



FACING FACTS QUARTERLY

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Honey, I Shrank the Demographics!

A number of prominent pundits and policy experts have begun to articulate a new perspective on our fiscal future. They tell us we don't have a demographic problem. Or even an entitlement problem. We merely have a health-care problem.

According to this new school of budgetary analysis, the "age wave" explanation is wrong. Yes, it's true that federal spending will soar to unsustainable heights over the next twenty-five or fifty years. But this rising extra cost burden has almost nothing to do with how fast America is growing older. Instead, almost all of it is driven by the "excess growth" in age-adjusted federal health spending per beneficiary—that is, the growth in excess of what is due to demographic aging—in Medicare and Medicaid.

If health benefits are such a large part of the fiscal problem, then logically every other form of federal spending must be a very small part of the problem. With increasing frequency and gusto, the new school argues that there is no general entitlement problem—or reason to look to Social Security and other cash benefit programs for savings.

Columnist Paul Krugman, after pinning all of the projected growth in federal spending on rising health costs in a recent *New York Times* op-ed, declares that "the whole Beltway obsession with the fiscal burden of an aging population is misguided." He then proceeds to lampoon Barack Obama as a "sucker" for proposing to reform Social Security. Budget expert Henry Aaron claims, in a *Health Affairs* essay this fall, that "anticipated budget problems are fully explained by projected growth in Medicare and Medicaid," and thus that any so-called general budget or entitlement crisis is "imagined" and "fictitious." Late last month, the Congressional Budget Office released a study concluding that demographics account for very little of overall entitlement growth. Commenting on the study to the press, CBO Director Peter Orszag expressed regret that he and other analysts have in the past focused so much on aging and cash benefits when, in truth, we now know that the real problem is health benefits.

One might suppose that such views would lead to urgent calls for a rigorous strategy of cost control for federal health benefits. But this is not the case—which brings us a curious turn in the new school's argument. Virtually none of these pundits and experts has proposed an actionable policy reform that would directly lead to major reductions in the future growth of federal health benefits. Instead, the new school mostly argues that the only way to curb those benefits equitably and efficiently is through a broad and

sweeping and national health-care strategy that encompasses both the private and public sectors. To be sure, they acknowledge that this may lead to even greater federal spending in the near term. But in the long term, they insist that a national solution is the only way to bring health cost growth, and hence federal benefit spending, under control.

There are two major problems with the new school of budgetary analysis.

First, their quantitative diagnosis of the problem is mistaken. The impact of demographic aging on the budget is hardly trivial. Between now and 2030, demographics will add 3.5 percent of GDP to the budget and account for more than half of the growth in federal entitlement spending. This should surprise no one: Over that same period,

ISSUE IN FOCUS

by Neil Howe and Richard Jackson

the number of Social Security and Medicare beneficiaries will nearly double.

Second, to the extent that the fiscal problem really can be attributed to excess growth in health costs, the new school is wrong to conclude that we must wait for a comprehensive national solution in order to do something about it. There are many equitable and efficient ways in which the federal government can directly reign in the growth in health benefit spending. Tying federal cost control to a national solution doesn't make it easier to reduce the fiscal burden and redress the generational inequity of our entitlement system. Indeed, it makes it harder.

Overall, the new school's argument has all the hallmarks of classic bait-and-switch. The new school adherents redefine the fiscal challenge exclusively in terms of rising Medicare and Medicaid costs, which enables them to discourage action on nonhealth entitlements. They then turn

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around and claim that Medicare and Medicaid are actually part of another bigger problem—national health-care spending—that must be solved first. And by the way, restructuring our national health system may take a lot of time and cost a lot of additional money before we save a dime. The new school starts by sounding like Chicken Little. They end by telling us to wait for the Mighty Quinn.

Anything But Trivial

Let's start with the numbers. According to the Medicare Trustees, who prepare the most widely accepted long-term projections of Medicare spending, the program's cost will rise from 3.2 percent of GDP in 2007 to 6.5 percent in 2030 and 9.0 percent in 2050. Meanwhile, projected forward with identical assumptions, federal spending on Medicaid will rise from 1.4 percent of GDP today to 2.4 percent in 2030 and 3.3 percent in 2050. Today, federal spending on the two programs combined comes to 4.6 percent of GDP. That figure is on track to nearly double by 2030 (to 8.9 percent of GDP) and nearly triple by 2050 (to 12.3 percent of GDP).

