

# MEDICARE ENTITLEMENT AGE



OFFICE OF INSPECTOR GENERAL  
AUGUST 1993 OEI-07-91-01600

# EXECUTIVE SUMMARY

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## PURPOSE

To assess the results of gradually raising the entitlement age for Medicare to 67 to make it consistent with the increased Social Security retirement age in the 21st Century.

## BACKGROUND

The Medicare program pays for medical expenses of persons age 65 or older and for the disabled. In 1992, the Hospital Insurance portion of Medicare covered 31 million aged and 4 million disabled individuals and made payments of \$85.0 billion. The Supplemental Medical Insurance portion covered 33.8 million individuals, with program expenditures of \$50.8 billion.

Historically, Social Security and Medicare have been closely linked. One example of this is that both Social Security and Medicare established 65 as their entitlement age.

The Social Security Amendments of 1983 increased the age of entitlement for Social Security unreduced benefits from 65 to 67 over the period 2003 through 2027, as one of several methods to strengthen the solvency of the Social Security Trust Fund. However, the age of entitlement for Medicare remained unchanged.

Recent concerns about the solvency of the Medicare Trust Funds, large deficits in the Federal budget, a growing interest in reforming the nation's health care financing systems, and general awareness of longer life expectancies make it important to reexamine the effects of coordinating Social Security and Medicare entitlement ages.

## METHODOLOGY

We conducted literature reviews to examine the relationships of government retirement and health insurance systems, life expectancies, economic trends, and factors which could affect the availability and utilization of health insurance.

The Health Care Financing Administration (HCFA) Office of the Actuary provided us with projected Medicare Hospital Insurance Trust Fund savings which would result if the Medicare entitlement age were gradually raised to 67 following the same schedule as the Social Security program. We performed several analyses of the projected savings in order to explain the significance of these estimates in today's dollars.

We examined various factors contributing to the uncertainty of the projected savings and analyzed the impact of a higher entitlement age on Medicare beneficiaries.

## FINDINGS

***Gradually changing the Medicare entitlement age to 67 would save the Hospital Insurance Trust Fund more than three quarters of a trillion dollars over a 30 year period beginning in the year 2003.***

The projected savings are \$446 billion for the 25 year transition period, years 2003 through 2027. During the five years immediately after full implementation of the policy, years 2028 through 2032, the savings would be \$324 billion. The savings for the 30 year period, years 2003 through 2032, would be \$770 billion.

The annual savings would be approximately \$65 billion per year in the years immediately after the entitlement age reached 67. In today's terms, this amounts to between \$4.7 and \$15.7 billion per year, depending on the measure used.

Medicare Hospital Insurance expenditures would be reduced by 3.4 percent and the trust fund deficit by 5.0 percent for the year 2028.

***The Medicare Supplementary Medical Insurance program would also save significant amounts.***

If the entitlement age had been changed to age 67 in 1991, Supplemental Medical Insurance savings would have been \$2.4 billion that year.

***Estimates of future savings are imprecise due to a number of uncertainties about which we can make only rough assumptions.***

Actual savings will depend on future prices, utilization patterns, work patterns, availability of employer provided insurance, and advances in health care technologies.

***The impact of raising the entitlement age on future Medicare beneficiaries is not known. However, providing substantial advance notice of the change, as has been done by Social Security, can reduce potential negative consequences.***

From our discussion of savings, it is obvious that increasing Medicare's entitlement age would contribute to a healthier Trust Fund. This is not an insignificant consideration, in light of estimates that the Medicare Trust Fund will become insolvent in 1999.

However, other effects that raising the entitlement age would have on future beneficiaries, such as changes in their access to needed medical services, are difficult to predict. The impact would depend on whether they work longer,

have access to other insurance, or delay health care until they are entitled to Medicare.

If enacted, this change would have to take into account alternative sources of financing that would be available to those who would be denied Medicare coverage. Furthermore, a phased-in transition which parallels Social Security's is essential if such a change is adopted. This would ensure that those affected would have appropriate advance warning of the change in time for them to make alternative health insurance arrangements.

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# INTRODUCTION

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## PURPOSE

To assess the results of gradually raising the entitlement age for Medicare to 67 to make it consistent with the increased Social Security retirement age in the 21st Century.

## BACKGROUND

The Social Security Act, [Public Law (P.L.) 74-271], and related laws established a number of Federal programs, including Social Security Retirement Insurance benefits and the Medicare program.

The Retirement Insurance benefits program (Social Security) insures and provides monthly benefits (unreduced if taken at age 65) to individuals and their dependents when the individual retires or reduces their income to levels that permit these payments. The benefits are funded through the tax contributions paid by employers, employees, and self-employed individuals.

The Medicare program is a health insurance program that provides payments for medical expenses incurred by Social Security retirees ages 65 or older, some disabled beneficiaries, and for some other individuals with chronic life-threatening illnesses.

The Medicare program is administered by the Health Care Financing Administration (HCFA). Medicare payments are funded through taxes paid by employers, employees, and self-employed individuals, with some funding from general revenues. Additional funding is obtained through monthly medical insurance premiums paid by Medicare beneficiaries who elect this coverage.

The Medicare program has two parts. Hospital Insurance, or Part A, and Supplementary Medical Insurance, or Part B.

The Hospital Insurance program pays for inpatient hospital services, inpatient care provided in skilled nursing facilities, home health care, and hospice care. Program Trustees reported that in Calendar Year 1992, approximately 31 million aged and 4 million disabled individuals were covered. In 1992, total income was \$93.8 billion while expenditures were approximately \$85.0 billion.

The Supplementary Medical Insurance program pays for physicians' services, outpatient hospital services, durable medical equipment, laboratory services, and other medical services and supplies. Program Trustees reported that in 1992, approximately 33.8 million individuals were covered. Income in 1992 was \$57.2 billion (or \$57.3 billion rounding individual income amounts). General revenues

provided \$41.4 billion or 72.3 percent of this income. Premiums paid by enrollees provided another \$14.1 billion or approximately 24.6 percent of the income for 1992 and the remaining \$1.8 billion or 3.1 percent was from accumulated interest and other income. Expenditures for 1992 were approximately \$50.8 billion.

