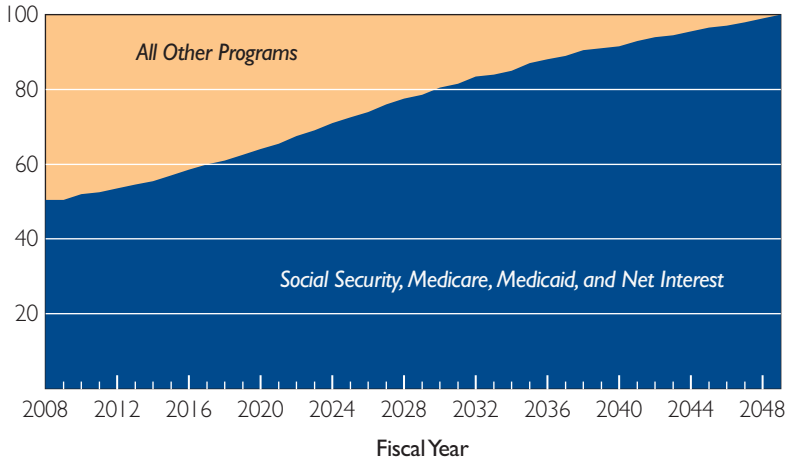
Biased budget rules are a major obstacle to fixing Social Security, Medicare, and Medicaid. Federal spending should be allocated based on national priorities, yet programs classified as entitlements are given a nearly untouchable status above discretionary programs.

Entitlement programs—including Social Security, Medicare, Medicaid, most antipoverty programs, farm subsidies, and refundable tax credits—are effectively on autopilot. Their budgets grow automatically each year without going through the regular budget process, being examined, or being forced to justify their growth. Smaller entitlement programs are examined only once or twice per decade when they are reauthorized. Large entitlement programs are not required to be reauthorized or re-examined.

Each year, when Congress begins writing the annual budget, it accepts the 53 percent of the budget (and growing) spent on entitlements as a given, sets aside an additional 9 percent for net interest, and then spends the rest of the year deciding how to allocate the remaining scraps to defense, homeland security, education, health research, transportation, justice, foreign aid, and the environment.

Chart 3 B 2114

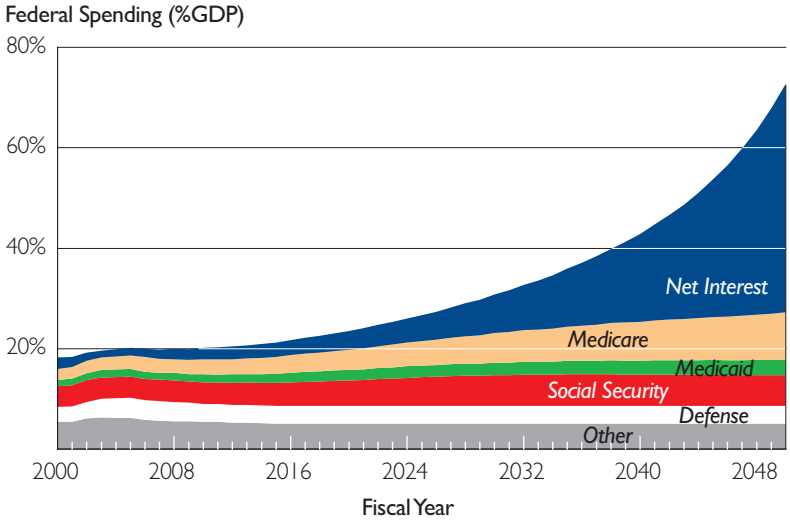
Bad Option 2: Funding Entitlements by Cutting Other Programs



Source: Heritage Foundation calculations based on data from the Congressional Budget Office.

Chart 4 B 2114

Bad Option 3: Funding Entitlements with Budget Deficits



Source: Heritage Foundation calculations based on data from the Congressional Budget Office.

This practice conflicts with America's budget priorities. It effectively gives Medicare drug subsidies for well-off Americans priority over body armor for American troops serving in Iraq and Afghanistan. It guarantees farm subsidies to corporate agribusinesses, leaving homeland security, education, and health research to fight over whatever tax dollars are left over.

These trade-offs are not theoretical. As Social Security, Medicare, and Medicaid costs surge over the next few decades, the funds available for other programs—such as defense, education, poverty relief, and veterans aid—will continue to shrink toward zero.

Approaches for a Solution. Entitlements were originally placed on autopilot to provide predictability in eligibility standards and benefit formulas. While overhauling these standards and formulas each year would be unwise, Congress could convert major entitlements into 30-year budgeted programs that must be reviewed and reauthorized every five years to keep spending within long-term allowable levels.

