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Understanding Social Insurance: Fairness, Affordability, And The 'Modernization' Of Social Security And Medicare

The economic, social, and political logic of social insurance must be the foundation of reforms, to continue these programs' success.

by Theodore R. Marmor and Jerry L. Mashaw

ABSTRACT:

Americans have been urged for several decades to view Social Security and Medicare as political relics—both unaffordable and unfair in light of contemporary demographic and fiscal circumstances and the practices of modern financial markets and modern medicine. Proposals abound for "modernizing" both systems to emphasize choice, competition, and individual ownership. This paper contends that critics of Social Security and Medicare have misanalyzed the problems of both programs and are urging misdirected reforms. The critics, we argue, are often wrong factually and sometimes confused conceptually. More fundamentally, these critiques and proposals are either ignorant of or hostile to the fundamental logic of social insurance. [*Health Affairs* 25 (2006): w114–w134 (published online 21 March 2006; 10.1377/hlthaff.25.w114)]

Social security and medicare are constant topics of political conversation. For more than two decades, conservative commentators and activists have attempted to convince the American public that these major social insurance programs are unwise, unsustainable, and ripe for major reform. At a more fundamental level, critics claim that these programs unfairly deny Americans freedom of choice and undermine personal responsibility for coping with economic risks. Defenders, by contrast, have often taken the position that our major social insurance programs in their current form are sacrosanct and that any tinkering with their structures will cause these two fundamental pillars of the U.S. social contract to crumble.[1]

Whatever the truth of either of these common rhetorical positions, the public policy results of the past several years attest, at the very least, to the durability of our major social insurance programs for the aged and disabled. Instead of trimming back Medicare, a Republican-dominated Congress recently added a wonderfully complex and expensive prescription drug benefit.[2] And despite one of the most extensive personal campaigns on a domestic issue ever launched by a U.S. president, George W. Bush has been unable to convince the American people that some portion of Social Security should be "privatized."[3]

In our view, the fate of Social Security and Medicare should be neither stasis because of political gridlock nor transformative change because of anxieties about the future. Both are crucial parts of the U.S. social contract and respond to deeply held notions of fairness and collective responsibility.[4] But they should not be immune to sensible adjustment to reflect changed circumstances. To see why, we need to understand why basic social insurance arrangements have been so remarkably durable both in the United States and elsewhere.

The short answer is, first, that the core features of social insurance arrangements are both economically sensible and socially and politically acceptable. Social insurance is part of the essential social glue that holds an individualistic polity together and that makes the economic risks of a market economy tolerable. Second, however fundamental to the U.S. social fabric,

social insurance programs have been and can be adjusted over time to meet fiscal, demographic, and technological challenges. They are not dinosaurs from another age, but evolving programs whose core principles can be expressed through a number of adaptations.

But some mutations are species-altering. In our view, much of the current enthusiasm for "modernizing" Social Security and Medicare has precisely that species-altering ambition. These reforms emphasize not protection against common economic risks in a changing world, but individualized risk bearing through increased responsibility and rewards for personal choice and increased "marketization" of social provision. We do not deny for a moment the value of personal choice, individual responsibility, and market competition. Indeed, supporting a society based on a viable vision of those values is the fundamental function of social insurance. But social insurance programs designed to maximize personal choice and promote market competition will simply not deliver adequate social insurance protections. To see why, we need to explore the basic structure of social insurance and its capacity to face contemporary challenges—that is, its capacity to modernize while continuing to play its fundamental social role.

The Durability And Desirability Of Social Insurance

Social insurance rests on the widespread acceptance of the desirability of protecting workers and their families from dramatic losses of economic status brought on by a set of common risks to labor-market participation. Across virtually all advanced industrial societies, those risks are taken to include age (both youth and old age), illness, accident, and involuntary unemployment. Indeed, a strong historical case can be made that beginning with Otto von Bismarck's social insurance initiatives in the late nineteenth century, the social provision of income protection against these risks has been a fundamental precondition for the flourishing of industrial capitalism. Looked at historically, social insurance is a deeply conservative idea, the major viable alternative to state socialism.

That social insurance programs have maintained their attractiveness as the appeal of socialism has waned is a testament to their economic sensibleness and their social respectability. And that latter feature is due in substantial part to a complex ethic of fairness that is built into social insurance arrangements and that has widespread appeal. Let us explain.

On the economic side, social insurance is a political precondition for the maintenance of market capitalism precisely because it tends to insure against risks that private insurance markets deal with poorly or not at all. Private, voluntary insurance is beset by two well-known difficulties: adverse selection (the highest-risk people tend to be the biggest demanders of insurance) and moral hazard (the tendency of the insured to incur more than their fair share of losses). When both of these problems are characteristic of an insurance market, insurance rapidly becomes unaffordable—a generally recognized description of markets that insure risks such as illness, accident, disability, or unemployment.[5] If anyone is to be insured at reasonable cost, it might be necessary to compel everyone, or nearly everyone, to be insured through a publicly mandated program.

Other risks, such as premature death or extended old age, have more modest adverse-selection and moral-hazard problems but encounter other difficulties. One is overoptimism. Another is the inherent difficulty of planning for things like retirement, given the massive uncertainty of individual life expectancies, long-run inflation rates, and the short-run performance of portfolios near or during retirement. Moreover, the simple myopia of Americans in planning for retirement has been demonstrated over multiple generations. Mandatory and near-universal programs of life and survivors' insurance and old-age insurance solve these problems and an additional one as well. Because we are unlikely to allow the aged to die in the streets, or their survivors to languish in poverty, compulsory participation in Social Security–style programs makes everyone a contributor to a common pool. This eliminates free riders and constrains demand for overly generous benefits.[6]

That programs make economic sense does not necessarily make them durable. They must also be understood as fair and socially respectable. Social insurance programs satisfy these conditions through several elements of their common design. First, the risks covered are generally not attributable to the fault of the beneficiary. Providing assistance where misfortune is not the fault of the victim taps into one basic strain of our common understanding of fair arrangements. This sense of fairness is increased by covering most people who are at risk and treating everyone equally as risk bearers. The financing of most social insurance, unlike commercial insurance premiums, does not vary with individual risk. Finally, financing (wholly or in substantial part) by contributions from covered workers makes benefits seem "deserved" or "earned" to most workers.[7] This socially respectable "fairness" pedigree is enhanced by administrative arrangements that do not question morally freighted matters such as family income and assets, household composition, or individual work effort.