### *Establishing 65 as the Entitlement Age:*

#### *For Social Security*

Otto von Bismarck of Germany is generally recognized as establishing the first compulsory old-age insurance program. That program established 70 as the retirement age. This was later reduced to age 65 in 1916. Britain followed suit in 1925 by establishing 65 as its program retirement age. A 1935 survey of State old-age insurance laws showed that 29 out of 42 States (69 percent) selected 65 as the eligibility age for their pensions. The Social Security Act, enacted in 1935, established 65 as the normal retirement age. In addition, The Railroad Retirement Act (P.L. 73-485) enacted in 1934 and subsequent legislation, used 65 as the retirement age.

Our research shows that the original selection of 65 for the Social Security retirement age was somewhat arbitrary. In the 1930's, the planners of Social Security considered the retirement age of 65 to represent a good compromise between the higher costs associated with paying benefits at age 60, and the limited eligibility for these benefits which would occur, due to shorter life spans, if age 70 was selected.

#### *For Medicare*

In the 1930's the President's advisors considered establishing a Federal health insurance program as part of the Social Security legislation. However, due to significant Congressional opposition to this proposal, health insurance coverage was not included in the Social Security legislation.

In the next three decades, Congress considered various legislative proposals for some form of Federal health insurance coverage. Health insurance bills were submitted in the 1960's to cover medical expenses for elderly individuals.

- In 1961, the Forand bill was introduced in Congress. This bill proposed Federal health insurance of hospital and nursing home expenses incurred by old-age beneficiaries.
- In 1963, the King-Anderson bill was introduced in Congress. This bill sought to provide hospital and related services to aged beneficiaries covered under the Social Security system. The Congressional hearings on this legislation established that 65 should be the age of entitlement for these benefits. No ages above 65 were discussed. Entitlement ages below 65 were discounted because a lower age would include too many individuals who were still working.

- In 1965, Congress enacted Health Insurance for the Aged legislation [Medicare (P.L. 89-97)]. Our review of Congressional committee reports shows that entitlement ages other than 65 were not seriously considered. The hearings included discussions that workers generally retire at age 65 and are then in need of the basic protection that would be provided in the proposed Medicare legislation.

***Legislation Increasing the Social Security Retirement Age***

In the early 1980's the Social Security Trust Fund was rapidly depleting its resources to pay benefits. The President established the National Commission on Social Security Reform. This bi-partisan Commission issued a report in January 1983 to the White House and to Congress. The report recommended the gradual increase in the Social Security retirement age. Factors cited by Commission members include:

- older workers will be in greater demand in future years;
- the ratio of younger workers to retirees will decline after the turn of the century, causing significant increases in taxes. An increased age (for Social Security entitlement) would reduce this burden; and
- future beneficiaries can adjust to an increased age (for Social Security entitlement) if they are given sufficient notice.

In 1983, Congress enacted the Social Security Amendments of 1983 (P.L. 98-21), which instituted a number of measures to strengthen the solvency of the Social Security Trust Fund. One of these measures was to increase the retirement age over the period 2003 through 2027 for unreduced monthly benefits (Table 1).

Table 1

SCHEDULE FOR INCREASING SOCIAL SECURITY RETIREMENT AGE		
Date of Birth	Full Retirement Age	Effective Dates
01/02/38 - 01/01/39	65 yrs and 2 months	03/02/03 - 03/01/04
01/02/39 - 01/01/40	65 yrs and 4 months	05/02/04 - 05/01/05
01/02/40 - 01/01/41	65 yrs and 6 months	07/02/05 - 07/01/06
01/02/41 - 01/01/42	65 yrs and 8 months	09/02/06 - 09/01/07
01/02/42 - 01/01/43	65 yrs and 10 months	11/02/07 - 11/01/08
01/02/43 - 01/01/55	66 yrs	01/02/09 - 01/01/21
01/02/55 - 01/01/56	66 yrs and 2 months	03/02/21 - 03/01/22
01/02/56 - 01/01/57	66 yrs and 4 months	05/02/22 - 05/01/23



<b>SCHEDULE FOR INCREASING SOCIAL SECURITY RETIREMENT AGE</b>		
<b>Date of Birth</b>	<b>Full Retirement Age</b>	<b>Effective Dates</b>
01/02/57 - 01/01/58	66 yrs and 6 months	07/02/23 - 07/01/24
01/02/58 - 01/01/59	66 yrs and 8 months	09/02/24 - 09/01/25
01/02/59 - 01/01/60	66 yrs and 10 months	11/02/25 - 11/01/26
01/02/60 and later	67 yrs	01/02/27 and later

This change was made in recognition of two primary factors:

- people are living longer (Appendix A, Chart 1), and
- increasing the retirement age would provide for the financial integrity of the program.

During consideration of this legislation, the Senate proposed an amendment that would have shifted the age of eligibility for Medicare in tandem with the increased Social Security retirement age. The Senate report stated, "The minimum age for eligibility for Medicare benefits would continue to be tied to the age at which unreduced retirement benefits are first available". This amendment was not adopted; therefore, no change was made to the eligibility age for Medicare benefits. However, this amendment proposal did affirm the belief by some members of Congress that there is a historical relationship between the eligibility age for Social Security and Medicare benefits.

## **METHODOLOGY**

### *Literature Review*

We researched the legislative history of the Social Security and Medicare entitlement ages. We also conducted literature reviews to learn about the relationships of: government retirement and health insurance systems, both foreign and domestic; life expectancies; economic trends; and factors which could affect the availability and utilization of health insurance.

