Part IV

The Chain-Letter Economics of Medicare

13. Health Care after Retirement

When we move into the 21st century, the United States and other developed countries will have a growing number of elderly citizens relative to the working-age population. The cost of income maintenance and health care for the elderly, whether paid through public or private programs, will be staggering. During the latter half of the 21st century, the annual cost of Social Security plus health spending for the elderly in the United States will equal one-half to three-fourths of all workers' wages.

Projections for America's Future

Under our current system of pay-as-you-go financing, each generation depends on the government to cover its Social Security benefits and most of its health care bills by taxing the next generation. If we continue this practice, the burden we create for tomorrow's workers will be impossible for them to bear. The year 2060 seems like the distant future—so distant that it is easy to ignore. But almost everyone who will be 65 years of age or older in that year already has been born. Those not yet born are the future generations of workers who will be expected to honor promises that are being made to today's young children—about their Social Security and health care retirement benefits.

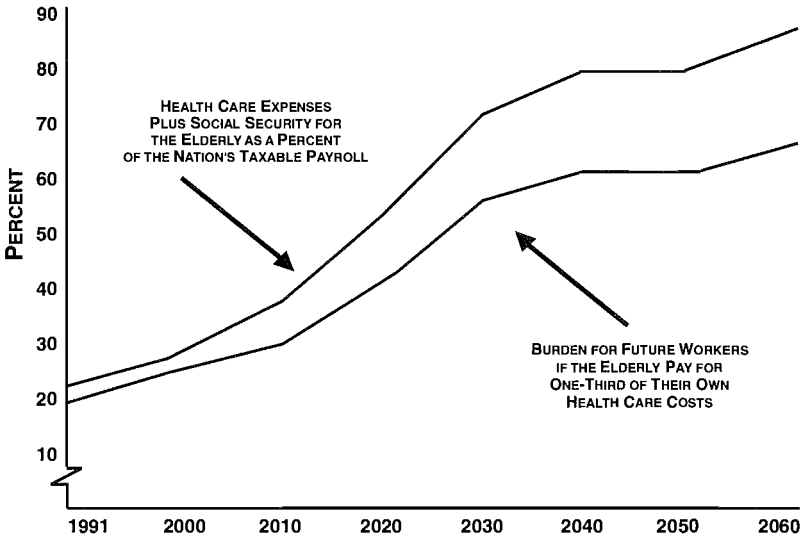
Here is the nightmare in America's future, based on official forecasts made by the Social Security Administration.

Social Security and Medicare Hospital Insurance

Projections about the future of Social Security and Medicare are made annually by the Social Security Administration.[1] These projections are often labeled "optimistic," "intermediate," and "pessimistic," and people are encouraged to believe that the intermediate

[1]See *The 1988 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds*, May 9, 1988 (hereinafter referred to as *Board of Trustees Report*).

Figure 13.1
THE NIGHTMARE IN OUR FUTURE*



SOURCE: National Center for Policy Analysis.

*Based on the Social Security Administration's Alternative III assumptions.

forecast is the most likely. But many students of Social Security believe that the pessimistic projection more closely reflects our recent experience.[2] Currently, spending on Social Security and Medicare hospital insurance (Medicare Part A) is equal to about 14 percent of the nation's total taxable payroll. As can be seen in Figure 13.1, during the retirement years of the baby boom generation, we will either have to double the tax burden for workers or cut promised benefits in half. As Table 13.1 shows, by the year 2030 the payroll tax will have to rise to about 34 percent of taxable wages to fund benefits promised under current law. By 2050, it will rise to

[2]The "pessimistic" projection is by no means the worst that can happen. In fact, the "pessimistic" assumptions often are more favorable than our recent experience. See John C. Goodman and Peter Ferrara, "Social Security: Who Gains? Who Loses?" NCPA Policy Report no. 127 (Dallas: National Center for Policy Analysis, May 1987), pp. 6–8. The assumptions behind all three projections are discussed in greater detail below.

Table 13.1

PROJECTED SOCIAL SECURITY BENEFITS AND MEDICARE HOSPITAL INSURANCE AS PERCENT OF NATION'S TAXABLE PAYROLL

Year	Optimistic Projection[1]	Intermediate Projection[2]	Pessimistic Projection[3]
1991	13.6%	13.7%	13.9%
2000	12.6	14.4	16.5
2010	13.1	15.9	19.4
2020	15.6	20.2	26.6
2030	17.4	24.1	34.4
2040	17.2	25.1	38
2050	16.8	25.4	40
2060	17	26.6	43

SOURCE: *The 1991 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds* (May 17, 1991), Appendix E, Table E-2 (pp. 138–39).

[1]Based on the Social Security Administration's Alternative I assumptions.

[2]Based on the Social Security Administration's Alternative II-B assumptions.

[3]Based on the Social Security Administration's Alternative III assumptions.

43 percent of the nation's taxable payroll.[3] This future payroll tax burden is greater than the combined burden of all federal, state, and local personal income taxes today.

Health Care Spending

By far the fastest rising component of the projections is our commitment to pay future health care costs. The burden of Medicare hospital insurance alone currently is about 2.61 percent of total taxable payroll. As Table 13.2 shows, the burden will probably more than double by 2010, more than triple by 2020, and more than quintuple by 2030.

These estimates considerably understate the magnitude of total health care spending for the elderly. Medicare hospital insurance today pays about 75 percent of their hospital costs, which represent 45 percent of their total health care spending. Thus, Medicare hospital insurance pays about 30 percent of the total health care costs for the elderly. The remaining costs are paid through Medicare Part B (funded 25 percent by premiums paid by the elderly and 75 percent by general tax revenues), Medicaid and other government programs (funded by general tax revenues), private health insurance, and out-of-pocket funds. As Table 13.2 shows, if nonhospital medical costs increase at the same rate as projected hospital costs, total health care spending for the elderly may equal 60 percent of the nation's taxable payroll by 2060.

Burden for Future Taxpayers

The Social Security Administration's practice of combining future Social Security payments with Medicare hospital insurance payments is based on a hidden assumption. The assumption is that society is contractually obligated to pay only those future medical costs that are funded by the Social Security (FICA) tax. Accordingly, anything the federal government does to shift costs from Medicare hospital insurance to Medicare Part B, the Department of Veterans Affairs, Medicaid, or private employers is viewed as reducing future obligations. That assumption is probably wrong. If the political marketplace communicates any clear message, it is that of an implicit contract with the elderly. Moreover, the political obligation

[3]The payroll tax rates cited are the rates necessary to pay Social Security retirement benefits, Medicare hospital insurance benefits, and survivors and disability benefits.

Table 13.2

PROJECTED HEALTH CARE EXPENSES FOR THE ELDERLY AS A PERCENT OF THE NATION'S TAXABLE PAYROLL, 1991 TO 2060

Year	Medicare Hospital Insurance[1]	Total Medicare[2]	Total Health Care Costs[3]
1991	2.65%	3.98%	8.79%
2000	4.16	6.24	13.77
2010	6.43	9.65	21.30
2020	10.50	15.75	34.77
2030	14.95	22.43	49.51
2040	16.93	25.40	56.07
2050	17.29	25.94	55.26
2060	18.04	27.06	59.74

SOURCE: *The 1991 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds* (May 17, 1991), Appendix E, Table E.2 (pp. 138–39).

[1]Based on the Social Security Administration's pessimistic projection.

[2]Projection based on the assumption that Medicare hospital insurance will be equal to two-thirds of total Medicare spending.

[3]Projection based on the assumption that Medicare spending will be equal to 45.3 percent of total health care spending of the elderly.

to ensure that all elderly citizens have access to health care is probably every bit as strong as the obligation to pay Social Security benefits.

Like Social Security, virtually all government programs that currently fund health care expenses for the elderly are financed on a pay-as-you-go basis. With few exceptions, no funds are being invested today to pay for health care costs that will be incurred in the future. Thus, unless there is a fundamental change in current policies, society will be able to pay for Social Security and health care for the elderly in 2060 only by taking income from people who are alive in 2060.

Table 13.3 shows the magnitude of Social Security benefits plus total health care costs for the elderly in future years. As the table indicates, it will reach one-third of total taxable payroll in just two decades. It will probably be almost 70 percent of the nation's taxable payroll by 2030 and about 85 percent by 2060.

It is not known precisely what share of their health care expenses the elderly currently pay with their own funds. A reasonable estimate is that they pay no more than one-third.[4] As our society ages, however, an increasing number of elders will be the "old elderly"—with fewer assets and less income than the "young elderly." This demographic change, in conjunction with the government's policy of discouraging private savings for future medical costs, will probably make it impossible for the elderly to continue paying one-third of their health care costs. Nonetheless, Table 13.4 assumes that the future working population still will be obligated to pay only two-thirds of the elderly's health care expenses. Even if this proves true, the total burden on the working population of covering the elderly's Social Security benefits and health care costs will probably exceed one-fourth of the nation's taxable payroll in just two decades, one-half of the nation's total taxable payroll by 2030, and about 65 percent by 2060.