How much of this growth is due to demographic aging and how much to "excess growth" in health costs? To answer this question, we need to take into account two distinct demographic drivers: the growth in the number of elderly relative to the total population, or what we will call the "age wave effect," and the rising average age of the elderly themselves, or what is often called the "aging of the aged." The growth in the number of elderly as a share of the population adds to spending by increasing the relative number of federal beneficiaries. The rising average age of the elderly also adds to it by increasing average costs per beneficiary. It does so because per capita health costs rise steeply with age, even among the elderly themselves.

We must also agree on a neutral benchmark for future growth in average costs per beneficiary at any given age (that is, in the age-adjusted cost per beneficiary). The most common benchmark, used by both the Trustees and the CBO, is the rate of growth in per capita GDP. One justification for the benchmark is that much of health-care spending consists of labor-intensive services, and so can be expected to increase along with income. Another is that, in a population with a stable age structure, health-care spending will remain unchanged as a share of GDP if the age-adjusted per capita cost rises at the same rate as per capita GDP.

With this benchmark, assessing the impact of demographic aging is a simple matter of arithmetic. (See technical note at right.) We calculate that it will add 1.5 percent of GDP to Medicare's cost by 2030 and 2.2 percent of GDP by 2050. Demographic aging thus accounts for 46 percent of the total cost growth the Trustees project through 2030 and 37 percent of the growth they project through 2050.

In Medicare, all of the demographically driven growth between now and 2030 is attributable to the age wave effect, that is to the surge in the number of beneficiaries as Boomers cross the threshold of old age. The aging of the aged plays only a minor role—and indeed, initially pulls down growth as the wave of newly enrolling Boomers actually reduces the average age of Medicare beneficiaries. After 2030, the growth in the number of beneficiaries slows

dramatically. However, as the outsized Boomer cohorts age into their high-cost 80s and 90s, the rapid rise in the average age of the elderly also begins to push up spending, partially offsetting the slower growth in enrollment.

Federal Spending on Medicare and Medicaid, as a % of GDP: Total and Components of Growth*

	2007	2030	2050
Medicare Spending	3.2%	6.5%	9.0%
<i>Current Spending Level</i>		3.2%	3.2%
<i>Demographic Aging</i>		1.5%	2.2%
<i>Age Wave Effect</i>		1.7%	2.0%
<i>Aging of Aged</i>		-0.1%	0.2%
<i>"Excess Cost" Growth</i>		1.8%	3.7%
Demographic Aging as % of Total Growth		46.2%	36.9%
Medicaid Spending	1.4%	2.4%	3.3%
<i>Current Spending Level</i>		1.4%	1.4%
<i>Demographic Aging</i>		0.1%	0.3%
<i>Age Wave Effect</i>		0.2%	0.2%
<i>Aging of Aged</i>		-0.1%	0.1%
<i>"Excess Cost" Growth</i>		0.8%	1.6%
Demographic Aging as % of Total Growth		13.2%	17.5%

*Assumes GDP per capita cost neutrality.

In Medicaid, the impact of demographic aging is smaller, mainly because the elderly only comprise a fraction of total beneficiaries. Medicaid also follows a different pattern, with the period of maximum demographic pressure arriving later. We calculate that demographic aging will add just 0.1 percent of GDP to federal Medicaid spending by 2030, or 13 percent of total projected cost growth. By 2050, however, it will add 0.3 percent, or 18 percent of total projected cost growth. The reason for the delayed impact is that Medicaid spending on the elderly, which mostly pays

Technical Note

All of our calculations use the demographic and economic projection scenarios underlying the 2007 Trustees' report. Age-specific per capita spending data for Medicare are from the 2005 Health Care Financing Review Statistical Supplement.; data for Medicaid are from the 1999 Medical Expenditure Panel Survey.