### *HCFA's Actuarial Projection*

At our request, and working in consultation with our office, the HCFA Office of the Actuary provided us with projected Medicare Hospital Insurance Trust Fund savings which would result if the Medicare entitlement age was made to correspond to the age of entitlement to full Social Security benefits. This projection takes into account such factors as: reimbursements rates for aged insured beneficiaries; the size of the

population whose benefits would be delayed; health care utilization rates; increasing medical costs; and average hourly earnings increases.

The Actuary's estimate covers years 2003 through 2032. Years 2003 through 2027 are the transition years, during which the Medicare entitlement would be gradually increased if it followed the same schedule as the age of entitlement for full Social Security benefits. At the beginning of year 2027, the entitlement age would reach age 67; no further increases would occur after that date. The years 2028 through 2032 make up the five year period immediately following this transition period.

Appendix B, Charts 2 and 3 provide a comparison between expenditures reduced by the projected savings and expenditures under current law, and a summary of Hospital Insurance Trust Fund savings for the 30 year period. Appendix C, Charts 8 and 9 reflect Trust Fund expenditures and income, and compare the Trust Fund deficit under the current law and the age 67 proposal for the years 2028 through 2032.

### *Portraying Savings in Today's Terms*

Because the gradual change in the retirement age and the associated actuarial estimates span a period of 30 years which ends 39 years from now, and because the savings are large, it is difficult to grasp the significance of the amounts calculated. We therefore performed several analyses to describe the results in today's terms and to gain additional perspective regarding the consequences of the change in entitlement age. The results are expressed as a range of estimates, reflecting the following concepts and methods.

*Constant Dollars* -- First, we noted that the Actuary's projections were based on current dollars. We converted the annual savings to constant dollars using the Consumer Price Index. The rate averaged 3.92 percent. The results are found in Appendix B, Chart 4.

*Today's Prices* -- Second, we know that medical costs generally outstrip the Consumer Price Index. For this reason, the Actuary's projections used the Prospective Payment System market basket rate and health industry wage increases to approximate health care inflation. The total average annual price increase included in the Actuary's estimates is 5.09 percent. We therefore used this rate to calculate the value of the Actuary's projected savings at today's prices. The result is found in Appendix B, Chart 5.

*Present Value* -- Third, we recognize that the time value of money may be affected by factors other than general inflation or specific price increases. For example, economists advocate considering the so called "present value" of future cash streams by taking into account the interest that could be earned by investment. The general practice is to reduce future dollar amounts to a present value which if invested today would grow to that future amount. A private business can perform this calculation by using an interest rate at which

it can invest its money today. Economists generally agree that a similar adjustment should be made in analyzing government savings and expenditures, but there is no consensus on the rate that should be used. We decided to use the rate of interest projected to be earned by the Medicare Trust Funds. This rate averaged 6.32 percent. The result is found in Appendix B, Chart 6.

*Current Policy* -- Fourth, to gain additional perspective regarding the savings in today's terms, we prepared our own analysis of the number of Medicare beneficiaries aged 65 and 66 and calculated the Medicare Hospital Insurance payments made on their behalf in 1991. Our data was taken from the HCFA 1991 Common Working File, one percent sample (1992 data was not available).

Our calculations show how much money would have been saved by the Medicare Hospital Insurance program if the Medicare entitlement age was raised to age 67 in 1991. We recognize that this method does not take into account the increase in the number of Medicare beneficiaries in future years, which would increase the estimated savings. Our estimate is intended purely as a very rough approximation of the financial impact of the entitlement age change in terms that can be appreciated now.

*Savings as a Percentage of Expenditures* -- We obtained from the HCFA Actuary their estimates of total Medicare Hospital Insurance expenditures under current law during the 30 year projection period based on the same factors which they used in calculating savings. This allows us to express the savings as a percent of expenditures, another way to gain perspective in coming to grips with large dollar amounts in the distant future (Appendix B, Chart 7).

We performed a similar analysis of 1991 expenditures for Medicare beneficiaries aged 65 and 66. While we noted above that our method understates total dollar savings because it fails to take into account the increase in the beneficiary population, it seems to overstate the percentage of savings for the same reason--it does not take into account the increased use of Medicare reimbursed health services by beneficiaries over the age of 67 in the distant future. Still, it gives us another view concerning the significance of changing the entitlement age.

These analyses provide a range of four estimates of the annual savings resulting from raising the Medicare entitlement age to 67, and two estimates of the Medicare Hospital Insurance Trust Fund savings as a percentage of expenditures.

### ***Supplemental Medical Insurance Trust Fund***

The HCFA Actuary did not make long range projections for the Supplemental Medical Insurance Trust Fund. We therefore made our own estimate of savings for this program using the technique described above for the Hospital Insurance program. That is, we calculated the amount of Medicare Supplemental Medical Insurance

payments made to beneficiaries aged 65 and 66 during 1991 (1992 data was not available). This was based on the one percent sample of the Common Working File.

### *Uncertainty Analysis*

In addition to putting future cash flows in today's perspective, using a range of estimates serves another purpose as well. Projections made far into the future are extremely uncertain. Presenting the results as a range rather than a single amount reminds the reader of the inherent uncertainty of such projections. In the Findings section of this report, we also describe a number of factors which cannot be accurately predicted but which can greatly affect the savings achieved by increasing the entitlement age.

### *Impact Analysis*

Changing the Medicare entitlement age would have significant impact on Medicare financing. It could also affect the health care practices and finances of Medicare beneficiaries. Based on our ongoing research and studies of Medicare and health financing policies, we identified some of these impacts. They are briefly discussed in the Findings section of the report.

We did not address the potential impact that a change in the Medicare entitlement age could have on other programs such as Supplemental Security Income and Medicaid. However, there could be an impact on these programs if individuals of limited financial means find themselves in need of health care coverage and assistance income during those months before they become entitled to Medicare.