The Problem of Expanding Medicare Coverage

The above projections understate the probable magnitude of the impact of future health care spending on the elderly because they

[4]The technical issues involved in making this estimate are discussed in John C. Goodman and Gerald L. Musgrave, "Health Care after Retirement: Who Will Pay the Cost?" NCPA Policy Report no. 139 (Dallas: National Center for Policy Analysis, May 1989), appendix A.

Table 13.3

PROJECTED SOCIAL SECURITY BENEFITS AND HEALTH CARE EXPENSES FOR THE ELDERLY AS A PERCENT OF THE NATION'S TAXABLE PAYROLL, 1991 TO 2060[1]

Year	Social Security[2]	Social Security Plus Total Medicare	Social Security Plus Total Health Care Expenses
1991	11.28%	15.26%	20.07%
2000	12.33	18.57	26.10
2010	12.94	22.59	34.24
2020	16.10	31.85	50.87
2030	19.51	41.94	69.02
2040	21.11	46.51	77.18
2050	22.71	48.65	77.97
2060	25.13	52.19	84.87

SOURCE: *The 1991 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds* (May 17, 1991), Appendix E, Table E-2 (pp. 138–39); and Tables 13-1, 13-2.

[1]Based on the Social Security Administration's pessimistic projections.

[2]Includes old-age, survivors, and disability payments.

Table 13.4
PROJECTED BURDEN FOR FUTURE WORKERS
(Assuming the Elderly Pay for One-Third of Their Health Care Expenditures)

Year	Burden as a Percent of Taxable Payroll
1991	17.14%
2000	21.51
2010	27.14
2020	39.28
2030	52.52
2040	58.49
2050	59.55
2060	64.96

SOURCE: Based on Table 13.3.

ignore the political pressure to expand Medicare. For example, Medicare currently pays less than 2 percent of nursing home costs for the elderly,[5] and 81 percent of the elderly's out-of-pocket medical costs in excess of $2,000 goes for nursing home care.[6] In addition, for every elderly patient in a nursing home, two equally disabled persons are not in nursing homes.[7] For these reasons, political pressure is mounting to expand Medicare to cover nursing home costs. But the costs of such coverage would be huge. If every elderly person in America spent just one year in a nursing home, the total cost would be about $627 billion, or roughly half of the entire federal budget.[8] One of the prime forces keeping the elderly out of nursing homes today is the high cost. If price were no object (that is, if Medicare coverage were extended), the number of elderly people in nursing homes would increase sharply.

[5]Task Force on Long-Term Care Policies, *Report to the Congress and the Secretary* (Washington: U.S. Department of Health and Human Services, 1987), p. 69.

[6]Thomas Rice and Jon Gabel, "Protecting the Elderly against High Health Care Costs," *Health Affairs* (Fall 1986), p. 16.

[7]Task Force on Long-Term Care Policies.

[8]John C. Goodman and Gerald L. Musgrave, "Health Care for the Elderly: The Nightmare in Our Future," NCPA Policy Report no. 130 (Dallas: National Center for Policy Analysis, October 1987), p. 5.

A Closer Look at the Assumptions behind the Projections

Because the Social Security Administration has published different projections for the next 65 years, which one should we believe? That depends on which projection is based on the most realistic expectations about the future. And the only way of evaluating the predictions is to compare them with our recent experience.

Table 13.5 summarizes the key assumptions used in each of the Social Security Administration's projections. The differences in the assumptions, which appear small, lead to huge differences in future taxpayer burdens—differences that are magnified over time. What follows is a brief analysis of some critical assumptions behind current forecasts.

Aging and the U.S. Fertility Rate

A nation's fertility rate is the average number of children that women of childbearing age will have over their lifetime. In developed countries, 2.1 is the replacement rate—the rate necessary to maintain the size of the current population. To keep the total population at its current size, each adult man and woman must be replaced by approximately two children.[9]

In 1960, virtually all developed countries had fertility rates in excess of 2.1, and most had rates substantially higher. Since then, however, as Table 13.6 shows, the rates have dropped. The United States, Canada, Iceland, and the Netherlands have experienced a drop of more than 50 percent over 25 years (see Table 13.7). In Belgium, Austria, Denmark, Australia, Germany, and New Zealand, the decrease was 40 percent or greater. Consequently, the vast majority of developed countries today have fertility rates substantially below the replacement rate. Overall, out of 22 industrial democracies, only 3—New Zealand, Ireland, and Israel—have fertility rates above the replacement level.[10]

[9]The 0.1 factor accounts for childhood mortality that occurs before females reach childbearing age.

[10]Ben J. Wattenberg, *The Birth Dearth* (New York: Pharos Books, 1987), chart 2A (p. 173).

Table 13.5

KEY ECONOMIC AND DEMOGRAPHIC ASSUMPTIONS FOR THE PERIOD FOLLOWING THE YEAR 2015

Assumption	Recent Experience	Optimistic Projection[1]	Intermediate Projection[2]	Pessimistic Projection[3]
Total fertility rate	1.83[4]	2.2	1.9	1.6
Annual increase in real wages (%)	0.5[5]	1.7	1.1	0.6
Annual increase in consumer price index (%)	6.6[6]	3.0	4.0	5.0
Annual decrease in mortality rate (%)	1.2[7]	0.3	0.5	1.0
Annual increase in hospital costs[8] (%)	6.3[9]	2.3	3.7	5.4

SOURCE: *The 1991 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds* (May 17, 1991), Tables 10, 11; and *The 1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (May 17, 1991), Tables A-1, A-3.

[1]Based on the Social Security Administration's Alternative I assumptions.

[2]Based on the Social Security Administration's Alternative II-B assumptions.

[3]Based on the Social Security Administration's Alternative III assumptions.

[4]Average number of children per woman of childbearing age for years 1975 to 1989.

[5]Average annual real wage rate for the years 1975 to 1989.

[6]Average annual increase for the period 1975 to 1989.

[7]Average annual decrease in the age/sex-adjusted death rate for the years 1975 to 1989.

[8]Measured as the annual rate of increase in Medicare hospital insurance expenditures minus the annual rate of increase in average hospital wages.

[9]Annual rate of growth of hospital inpatient expenditures (approximately 93 percent of hospital income spending) minus the rate of growth in wages for years 1975 to 1989.

Table 13.6
DROP IN FERTILITY RATES, 1960 TO 1985

Country	Change
Australia	−43%
Austria	−42
Belgium	−40
Canada	−55
Denmark	−44
Finland	−37
France	−33
Germany	−44
Iceland	−56
Ireland	−34
Israel[1]	−23
Italy	−39
Japan	−10
Luxembourg	−39
Netherlands	−52
New Zealand	−44
Norway	−39
Spain	−39
Sweden	−23
Switzerland	−35
United Kingdom	−33
United States	−51

SOURCE: Ben J. Wattenberg, *The Birth Dearth* (New York: Pharos Books, 1987), Chart 2A (p. 173).
[1]Jewish population only.

The fact that the fertility rate in the United States and other developed countries is well below the replacement rate has generally gone unreported.[11] Yet, as Figure 13.2 shows, even if we maintain our current fertility rate, the population of the United States

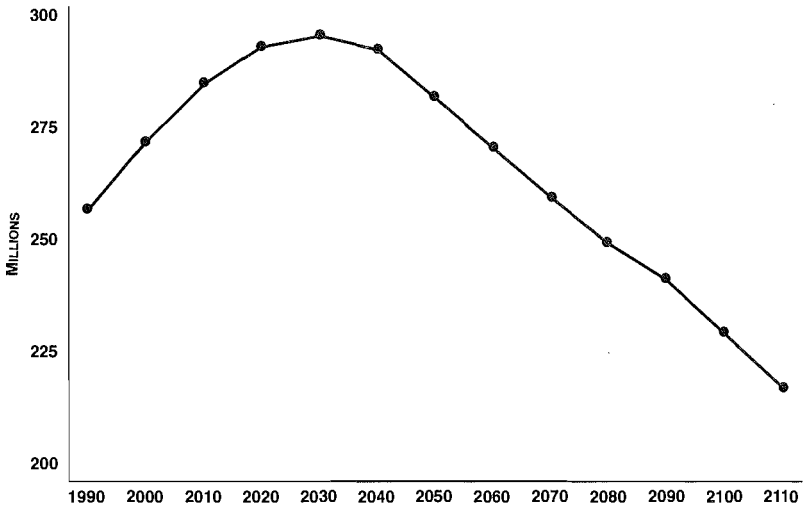
[11]For example, the Bureau of the Census "middle level" projections assumed a fertility rate of 2.1 until 1984 (when it was reduced to 1.9), despite the fact that the average fertility rate for the ten previous years was 1.796. See Wattenberg, pp. 26–27 n. 3. The intermediate projection of the Social Security Administration—the one most widely quoted in and out of government—did not use a fertility rate of less than 2.0 until 1988. See the *Board of Trustees Report*. In addition, two former administrators in the U.S. Department of Health and Human Services published a book in the mid-1980s on Medicare policy in which all of the forecasts assumed a (replacement)

Table 13.7
PROJECTED U.S. POPULATION GROWTH, 1990–2050

Population Group	Percent Increase
Total population	−6%
Ages 65–74	51
Ages 75–84	78
Age 85+	246

SOURCE: Based on U.S. Bureau of the Census lowest series projection. U.S. Bureau of the Census, *Projections of the Population of the United States by Age, Sex and Race: 1983 to 2080,* Current Population Reports, Series P-25, no. 952 (Washington: U.S. Government Printing Office, 1984), Table 6.