Our results were obtained using standard compositional analysis. For Medicare, we use the official Trustees projection; for Medicaid, we generate a long-term projection using the same age-adjusted per capita rate of "excess cost" growth assumed by the Trustees. We isolate the impact of demographic aging by comparing the long-term cost projections with the growth that would occur due to the following three demographic changes alone: (1) the change in the number of elderly (aged 65 and over) relative to the nonelderly (age 0-64); (2) the change in the age composition of the elderly; and (3) the change in the age composition of the nonelderly. We make two minor simplifying adjustments: We treat disabled Medicare beneficiaries as "elderly" in calculating the relative change in the number of elderly; and we combine the change in the age composition of the nonelderly, whose impact is very small, with the change in the age composition of the elderly. Neither adjustment materially affects the results.

for long-term care, is highly sensitive to the aging of the aged. Per capita, elders aged 85 and over consume 13 times as much in long-term care services as elders aged 65 to 74.

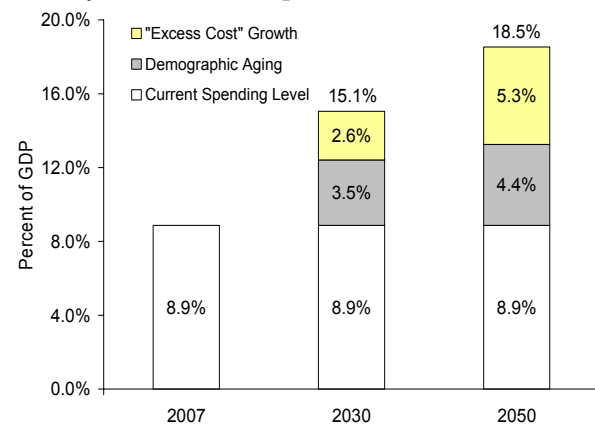
While the impact of demographic aging on Medicare will be greatest in the 2010s and 2020s, as Boomers enter their “active adult” years, the full impact on Medicaid won’t be felt until the 2030s and 2040s, when Boomers become heavy consumers of long-term care assistance.

The contribution of demographics to the growth in federal health benefit spending is thus anything but trivial. Adding together Medicare and Medicaid, we find that demographics account for 39 percent of total cost growth through 2030 and 32 percent through 2050.

These estimates, moreover, are conservative. The GDP per capita cost neutrality assumption we have adopted, though commonly used, may not be the most appropriate. To the extent that health-care costs are affected by labor inputs, one would expect them to track the trend in GDP per worker rather than GDP per capita. Using future growth in per worker GDP as a benchmark, we calculate that demographic aging would account for 46 percent of the total combined growth in Medicare and Medicaid costs through 2030 and 38 percent through 2050.

So far we have ignored Social Security, whose projected growth is entirely driven by demographic aging. Including all three major entitlement programs—Social Security, Medicare, and Medicaid—demographics will add 3.5 percent of GDP to the federal budget by 2030 and 4.4 percent of GDP by 2050, accounting for 57 percent of total spending growth over the first period and 45 percent over the second, assuming a per capita GDP cost neutrality benchmark. The corresponding figures assuming a per worker GDP benchmark are 63 percent and 50 percent.

Federal Spending on Medicare, Medicaid, and Social Security: Total and Components of Growth*



*Assumes GDP per capita cost neutrality.

Many of those who assert that demographics only account for a small portion of the future growth in entitlement spending do so on the basis of partial and misleading measures. Academic studies often consider only the aging of the aged. The CBO, whose recent study concludes that aging accounts for only one-quarter of the growth in federal health spending through 2030 (and much less than one-quarter thereafter), also fails to take all of the demographic

dynamics into account. Surprisingly, it entirely overlooks the impact of the aging of the aged on Medicaid. Its conclusions contradict earlier CBO analysis, whose larger estimates are completely consistent with our own.*

Some adherents of the new budget school also minimize the importance of demographic aging by assuming rates of excess per capita growth that are much higher than those used in the Trustees’ projections, especially in the long run. The CBO, for example, closely follows the Trustees through 2030, but assumes a higher rate thereafter.

It is ironic to observe how this new school assumption is being used by many policy experts opposed to cost-cutting reform of federal entitlements. Not so long ago, these experts typically assumed little or no excess cost growth in order to keep projections of entitlement spending, health and nonhealth together, as low and as unthreatening as possible. Now many are assuming soaring rates of excess cost growth in order to make every other fiscal problem seem trivial by comparison. Objectively, other fiscal challenges like Social Security remain as daunting as ever. But now, by comparison, they don’t *seem* as daunting.