Our review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

## FINDINGS

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**Gradually changing the Medicare entitlement age to 67 would save the Hospital Insurance Trust Fund more than three quarters of a trillion dollars over a 30 year period beginning in the year 2003.**

According to the actuarial projection, gradually changing the Medicare entitlement age to 67, following the same schedule mandated under current law for the age of entitlement to full Social Security benefits, would reduce Medicare expenditures for the Hospital Insurance program by \$446 billion during the 25 year transition period, years 2003 through 2027. During the five years immediately after full implementation of the policy, years 2028 through 2032, the savings would be \$324 billion. The savings for the 30 year period, years 2003 through 2032, would be \$770 billion.

While there are other options available for a transition period, such as a shorter period than 25 years, for reasons discussed in the background, we have tied our projections to the Social Security age and transition period.

**The annual savings would be approximately \$65 billion per year in the years immediately after the entitlement age reached 67. In today's terms, this amounts to between \$4.7 and \$15.7 billion per year, depending on the measure used.**

In the year 2028, the first year after the entitlement age reached 67, Medicare Hospital Insurance expenditures would be reduced by \$60.3 billion. Five years later, in the year 2032, this would rise to \$67.4 billion. To better understand the significance of these amounts, the following statements express, in varying ways, the annual savings in today's terms.

**Constant Dollars.** Eliminating the effects of general inflation, the annual savings would be \$15.7 billion.

**Today's Prices.** Eliminating the effects of medical inflation, the annual savings would be \$10.6 billion.

**Present Value.** The present value of annual savings, based on the average rate of interest for the Hospital Insurance Trust Fund would be \$7.1 billion.

**Current Policy.** If the age of entitlement had been changed to 67 in 1991, the Hospital Insurance Trust Fund would have saved \$4.7 billion that year.

**Medicare Hospital Insurance expenditures would be reduced by 3.4 percent.**

The \$60.3 billion saved in the year 2028 is 3.4 percent of the estimated \$1.8 trillion which would be expended by the Medicare Hospital program if the entitlement age remains at 65.

**The Medicare Hospital Insurance deficit would be reduced by 5.0 percent.**

We have calculated the projected deficit in the five years after the transition period before and after applying the projected benefit savings (Appendix C, Chart 9). The percentage of savings decreases from 5.0 percent in 2028 to 4.3 percent in 2032, due primarily to the rapid growth in the deficit from \$1.19 trillion in 2028 to \$1.64 trillion in 2032.

**The Medicare Supplementary Medical Insurance program would also save significant amounts.**

As noted in the Methodology section, the HCFA Actuary did not make projections of the Medicare Supplementary Medical Insurance Trust Fund expenditures that would result from a change in entitlement age. However, we calculated that if the entitlement age had been changed to age 67 in 1991, Supplemental Medical Insurance savings, including a small number of disabled beneficiaries, would have been \$2.4 billion or 6.3 percent.

**Estimates of future savings are imprecise due to a number of uncertainties about which we can make only rough assumptions.**

Estimating the financial effects of today's decision on program costs 34 years hence requires that we make a number of assumptions about future beneficiaries' use of medical services, their future access to private insurance, and the future costs of medical care. For example, the model prepared by HCFA's Office of the Actuary, discussed above, assumes that beneficiaries will use services in patterns similar to today's; that most beneficiaries will continue working and purchase employer group health insurance until they become eligible for Medicare, but some will become uninsured; and that costs of medical care will rise at moderate rates throughout the period. While we believe these to be reasonable assumptions, different conclusions would lead to different estimates. For example:

- If older Americans lose access to affordable, employer-provided health insurance as a result of early retirement, they might forgo preventive care and delay needed services until they became Medicare entitled. Costs to the program would increase as beneficiaries entered the program in poorer health and in need of services which had been delayed.

- If health care costs rise at rates far above the Consumer Price Index or Prospective Payment System market basket rate, the program would save more than we've calculated by not covering those aged 65 and 66.
- Advances in medical technology might have an effect on our estimates as well. For example, new technologies to detect and successfully treat diseases might create healthier 65 and 66 year olds who use fewer services than their counterparts today. In this case, the program would save less than we've estimated by not covering this group. On the other hand, demand might increase for new high technology services by 65 and 66 year olds, and Medicare would save more than we've estimated by not covering this group.
- Coverage policies will also have an effect on our estimate. If Medicare coverage policies are more generous than private insurance policies, beneficiaries might delay some care until they become Medicare eligible and the services are covered. Our projections would then be overestimated, since the elderly would simply defer their health care consumption until older.

**The impact of raising the entitlement age on future Medicare beneficiaries is not known. However, providing substantial advance notice of the change, as has been done by Social Security, can reduce potential negative consequences.**

Increasing Medicare's entitlement age would contribute to a healthier Trust Fund, even though the effect on the projected deficit is modest. Clearly this change would not, in and of itself, solve the fiscal crisis facing the program. Any steps that can be taken now, however, to begin to address the projected financial shortfalls in the program would help beneficiaries by ensuring the solvency of the program and potentially reduce the need to call for increased contributions from beneficiaries or taxpayers to keep the program fiscally sound. On the other hand, other considerations might argue against making such a change. A healthier Trust Fund, while not an insignificant benefit, might be outweighed by potential negative effects on beneficiaries. For example, would beneficiaries have access to other, comparable health insurance at ages 65 and 66, prior to entering the program? If not, would they delay seeking and receiving needed health care during this time? Would the States then face additional costs of caring for or insuring these older Americans? Would hospitals face larger uncompensated care burdens?

The responses to these questions can only be speculative. This is particularly true, since both the phased in Social Security entitlement age change and health care reform efforts will almost certainly affect employment patterns and older Americans' access to private health insurance at affordable prices. For example:

- Older Americans might choose to delay retirement to an older age in the future, in light of the change in Social Security entitlement age and the fact that Americans are living longer (Appendix A, Chart 1). Consequently, they may continue to be covered under their employer's health plan until they become

eligible for Medicare. Older Americans might also feel forced to continue working in order to remain eligible for their employers' group health plan.