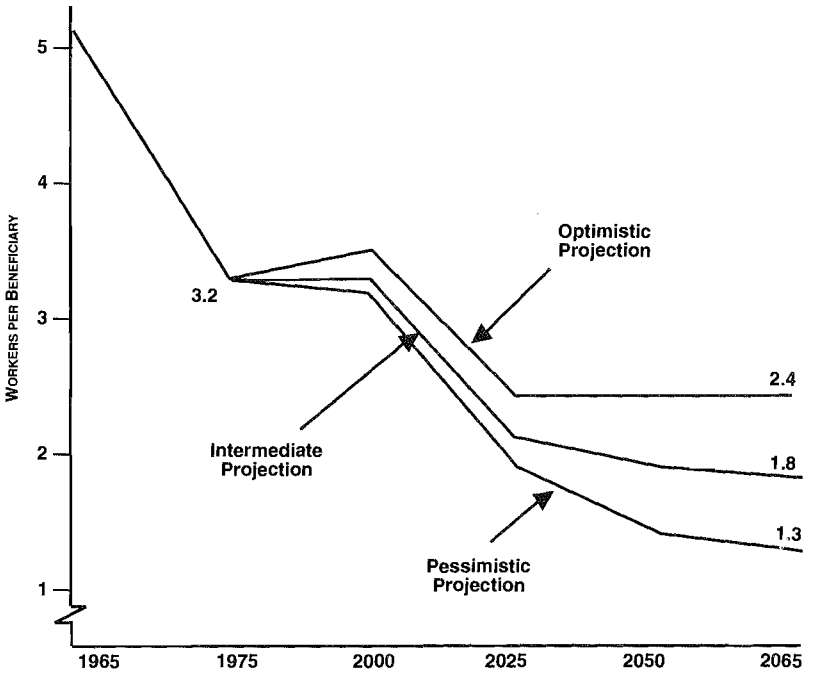
Figure 13.2
PROJECTED U.S. POPULATION, 1990 TO 2110*



*Pessimistic projection, based on the Social Security Administration's Alternative III assumptions.

fertility rate of 2.1 without giving any justification. See Karen Davis and Diane Rowland, *Medicare Policy: New Directions for Health and Long-Term Care* (Baltimore: Johns Hopkins University Press, 1986), pp. 121–23.

Figure 13.3
NUMBER OF WORKERS FOR EACH SOCIAL SECURITY BENEFICIARY, 1965 TO 2065



SOURCE: Social Security Administration.

will peak in the first half of the 21st century and will decline continuously thereafter.

The implications of declining fertility rates are devastating for the social security systems of all developed countries. As Figure 13.3 shows, there will be a declining number of workers to support each elderly beneficiary in the United States. Unless there are major lifestyle changes, almost all developed countries will experience indefinite population aging and growing payroll tax burdens for social security and other retirement benefits.

Aging and Health Care Costs

As a country ages, its health care costs inevitably rise. And the faster it ages, the faster those costs rise. At the turn of this century,

only 4 percent of the population was 65 or older. Today that figure is 12 percent. And it is projected is be 20 percent by 2030 and almost 25 percent by 2050 (see Table 13.7).[12] Thus, the elderly constitute the fastest growing segment of the population, and among them, the old elderly are the fastest growing group. Although the total population of the United States will probably be smaller in the year 2050 than it is today, the percentage of elderly will have doubled, and the old elderly (ages 85 and older) will have almost quadrupled. Although the old elderly represented only 9 percent of the elderly population in 1980, they will represent 20 percent by 2050.[13] The aging of the population will continue indefinitely. Among 65-year-old retirees, a male today can expect to live to the age of 80 and a female to the age of 84. By the year 2065, as Figure 13.4 shows, about one-half of all 65-year-old men will live to age 86, and about one-half of all 65-year-old women will live to age 91.[14]

It is inevitable that larger numbers of elderly people will increase the demand for health care resources. The elderly see physicians 20 percent more often than the nonelderly do, and they are admitted to hospitals at twice the rate.[15] The cost of their hospital care is higher, too. On the average, people today can expect to incur more than half of their lifetime health care costs after the age of 65.[16] Average health care spending is about four times higher for the elderly than for the nonelderly.[17] Moreover, health care expenses for the elderly are growing at 2.6 times the rate for the nonelderly.[18]

[12]U.S. Bureau of the Census, Current Population Reports, series P-25, no. 952 *Projections of the Population of the United States by Age, Sex and Race: 1983 to 2080* (Washington: U.S. Government Printing Office, 1984), lowest series projection, Tables E, F (pp. 7–8).

[13]Ibid.

[14]*Board of Trustees Report,* Table ll, pp. 37–38.

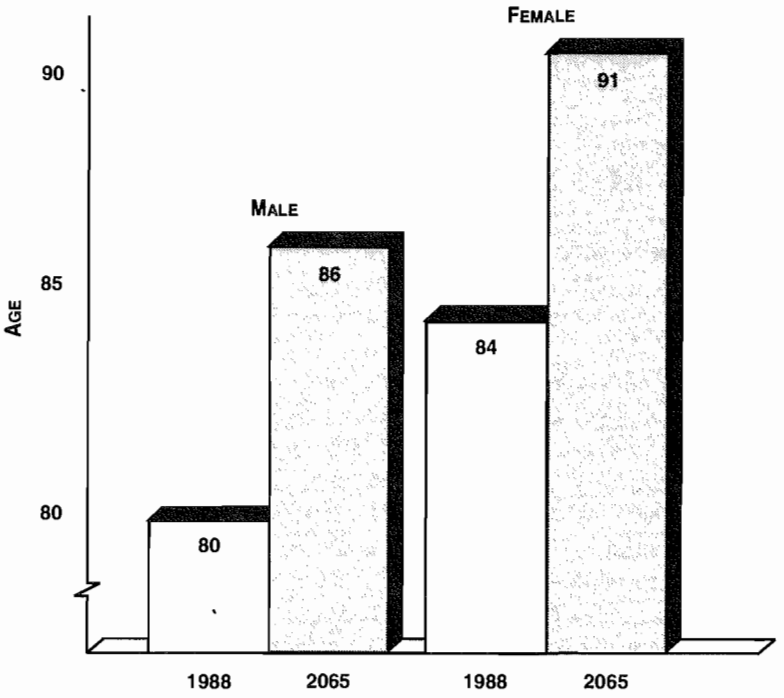
[15]George W. Bush et al., "Prefunding of Postemployment Health Care: The Pension Analogy, the Insurance Need," in Robert D. Paul and Diane M. Disney, eds., *The Sourcebook on Postretirement Health Care Benefits* (Greenvale, NY: Panel, 1986), p. 296.

[16]Estimates of the Health Care Financing Administration.

[17]U.S. Department of Health and Human Services, *Catastrophic Illness Expenses: Department of Health and Human Services Report to the President* (Washington, November 1986), p. 8.

[18]Deborah J. Chollet and Robert B. Friedland, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," in Frank B. McArdle, ed., *The Changing Health Care Market* (Washington: Employee Benefit Research Institute, 1987), p. 206.

Figure 13.4
EXPECTED AGE OF DEATH FOR PEOPLE 65 YEARS OLD, 1988 TO 2065



Among the old elderly, health care utilization and costs are even higher. On the average, hospital costs for people aged 85 and older are about 67 percent more than for those aged 65 to 75.[19] Long-term care for the old elderly is about ten times more costly than for the young elderly.[20] And although only 2 percent of senior citizens in their mid-60s and early 70s enter nursing homes, about 23 percent of the old elderly do so.[21]

[19]Estimates of the Health Care Financing Administration. For a recent discussion of these projections and related issues, see Peter G. Peterson, "The Morning After," *Atlantic Monthly*, October 1987, pp. 62–64.

[20]Ibid.