Given these characteristic features of social insurance regimes, relative political stability has been their predictable fate. That they cover common risks and have broad coverage of the population means that social insurance programs engage most of the electorate. And because everyone is both a contributor and a potential beneficiary, the politics of social insurance tends to be "us-us" rather than "us-them." Each individual's sense of earned entitlement or deservingness makes it politically costly to renege on promises in social insurance programs.[8]

Clouds Over Camelot

The social, economic, and political "logic" of social insurance helps explain why these programs represent the largest category of federal nondefense spending and why they have persisted over such a long period in the United States and elsewhere. But sound general principles do not necessarily produce optimally designed programs. And as the economy and society change, arrangements that fit well in one era can become outdated. A society's underlying sense of "fairness" or "appropriateness" in guarding against risks to loss of labor-market income can change as well.

Critics of U.S. social insurance arrangements claim that this is precisely what has happened to America's largest social insurance programs, Social Security and Medicare. Demographic shifts, changes in financial markets, and hyperinflation in medical care have merged with a "promarket" ideological shift to produce severe criticisms of U.S. social insurance. At base, the claim is that Social Security and Medicare have become both unaffordable and unfair. Fairness and affordability, critics claim, would be increased by reducing collective responsibility for both income support and medical care coverage in old age. And while the techniques in the two domains are somewhat different, recent "reform" proposals for Social Security and Medicare have virtually all emphasized more individual responsibility, more consumer choice, and greater reliance on market competition.[9]

This is not the place to engage the details of the many reform proposals that have been put forward. We focus instead on the broad conceptual claims of unfairness and unaffordability. Unpacking the meaning of these terms provides an important, and often missing, perspective on what is really at stake in contemporary debates. Social insurance programs dominate our domestic fiscal policy, but most Americans have limited familiarity with both the core ideas of social insurance and their historical sources.

Social Security: Fairness, Affordability, And Modernization

The fairness debate. Fairness critiques take several forms, but two center on the levels of benefits available to workers of different incomes and on intergenerational fairness. On benefit levels, critics make two very different fairness complaints. For some, the problem is that workers who make more and put in more do not get the same "rate of return" as lower-paid workers who contribute less. Others claim that U.S. social insurance redistributes too little to the poor while

paying benefits to millionaires who don't need them.[10]

What these critics fail to understand is that social insurance successfully blends these two different visions of fairness. U.S. workers can rightly expect that the larger their Social Security contribution, the greater their retirement benefits. Larger "contributions" (the common euphemism for payroll taxes) mean that higher-wage workers receive larger pensions than lower-wage workers. But the degree of financial hierarchy in Social Security is reduced by another of its purposes: the commitment to a minimally adequate income for lower-wage workers. The ratio of benefits to former wages is higher the lower a worker's average wages. In short, the United States has constructed a worker-contributor, not a saver-investor or a donor-beneficiary, vision of fairness. The "every boat on its own bottom" ethos of the market economy is tempered by the "everybody in the same boat" ethos of social insurance. Charitable ideals of redistribution from rich to poor are mediated by a contribution-based vision of deservingness.

Fairness criticisms may also take a somewhat broader form: the claim that no one is getting a "fair return" on their Social Security contributions. This version of the fairness argument usually features a thought experiment that imagines everyone putting their Social Security contributions into the stock market. Then, looking at average returns on common stock over long periods of American history, the analyst demonstrates that the return on these investments would greatly exceed the "returns" from Social Security contributions. Social Security thus fails to give us a fair return on investment.[11]

This argument, as noted, involves some sort of category error. Social Security is a complex blend of insurance against both a premature death and an unexpectedly long life. It is not a mutual fund. Moreover, a mutual fund will protect effectively against neither. Everyone will not be average. Individual investors will not only die at different ages, they will also have widely varying returns on their portfolios. In the stock market thought experiment, individuals bear their longevity and investment risks. This is not reforming social insurance; it is abolishing it.

In fact, shifting Social Security to a mandatory savings and investment scheme actually eliminates any fairness claim for the returns voluntary investment produces in financial markets. As a matter of deservingness, the "investor" notion of fairness rewards prudence and self-denial—giving up current consumption as a hedge against an uncertain future. But compelling workers to save a fixed percentage of wages rewards neither prudence nor self-sacrifice; the saver, after all, did not choose to save. And the sacrifice involved is inversely related to affluence.

To some degree, the clash between individualistic and collective visions of fairness frames the debate about risk bearing in the right terms. And we believe that the social, political, and economic arguments that have accounted for the durability of social insurance remain persuasive. Opinion polling suggests that most Americans approve of social insurance's pragmatic blend of deservedness and equality. They have little taste for running the risks that "privatizers" of various stripes believe they should prefer in an every-family-for-itself vision of an "ownership society," mitigated only by charity-based notions of a social obligation to help the worst-off in society.[12]

The fairness of shifting yet more financial risk to average American families is even more doubtful when placed in the context of the overall U.S. retirement policy. Tax policy already offers greater subsidies to the retirement savings of higher earners than to those of lower earners. The home mortgage interest deduction and the nontaxability of individual retirement account (IRA), Keogh, 401(k), and defined-contribution plans provide much more assistance for wealth accumulation to high earners than to low earners. The current structure of Social Security pensions reduces this imbalance somewhat. A shift to private accounts would almost certainly eliminate this important equalizing feature of the overall retirement system. Since the "personal circumstances" influencing lifetime earnings include being born black or white, male or female, able-bodied or impaired, or into a rich or poor family, the unfairness of this approach seems manifest.

Privatization schemes also trade a portion of Social Security's protections—survivors' benefits—for ownership, which passes to one's heirs at death. Security for younger workers and lower-wage workers' families is again being traded for increased benefits to higher-wage workers, and particularly to the survivors of those who do not outlive the value of their individual accounts. This is not a trivial trade. Social Security survivors' benefits provide monthly income to 7.5 million Americans, roughly equivalent to a $400,000 life insurance policy for each worker.[13] In short, the personal-accounts approach increases stock market and other risks to families who are poorly positioned to bear them.

The other major fairness claim that motivates some "reformers" has to do with intergenerational fairness. These critics of Social Security make much of the supposed unfair burden that retirees will in the future place on the working young. The "poster child" for this claim is a graphic showing that in the absence of major changes in immigration or fertility, the ratio of workers to retirees will fall during the next several decades from the current 3:1 to 2:1. The image here is of an affluent older cohort enjoying a secure retirement on the backs of increasingly hard-pressed wage earners. But the real picture is quite different.

First, most Americans over age sixty-five have modest incomes, and Social Security provides a huge proportion of those incomes for all but the most affluent (Exhibit 1).[14] Second, the real question for tomorrow's workers is how many dependents they will be supporting, not how many old-age pensioners. Here the data are clear. As elderly Americans have increased in number, that has been more than offset by the decrease in the number of children Americans are raising. Exhibit 2 shows that American workers were supporting many more dependents (that is, nonworkers) in 1965 than they will be in the foreseeable future.

Exhibit 1.