- Older Americans may continue to retire prior to becoming eligible for Social Security, as they have in the past. Upon retirement, they might continue the employer's group health plan, forego private insurance, or choose a modest insurance package.
- People may delay seeking needed care. This could result in increased costs once medical attention is sought, as well as personal suffering by the beneficiary. Older Americans might also seek and receive needed care, but be unable to pay for it, thus creating financial pressures on States through the Medicaid program or other State program for the uninsured, and providers.

If enacted, this change would have to take into account alternative sources of financing that would be available to those who would be denied Medicare coverage.

The amount of advance notice provided of the change would also affect whether negative consequences to older Americans would arise. Without advance notice, older Americans would be unable to plan for their health care needs and costs during the years that would no longer be covered by Medicare. A phased in transition, paralleling the transition to an older entitlement age for Social Security, would allow older Americans time to plan for their health care needs and expenses and help avoid undesirable consequences.

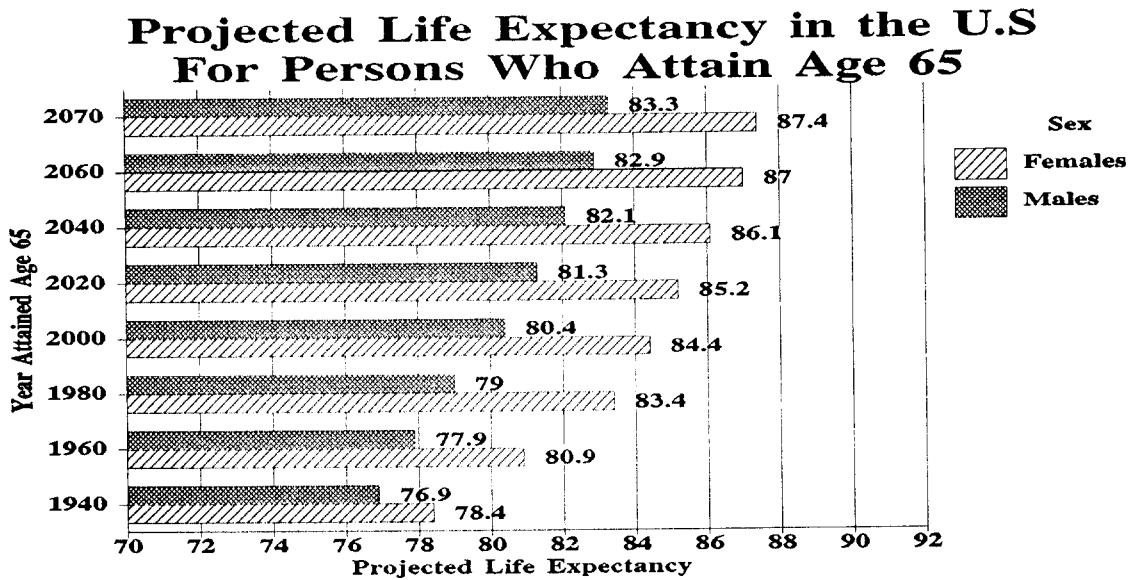


# APPENDIX A

## LONGEVITY INCREASES

In 1980, the average life expectancy for persons who had attained age 65 was 79 years for males and 83.4 years for females. By the year 2000, this is expected to increase to 80.4 and 84.4 years respectively. Chart 1 demonstrates the gradual increase in life expectancy for males and females that attain age 65 through the year 2070.

Chart 1

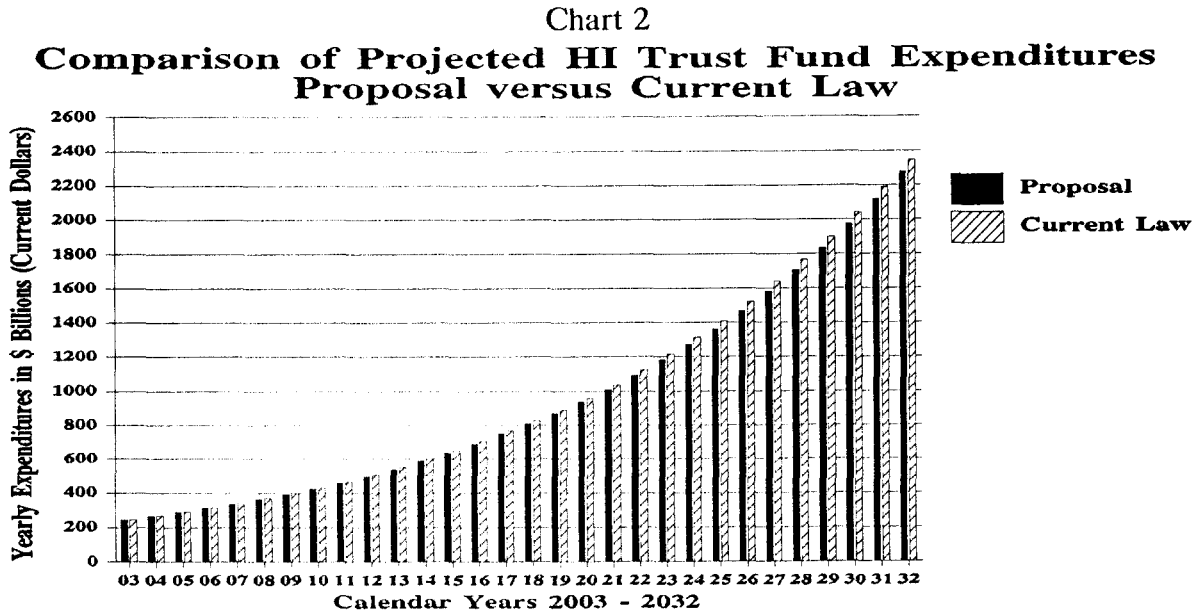


Source: The 1993 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Fund and the Federal Disability Insurance Trust Fund