[21]Phillip Longman, *Born to Pay: The New Politics of Aging in America* (Boston: Houghton Mifflin Co., 1987), p. 88.

The elderly, who represent only 12 percent of the U.S. population today, consume almost one-third of all U.S. health care services.[22] By the middle of the next century, the elderly will represent 24 percent of the population and consume as much as two-thirds of our health care resources. Even without costly medical breakthroughs, the aging population will create impossibly burdensome costs.

Future Costs and the Achievements of Medical Science

All Social Security Administration forecasts are based on the premise that no radical breakthroughs will occur in medical science—breakthroughs that will eliminate life-threatening diseases or significantly increase life expectancy. But such developments are not merely possible; over a 65-year time span, they are almost inevitable.

Seventy years ago, no one could have imagined the medical procedures that are commonplace today. Similarly, we cannot possibly predict what medical science will achieve over the next 65 years. We do have two advantages over forecasters in the past, however. First, we know that modern society has given medical researchers a blank check. Invent it, we have told them; show us that it improves health care; and we will buy it. As a result, we have virtually guaranteed that the medical research and development industry will work hard at making new discoveries that will cost us more money. Second, unlike our counterparts of 65 years ago, we have a fairly good idea of the direction in which medical science will progress. For example, it is virtually inevitable that scientists will produce a complete mapping of the genetic code. The question is not if, only *when.* Given that many life-threatening diseases are related to our genetic resistance to them, a complete understanding of an individual's genetic makeup opens the door to the genetic prevention of disease by artificial intervention. In the case of cancer, for example, Americans are constantly exposed to carcinogens. They occur naturally in the food we eat, the water we drink, and the air we breathe. But some people, partly because of their genetic

[22]Frederic D. Wolinsky, Ray R. Mosely II, and Rodney M. Coe, "A Cohort Analysis of the Use of Health Services by Elderly Americans," *Journal of Health and Social Behavior* 27, no. 3 (1986): 209.

endowment, resist exposure better than others.[23] Once we understand the mechanism of susceptibility or resistance (which probably will not require a complete understanding of the genetic code), we will be able to sharply reduce and perhaps eliminate death from cancer.

The biggest uncertainty is what the achievements of modern science will do to the future financial burden of income maintenance and health care for the elderly. For example, heart disease, cancer, and strokes currently account for 75 percent of all deaths among the elderly. Moreover, these three diseases are responsible for 20 percent of all physician visits, 40 percent of all hospital days, and 50 percent of all days spent in bed.[24] If we could costlessly eliminate all three diseases, we would also eliminate three major categories of health care spending. But it is not clear that our total financial burden would go down, for the elderly would live longer and collect more Social Security checks. They would then eventually die of some other—possibly expensive-to-treat—disease.

Virtually all new government health care programs have been accompanied by a forecast of their future expenses and those forecasts invariably underestimate program costs. Assuming the past is a guide to the future, the burden of health care costs for the elderly will be much greater than even the pessimistic forecast.

Our Chain Letter Approach to Funding Retirement Needs

America is in love with chain letters. At the federal level, we have Social Security, Medicare, federal civil service retirement, and Department of Veterans Affairs retirement chain letters. Many state and local government retirement programs also are run like chain letters. In the private sector, many company pensions and virtually all health care promises have chain letter characteristics.

Under this approach, each generation avoids making the sacrifices necessary to pay its own way and expects the next generation to pay. Using this approach, there are only three sources of funds

[23]For example, researchers now believe that more than half of all cases of colon and rectal cancer are directly related to a genetic predisposition to such cancers. See Lisa A. Cannon-Albright et al., "Common Inheritance of Susceptibility to Colonic Adenomatus Polyps and Associated Colorectal Cancers," *New England Journal of Medicine* 319, no. 9 (September 1, 1988): 533–37.

[24]Bush et al., pp. 303–4.

Table 13.8
SOURCES OF PAYMENT FOR NONINSTITUTIONAL HEALTH CARE EXPENSES FOR THE ELDERLY[1]

Source	Share of Payment
Medicare[2]	60.4%
Out-of-pocket expenses and Medigap insurance purchased by the elderly	22.1
Employer- or union-provided health insurance[3]	7.4
Medicaid	6.0
Veterans' medical care	4.0

SOURCE: Timothy M. Smeedling and Lavonne Straub, "Health Care Financing among the Elderly: Who Really Pays the Bills?" *Journal of Health Politics, Policy and Law* 12, no. 1 (Spring 1987), Table 1 (p. 39), Table 3 (p. 43).
[1]Excludes payments for nursing home care.
[2]Includes supplemental medical insurance (SMI) premiums paid by elderly for coverage under Medicare Part B.
[3]Includes premiums paid by the elderly.

available to pay retirement benefits: (1) the income and assets of the elderly themselves, (2) the income and assets of private companies that have promised to pay, and (3) federal government taxes on the income and assets of the general public.

Table 13.8 shows the current sources of health care funding for the elderly for expenses incurred outside of nursing homes. Throughout the 1980s, attempts were made—in both the public and private sectors—to shift costs among these various sources of payment. For example, state governments paid Medicare Part B premiums for elderly Medicaid patients in an attempt to shift medical costs to the federal government. State governments also stepped up their efforts to make Medicaid the payer of last resort by collecting whenever possible from Medicare and private insurance. Although almost all employer-provided insurance is integrated with Medicare and designed to pay for expenses not paid by Medicare,[25] Congress recently made employers the payer of first resort

[25]For a description of the types of employer plans, see Jonathan C. Dopkeen, "Postretirement Health Benefits" in Paul and Disney, pp. 559–60.

for employees who continue to work after they qualify for Medicare at the age of 65.[26] Many people believe that Medicare's cost-containment efforts are partly designed to shift costs from Medicare patients to other patients, and increases in Medicare copayments and deductibles clearly are an attempt to shift costs from Medicare to the elderly themselves. However, about 23 percent of elderly males outside of nursing homes potentially can escape many of these payments by turning to the free care made available by the Department of Veterans Affairs.[27] The net result of these activities is simply to shift costs back and forth among pay-as-you-go funding sources. None of these cost-control attempts comes to grip with the reality that postretirement health care is not being prefunded by any current program.

What follows is a brief description of the pay-as-you-go nature of the three major sources of funding: the Social Security and Medicare trust funds, out-of-pocket funds of the elderly, and employer-provided postretirement health insurance.

The Myth of the Social Security Trust Funds

Partly in response to growing public concern over the program's future, one commissioner of Social Security, Dorcas Hardy, sent a letter to all Social Security recipients during the Reagan administration assuring them that the trust fund was accumulating assets and would remain in the black indefinitely into the future. Her announcement was accompanied by talk of a Social Security surplus that would grow to $12 trillion to $14 trillion.

What happens to the surplus? Contrary to popular myth, the Social Security Administration is not stashing money away in bank vaults. When revenues exceed expenditures, the Social Security Administration lends the surplus to the U.S. Treasury and the government uses the money to finance current spending. In other words, the federal government lends the money to itself, and the trust funds consist of nothing more than IOUs that the government writes to itself. To pay future benefits, the government will have to levy additional taxes at the time the payments are due.

[26]Ibid., 583.

[27]Timothy M. Smeedling and Lavonne Straub, "Health Care Financing among the Elderly: Who Really Pays the Bills?" *Journal of Health Politics, Policy and Law* 12, no. 1 (Spring 1987): 37.

As a practical matter, annual Social Security surpluses are used to finance the federal deficit. For example, when Social Security is combined with Survivors and Disability Insurance along with Medicare hospital insurance, as it should be, projected annual surpluses will never exceed 0.85 percent of the gross national product (GNP), or about $40 billion in current dollars—well below the deficit that these surpluses help finance. If current promises to pay benefits are kept, the total (accounting) surplus will vanish by the year 2013, and a continuously growing deficit will appear thereafter.[28] The surplus and deficit projected for the years 2000 through 2060 are shown in Figure 13.5. They are based on the Social Security Administration's intermediate projection; however, when the pessimistic projection is used, the future looks far bleaker. Under the pessimistic projection, the total (accounting) surplus will vanish by 1997. By the year 2035, when today's young workers retire, the Social Security (accounting) deficit will be 7 percent of GNP or about $350 billion in 1989 dollars.[29]

To repeat: The accounting surplus reported by the Social Security Administration does not represent a store of funds from which to pay future benefits. It represents nothing more than a promise to raise future taxes.