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To be sure, if one looks at public expenditures, supporting oldsters is more expensive than supporting youngsters. But most supports for children go through family budgets, not through public budgets. The real question of intergenerational fairness is whether future generations are going to pay more for the support of their parents than they received from their parents for their support. The answer seems to be "no." A serious attempt to estimate these transfers during the next generation finds that, on average, parents would still transfer more to their children than children to their parents, even if all future Social Security and Medicare deficits were closed by increasing taxes on workers.[15]

Although it has become almost a cliché, this intergenerational-equity issue in retirement pensions is really mostly a distraction. The first generation of pensioners eligible for Social Security retirement benefits indeed enjoyed a windfall, but that is history. The simple economic logic of retirement finance is just this: Either generation *X* can prefund its own retirement, or it can fund the retirement of *X*– 1 and have its retirement funded by *X* + 1. Without going into pages of argument about risk-adjusted returns, possible changes in savings and growth rates, and other questions, both arcane and speculative, we are prepared simply to assert the obvious: The best guess is that the burdens on current and future generations under the two schemes will be equivalent.

In short, criticisms of Social Security because it is "unfair" seem either confused or misinformed. But what about affordability?

The question of affordability. Debates over Social Security pensions generally arise as a response to a present or anticipated fiscal crisis. To some degree, these are merely occasions for replaying in differing keys the profound opposition that social insurance has always generated among economic conservatives. The past two decades provide ample illustration of this.

In the early 1980s, when public officials announced that Social Security accounts would be "bankrupt" without adjustment, Americans accepted without commotion the changes made by the 1983 Greenspan Commission on Social Security Reform. These changes bolstered Social Security instead of revamping it; they involved a combination of modest reductions of benefits and small increases in social insurance taxes.[16]
Then, as a result of the early 1980s reforms, surpluses grew in Social Security's accounts. Oddly enough, this, too, awakened critics. Some fiscal gurus—including the *New York Times* economic columnist Peter Passell—complained then that growing surpluses constituted a crisis in "slow motion."[17] The point is straightforward: When both deficits and surpluses bring cries of alarm, the evidence points toward ideological opposition, not episodes of programmatic crisis.[18] In the mid-1990s, long-term projections revealed the possible exhaustion of these surpluses, and the rhetoric of imminent disaster reemerged. What is the fiscal truth of the matter?

There is, of course, no "fiscal truth" of the matter. The uncertainties of seventy-five-year projections are manifest. Imagine predicting the economic position of the United States in 2005 from the vantage point of 1930. Indeed, serious students of the actuarial assumptions upon which "crisis" talk is now based question whether or not, with more realistic assumptions, particularly concerning long-term economic growth rates, there is likely to be a fiscal shortfall in Social Security.[19] But it has become conventional to use the Social Security actuaries' midpoint projections as the "true" state of the future world. If we do that, is there a crisis demanding major transformation?

Clearly not. According to most informed commentators, Social Security's fiscal future can be stabilized through quite moderate program adjustments. As Robert Ball, former commissioner of Social Security in both Democratic and Republican administrations, has repeatedly argued, the system is today accruing substantial surpluses, and Social Security reserves are estimated to last until at least the year 2042.[20] Thereafter, these reserves must be retired to pay current benefits that exceed the level of current taxes. By 2070—sixty-four years from now—benefits are projected to exceed taxes by about 5.5 percent of taxable wages.[21] So unless some adjustments are made in benefit levels, taxation levels, or trust-fund earnings, Social Security's retirement program would not be able, on current forecasts, to pay all of its bills. From this perspective, critics are technically correct; the precise promises of the current system cannot be maintained on present assumptions. On the other hand, the pessimistic assertion that something very like the current system cannot be financed is nonsense.

Indeed, there are many ways to close this projected gap in future funding with modest changes in current contributions and benefit levels. A rise in the "cap" on FICA contributions, including all state and local employees in the program, accelerating the phase-in of the increase in the normal retirement age, and inflating benefits by a more accurate Consumer Price Index (CPI) are but a few of the sensible proposals that serious students of Social Security's fiscal health have proposed as a balanced means of restoring confidence that the program is on a sound financial footing. This is not the place to discuss the details of these and other proposals.[22] The point is simply to illustrate the silliness of the-sky-is-falling, we-have-to-do-something-drastic rhetoric that has surrounded the debates. And, of course, "privatizing" or "personal accounts" have nothing to do with solving any projected fiscal imbalance in Social Security's revenue and payments. These proposals make the fiscal situation much worse and require massive borrowing—along with large benefit reductions—to balance the books.

Ideology. The real issue here is not economics but political ideology. Most privatizers want to privatize because they do not trust the government, or because they believe that the American people do not trust the government, or because they think that Social Security depresses savings

rates. The lack-of-trust argument takes two forms. In one incarnation, the claim is that Americans prefer market risk to political risk and will demand that they, rather than a government agency, should have control over investment decisions. The second form of the argument is that the government cannot be trusted to invest in the private capital markets without meddling with them as well. Neither argument is persuasive.

To give the first argument its due, privatization might be regarded as an attempt—indirect, to be sure—to shore up confidence in the system. Americans who own an individual or personal security account might view their investment as more secure than a claim on Social Security. If so, this surely has more to do with the years of crisis talk to which the public has been exposed than with any reasonable judgment about the program's sustainability. The Social Security system avoids individual inflation risks, bankruptcy risks, and market risks. It has been running for more than sixty years without ever missing a payment. It continues to have the overwhelming support of the American populace, and Americans say that they are quite willing to pay some additional taxes to ensure the financial soundness of the system into the distant future. It is conceivable that Americans will come to prefer risky over nonrisky investments. We cannot fully discount the Lake Wobegon effect—overoptimism among young workers that the return on their lifetime investments will be above average. If so, Americans would be increasingly susceptible to the argument that Social Security provides an inferior "return" on their contributions.

The greater risk, however, is that partial privatization will lead to inexorable pressure for full privatization. Investment of some Social Security funds in stocks, rather than Treasury bonds, will very likely improve the investment performance of Social Security over the long run. But if this investment is made in a privatized form, it will appear that the improvement has come through privatization of accounts rather than from a simple shift in investment holdings. (This would actually be doubly misleading. Shifting the Social Security Trust Fund's investments to include some stocks is much more efficient than creating millions of private accounts.)[23] And because most workers unfortunately tend to ignore the life insurance, dependents' benefits, and inflation protection that are a part of the Social Security pension package, this argument might be persuasive to many.

Even more importantly, workers might ignore the crucial protection that social insurance provides to everyone against low average lifetime earnings, poor performance of their individual investments, and higher taxes (or intrafamily transfers) to support those who do have these experiences. Indeed, the thin understanding of the realities of social insurance has contributed to a distorted public debate on reform. The less the stake that U.S. workers think they have in the collective provision of retirement benefits through Social Security, the more likely the erosion of political support for the system. Partial privatization in this scenario would be destabilizing rather than anchoring.