# APPENDIX B

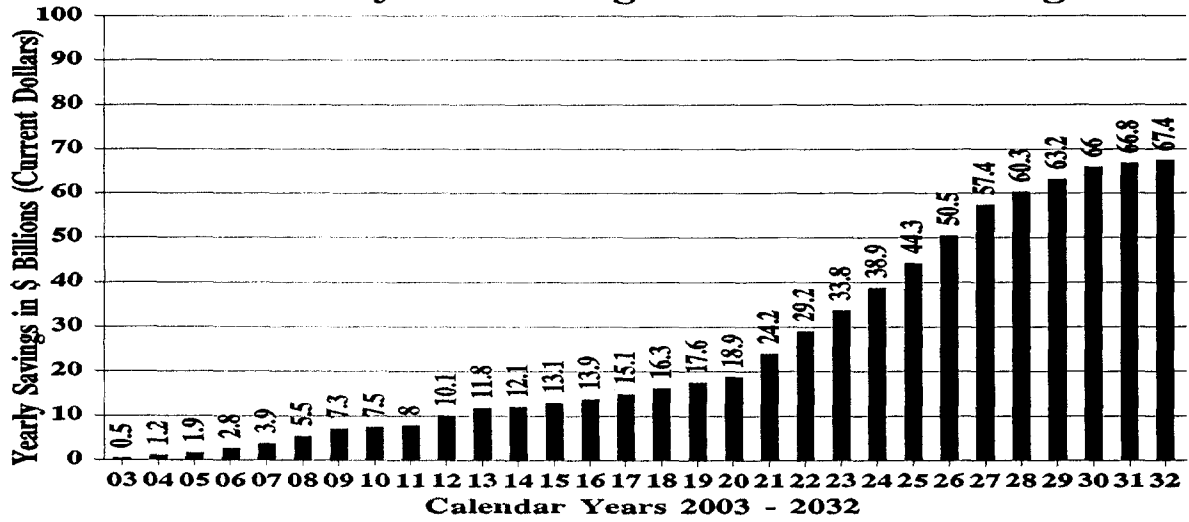
## SAVINGS PROJECTIONS

In conjunction with our office, the HCFA Office of the Actuary projected the Hospital Insurance Trust Fund expenditures and savings resulting from gradually increasing the Medicare entitlement age to 67 on the same schedule as the age of entitlement for unreduced Social Security benefits. The base year used in calculating the savings was 1990, the most current data available. The results are shown in Charts 2 and 3. Chart 2 compares the projected expenditures under current law and the proposed age 67 entitlement provisions. Correspondingly, Chart 3 projects the Hospital Insurance Trust Fund savings through 2028, and for the subsequent 5 years.



Source: Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary

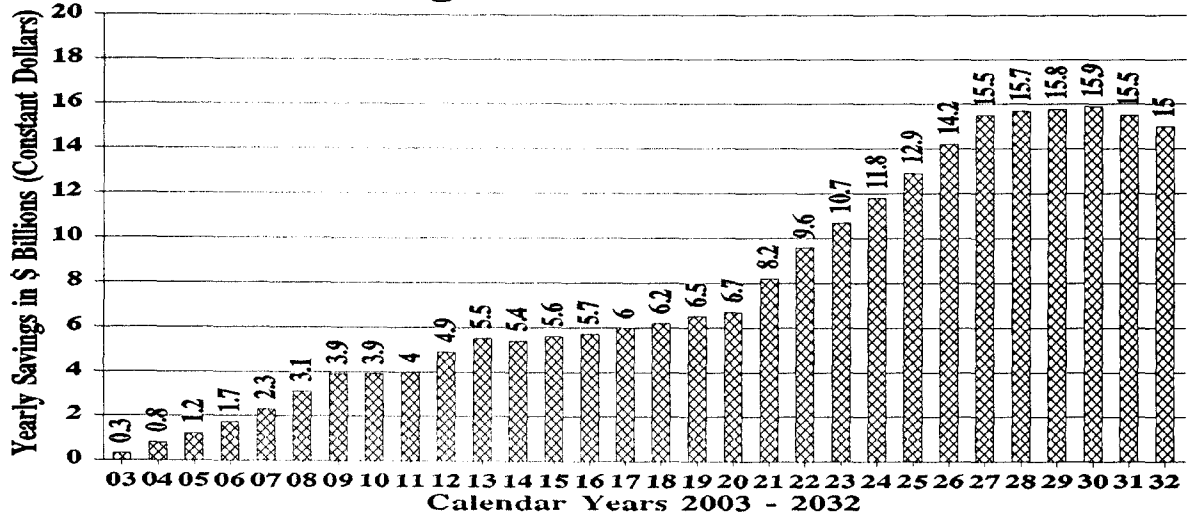
**Chart 3**  
**Projected HI Trust Fund Savings**  
**Achieved By Increasing the Entitlement Age**



Source: The Department of Health and Human Services, Office of Inspector General

Based upon the HCFA Actuary's estimates, we converted the projected savings estimates from current dollars to constant dollars by backing out general inflation as measured by the Consumer Price Index. This rate averaged 3.92 percent. The resulting constant dollar estimates are shown in Chart 4.