Additionally, Congress could create triggers that would automatically adjust the program if current and future spending trends exceed the allowable amount. (This is similar to a law that triggers reform proposals when outside sources are needed to fund at least 45 percent of Medicare spending.[7]) As long as the 30-year budget and five-year targets are written realistically, any annual adjustments would be small.

The Coming Costs

Over next few decades, the cost of providing promised Social Security, Medicare, and Medicaid benefits will exceed projected revenues by trillions of dollars.

Social Security. Social Security was created in 1935 to provide pensions to Americans age 65 and over.[8] Old Age and Survivors Insurance is funded by a 10.6 percent payroll tax, split equally between employer and employee, on the first $102,000 earned—a level that is adjusted annually for inflation.[9]

Initial Social Security benefits are calculated based on the worker's average monthly income, called the Average Indexed Monthly Earnings (AIME), during the worker's 35 years of highest earnings. (Each year's earnings are indexed for subsequent average wage growth in the economy).[10] Monthly benefits equal a percentage of the AIME, ranging from 90 percent for very low earners down to 15 percent for the highest earners.[11] After the initial benefit is determined, it is indexed annually for price inflation.

Currently, the average annual benefit is approximately $15,000. Those who live long can receive benefits well in excess of what they paid into the system. Those who die young can pass only minimal benefits on to their survivors. For the most part, they can leave little to nothing of their contributions for their heirs.

The Problem. Social Security spending is projected to increase from 4.3 percent of GDP today to 6.1 percent by 2050—an increase of 1.8 percent of GDP. Today, a spending increase of 1.8 percent would equal $246 billion, or $2,130 per household. Of this spending hike, 55 percent would result from demographic changes, and 45 percent would result from higher benefit levels.

The demographic side is simple. The 77 million retiring baby boomers born between 1946 and 1964 will overwhelm a Social Security system that

7. Public Law 108–173.
8. A retiree may choose to begin receiving Social Security benefits at age 62, albeit at permanently reduced levels.
9. Social Security Disability Insurance accounts for an additional 1.8 percent payroll tax, making the entire Social Security payroll tax 12.4 percent.
10. All income earned before age 60 is adjusted upward for average wage growth in the economy; earnings after the worker's 60th birthday are adjusted for price inflation.
11. For an individual who first becomes eligible for old-age insurance benefits in 2008, the benefits formula is 90 percent of the first $711 of the AIME, plus 32 percent of the income between $711 and $4,288, plus 15 percent of the income over $4,288. The thresholds are adjusted annually. See Social Security Administration, Office of the Chief Actuary, "Primary Insurance Amount," updated October 17, 2007, at *www.ssa.gov/OACT/COLA/piaformula.html* (February 25, 2008).

currently pays benefits to only 42 million seniors.[12] Not only will more Americans retire, but they will live longer and collect benefits longer. In 1940, a 65-year-old senior could expect to live 13 more years. Today, that figure is 18 years and is projected to increase to 22 years in coming decades. The combination of 77 million retiring baby boomers and longer life spans will double the number of Social Security beneficiaries by 2030, while the number of taxpaying workers will increase by just 17 percent.[13]

This will endanger the program because today's benefits are paid by today's payroll taxes. Social Security's sustainability depends on having enough workers to support all of the retirees. In 1960, five workers supported each retiree. This ratio has fallen to 3:1 and will drop to 2:1 by 2030. A 2:1 ratio means that each married couple in 2030 will be supporting the Social Security and Medicare benefits of one retiree.

Higher benefit levels will drive the rest of the cost increase. As stated, initial Social Security benefits are calculated by adjusting lifetime incomes upward for the economy's average wage growth over a person's working life, which is historically higher than price inflation. This pushes people's AIMEs well above their inflation-adjusted lifetime earnings. Because of this more generous formula, the CBO estimates that the average retiree's inflation-adjusted benefits will nearly double by 2075.[14]

What About the Trust Fund? The Social Security Trust Fund is the most misunderstood aspect of this program. In 1983, with Social Security's finances in dire straits and baby boomers approaching retirement, lawmakers raised the payroll tax so that Social Security could build a $5 trillion "surplus." Beginning in 2017, when the payroll tax can no longer cover the rising annual program costs, this "trust fund" would be large enough to cover all program shortfalls until 2040. At least, that was the idea.