There is, of course, no reason to treat this scenario as more likely than some others. Many private-account holders will have below-average returns, and the vagaries of the securities markets as a whole might spook many participants into demanding a return to the security of Social Security pensions. Both perceptions and politics are uncertain for a partially privatized system—yet another reason to avoid drastic changes in a well-functioning system.

In short, there is nothing that can responsibly be called a fiscal crisis in Social Security pensions. The existing problems are easily manageable, and the remedies are so affordable that if no one had mentioned them, they could probably have been implemented without many noticing the changes. On the other hand, crucial values of fairness are at stake in the proposals to "privatize" Social Security pensions. We simply believe that the critics are on the wrong side of that argument. Privatizing Social Security is a contradiction in terms. Markets can supply a marvelous array of investment vehicles, but they cannot supply social insurance.

Medicare: Fairness, Affordability, And Modernization

Medicare, largely ignored in the battle over health care reform in the early 1990s, returned to center stage following the Republican congressional victories of 1994. Given bipartisan calls for reductions in the nation's budget deficits and hostility among some Republicans to Medicare's social insurance roots, it was almost certain that Medicare would again generate intense and very public debate and conflict. Moreover, like Social Security pensions, long-term projections for Medicare spending prompt worries about unsustainable budget outlays.[24] The public commentary about Medicare, therefore, reveals similar claims of unaffordability, unfairness, and somewhat masked ideological objections—operating under the banner of "modernization"—to social insurance itself.[25]

The question of affordability. Fearful projections of Medicare's fiscal future reflect a problem of U.S. medicine, not a crisis caused by Medicare's structure. For most of Medicare's history, program spending grew about as rapidly as outlays in the private medical economy. Exhibit 3 shows a number of temporal shifts, which help explain particular episodes of fearfulness. From the early 1990s, per capita medical costs grew much faster than per capita gross domestic product (GDP) in both the private sector and Medicare. But from about 1993 through 1997, private health outlays grew far less rapidly than Medicare outlays. This itself prompted many cries of alarm. Since then, however, the relationship has shifted back and forth. The important reality in the period after 1997 is rapid inflation in U.S. medical care generally, not just, or even particularly, in Medicare.

Exhibit 3.

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Over the very long run—from, for example, 1970 to 2001—Medicare spending per enrollee grew less rapidly (9.6 percent per year) than spending for the privately insured (11 percent). Over the period 1990–2003, spending rose at similar rates for both Medicare and private insurance.[26] These data give one no reason to be complacent about the costs of U.S. medical care. But neither do they support any claim of a distinctive problem in Medicare's capacity to control medical inflation.

Yet whenever there is a more rapid rate of increase in Medicare spending in combination with projected deficits in the Medicare Part A Trust Fund, critics use projections of Medicare's future outlays to suggest that the program must be fundamentally reformed. Suggestions for reform are often fabulously complex, but they tend to have these common features: the explicit or implicit claims that the "common pool" or social insurance features of Medicare are the cost-control culprit and that adding choice, competition, and individual responsibility (the contemporary mantra is "consumer-driven health care") will solve the problem. There is almost no evidence for these beliefs.

The "common pool" feature of Medicare cannot plausibly be a cause for fiscal concern. In other developed countries, experience has repeatedly demonstrated the superior capacity of more-universal social insurance programs to restrain growth in overall medical spending. Any comparison of growth in health spending of the United States and social-insurance nations like Germany, the Netherlands, and France would show that U.S. spending has grown more rapidly in recent decades. And these are countries with both older populations and more widespread use of health care than is the case in the United States.[27]

One might more plausibly argue that fiscal restraint is difficult because Medicare does not cover everyone. Medicare has been given few instruments to control capital spending. But its powerful

constraints on payments to hospitals and doctors spill over onto pressures on private payers. The latter fight back by adapting some of Medicare's techniques, which then increases political pressures from providers to ease up on cost control. What the experience of the past thirty years demonstrates is that fragmented U.S. arrangements for financing medical care are comparatively weak instruments for controlling spending growth. That does not indict Medicare's social insurance character, but it does highlight a serious problem that Medicare (and the rest of the medical economy) will have to confront.

Once again, however, critics are touting individual responsibility, choice, and competition as the "solution" to both the problems of U.S. medicine generally and Medicare's fiscal problems in particular.[28] One response is a broad proposal for the health savings accounts acronymically known as HSAs. Instead of participating in group insurance at the place of employment or paying the health insurance portion of FICA taxes, Americans are urged to contribute (tax free) to HSAs to cover their medical care needs. A version of such accounts is included in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Presumably the buildup in these accounts, along with an inexpensive "high deductible" or "catastrophic" insurance policy, would provide sufficient reserves for medical care while employed and during old age.

There are major transitional problems with this scheme, but those need not distract us from the main line of argument. For the young, the healthy, and the affluent, an HSA approach is a great deal—particularly so if, as is virtually certain, these tax-free savings could be tapped for other purposes once a sufficient cushion was achieved. What happens to the rest of the population is only slightly less clear but broadly predictable. With "good risks" now not contributing to the insurance pool, bad risks must be "insured" by general taxation. In short, instead of medical care as a part of social insurance, the system would move rapidly toward segmentation: private insurance for the young, healthy, and relatively well-off; welfare medicine for everyone else. Moreover, according to estimates by the American Academy of Actuaries, the flight of the healthy to HSAs could more than double the premiums for those left in either the basic Medicare program or more-comprehensive private policies. Medicare would then appear to be hopelessly unaffordable, making it yet more politically vulnerable.[29]

An alternative "privatization" approach retains social insurance coverage for the elderly but attempts to save public funds by having private managed care plans compete for Medicare patients. This alternative poses no direct threat to social insurance. Rather, the worrisome issue is whether managed care can both save money and deliver decent medical care at the same time to the elderly, or to anyone else. These are crucial questions for the whole of U.S. medicine, not just Medicare.

Fairness. Indeed, the current controversies over Medicare's financing divert us from the more fundamental issue of whether the insurance risks of ill health should be dealt with in a universal, contributory, "social insurance" program or left to a patchwork system of private payment, private insurance, and diverse public subsidies for veterans, the aged, the poor, participants in employment-based health insurance, and so on. For although we think of Medicare as the socialization of the costs of health risks—which it is—we often forget that it is an unfinished program of social insurance. Medicare was meant to be the first step toward a much broader social insurance approach to sickness expenses. To make sense of claims that Medicare is unfair—because it spends too much on the elderly, shifts undue burdens to working-age adults, or undermines cost-conscious utilization—one needs to understand Medicare's origins, why it did not expand as its framers expected, and what that has meant for debates about its supposed failings today.