Out-of-Pocket Expenses of the Elderly

At the time Medicare and Medicaid were initiated in 1965, there was considerable pressure on Congress to relieve the elderly of the financial responsibilities of health care. But the elderly now spend a larger share of their income out-of-pocket on health care than they did before the programs existed. In 1962, for example, the elderly spent less than 8 percent of their own income for health care; today, despite the phenomenal growth in Medicare and Medicaid, they spend 15 percent.[30]

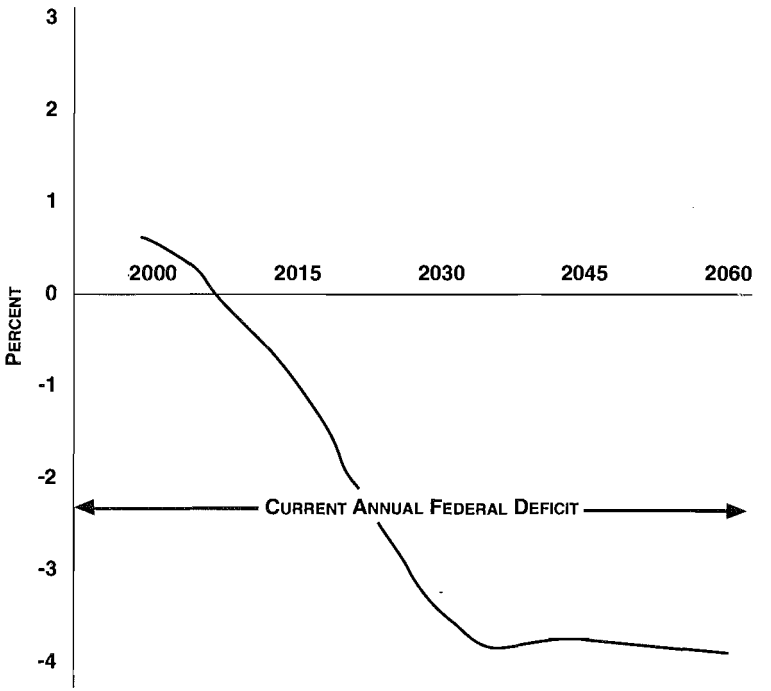
What is true of Medicare is also true of other forms of health insurance. For example, elderly individuals with Medigap insurance generate 67 percent more health care spending than those

[28]Peter Ferrara, *The Great Social Security Hoax,* Heritage Foundation Backgrounder no. 662 (July 1988).

[29]Ibid.

[30]Smeedling and Straub, p. 36.

Figure 13.5
PROJECTED ANNUAL SOCIAL SECURITY AND MEDICARE SURPLUS/DEFICIT AS PERCENTAGE OF GROSS NATIONAL PRODUCT, 2000 TO 2060*



*Based on the Social Security Administration's intermediate assumptions.

without, and they spend 15 percent more out-of-pocket.[31] In general, health insurance does not replace money the elderly would otherwise have spent on health care; it adds to the total spent. Nonetheless, there clearly is a limit to the amount that the elderly can pay for health care. In addition, out-of-pocket expenditures are highest among those who can least afford it—the old elderly. For elderly families aged 65 to 69, out-of-pocket expenses for health

[31]Davis and Rowland, p. 36.

equal only 4 percent of income.[32] For those aged 85 and older, out-of-pocket expenses equal 38 percent of income.[33] But the old elderly have only two-thirds as much income as the young elderly.[34]

Because the old elderly are the fastest growing segment of our population, and because people are not being encouraged to save for their own retirement, our ability to extract greater out-of-pocket payments from retirees will surely decrease.

Commitments of Private Employers

Just as almost all large companies provide private pensions, most now pay certain postretirement health care expenses as well. Currently, about 95 percent of all large firms and a significant number of smaller ones provide postretirement health care benefits.[35] About one in four retirees is now covered by employer- or union-provided health insurance.[36] About one-third of all workers[37] and two-thirds of workers with employer-provided insurance[38] work for an employer who provides coverage for postretirement health care. The cost of this commitment is soaring.[39] In 1974, when many companies began covering postretirement medical expenses, Fortune 500 companies averaged twelve employees for every retiree. Today, there are only three workers for every retiree. For many companies, retiree health plans already are more costly than retiree pension benefits.

Some companies are especially burdened. For example, Bethlehem Steel Corp. had only 33,000 active employees in 1988 but supported 70,000 retirees and their spouses.[40] Among companies

[32]Anne M. Rappaport and Robert W. Kalman, "Financing Postretirement Medical Benefits: Assuring Economic Security for Retirees," in Paul and Disney, p. 271.

[33]Ibid.

[34]Bush et al., p. 321.

[35]Dopkeen, p. 565.

[36]Ibid., p. 583.

[37]Ibid., p. 566.

[38]Chollet and Friedman, "Employer-Paid Retiree Health Insurance," p. 210.

[39]See *America's Health Care Challenge: New Directions for Business, Government and Individuals* (Minneapolis: Northwestern Life Insurance Co., 1986); and Employee Benefit Research Institute, *Measuring and Funding Corporate Liabilities for Retiree Health Benefits* (Washington: EBRI, 1988).

[40]Amanda Bennett, "Firms Stunned by Retiree Health Costs," *Wall Street Journal*, May 24, 1988, p. 37.

reporting postretirement health care expenses, the annual expense was equal to 57 percent of net income at USX, 44 percent at Bethlehem Steel, and 23 percent at General Motors.[41] Postretirement health care expenses also are considered to have been a major factor in some corporate bankruptcies, including those of Allis-Chalmers and LTV.[42]

What is the magnitude of postretirement health care commitments for U.S. companies? Because companies have not been required to report their postretirement health care liabilities on their balance sheets, no one knows for sure. The estimates vary, ranging from a Department of Labor estimate of $98 billion to an American Enterprise Institute estimate of $332 billion. (See Table 13.9.) In general, almost all of this liability is unfunded. A study by Coopers & Lybrand and Hewitt Associates found that only 9 out of 4,000 companies surveyed were setting aside funds for retiree health benefits.[43] Other studies have placed the number of companies that prefund these obligations at less than 2 percent.[44]

Under a new accounting rule, to take affect in 1993, employers for the first time will be required to estimate and report their unfunded liabilities.[45] The results are expected to be shocking. According to one estimate, if the entire corporate sector had accrued liabilities for postretirement health care in 1989, corporate profits would have been reduced by 20 percent and net worth would have been reduced by 14 percent.[46] Among companies that have already calculated the effect of the accounting rule change, the cost will be $2.7 billion at General Electric Company, $2.26 billion at International Business Machines Corporation, and $1 billion each at Aluminum Company of America and American Airlines.[47] Chrysler Corporation's 1990

[41]*Business Week*, September 12, 1988, p. 94.

[42]*Institutional Investor*, May 1988, p. 106.

[43]Coopers & Lybrand and Hewitt Associates, *Non-Pension Benefits for Retired Employees—Study of Benefits and Accounting Practices* (1985).

[44]Dopkeen, p. 584.

[45]The Financial Accounting Standards Board (FASB) has issued the new rule in FASB, *Statement 106*.

[46]Mark J. Warshawsky, "Retiree Benefits: Promises Uncertain?" *The American Enterprise*, July/August, 1991, p. 63.

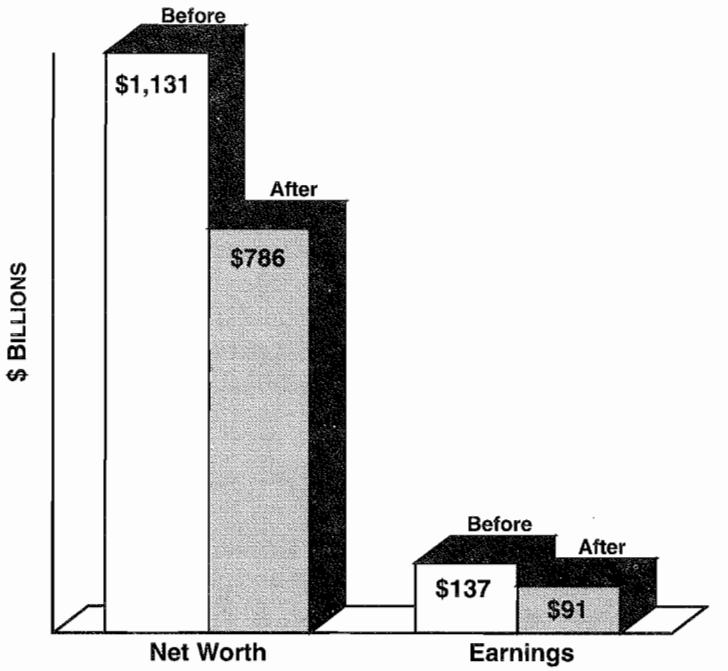
[47]Ibid.

Table 13.9
ESTIMATES OF ACCRUED LIABILITIES FOR RETIREE HEALTH BENEFITS: ALL PRIVATE CORPORATIONS
($ Billions)

Estimator	Current Retirees	Active Workers	Total
Department of Labor (1983)	$40.7	$57.4	$98.1
General Accounting Office (1988)	93.0	128.0	221.0
Employee Benefit Research Institute (1988)	98.0	149.0	247.0
American Enterprise Institute (1988)	145.0	187.1	332.1

SOURCE: Mark Warshawsky, *The Uncertain Promise of Retiree Health Benefits: An Evaluation of Corporate Obligations* (Washington: American Enterprise Institute, forthcoming).