First the Bait, Now the Switch

Given how dramatically the new school plays up the explosive projected growth in federal health benefit spending, we might expect that its followers would be issuing a cascade of cost-reduction proposals for Medicare and Medicaid. But they aren’t. None of them is advancing an aggressive long-term strategy for controlling federal health benefit costs—for instance, capping both Medicare and Medicaid. Indeed, few support even one of the modest health benefit cuts or caps currently under consideration by Congress.

Most of them, instead, argue that federal health benefit spending cannot be addressed without first enacting a “systemic” or “comprehensive” restructuring of the entire health-care sector of our economy. And this, they concede, is a task that encompasses several other national health-care imperatives—such as coverage and affordability—that will require a lot more spending before the hypothetical long-term savings kick in. First the bait, now the switch.

Since everyone agrees that excess health cost growth is at least a major contributor to long-term federal spending growth, it’s useful to back up and re-examine this turn in the argument: Why, exactly, is a direct cost-cutting reform of Medicare or Medicaid infeasible?

One reason, advanced by many analysts, is that the same hospitals and doctors serve both public and private patients, and that we thus cannot change the price and treatment style for one group without doing the same for the other. According to Aaron, “private- and public-sector health care spending is largely done by the same providers in the same settings. This simple fact means that slowing growth of public-sector health care spending without reining in private-sector health care spending is impossible....” As a general proposition about government and cost control, however, this cannot be true. We can economize on the combat aircraft we buy from Boeing (which also produces civilian craft) without nationalizing the company.

* See *The Long-Term Budget Outlook* (CBO, December 2003) and *The Long-Term Budget Outlook* (CBO, December 2005).

Likewise, we can trim federal housing and rental subsidies without imposing federal control over all builders and landlords.

In certain respects, of course, health care is not like other goods and services. While controlling benefit outlays, the federal government wants to be able to guarantee quality and availability—something it could not do if it were simply another small purchaser. But in fact the federal government is a massive purchaser, accounting in direct and indirect outlays (for Medicare, Medicaid, civil service, military, and veterans programs) for roughly 40 percent of total U.S. health-care spending. This vast market share gives it an extensive—and largely underutilized—power to influence the price, quality, availability, and delivery of health care to all patients, as well as to restructure medical practice around outcomes analysis, best-practice guidelines, care management, wellness programs, digital records, and all the other sound practices long advocated by health policy reformers, including many new school adherents.

If balance and fairness requires that a policy of ambitious long-term cost restraint in federal health benefits be accompanied by some demand restraint in the private sector as well, even this could be easily achieved by a few simple tax or regulatory changes. Congress could start by enacting a significant cut in the tax expenditure for employer-paid health care, which amounts to a regressive \$200 billion annual subsidy to private health consumers. The bottom line is that there are many effective ways to control federal health benefit costs efficiently and fairly without resorting to a comprehensive public-private solution.

The Wrong Message

Still, most of the new school persists in its attachment to a national plan—and for reasons that ultimately may have more to do with calculations about politics than policy. Some of the new school analysts believe, optimistically, that sweeping system-wide reforms can achieve large cost savings with little or no reduction in quantity or quality of care. Others believe, more pragmatically, that whatever sacrifices cost control may require, it is best to court voters with a comprehensive plan that mixes cuts with so many new benefits that it doesn't seem to require any overall sacrifice.

Either way, the new school's assumption that comprehensive reform will make it easier to reduce the growth in federal health benefit spending is almost certainly wrong. By delaying action and fueling public expectations about expanded benefits, the push for a comprehensive solution if anything makes cost control harder to achieve.

To begin, let's deflate the optimism about the room for painless cost control: There is no assumed waste or inefficiency or "air" in the Trustees' projections that Congress can eliminate with a magic wand. Recall our earlier discussion: At least two-fifths of the projected rise in the cost of Medicare and Medicaid as a share of GDP between now and 2030 is driven by demographic aging. This means that at least two-fifths is needed simply to keep delivering the same level of care to each beneficiary, at each age, as we do today. The remainder of the rise, the "excess" cost growth, is driven by other powerful forces. There are the ongoing advances in medical testing, screening, diagnostics, pharmaceuticals, and surgery that are pushing up the cost of the

research, technology, and skilled labor underlying every medical visit. There is also the steady rise in the standard of "health" that Americans expect their doctors and hospitals to deliver, which now includes everything from good looks and good sex to a better mood and a better golf swing.