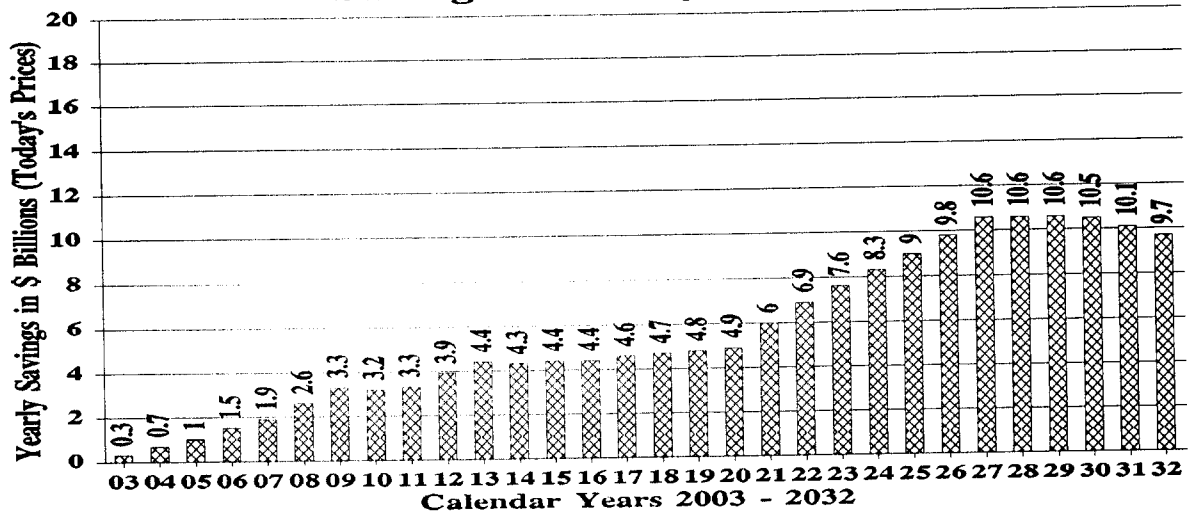
**Chart 4**  
**Savings in Constant Dollars**



Source: The Department of Health and Human Services, Office of Inspector General

We also converted the actuarial estimate to today's prices by subtracting price increases specific to the Medicare Hospital Insurance program. For the calculation, we used a rate of 5.09 percent, the average annual rate of total price increases used in the actuarial estimates. The results are shown in Chart 5.

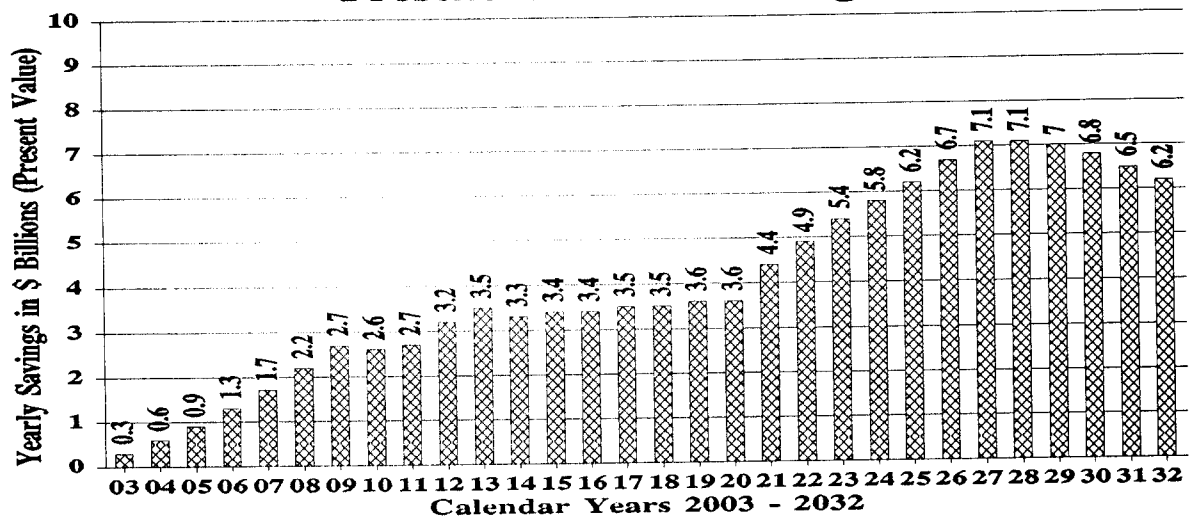
Chart 5  
Savings in Today's Prices



Source: The Department of Health and Human Services, Office of Inspector General

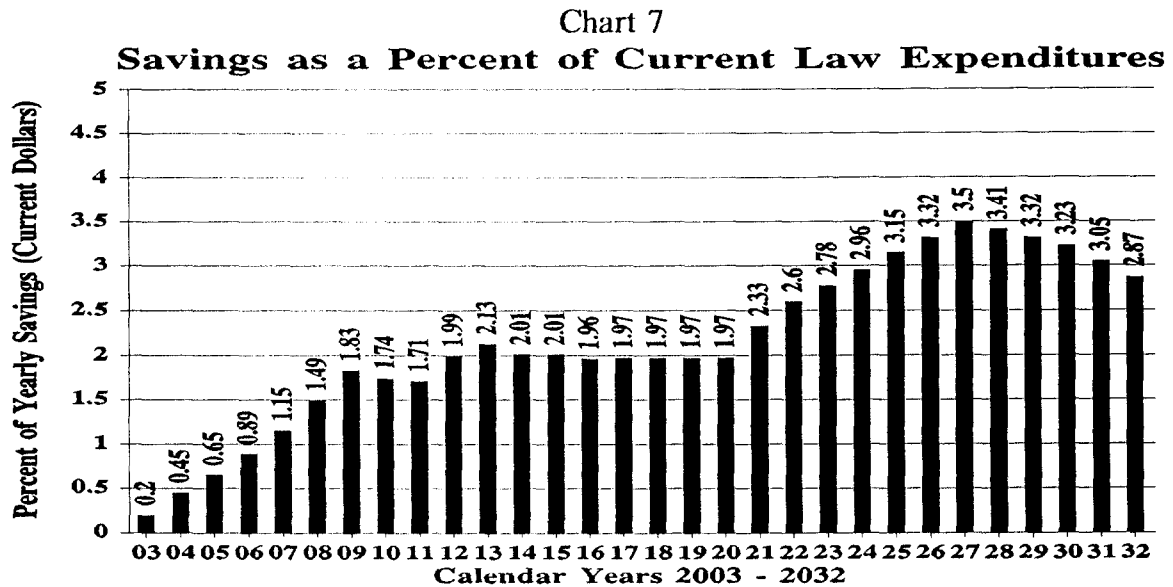
We computed the present value of the savings estimates using 6.32 percent, the average rate of interest projected to be earned by the Medicare Trust Funds. The results are shown in Chart 6.