Figure 13.6
HOW ACCRUAL OF LIABILITIES FOR RETIREE HEALTH BENEFITS WOULD HAVE AFFECTED 676 CORPORATIONS IN 1989



SOURCE: Mark J. Warshawsky, "Retiree Health Benefits: Promises Uncertain," *The American Enterprise* (July/August 1991), Figure 2 (p. 63).

retiree health care costs were $298 million, but the company calculates that its future liability is as much as $6 billion.

Of course not all companies will be equally affected by the accounting change. Some do not offer postretirement health care benefits. Figure 13.6 shows what the accounting change will mean for 676 companies with higher-than-average liabilities. As the figure shows, accruing the liabilities will reduce earnings by 33 percent and net worth by almost 30 percent.

At one time it was thought that an employer who faced financial problems could simply cease providing the postretirement health

care benefits. A series of court rulings has altered that assumption. In many cases, the courts have ruled that such promises are legally binding. That is one reason why Joseph Califano, former secretary of the Department of Health, Education, and Welfare, described the problem as "one of the world's greatest time bombs." Note also that the funding of postretirement health care by employers is not strictly a problem of paying for health care for the elderly. Among Fortune 500 companies, the average retirement occurs at 58.3 years of age.[48]

This mounting liability not only threatens the financial health of corporate America, but virtually ensures that employers will turn to the federal government—and therefore to taxpayers—to pick up a larger share of postretirement health care costs. For example, several companies (including Chrysler) and unions have announced support for a proposal to reduce the Medicare eligibility age from 65 to 60. Such a change would reduce total retiree health care liabilities by more than two-thirds and shift the burden to taxpayers.[49]

Government Barriers to Prefunding Postretirement Health Care Expenses

The fact that all major funding for health care expenses of the elderly is on a pay-as-you-go basis is no accident. The failure to save and invest today for expenses we know will arise tomorrow is exacerbated by a federal policy that discourages prudence and encourages increasing dependence on government.

Federal government policy toward health care expenses approaches the bizarre. We subsidize and encourage current health care spending while simultaneously discouraging savings for health care expenses during the retirement years. Tax subsidies for current health care expenditures are about $60 billion per year. Yet, with few exceptions, the federal government allows no tax deduction for the prefunding of future health care expenses and prohibits or penalizes the use of tax-deductible retirement savings to pay medical bills or purchase postretirement health insurance. A summary of the major elements of this perverse policy follows.

[48]Dopkeen, p. 558. Note that individuals become eligible for Medicare at age 65.

[49]Milt Freudenheim, "A Plan to Cover Early Retirees," *New York Times*, December 10, 1991.

Restrictions on Individuals

Under current tax law, individuals are not taxed on employer-paid health insurance premiums. In addition, individuals may deduct medical expenses above 7 percent of their income. But they may not deduct funds set aside to pay medical expenses during retirement. The one exception is that they may use funds in 401(k) savings plans to pay large medical bills. Because of the setup cost of these plans, however, they are often unavailable to the self-employed and to employees of small firms. Moreover, because 401(k) plans are employer-based, they are completely unavailable to the unemployed. Ironically, although Congress created tax deductions for individual retirement accounts (IRAs), Keogh plans, and 401(k) plans to encourage retirement savings, tax law forbids using the funds to obtain postretirement health insurance. Congress also has restricted the ability of individuals to save. The IRA deduction, for example, has been greatly limited despite research that concluded that 97 percent of every dollar put into an IRA account adds to total personal savings.[50]

Restrictions on Employers

Companies also are discouraged from saving for postretirement health care expenses. Prior to 1984, employers could use several vehicles to prefund employees' postretirement health care expenses. "Tax reform," however, severely limited the employers' ability to do that, despite a liability as high as $2 trillion. Employers are allowed one important option that is denied to individuals: They may take tax deductions for funds set aside to self-insure employer-provided health insurance. The amount is limited, however, and employer self-insurance appears to be prohibited from prefunding health costs to be incurred in the distant future.[51]

Employer Funding Options

The status of other common methods used by employers to fully or partially prefund postretirement medical expenses for their

[50]Steven F. Venti and David A. Wise, "Have IRAs Increased U. S. Saving? Evidence from Consumer Expenditure Surveys," Working Paper no. 2217 (National Bureau of Economic Research, April 1987).

[51]For a description of employer self-insurance and the reasons for this phenomenon, see John C. Goodman and Gerald L. Musgrave, "The Changing Market for Health Insurance: Opting Out of the Cost-Plus System," NCPA Policy Report no. 118 (Dallas: National Center for Policy Analysis, September 1985).

employees is summarized below. It should be borne in mind, though, that Congress, in its desire to remove tax deductions and increase federal revenues, has closed off virtually every option available to prefund postretirement health care expenses. To make matters worse, the few opportunities that do remain are being met with increasing congressional hostility.

401(h) Trusts

Primarily designed for pension plans, these trusts have been restricted by Congress. Contributions for medical benefits cannot exceed 25 percent of total contributions to the plan.[52]

501(c)(9) Trusts

Prior to 1984, tax-qualified trusts known as voluntary employee beneficiary associations (VEBAs) were ideal vehicles for prefunding postretirement health care. Today, contributions cannot take into account future medical inflation or increases in the use of medical services. This restriction alone limits the ability to fund future liabilities by 50 to 70 percent.[53]

Overfunded Pension Plans

It is not clear to what extent companies can put excess funds into a pension plan with the intention of using the excess to pay retirees' medical benefits.[54] Although the Reagan administration proposed such an option, Congress has not yet agreed.[55]

Company-Owned Life Insurance

Under current law, the best way for employers to prefund postretirement health insurance is by purchasing life insurance policies on their employees. Companies are increasingly turning to this option.[56] Under this procedure, the employer pays the policy premium and is the beneficiary. If an employee dies, the employer

[52]For a summary of the restrictions on the use of 401(h) trusts to prefund postretirement health care benefits, see Chollet and Friedland, pp. 211–14.

[53]David L. Glueck, "Congress, Auditors Pinch Retiree Plans," *Business Insurance*, June 2, 1986. For a summary of the restrictions on the use of 501(c)(9) trusts to prefund postretirement health care benefits, see Chollet and Friedland, pp. 211–14.

[54]See Dopkeen, pp. 577–78

[55]See Eduardo V. Feito and Murray S. Akresh, "Retiree Medical Benefits: Understanding the Concerns," *Journal of Compensation and Benefits* (March/April 1988): 277.

[56]See *Institutional Investor*, May 1988, pp. 108–9.

receives the death benefit tax free. While the employee lives, the cash value in the policy continues to accumulate tax free. Under either contingency, the funds can be used to pay health care benefits for retirees. If corporate-owned life insurance is placed inside a VEBA trust, the insurance premiums are deductible. If it is not, the premiums are not deductible but the company may borrow against the cash value of the policy and deduct the loan interest. However, Congress already has restricted the ability of employers to borrow against the cash value of policies, and some members would like to impose further restrictions.[57]

Building a New Approach to Funding Health Care and Retirement Needs

There is no coherent federal policy that promotes current saving to meet future needs. The few provisions that do encourage retirement savings appear randomly throughout the tax code, are largely unrelated to one another, and are totally unrelated to any clear policy objective. Congress should at the least retain the few retirement savings incentives that now exist. Much more can be done, however. To avert the financial nightmare in America's future, Congress should adopt policies with the following goals.

Saving for Postretirement Health Care Costs through Medical IRAs

The concept of medical IRAs (MIRAs), first proposed by the National Center for Policy Analysis (NCPA) in January 1984,[58] is steadily gaining public support. The concept has been endorsed by the American Medical Association; the U.S. Chamber of Commerce; former secretary of the Department of Health and Human Services, Otis Brown; numerous public policy groups; and members of Congress whose views span the ideological spectrum—from the late Sen. Claude Pepper (D-FL) to Rep. Philip Crane (R-IL). In a recent survey of employee benefits officers of large corporations, the creation of MIRAs was the most popular of all current proposals dealing with unfunded postretirement health care benefits.[59]

[57]See *Institutional Investor*, May 1988, p. 113.

[58]Peter Ferrara, John C. Goodman, Gerald L. Musgrave, and Richard Rahn, "Solving the Problem of Medicare," NCPA Policy Report no. 109 (Dallas: National Center for Policy Analysis, January 1984).

[59]"Introduction and Survey Highlights of the EQUICOR Health Survey VI: Looking to the Future of Retiree Health Benefits," in Paul and Disney, p. 108.