What is the future rate of excess growth that the Trustees assume in their projections? Much less than the rate—after 2030 less than half the rate—that we have actually experienced from 1975 to 2005. In other words, we will need serious cost control simply to keep spending from exceeding the Trustees' projections. We cannot expect to cut excess growth beneath those projections without any pain—that is, without directly or indirectly denying payment to some patients and some providers for some services they would otherwise want.

To be sure, by pumping up future excess cost growth far above what the Trustees assume, the new school may succeed in raising the projections so high that they become "easy" to cut. But this is a mere numbers game that adds nothing to the policy discussion. Everyone agrees that future health benefit outlays that are anywhere near the Trustees' projections are already unsustainable. It is no help to conjure up even deadlier dragons and then slay them. The dragons we already face are fearsome enough.

None of this is to say that it is impossible to provide superior care at lower cost. Health policy researchers are to be commended for their growing attention to the perverse incentives, misallocation and overutilization of resources, and disparate outcomes that afflict our entire health system. We now know, for example, that Medicare's DRG and RVS reimbursement systems can reward providers whose treatments are less effective and that the per capita consumption of health care shows a wide regional variation that is uncorrelated with any measurable health outcome. Reforms based on this research have the potential to generate significant savings.

Yet we should be careful not to exaggerate how easy this savings will be to achieve. Some experts suggest that as much as 30 percent of U.S. health-care dollars are ineffective. That may be so, but to eliminate the waste we need to know which 30 percent and how we can refrain from spending the errant dollars. It's a bit like saying that 30 percent of what Americans eat is bad for their health: The observation may be true, in some sense, but it leads to no obvious policy recommendation.

The biggest problem is that much of the ineffective spending identified by health policy researchers reflects post-hoc analysis. (It is often said, for example, that it is wasteful to spend so much on patients in their last six months, something no one could have known until the patients died.) It is thus unclear how much of the waste can actually be eliminated by new rules of practice. Even where reforms might be effective, most will require changes in patient expectations and provider habits that will certainly be perceived as onerous, inconvenient, and (to some) even life-threatening. Moreover, reforms that eliminate waste will only constitute one-time savings; they are unlikely to change the growth rate of health spending over time.

All of this serves to make a fairly simple point: Restraining the future growth of federal health benefit spending is certain to be difficult and painful no matter how narrowly or how broadly we define the task. Out of fiscal necessity, federal beneficiaries and their providers in years to come will

have to lose some of their accustomed freedom to choose the type, variety, quantity, and institutional setting of the reimbursable services they consume. Meanwhile, out of economic necessity, private patients and their providers will be losing many of the same accustomed freedoms.

The new school's attachment to a comprehensive national solution obfuscates the urgency and difficulty of the fiscal choices ahead. To subordinate federal cost control to a national solution is to delay it, perhaps indefinitely—since federal cost control must now depend upon political agreement on a much wider variety of issues. Just as important, it sends the wrong message to an American public whose understanding of national health reform has nothing to do with federal cost constraint at all.

Nearly everything that political leaders say about national health reform is about increasing benefits—from expanded insurance coverage and more covered-service mandates to new subsidies for low- and middle-income families. Some of these proposals may be worthwhile, assuming that Congress can find some way to pay for them. But of all the things that a national health plan may mean to the public—more benefits, more taxes, or more federal debt—one thing it does not mean is less federal spending.

The Fundamental Fiscal Reality

Throughout their writings, the new school struggles to redefine the explosive projected growth of Medicare and Medicaid as something other than a fiscal issue. They see this growth as evidence of a serious *national* health-care problem—as opposed to just a *federal* health-care problem. In doing so, they want to erase the dividing line between private and public patients. No matter who goes into the doctor's office, they say, we're all in this together.

Yet there is one critical dividing line between private and public patients that cannot be ignored. Private care is paid for today by private payers, typically the patients themselves or their employers, while a substantial share of public care will be paid for tomorrow by younger and future generations—either through Treasury debt that they will someday have to repay or through unfunded liabilities that must be subtracted from their future living standards. In this sense, Medicare spending has more in common with Social Security spending—a kinship the new school denies—than with Blue Cross and Blue Shield.

The truth is that our entire system of federal benefits is tilted toward the old. Per capita, federal benefits to the elderly tower ten-to-one over benefits to the nonelderly. Once one understands this generational tilt between younger payers and older receivers, between the future and the past, one must acknowledge that we do indeed face an entitlements challenge, just as we face a demographic challenge.