In practice, Congress has already spent this money. Each year, the Social Security program lends its surplus to Congress to spend on regular government programs in return for special-issue Treasury bonds, which are backed only by the federal government's promise to repay them. In 2017, when Social Security begins to redeem these bonds, Congress—and the taxpayers—will start to repay the entire $5 trillion from scratch.

This means the trust fund does not save taxpayers a dime. Future taxpayers are still on the hook for the entire $5 trillion Social Security deficit between 2017 and 2040. The "assets" of the trust fund are only an IOU, a tally of how much the American people will have to repay the system. Congress taxed workers to build the trust fund, spent the money, and will have to tax them a second time to repay the trust fund.

Critics respond that the federal government has never defaulted on its debt, so the Social Security program will definitely be repaid the $5 trillion, allowing it to pay full benefits until 2040. While this may be true, the key question is how lawmakers will find the extra $5 trillion. These critics must be counting on big tax increases or spending cuts elsewhere in the budget beginning in 2017.

Thus, 2040 is not a very important date. The program currently runs an $85 billion annual surplus that Congress uses to fund other federal programs, thereby reducing the budget deficit by that amount.[15] The surplus will begin decreasing by 2012, and Congress will be less able to use these funds to reduce the budget deficit artificially. By 2017, Social Security will begin running a deficit, and Congress will need to begin transferring outside taxes into the system to pay full benefits. After

12. This figure includes recipients of survivors benefits. Approximately 8.8 million more receive Social Security disability payments. See Social Security Administration, Office of Policy, "Monthly Statistical Snapshot," December 2007, at *www.ssa.gov/policy/docs/quickfacts/stat_snapshot* (February 25, 2008).
13. Congressional Budget Office, "The Looming Budgetary Impact of Society's Aging," *Long-Range Fiscal Policy Brief*, July 3, 2002, at *www.cbo.gov/ftpdocs/35xx/doc3581/July3.pdf* (February 25, 2008).
14. Congressional Budget Office, "The Future Growth of Social Security: It's Not Just Society's Aging," *Long-Range Fiscal Policy Brief*, July 1, 2003, at *www.cbo.gov/ftpdocs/43xx/doc4380/07-01-SocSecAging.pdf* (February 25, 2008).

2017, the amount of outside taxes needed to pay all promised benefits will grow every year.

Approaches for a Solution. The options for preserving Social Security's solvency are relatively straightforward. Rather than dumping large debt or tax increases on the next generation, several feasible options exist to restrain program costs. One option is to raise the retirement age (currently set to rise to 67 by 2030) by two months each year until it reaches 70, which would allow future seniors an average retirement of 17 years.

A second option would income-adjust benefits to target needy seniors more effectively. This could be accomplished through "progressive indexing," which would index initial benefit levels for middle-income and upper-income families to price inflation rather than wage growth, eliminating much of the increased Social Security costs driven by higher benefits. This would also target more benefit growth to lower-income retirees. If accompanied by an increase in the retirement age, progressive indexing could eliminate the entire Social Security shortfall.[16]

Finally, many economists believe that the consumer price index overstates inflation. Aligning Social Security's inflation adjustment with the actual (and lower) inflation rate would save money while still providing benefit growth.

In the long run, a more generationally equitable system would add a Social Security option in which individuals set aside money for their own retirement that they own themselves. The challenge is funding the transition period when one generation will need to fund current senior citizens' benefits while prefunding its own retirement.

Personal accounts by themselves do not reduce the taxpayer liabilities to current seniors. However, if Congress slightly pared back the growth rates of benefits for upcoming retirees and allowed workers to direct a portion of their payroll tax savings into personal retirement accounts, workers could harness enough long-term investment growth to do much better than they can under today's system. This is the most realistic way to fund two generations of retirement on one generation's payroll tax. Millions of Americans with 401(k) plans and IRAs already understand how even safe investments can grow significantly over several decades.[17]

Medicare. Medicare was created in 1965 to provide medical care to Americans age 65 and older. An average of just under $10,000 is spent annually on each of Medicare's 43 million enrollees.[18] Medicare has three main components:

- **Medicare Part A** covers hospital and skilled nursing care. It is funded by a 2.7 percent payroll tax (split equally between employer and employee) on all income. For most enrollees, Medicare operates as a fee-for-service system, meaning that once the enrollee satisfies a modest deductible, Washington reimburses participating health care providers for services based on a set payment schedule.
- **Medicare Part B** covers physical and outpatient care. This optional program, in which most Medicare recipients participate, requires recipients to pay a monthly premium set at approximately 25 percent of total program costs, leaving the taxpayers to fund the remaining 75 percent.
- **Medicare Part D** is the new prescription drug benefit enacted in 2003. This optional program is funded mostly from general tax revenues, although enrollees pay a small deductible and monthly premium. Enrollees choose from com-