Several MIRA proposals have been introduced in Congress and have enjoyed both conservative and liberal support. In some versions, as in the original NCPA proposal, MIRAs would be used to privatize Medicare. In others, MIRAs would pay for medical expenses not covered by Medicare. In all versions, MIRA legislation would establish an explicit federal policy encouraging individuals to save for future health care needs. (See chapter 16.)

Integrating Lifetime Choices through Medical Savings Accounts

MIRAs would be an enormous improvement over our pay-as-you-go Medicare program. However, most MIRA proposals share with Medicare a principal defect: They would create an artificial dividing line—the age of 65, for example—beyond which individuals would pass from one method of health care finance to another. Health status, though, is partly a result of an individual's lifetime decisions, and rational health care finance requires an integrated lifetime plan. For example, it would not seem desirable to allow individuals to become financially impoverished by health care costs incurred at age 60 while hundreds of thousands of dollars sit in their MIRA accounts, untouchable until they reach the age of 65. An age limitation on the use of MIRA funds also discriminates against blacks and other minorities who have below-average life expectancies.[60] For example, according to current life expectancy tables, 40.1 percent of black males will die before the age of 65.[61] Under many MIRA proposals, these individuals would not have access to their MIRA funds to pay medical bills arising near the time of their death.[62]

A better approach—and one advocated by the authors for many years— would be to create medical savings accounts that could be used over the course of a lifetime, not merely after retirement.

Integrating Personal Choices with Employee Benefits Plans

Under current tax law, employer-paid health insurance premiums and health care expenditures are not included in employees'

[60]See John C. Goodman and Peter Ferrara, "Social Security and Race," NCPA Policy Report no. 128 (Dallas: National Center for Policy Analysis, June 1987), pp. 3–4.

[61]U.S. Bureau of the Census, *Statistical Abstract of the United States, 1987* (Washington: U. S. Government Printing Office, 1986), Table 106 (p. 70).

[62]Their MIRA accounts would become part of their estates, however, and become the property of their families or heirs.

taxable incomes—and, therefore, are effectively deductible. This tax advantage is withheld from individuals who purchase health insurance or health care services on their own. Similarly, employers are allowed tax deductions for money set aside to pay future medical costs for their employees (for brief periods of time) if they are self-insured, but no similar provision allows individuals to self-insure.

Absent the tax law, the only reason for employers to provide health insurance rather than paying higher wages would be the economies of scale that might make employer-arranged group insurance the most cost-effective choice for some employees. If such economies exist, they should be uncovered through free-market competition rather than artificial tax incentives. Additionally, employees should be free to integrate personal savings, personal health insurance, and employment fringe benefits into rational, lifelong financial plans. To achieve these objectives, however, we must make major changes in the employee benefits policies of most companies—and in the tax law.

Dismantling the Corporate Welfare State

Economic theory teaches that the value of a worker to a firm is equal to the worker's contribution to production and sales. Other things being equal, employees will tend to receive salaries and fringe benefits equal to the value of what they produce. In many corporations, though, the value of fringe benefits is related only loosely—if at all—to the workers' productivity. Because employers cannot successfully compete in the marketplace unless their total labor costs are roughly equal to the value of their employees' collective output, considerable redistribution of income takes place within the modern corporation.

Take company pensions, for example. Under the defined-contribution plans common in the academic world, employer contributions are related to workers' salaries, and the combined employer-employee contribution becomes the private property of the employee. But the most common form of pension in the for-profit sector is the defined-benefit plan. Under this arrangement, pension benefit formulas are back-end-loaded, with full benefits being paid only if employees remain with the firm for the whole of their work life. Even fully vested employees lose thousands of dollars in pension benefits if they leave employment prior to retirement. Numerous studies have shown that defined-benefit pension plans lead to

considerable redistribution of income.[63] Funds are redistributed from those who leave the firm to those who stay, from younger to older workers, and from those with shorter life expectancies to those with longer ones.

Like the defined-benefit pensions, postretirement health care benefits are defined benefits. They involve even more redistribution of income among employees than typical pension plans. What follows is a brief description of some of their characteristics.

1. **Postretirement health care benefits are usually the same for all retirees, regardless of final salary.** As Table 13.10 shows, in a representative postretirement health care benefit plan, there is no relationship between the benefit offered and the employees' salaries and productivity. For example, for 55-year-old retirees, the benefit is equal to about 55 percent of salary for a $100,000-a-year worker and about 336 percent of salary for a $15,000-a-year worker.
2. **Unlike defined-benefit pensions, postretirement health care benefits are indexed.** Because the benefit is a service rather than a cash benefit, its cost rises with medical inflation and increased use of health care services. For that reason, postretirement health care benefits are usually more valuable than pension benefits for low-income employees. In a representative plan, for 55-year-old retirees earning $25,000 a year, postretirement medical benefits are almost twice as valuable as pension benefits. For $15,000-a-year employees, medical benefits are more than three and one-half times more valuable than pension benefits.
3. **The value of postretirement benefits is unrelated to years of service to the firm.** Unlike pension benefits, postretirement medical benefits are an all-or-nothing arrangement. Employees receive either the full benefit or nothing. Moreover, the benefit is usually totally unrelated to the worker's lifetime service to the firm. In one survey of 250 large companies, at

[63]See Dennis G. Logue, "Pension Plans at Risk: A Potential Hazard of Deficit Reduction and Tax Reform," NCPA Policy Report no. 119 (Dallas: National Center for Policy Analysis, October 1985), pp. 6–9; and Edward J. Harpham, "Private Pensions in Crisis: The Case for Radical Reform," NCPA Policy Report no. 115 (Dallas: National Center for Policy Analysis, January 1984).

Table 13.10

RELATIONSHIP BETWEEN FINAL SALARY AND PRESENT VALUE OF POSTRETIREMENT HEALTH CARE BENEFITS

Annual Final Salary	Present Value of Health Care Benefits	Percent of Final Salary
Retirement at age 65		
$100,000	$32,000	32%
50,000	32,000	64
25,000	32,000	128
15,000	32,000	213
Retirement at age 55		
$100,000	$55,000	55%
50,000	55,000	110
25,000	55,000	220
15,000	55,000	336

SOURCE: Martin J. Zigler, *Postretirement Health Care Benefits* (Tillinghast, Nelson and Warren, Inc., 1985), p. 25 ff., cited in Dopkeen, Table 2 (p. 569).

the normal retirement age, 40 percent of the companies provide the benefit with no years-of-service requirement. An additional 43 percent offer the benefit to employees who have spent five years or less with the firm.[64]

4. **Retirees usually pay little or no premium for their health insurance coverage.** The elderly who are covered by employer-provided health insurance pay very little in premiums. For example, of retirees with individual coverage, 55.8 percent make no premium payment. Of retirees with coverage that includes their spouses, 46.5 percent make no premium payment. Only 3.5 percent of all companies require their retirees to pay the "full premium," and even in those cases, the "full premium" is the average premium paid by all employees, not the actuarially fair premium.[65]

Employer-provided health insurance benefits, as currently structured, are troublesome from the point of view of public policy. Employees today cannot possibly know whether they will be covered by such insurance during their retirement, since there is no guarantee they will be employed by any particular employer at or near their retirement. As a result, they cannot integrate personal financial planning for their retirement years with employer-provided benefits.

Creating Equity in the Tax Law

The tax law creates artificial distinctions between individuals who receive fringe benefits from employers and those who purchase identical benefits on their own. As a practical matter, the law discriminates against employees of small firms, the self-employed, and the unemployed. And because of the structure of most employer-provided health insurance, individual planning for medical expenses during retirement is almost impossible.

A much more equitable method would be to permit all individuals—regardless of employment status—to retain a certain portion of their earned income (say, 10 or 15 percent) tax-free, provided that it is used for certain well-defined purposes. Under this proposal, the cash value of every qualified fringe benefit would be attributed to

[64]Dopkeen, p. 560.

[65]Ibid., pp. 561–62.

a specific employee. The tax law would remain neutral, however, with respect to the manner in which such benefits were acquired. For example, some workers might wish to obtain low-premium catastrophic health insurance through their employer and place the premium savings in their own MIRA to self-insure for small medical bills. Others might prefer to have their employers maintain cash balances in individual medical accounts in addition to company-provided health insurance.

The important goal would be to maximize individual and company freedom of choice in planning for income security and health care needs. That would permit individual preferences and market forces, rather than tax law, to determine retirement choices.

Integrating Choices between Medical and Nonmedical Goods and Services

One way to achieve the complete privatization of Social Security, Medicare, and Survivors and Disability Insurance is through "Super IRAs."[66] This arrangement would be similar to the Chilean system, under which workers are given generous tax incentives to opt out of Chile's social insurance programs by investing in the Chilean equivalent of IRA accounts and by purchasing private health, disability, and life insurance.