From this vantage point, the entire logic of the new school points in the wrong direction. To the extent that federal health benefit programs are likely to grow faster than previously expected, it becomes *more*, not less important, to restrain cash benefit programs, such as Social Security, in order to help correct the fiscal and generational imbalance. The new school, by focusing attention on our entire national health system, diverts attention from this basic fiscal reality and all of its economic, social, and ethical implications.

Getting Our Priorities Straight

Stretched end-to-end, the new school's chain of fiscal reasoning goes something like this. Federal health benefit spending projections are on a super-scary growth path. By comparison, the growth of every other type of federal spending is trivial and of no real concern. The federal health benefit problem, however, can only be solved if we address it as part of a plan that also addresses our overall national health-care problem. This in turn is very complex and may require a great deal of time—and ultimately a great deal of additional federal spending—to solve.

We start with alarm over fiscal excess, and we end with a strategy that seems destined for fiscal excess. We start with runaway Medicare and Medicaid projections. And we end with the suggestion to put all efforts to control long-term federal spending on hold until we agree to pay for a national master plan that (presumably) does everything from restructure state risk pools and bail out the legacy costs of the auto industry to expand SCHIP, help the low-income uninsured, and fill in the Medicare Part D doughnut hole.

The pundits and experts who go along with this reasoning fall into two groups. There are those who (for whatever reason) don't believe that rapidly rising federal spending is a legitimate concern and see the argument as a clever way to get the new benefit expansions they want. And there are those who honestly believe that a national plan designed by the experts, after being hammered out by Congress in the presence of a public to whom the need for sacrifice has never been explained, will still include the sort of serious long-term cost controls that they believe are necessary.

Of these two groups, the former has a better understanding of political reality. Rewind back to 1993, when President Clinton arrived in the White House with health-care reform high on the executive agenda. For more than a year, countless experts testified that federal health benefit outlays were out of control, and that the only way to restrain them was to enact a comprehensive national reform plan. President Clinton's National Health Security Plan, which appeared the next year, was supposed to provide this restraint. But by the time it was presented to Congress, after being reshuffled in response to all the lobbyists and polls and focus groups, it became all about benefit expansion.

The new President who arrives in the White House in 2009, whether Democrat or Republican, is likely once again to take up the national health-care reform agenda. We see the same argument being made that national reform is needed to control runaway federal costs. The question is: Will history repeat itself? Are political leaders and the public any better informed today about the painful steps needed to meet the long-term fiscal challenge than they were fifteen years ago?

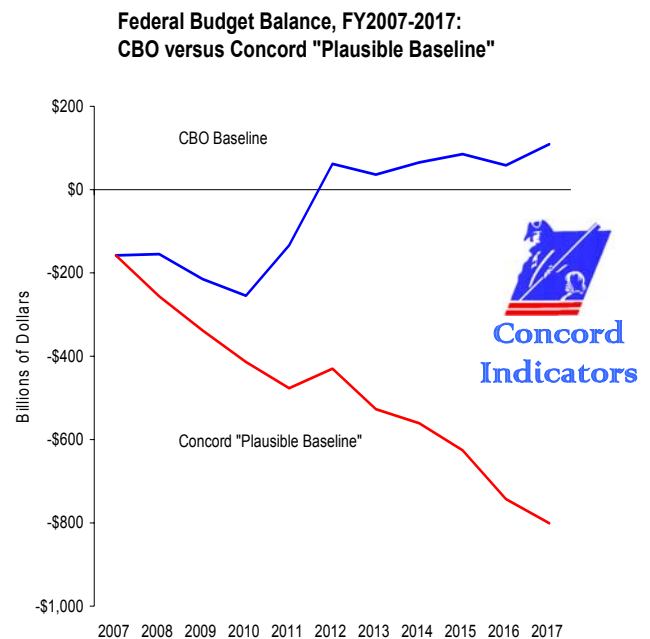
The stakes are large. By 2009, the oldest Boomers will be only two years away from Medicare eligibility. We cannot once again allow entitlement reform to be hijacked by national health reform. The problem is not just the demise of entitlement reform. The problem is that without entitlement reform we will never find the fiscal resources to pursue other worthwhile public objectives, including national health reform. Time is running out. We had better get our priorities straight before it's too late. ■