Medicare's original advocates took for granted that the rhetoric of enactment should emphasize the expansion of access, not the regulation and overhaul of American medicine. Decades of controversy about universal government health insurance had prompted reformers to concentrate on Social Security retirees as a promising step toward broader social insurance coverage of sickness expenses. The clear aim of the original Medicare bills in the early 1960s was to reduce

the risks of financial disaster from hospital expenses for the elderly and their families. And the understanding then was that Congress would demand a largely hands-off posture toward the hospitals providing the care that Medicare would finance.[30]

The reform strategy of the 1950s and early 1960s was clearly incremental, proceeding from the accurate assumption that social insurance programs enjoyed vastly greater public acceptance than did means-tested assistance programs. Leaders within the Social Security Administration made sure that Medicare fell firmly within the social insurance tradition of benefits "earned," not given as charity. The aged were targeted as the first group for coverage because they had lower earning capacity and higher medical expenses than any other age group and had already "paid" their social security dues. The original Medicare bill avoided a means test by restricting eligibility to people older than age sixty-five (and their spouses) who had contributed to Social Security during their working lives. The initial plan in fact limited benefits to sixty days of hospital care. Physician services were originally excluded in hopes of softening the medical profession's hostility to the program.[31]

The form adopted—Social Security financing for hospital care and premiums, plus general revenues for physician spending—had a political explanation, not a clearly consistent social insurance rationale. Part A of the legislation, Hospital Insurance (HI), was based on social insurance principles of funding, eligibility, and common benefits. Physician insurance (Part B), known as Supplementary Medical Insurance (SMI), was an unexpected afterthought and was financed by a combination of general revenues and individual, flat-rate premiums that were voluntary but highly subsidized. So, from the beginning, there were some grounds for confusion over Medicare's social insurance structure. However, the key assumption in 1965 was that the program would expand in coverage and adopt a more unified structure of finance. The future was to be universalistic, and benefits were to expand to protect against the major costs of illness.

As a result, the original legislation was not tightly linked to the special circumstances of the elderly. Left out were provisions that specially addressed the problems of the chronically sick elderly—those whose medical conditions would not dramatically improve and who needed to maintain independent functioning more than to triumph over discrete illness and injury. Viewed as a first step of reform, of course, the Medicare strategy made sense to its promoters. But from the perspective of 2003, with essentially no serious restructuring of its benefits, Medicare was open to the charge that it needed expansion, especially insurance protection against the costs of prescription drugs.

From the standpoint of universal protection, moreover, Medicare was and remains somewhat conceptually divided. It separates retired workers from those still on the job, thus breaching one version of social solidarity and giving rise to concerns about unfair special treatment for one segment of society. And because Medicare covers only two groups of the population, those "retired" because of age or disability, it can all too easily take on the coloration of interest-group politics. These politics are not the vitriolic struggles of us-them welfare policy. But it is quite easy to claim as "unfair" the relatively generous treatment of Medicare beneficiaries with the circumstances of ordinary American families flailing in the sea of either uncertain insurance coverage or added constraints on their choices within insurance coverage. The question is whether the rest of the population shares this vision of unfairness as opposed to wanting Medicare's security and choices in their own coverage.

Precisely this charge of perceived unfairness arose in the mid-1990s and from sources otherwise friendly to social insurance. As a matter of principle, according to Henry Aaron and Bob Reischauer in *Health Affairs* (1995), Medicare beneficiaries "should have a degree of choice among health plans similar to that enjoyed by the rest of the population."[32] The grounds for this assertion were never stated explicitly but certainly emphasized that Medicare beneficiaries had more choices than the rest of the population, who might have a choice of insurance "plan" but no coverage for "out of plan" services. Described as the "last refuge of unregulated fee-for-service care," Medicare was, in this view, unfair to those with less choice. There was and is no empirical

evidence for the implication that the non-Medicare population regarded Medicare's greater choice as "unfair." What is more, the data that do exist show that Medicare beneficiaries were more satisfied with their medical insurance coverage than other insured Americans were with theirs in the 1990s.[33]

Changes in private medical insurance have also made Medicare appear to be an outlier—a form of insurance that is now perceived by critics as too generous. When adopted, Medicare duplicated the structure of Blue Cross's regulated form of private social insurance. The addition of Part B, modeled on the federal employees plan for highly paid civil servants, was unexpected and did not strictly follow the classic form of compulsory social insurance contributory financing. But its combination of generous tax subsidies from general revenues and modest monthly premiums meant that all but a tiny minority joined the Part B common pool. So what we had at the outset was a Medicare program that looked a lot like existing community-rated Blue Cross and Blue Shield plans.

Developments during the past two decades have undermined this common experience of health insurance coverage. Traditional Blues plans have largely disappeared; where they exist, they are exceedingly expensive. In that respect, we have no argument with the claim that Medicare has become a structural outlier. So there is a parallel with Social Security and private investment developments. The diffusion of shareholding and defined-contribution forms of tax-free saving for retirement gives support to critics of Social Security that it, too, should "modernize" itself in line with these developments in private financial markets that emphasize individual risk bearing. This would have seemed ludicrous in the early years of Social Security, just as it would have seemed absurd to celebrate insurance firm competition and managed care in the context of the 1960s or to suggest that Medicare's older form and more comprehensive coverage were out of step with what was available to the rest of the population. But that argument can now be made, and it carries with it an implicit claim of unfair special treatment and wasted resources—resources that could be put into more "modern," "competitive" health insurance markets.

As we have noted, there is no evidence that any substantial number of Americans accept this "unfairness" claim or favor moves to align Medicare's coverage with what has emerged in the private market. Nor, as the discussion of affordability reveals, is there any reason to believe that competition yields cost savings that will permit a "fairer" distribution of coverage. Indeed, the only "modernization" movement that has gained traction is the complaint about Medicare's failure to respond to changes in the nature of medical care, not changes in insurance plans. There the critics had obvious grounds for their charge. In 1965, drugs used outside the hospital were a modest part of the medical budget, and, in any case, Medicare reformers assumed that there would be persistent expansions of populations and services covered. Neither development took place according to plan. As pharmaceuticals came to play a larger role in medical care and as the world of private U.S. health financing diverged from the older Blue Cross Blue Shield model, Medicare did become both an outlier in form, and, in substance, it fell short of the breadth of services covered by many private plans. Medicare beneficiaries were not getting the drug coverage that had become standard for other insured Americans.