15. Office of Management and Budget, *Historical Tables, Budget of the United States Government, Fiscal Year 2009* (Washington, D.C.: U.S. Government Printing Office, 2008), pp. 289–301, Table 13.1, at *www.whitehouse.gov/omb/budget/fy2009/pdf/hist.pdf* (February 11, 2007). Intragovernmental interest revenues are excluded from the Social Security surpluses because they are transfers from other taxes into the Social Security program and therefore not true program revenues.
16. Robert C. Pozen, "PIN Money," *The Wall Street Journal*, January 9, 2007.
17. For a blueprint for reforms, see David C. John, "How to Fix Social Security," Heritage Foundation *Backgrounder* No. 1811, November 17, 2004, at *www.heritage.org/Research/SocialSecurity/bg1811.cfm*.
18. Steve Teske, "2006 Medicare Spending Rose 18.7 Percent Due to RX Drug Benefit, Researchers Say," Bureau of National Affairs *Daily Report for Executives*, January 8, 2008. In 2006, an average of $9,538 was spent on each fee-for-service beneficiary, and $10,133 was spent per managed care enrollee.

peting private health plans, which are reimbursed by Washington.

Only Medicare Part A is a social insurance program in which retirees "earn" their benefits with lifelong payroll taxes. Benefits for Medicare Parts B and D are not earned with payroll taxes. They are financed by general revenue (75 percent) and premiums (25 percent) paid by the senior enrollee.

The Problem. Medicare costs are projected to more than triple from 2.7 percent of GDP today to 9.4 percent by 2050. In current terms, a cost increase of 6.7 percent of GDP would equal $916 billion, or $7,930 per household annually.

Even this projection assumes that per capita Medicare costs will grow only about 1 percentage point faster than GDP, even though Medicare costs have grown an annual average of 2.4 percentage points faster than GDP since the 1970s.[19] If this trend continues, actual Medicare costs through 2050 could be double the current projection.

Medicare faces the same demographic challenges as Social Security, and the projected increase in seniors over age 85 will add additional strains.[20] It also faces steep inflation in health care costs that will increase its long-term debt well beyond Social Security's debt. Overall, health spending has been increasing 7 percent to 10 percent annually. Health spending averaged $7,026 per person in 2006, or 16 percent of GDP.[21] Furthermore, creation of the Medicare prescription drug entitlement added approximately $8 trillion to Medicare's 75-year unfunded obligations.[22]

What About the Trust Fund? Medicare Part A is funded by payroll taxes that are theoretically "saved" in a trust fund for future retirees. Parts B and D are not funded by payroll taxes. As with Social Security, Congress has already spent all past surpluses for Part A, leaving taxpayers to fund all future shortfalls from scratch. The program is projected to begin running a deficit in 2010 (2007 if interest income is excluded) and then remain in deficit indefinitely.[23] Because at least 75 percent of Parts B and D is funded by taxpayers, these programs also face enormous long-term deficits.

Approaches for a Solution. Medicare reform is very complex. While Social Security transfers income from one group to another and therefore can be fixed with formula changes, fixing Medicare is more difficult because it is a major part of the health care economy. Thus far, reforms have centered on reducing payment rates to doctors and hospitals, but payment rates are already well below market prices. This amounts to rationing health care, which may reduce costs but will not advance better care or encourage more rational decisions.

Some reforms, which could be made quickly, would significantly rein in Medicare costs. One new approach would be to reduce the massive Part B and Part D subsidies for upper-income families. These programs are not social insurance: Enrollees did not earn their benefits with payroll taxes. Rather, they are large subsidies from taxpayers. Part B recently began modest income-relating. President Bush has proposed larger means-testing of Parts B and D.

19. *Ibid.*, p. 23.
20. The percentage of Americans ages 85 and older is projected to increase from 1.5 percent in 2000 to 5 percent in 2040. See Douglas Holtz-Eakin, "Implications of Demographic Changes for the Budget and the Economy," statement before the Committee on Ways and Means, U.S. House of Representatives, May 19, 2005, p. 2, at *www.cbo.gov/ftpdocs/63xx/doc6365/05-19-Long-Term.pdf* (February 25, 2008).
21. Aaron Catlin, Cathy Cowan, Micah Hartman, and Stephen Heffler, "National Health Spending in 2006: A Year of Change for Prescription Drugs," *Health Affairs*, Vol. 27, No. 1 (2008) pp. 14–29, at *http://content.healthaffairs.org/cgi/content/abstract/27/1/14* (February 25, 2008).
22. U.S. Government Accountability Office, *Fiscal Year 2007 Financial Report of the United States Government*, December 2007, p. 46, at *www.gao.gov/financial/fy2007financialreport.html* (February 25, 2008).
23. Boards of Trustees, Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, *2007 Annual Report*, April 23, 2007, p. 48, Table III.B4, at *www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf* (February 25, 2008). Interest income is often excluded because it is not true revenue from the program, but rather outside funding from general revenues.