Chart 6  
Present Value of Savings



Source: The Department of Health and Human Services, Office of Inspector General

The HCFA Actuary also provided us with projections of Medicare Hospital Insurance expenditures that would occur under current law, i.e., without raising the entitlement age. These used the same underlying assumptions as the projections of savings. Thus, we were able to compute the percentage that savings are of current law expenditures. The results are shown in Chart 7.

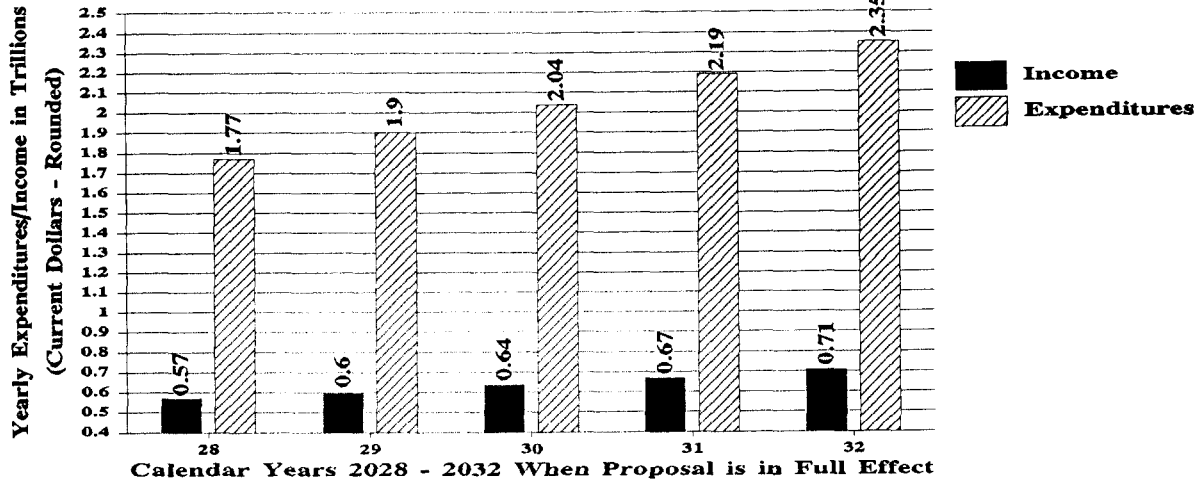


Source: The Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary

Finally, we estimated the savings that would have been achieved in both the Hospital Insurance and the Supplemental Medical Insurance programs if the Medicare entitlement age had been increased to 67 in 1991. We calculate that the Hospital Insurance program would have saved \$4.7 billion and the Supplemental Medical Insurance program \$2.4 billion in 1991 if 65 and 66 year old beneficiaries had not been covered. These savings incorporate the offset of \$0.8 billion in revenues, which is the amount of premiums that would not be collected from 65 and 66 year olds if the entitlement age is revised. We also excluded End Stage Renal disease beneficiaries from this calculation but were unable to exclude non-End Stage Renal disease disabled 65 and 66 year olds who would be eligible for benefits regardless of age.

# APPENDIX C

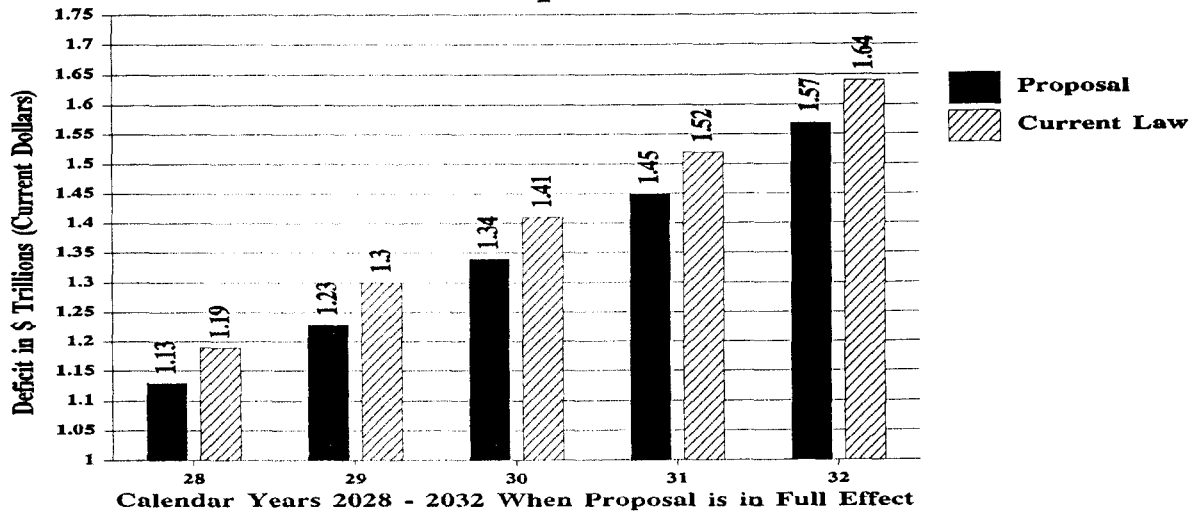
Chart 8  
**Projected HI Trust Fund Expenditures and Income Under Current Law**



Source: The Department of Health and Human Services, Office of Inspector General

The full extent of the progressive Trust Fund deficit for years 2028 - 2032 is demonstrated in Chart 8. For the sake of comparison, we also show the net deficit under the present current law and the age 67 proposals in Chart 9. Because of rounding there may be discrepancies in the current law deficit between Charts 8 and 9.

Chart 9  
**Comparison of Projected HI Trust Fund Annual Deficit - Proposal versus Current Law**



Source: The Department of Health and Human Services, Office of Inspector General

# APPENDIX D

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