Modernization. As of 2003, Medicare could be perceived as unfair in two ways: Medicare beneficiaries had more comprehensive coverage and choice of providers than many insured nonretired people had, and less coverage of increasingly important and expensive prescription drugs. Enter MMA of 2003, a fantastically complex piece of legislation designed to combat both "unfairnesses" by rolling them into a common call for "modernization." Medicare beneficiaries would obtain drug coverage, but in a "choice of plans" form that relies on private insurance provision, competition, and consumer choice. Moreover, the statute goes beyond drug coverage to pursue the "modernization" of other health care coverage areas through a complex set of incentives and financing arrangements that are intended to promote movement out of traditional Medicare into private plans that look like those available to most other insured Americans. "Modernization" in this guise also implicitly promises cost containment through competition. Indeed, the statute goes so far as to prohibit the one proven cost-constraint mechanism in

Medicare's arsenal: use of its market power to bargain down prices, a technique that apparently has too close an ideological relationship to government price setting or regulation.

This description oversimplifies matters, and there are indeed many devils in MMA's details. But this discussion is about social insurance fundamentals. Hence we want to emphasize here only the disjunction between the basic idea of risk pooling and shared sacrifice that animates social insurance and the directions that "reforms" such as MMA suggest for the future of Medicare.

The basic idea is just this: The dynamic promoted by MMA is the dynamic of risk segmentation, not risk pooling. "Plans" must compete on price and coverage, which in the health insurance industry means competing for healthy beneficiaries. As these healthy beneficiaries are siphoned off into private plans, the pool of insured people remaining in the traditional program will become riskier and riskier, which translates into more and more costly. And, of course, the funds that are subtracted from the traditional program to pay for participation in the privatized medicine market will be unavailable to support the traditional program. Traditional Medicare will, therefore, look more and more costly—and financially troubled—not because of any increased costs, but because high risks have now been separated from low risks.

A number of responses can be imagined to deal with this worsening fiscal picture in the traditional program: (1) moving everyone into private plans with subsidies for lower-income and unhealthy beneficiaries who cannot afford the premium; (2) increased subsidies to the traditional Medicare program through general taxation; and (3) higher premiums or lower subsidies for more well-to-do participants in Part B of the program. Other scenarios are obviously available.

Note, however, that all of these approaches undermine the basic social contract that has made social insurance both politically popular and reasonably stable. Not only will participants now see themselves not as in a common pool sharing common risks, but as in separate plans they have "chosen"; some will see themselves as gaining insurance through their contributions to the system, while other are subsidized recipients of governmental largesse. How that vision will play itself out in our continued willingness to provide generous coverage to our least-healthy citizens remains to be seen. But, in our view, it is a dangerous experiment with the socially valuable "us-us" politics that has characterized our major social insurance programs, which are like little else in contemporary U.S. public life.

Are these worries fanciful? We think not. Indeed, the third scenario suggested above is included in MMA. The law makes premium levels rise sharply for the richest 2 percent of retired beneficiaries. This appeal to "soak the rich" populism represents a (largely masked) threat to social insurance principles. It constitutes another road to unraveling the broad political support that social insurance programs have by virtue of their eligibility and financing. Here is why. The purpose of any insurance is to spread the costs of a risk, not to concentrate those costs. The key feature of social insurance is to distribute costs as widely as possible, redistributing income from higher- to lower-income citizens and from the healthier to the sicker. Spreading costs over a lifetime of work is precisely what the current financing of Medicare's Part A hospitalization coverage does.

Imagine now subjecting upper-income retirees to a premium for their medical insurance set at, to use the current idea, 50 percent of the average Medicare expenses for physician and related coverage (Part B). The sickness expenses of the elderly, as with any group, are wildly uneven. The top 10 percent of users spend more then twenty times what the cheapest 90 percent spend.[34] Any benefit manager for any sizable firm with relatively healthy retirees will be able to find group policies for them that will compete with a "means-tested" Medicare Part B program financed by "income-related" premiums. These healthy elders will opt out of Medicare Part B, leaving only the less well in Medicare. Premiums for the latter group will have to go up. This is an obvious road to undermining the broader risk pool that Medicare's social insurance roots express.

MMA was in many respects legislation by stealth. In this statute and elsewhere, "modernization"

has become a code word that masks ideological hostility to the social insurance structure with which Social Security and Medicare began. It holds out the hope—for who can be against modernizing?—that truly modern systems of social provision will be both more affordable and fairer than "relics" of our New Deal and Great Society past that have outlived their usefulness. And in the current U.S. political context, to be modern means to understand the power of individual choice, market competition, and personal responsibility to remake social policy to fit the demands of the twenty-first century.

From what has been said, it is obvious that we believe these "hopes" to be profoundly misguided. Fragmenting risk pools will not increase Medicare's fairness, and choice and competition have no proven record of cost control in medical care either in the United States or elsewhere. Modernization in this guise is a Trojan horse. Inside is a complex set of devices that increase individual risk bearing and decrease the security traditionally provided by social insurance.

A Concluding Note

Throughout this essay we have viewed "universal" social insurance through the lens of a peculiarly American approach to public provision. For Americans, "universal" has generally meant all workers or contributors, not all citizens or residents. We should not leave this discussion, therefore, without underscoring the profoundly traditional—indeed, conservative and work-oriented—vision that U.S. universalism embraces. It says not that you are entitled because you are a part of the nation, but that you are entitled because of your contribution to the nation. Funding is linked to earnings and entitlement is defined by years of work. Hence, for Americans, universalistic entitlement has always been a concept tied to, supported by, and supporting a market economy. That the protection of social insurance—and the demand for its expansion—should be thought to be the distinctive position of "liberals" is, to say the least, ironic. That its reform should be thought to be in the direction of marketlike devices that shift risks back onto individuals and families already buffeted by the staggering economic uncertainties of a rapidly globalizing economy is, in our view, profoundly misguided. Modernization in this form misunderstands what social insurance is about.

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NOTES

1. For critics, see, among others, P.J. Ferrera and M. Tanner, *A New Deal for Social Security* (Washington: Cato Institute, 1998); and S.M. Butler, "Medicare Price Controls: The Wrong Perspective," *Health Affairs* 17, no. 1 (1998): 72–74. For an example of a defense of this line of thinking, see S. Beard, J.L. Mashaw, and T. Marmor, "Is There a Social Security Crisis?" *American Prospect* 8, no. 30 (1997): 16–19.
2. See, for example, R. Pear, "Drug Plan Enrollment Opens amid Confusion," *New York Times,* 16 November 2005.
3. See "Social Security Plan Hits Shoals,"*Los Angeles Times,* 27 June 2005; for examples of President Bush's rhetoric on the subject, see G.W. Bush,“ Remarks in a Discussion on Strengthening Social Security in Greece, New York,"*Weekly Compilation of Presidential Documents* 41, no. 21 (30 May 2005); and the *New York Times* transcript, "We Must Pass Reforms That Solve the Problems of Social Security," *New York Times,* 3 February 2005.
4. For different treatments, see M.J. Graetz and J.L. Mashaw, *True Security: Rethinking American Social Insurance* (New Haven, Conn.: Yale University Press, 1999); N. Altman, *The Battle for Social Security: From FDR's Vision to Bush's Gamble* (New York: Wiley, 2005); and T.S. Jost, "Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance," *New York University Law Review* 76, no. 2 (2001): 419–492.