Federal Budget: Debt & Deficits			Fed Outlays: FY 2007 [‡]		
	Bil \$	% GDP		Bil \$	% Budg
Gross Federal Debt: End of November 2007	\$9,149	66.7%	Social Security	\$581	21.2%
Statutory Debt Limit	\$9,815	NA	Medicare	\$436	15.9%
Publicly Held Debt: End of November 2007	\$5,147	37.5%	Medicaid	\$192	7.0%
Debt Held by Foreigners: End September 2007	\$2,247	44.5%*	Other Entitlements	\$445	16.3%
Budget Balance in FY 2007	-\$158	-1.2%	Domestic Discretionary	\$495	18.1%
Budget Balance in FY 2008: CBO Estimate	-\$155	-1.1%	Defense	\$547	20.0%
Budget Balance in FY 2008: Concord Estimate [†]	-\$256	-1.8%	Net Interest	\$235	8.6%
10-yr Budget Balance: CBO Projection	-\$343	NA	Offsetting Receipts	-\$196	-7.2%
10-yr Budget Balance: Concord Projection [†]	-\$5,174	NA	TOTAL OUTLAYS	\$2,735	100%
Budget Balance in FY 2017: CBO Projection	\$109	0.5%	TOTAL REVENUES	\$2,577	NA
Budget Balance in FY 2017: Concord Projection [†]	-\$801	-3.7%	TOTAL DEFICIT	-\$158	NA

*Percent of publicly held debt. †Concord's "plausible baseline" assumes discretionary spending grows with GDP, operations in Iraq and Afghanistan are gradually scaled back to about one-third of today's level, and all expiring tax provisions are extended with AMT relief. ‡August 2007 CBO baseline.

GAO's Long-Term Budget Scenario* (% GDP)					
	1962	1980	2000	2020	2040
Discretionary	12.7%	10.1%	6.3%	7.6%	7.6%
Entitlements*	4.9%	9.6%	9.8%	13.7%	20.0%
Net Interest	1.2%	1.9%	2.3%	2.8%	11.6%
Revenue	17.6%	19.0%	20.9%	18.4%	18.6%
Budget Balance	-1.3%	-2.7%	2.4%	-5.7%	-20.6%
Pub Held Debt	43.7%	26.1%	35.1%	61.4%	251.1%

*GAO August 2007 update. Assumes discretionary spending grows with GDP and all expiring tax provisions are extended; entitlements are net of offsetting receipts.



Note: Concord's "plausible baseline" assumes discretionary spending grows with GDP, operations in Iraq and Afghanistan are gradually scaled back to about one-third of today's level, and all expiring tax provisions are extended with AMT relief.

National Savings (% GDP)		
	2006	3rd QTR 2007
Personal Savings Rate*	0.4%	0.6%
Net Private Savings	3.4%	3.1%
State & Local Savings	0.2%	0%
Federal Savings	-1.7%	-1.7%
Net National Savings	1.9%	1.4%
Current Account Balance	-6.0%	-5.0%
Intl Investment Position	-19.3%	NA

*Percent of disposable income.

Social Security & Medicare*	Social Security	Medicare HI	Medicare SMI	Social Security & Medicare
Payroll Cost Rate in 2007	11.2%	3.1%	2.8% [†]	17.1% [†]
Payroll Cost Rate in 2040	17.3%	7.6%	7.1% [†]	32.0% [†]
75-Year Liability (PV \$)**	\$6.8 TRILLION	\$11.9 TRILLION	\$22.3 TRILLION	\$41.0 TRILLION
Infinite-Horizon Liability (PV \$)**	\$15.7 TRILLION	\$29.8 TRILLION	\$44.8 TRILLION	\$90.3 TRILLION
Date of First Cash Deficit	2017	2007	NA	NA
Date of Trust-Fund Insolvency	2041	2019	NA	NA
Cash Deficit in Year of Insolvency (2007 \$)	-\$368 BILLION	-\$71 BILLION	NA	NA

*Data are from 2007 Trustees reports. **Unfunded liabilities are not offset by trust-fund assets. †Figures for Medicare SMI are net of beneficiary premiums. Although SMI is not financed with payroll taxes, net expenditures are shown here as a percent of payroll to facilitate comparison.