Long-term fundamental reform will likely involve bringing more choice and competition into health care, such as moving Medicare from a defined-benefit system to a defined-contribution system. The Federal Employees Health Benefits Program (FEHBP) has held down costs by creating a voucher-type system for federal employees to purchase coverage from competing health plans that offer differing coverage and costs.[24] By creating more choice and competition, the FEHBP has held down cost increases and may serve as a model for Medicare reform.

Medicaid. Medicaid is a federal–state partnership, created in 1965, that provides medical care to 46 million low-income individuals. States run their own Medicaid programs, while Washington sets minimum eligibility and benefit standards and reimburses states for an average of 57 percent of all program costs. Approximately one-third of Medicaid spending is on senior citizens, partly because Medicare does not cover most long-term care such as nursing homes. Overall, Medicaid finances 40 percent of all long-term care costs.[25]

The Problem. Federal Medicaid spending is projected to jump from 1.4 percent of GDP to 3.1 percent by 2050. Today, a 1.7 percent of GDP spending hike would equal $232 billion, or $2,012 per household. Most of this spending growth will come from senior citizens, whose long-term care costs are not covered by Medicare.

Two other factors will also drive up Medicaid costs: inflation of health care costs and the funding structure, which encourages states to overspend on Medicaid. Because Washington reimburses states for 57 percent of all costs, every dollar that a state spends on Medicaid guarantees an additional $1.33 grant from Washington. Consequently, states have a stronger incentive to allocate their budgets to expand Medicaid benefits and eligibility levels rather than to provide tax relief or education, regardless of the state's actual needs.

Not surprisingly, approximately 60 percent of the average state's Medicaid budget is now spent on optional services and populations beyond the federal minimum.[26] These optional services, such as weight-loss help and substance-abuse treatment, have played a large role in increasing the program's spending by an inflation-adjusted 227 percent since 1990.[27]

Approaches for a Solution. Converting Medicaid into a block grant to states would eliminate state incentives to overspend on Medicaid. Additionally, giving states more flexibility to craft different Medicaid packages for different individuals based on their unique personal circumstances could save money while improving service delivery.[28] State incentives to help individuals purchase long-term care insurance could also substantially reduce Medicaid's burden insofar as these expenses are concerned.

Conclusion

Unless lawmakers promptly reform Social Security, Medicare, and Medicaid, America faces a future of soaring taxes and government spending that will cause poor economic performance. Americans will pay onerous taxes, and future generations will have lower living standards than Americans enjoy today. The longer lawmakers wait to enact the necessary reforms, the more painful those reforms will be.

—Brian M. Riedl is Grover M. Hermann Fellow in Federal Budgetary Affairs in the Thomas A. Roe Institute for Economic Policy Studies at The Heritage Foundation.

24. Robert E. Moffit, "Lessons of Success: What Congress Can Learn from the Federal Employees Program," Heritage Foundation *WebMemo* No. 565, September 14, 2004, at *www.heritage.org/Research/HealthCare/wm565.cfm*.
25. Kaiser Family Foundation, "Medicaid's Role in Long-Term Care: Q & A," at *www.kff.org/medicaid/upload/Medicaid-s-Role-in-Long-Term-Care-Q-A-Fact-Sheet.pdf* (February 25, 2008).
26. Raymond C. Scheppach, "Unfunded Mandates: A Five-Year Review and Recommendations for Change," testimony before the Subcommittee on Energy Policy, Natural Resources, and Regulatory Affairs, Committee on Government Reform, and the Subcommittee on Technology and the House, Committee on Rules, U.S. House of Representative, May 24, 2001, at *www.rules.house.gov/archives/rules_sche12.htm* (February 25, 2008).
27. See Office of Management and Budget, *Historical Tables*, pp. 144–149, Table 8.6.
28. See John S. O'Shea, "More Medicaid Means Less Quality Health Care," Heritage Foundation *WebMemo* No. 1402, March 21, 2007, at *www.heritage.org/Research/HealthCare/wm1402.cfm*.