5. Graetz and Mashaw, *True Security,* 15–66.
6. See, for example, J. Tobin, "The Future of Social Security: One Economist's Assessment," in *Social Security: Beyond the Rhetoric of Crisis,* ed. T.R. Marmor and J.L. Mashaw (Princeton, N.J.: Princeton University Press, 1988), 41–68; see also T.R. Marmor, "Coping with a Creeping Crisis: Medicare at Twenty," in ibid., 177–199.
7. This is not the case for two programs conventionally regarded as examples of social insurance: unemployment insurance and workers' compensation. In these two cases, the injured or unemployed worker is the beneficiary, not the funder. Employers finance both programs, but their premiums vary with their experience. Experience rating with the unemployment or accident rate is meant to be a signal to the employer to orient toward prevention. Whether or not this has worked out well is not a topic to be taken up here. For an argument that it has not, see Graetz and Mashaw, *True Security,* 73–87. Moreover, there are some forms of deservingness in U.S. social programs that do not depend on financial contributions. For example, workers are often viewed as having "traded" their rights to tort recovery for the more certain, but smaller, benefits of workers' compensation. And generous veterans' programs rely on the idea of contribution, but in the form of services provided (in war or elsewhere) rather than contributions in cash. Likewise, child allowances in the U.S. tax code can be regarded as social pooling of resources reallocated to children to produce a healthier, better-educated citizenry.
8. For illustrations, see E.D. Berkowitz, *Robert Ball and the Politics of Social Security* (Madison: University of Wisconsin Press, 2003); T.R. Marmor, *The Politics of Medicare,* 2d ed. (New York: Aldine de Gruyter, 2000); R.M. Ball, "The Original Understanding on Social Security: Implications for Later Developments," in *Social Security*, ed. Marmor and Mashaw, 17–40; and Altman, *The Battle for Social Security.*
9. For examples of such language, see D. Durenberger, "Senator Durenberger's Crusade: Long-Term Care for All Americans," *Caring* 18, no. 9 (1999): 22–28; and National Bipartisan Commission on the Future of Medicare, "Building a Better Medicare for Today and Tomorrow," 16 March 1999, http://thomas.loc.gov/medicare/bbmtt31599.html (accessed 27 February 2006). For a discussion, see T.R. Marmor, "How Not to Think about Medicare Reform," *Journal of Health Politics, Policy and Law* 26, no. 1 (2001): 107–117.
10. M. Feldstein, "Rethinking Social Insurance," Presidential Address to the American Economic Association, 8 January 2005, http://www.nber.org/feldstein/aeajan8.pdf (accessed 27 February 2006).
11. P.J. Harmelink and J.F. Speyrer, "Social Security: Rates of Return and the Fairness of Benefits,"*CATO Journal* 14, no. 1 (1994): 37–55; and M. Feldstein and A. Samwick, "Social Security Rules and Marginal Tax Rates," *National Tax Journal* 45, no. 1 (1992): 1–22.
12. T.R. Marmor and G.J. McKissick, "Medicare's Future: Fact, Fiction, and Folly," *American Journal of Law and Medicine* 26, nos. 2 and 3 (2000): 225–253; A. Negourney and J. Elder, "Bush Doesn't Share Public's Priorities, New Poll Indicates," *New York Times,* 3 March 2005; and R. Morin and D. Russakoff, "Social Security Problems Not a Crisis, Most Say," *Washington Post,* 10 February 2005.
13. National Committee to Preserve Social Security and Medicare, "Disability Insurance and Survivors' Benefits," January 2006, http://www.ncpssm.org/news/archive/vp_surviorsbene (accessed 27 February 2006); and G. Anrig, "Ten Myths about Social Security," 26 January 2005, http://www.socsec.org/publications.asp?pubid=507 (accessed 27 February 2006).
14. Social Security Administration, *SSA's Performance and Accountability Report for Fiscal Year (FY) 2005: Management's Discussion and Analysis,* http://www.ssa.gov/finance/2005/MDA.pdf (accessed 27 February 2006).
15. L.H. Thompson, "Paying for Retirement: Sharing the Gain," in *In Search of Retirement Security,* ed. T. Ghilarducci et al. (New York: Century Foundation Press, 2005), 115–125.
16. P.C. Light, *The True Size of Government* (Washington: Brookings Institution, 1999).
17. P. Passell, "Investing It: Can Retirees' Safety Net Be Saved?" *New York Times,* 18 February 1996.
18. For a discussion, see T.R. Marmor, J. Mashaw, and P. Harvey, *America's Misunderstood Welfare State: Persistent Myths, Enduring Realities* (New York: Basic Books, 1990), especially chap. 1.
19. D. Langer, "Does the Social Security Crisis Add Up?" *New York Times,* 16 January 2005. See

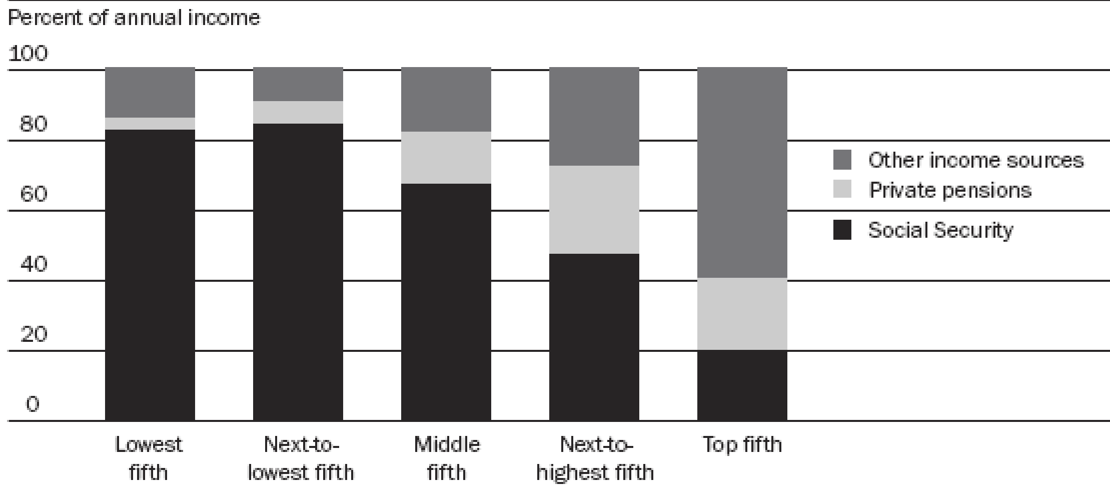
also Langer's testimony before the Senate Special Committee on Aging, 30 June 1998, http://www.ourfuture.org/issues_and_campaigns/socialsecurity/key_issues/finances_of_social_security/readarticle801.cfm (accessed 27 February 2006).
20. For a discussion of Social Security financing, see R.M. Ball with T.N. Bethell, *Straight Talk about Social Security* (New York: Century Foundation Press, 1998).
21. Ibid.
22. The Social Security Advisory Board gives projections for such minor adjustments in its most recent report, *Social Security: Why Action Should Be Taken Soon,* September 2005, http://www.ssab.gov/documents/WhyActionShouldbeTakenSoon.pdf, pp. 34–37 (accessed 27 February 2006).
23. P. Diamond and J. Geanakoplos, "Social Security Investment in Equities I: Linear Case," Working Paper no. 2 (Chestnut Hill, Mass.: Center for Retirement Research at Boston College, 1999).
24. Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Health Insurance Trust Funds, *2005 Annual Report,* 23 March 2005, http://new.cms.hhs.gov/ReportsTrustFunds/downloads/tr2005.pdf (accessed 27 February 2006).
25. J. Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003); and Marmor, *The Politics of Medicare.*
26. C. Boccuti and M. Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," *Health Affairs* 22, no. 2 (2003): 235.
27. T.R. Marmor, "From the United States," in *Dutch Welfare Reform in an Expanding Europe: The Neighbours' View,* ed. E. de Gier, A. de Swaan, and M. Ooijens (Amsterdam: Het Spinhuis, 2004), 111–134.
28. For some illustrations, see S. Butler and D.B. Kendall, "Expanding Access and Choice for Health Care Consumers through Tax Reform," *Health Affairs* 18, no. 6 (1999): 45–57; and H.J. Aaron and R.D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs* 14, no. 4 (1995): 8–30.
29. American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues* (Washington: AAA, May 1995), 2–8; see also M. Moon, L.M. Nichols, and S. Wallin, "Winners and Losers under Medical Savings Accounts," *Spectrum* 70, no. 1 (1997): 26–29; and L. Nichols, M. Moon, and S.W. Wallin, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans," 1 April 1996, http://www.urban.org/url.cfm?ID=406690 (accessed 4 March 2006).
30. For discussion of the history of Medicare, see Marmor, *Politics of Medicare.*
31. Ibid.
32. Aaron and Reischauer, "The Medicare Reform Debate."
33. Boccuti and Moon, "Comparing Medicare and Private Insurers"; and Marmor and McKissick, "Medicare's Future," 238–245.
34. S.M. Lieberman et al., "Reducing the Growth of Medicare Spending: Geographic versus Patient-based Strategies,"*Health Affairs* 22 (2003): w603–w613 (published online 10 December 2003; 10.1377/hlthaff.w3 .603).

Theodore Marmor (theodore.marmor@yale.edu) is a professor of public policy and management at the Yale School of Management and a professor of political science at Yale University in New Haven, Connecticut. Jerry Mashaw is the Sterling Professor of Law and Management and a professor in the Institute for Social and Policy Studies, Yale University.

Read related papers by Henry J. Aaron and Thomas R. Saving.

EXHIBIT 1

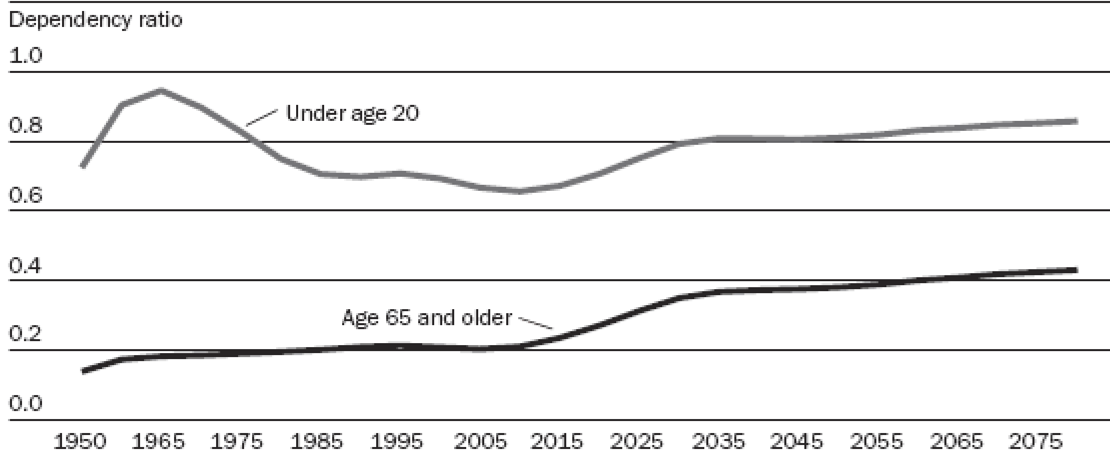
Income Of U.S. Elderly People, By Income Quintile And Source Of Income, 2002



SOURCE: Social Security Administration, *Income of the Population Fifty-five or Older 2002*, March 2005, http://www.ssa.gov/policy/docs/statcomps/income_pop55/2002 (accessed 28 February 2006).

NOTES: Lowest fifth: $9,720 and below; second fifth: $9,721–$15,180; middle fifth: $15,181–$23,879; next-to-highest fifth: $23,880–$40,981; top fifth: $40,982 and above. "Other income sources" includes earnings, income from assets, public assistance, and other. "Private pensions" includes railroad retirement and government employee pensions as well as private pensions and annuities.

EXHIBIT 2
Ratio Of Population Under Age 20 And Over Age 65 To Population Ages 20–65, 1950–2080



SOURCE: Social Security Trustees, *2005 OASDI Trustees Report*, http://www.ssa.gov/OACT/TR/TR05/V_demographic.html (accessed 28 February 2006), using intermediate assumptions.

EXHIBIT 3
Trends In Health Care Costs Per Capita, United States, 1991–2003

	Percent change by spending category			
	GDP per capita	Non-Medicare health services	Large employer premiums	Medicare per enrollee
1991–1993	3.3	6.2	10.1	–[a]
1994–1997	4.4	2.4	2.4	–[a]
1998–2000	4.6	6.7	5.0	0.3
2001–2003	2.8	9.0	13.3	7.2
1990–1995	3.7	(4.5)	(7.4)	(8.7)
1995–1997	4.8	(2.6)	(1.3)	(6.5)

SOURCE: J. White, "Transformations of the American Health Care System: Risks for Americans and Lessons from Abroad" (Unpublished manuscript, 2006).

NOTE: GDP is gross domestic product.

[a] Not available.