Other countries have extended this concept further. Under Singapore's totally private system of forced savings and Britain's partially privatized social security system, individuals may use their IRA-type savings to purchase a house. Of all countries, Singapore has gone the furthest in giving individuals the freedom to allocate forced savings among three alternatives: (1) the purchase of a house, (2) income maintenance during retirement, and (3) medical expenses before and after retirement.[67]

[66]See Peter Ferrara, *Social Security: The Inherent Contradiction* (Washington: Cato Institute, 1980); Peter Ferrara, ed., *Social Security: Prospects for Real Reform* (Washington: Cato Institute, 1985); Peter Ferrara, "The Social Security System," in Stuart Butler, Michael Sanera, and W. Bruce Weinrod, eds., *Mandate for Leadership II: Continuing the Conservative Revolution* (Washington: Heritage Foundation, 1984); and Peter Ferrara, *Rebuilding Social Security, Part 2*, Heritage Foundation Backgrounder no. 346 (April 1984).

[67]For a description of the social security systems of Chile, Britain, and Singapore, see chapter 20.

Singapore's system implicitly recognizes the fact that individual preferences and circumstances differ. It also recognizes that health care is only one of many goods and services that people want, and it gives them considerable freedom to match their spending decisions to their own needs and preferences.

The Need for Change

The current pay-as-you-go system of providing for the income maintenance and health care needs of elderly retirees has all of the characteristics of an officially sanctioned chain letter. Those who have retired early under the system have done well. Elderly retirees receive Social Security retirement benefits four to six times greater and Medicare benefits ten to twelve times greater than the taxes they paid.

Today's young people are at great risk because of political promises that are being made with no realistic plan for fulfillment. Genuine security for future retirees can be achieved only by phasing out the system under which each generation hopes that the next generation will pay for its retirement needs. We must move as rapidly as possible to a new system under which each generation saves to pay its own way in retirement.

14. The Uneasy Case for Medicare

Because of record deficits, our federal budget is being scrutinized to determine which programs have merit and which do not. As one looks down the list of spending programs, it is clear that various programs exist to meet fairly well-defined objectives—for example, to help the needy, to help minority groups, to provide for the national defense, and to promote the general welfare. Even within the category of federal spending on health care, most programs exist to meet clearly defined social goals. Medicaid exists to provide health care for the poor. The Department of Veterans Affairs hospital system arguably is part of our national defense effort. Medical research arguably promotes the general welfare. Medicare, however, does not fall into any such category. The more carefully one looks at Medicare, the more difficult it is to understand its rationale.

Medicare Beneficiaries Did Not Pay for the Benefits They Receive

Medicare is an insurance policy that pays the health care bills of those who qualify as beneficiaries. In any given year, only a small percentage of beneficiaries will have substantial bills paid by Medicare. On the average, about 78 percent of all Medicare spending pays for health care services used by only 11 percent of the program's beneficiaries. About 40 percent of all beneficiaries generate no Medicare payments.[1] However, even those who have no medical bills derive something of value from Medicare: protection of assets from unforeseen medical expenses and the sense of security that protection affords.

[1]Congressional Budget Office, *Changing the Structure of Medicare Benefits* (Washington, March 1983), p. 17. See also Karen Davis, "Medicare Reconsidered," prepared for the Duke University Medical Center 7th Private Sector Conference on the Financial Support of Health Care of the Elderly and the Indigent, Durham, N.C., March 14–16, 1982; cited in *New England Journal of Medicine* 306, no. 21 (May 27, 1982): 1310.

One way to evaluate Medicare is to ask what a beneficiary would pay for a similar insurance policy in the private marketplace. Ignoring administrative costs, private insurers would have to charge premiums roughly equal to the amount that Medicare spends per beneficiary per year. In 1989, that amount was about $2,970.[2] Thus the value of Medicare to retirees is about one-half of the value of the annual Social Security benefit of $6,802.[3]

A little known fact about Medicare is that its beneficiaries have paid into the program in taxes only a small fraction of the amount they are receiving and can expect to receive in benefits. For a retiree who earned the median wage, all Medicare tax payments can be expected to be recovered in one year and five months. Retirees who paid the maximum tax since the program began can expect to receive all of their Medicare tax payments back in four years and five months. Given that those who are now 65 can expect to live to 86, their expected benefits are going to be far in excess of their contributions.[4] For example, even without future increases in Medicare benefits, male beneficiaries who are now age 65 can expect to receive 17 times more in Medicare benefits than they paid in taxes, those who are 70 can expect 31 times more, those who are 75 can expect 63 times more, and those who are 80 can expect 137 times more. If these beneficiaries have dependent spouses who never worked and never paid Medicare payroll taxes, expected Medicare benefits will more than double.[5]

Medicare, then, is a program that takes billions of dollars from some Americans to pay the medical bills of others. For those on the receiving end, the program is a bonanza.

[2]Spending per beneficiary under Medicare Part A (hospital insurance) was approximately $1,787 and net spending under Medicare Part B (supplemental medical insurance) was $1,153. The difference between the sum of these two figures and $2,970 is attributable to the differences between calendar year data and fiscal year data.

[3]"National Health Expenditures," *Health Care Financing Review* (Winter 1990), Tables 7, 9 (pp. 10, 12).

[4]Ignores interest rate compounding.

[5]These estimates are based on life expectancy statistics available from the National Center for Health Statistics. They assume the worker earned the median wage each year since Medicare was enacted and that he retired at age 65. The calculations ignore the time value of money.

Medicare Beneficiaries Are Financially Better Off Than Medicare Taxpayers

When the Medicare program was enacted in 1965, it was part of the War on Poverty. Ever since, it has been viewed as a poverty program. Yet, Medicare does not take from the rich and give to the poor; if anything, it does the reverse. By virtually every estimate, the elderly as a group have more aftertax income and more wealth per capita than the nonelderly.

Since the early 1980s, for example, the Bureau of the Census has reported that the elderly have a higher per capita income than the nonelderly, both before and after paying taxes. According to former secretary of commerce Peter Peterson, Bureau of the Census statistics for 1984 showed that per capita cash income was $10,316 for the elderly, compared with $10,190 for those under the age of 65. Aftertax, the elderly had 13 percent more annual income, $8,886 compared with $7,876 for the nonelderly. If noncash medical benefits from public and private insurance are included, the elderly had 33 percent more annual income—$11,386 compared with $8,576 for the nonelderly.[6]

Tax returns filed with the Internal Revenue Service tell a similar story. In 1986, as Table 14.1 shows, elderly taxpayers had $31,865 in pretax income, compared with $26,199 for the nonelderly. Since these returns typically reflect household income, the discrepancy would be even greater if calculated on a per capita basis. Since the average adjustment to gross income is $8,425 for elderly taxpayers, compared with $2,024 for nonelderly taxpayers, the elderly pay less tax on more income.

Every method of estimating income has problems. For example, the Bureau of the Census typically underestimates income, intentionally excluding the value of employee fringe benefits and capital gains income.[7] Tax returns exclude those people who do not file (about 38 percent of the elderly and 5 percent of the nonelderly), and

[6]Peter Peterson and Neil Howe, *On Borrowed Time* (San Francisco: Institute for Contemporary Studies, 1988), p. 94.

[7]Including these items would support our general conclusion. For example, the value of Medicare insurance for an elderly individual is much greater than the value of employer-provided, private insurance for a nonelderly individual. In addition, elderly taxpayers have almost three times as much capital gains income as nonelderly taxpayers.

Table 14.1
AVERAGE INCOME OF TAXPAYERS[1]

Source of Income	Elderly[2]	Nonelderly
Wages and salaries	$ 4,727	$21,864
Social Security benefits[3]	4,622	122[4]
Pensions	4,694	521
Interest	6,952	861
Dividends	2,317	351
Capital gains[5]	7,266	2,459
Other capital income	1,287	21
Total[6]	$31,865	$26,199

SOURCE: Estimates based on tax return data. See Internal Revenue Service, *Statistics of Income—1986, Individual Income Tax Returns* (Washington: U.S. Government Printing Office, 1988), Table 2.5. Reprinted from John C. Goodman, Aldona Robbins, and Gary Robbins, *Elderly Taxpayers and the Capital Gains Debate*, NCPA Policy Report no. 153 (Dallas: National Center for Policy Analysis, July 1990), Table II (p. 3).

[1]Refers only to people who filed tax returns for 1986, the latest year for which statistics at this level of detail are available. Note that about 38 percent of elderly families and 5 percent of nonelderly families do not file tax returns. See U.S. Department of the Treasury, *Financing Health and Long-Term Care: Report to the President and Congress* (Washington: March 1990), Table 4.1.

[2]At least one person on the tax return is age 65 or older.

[3]All Social Security benefits reported, including untaxed benefits. The reported figure is below the actual number because most low-income taxpayers do not report this item.

[4]Includes early retirees, ages 62 to 64.

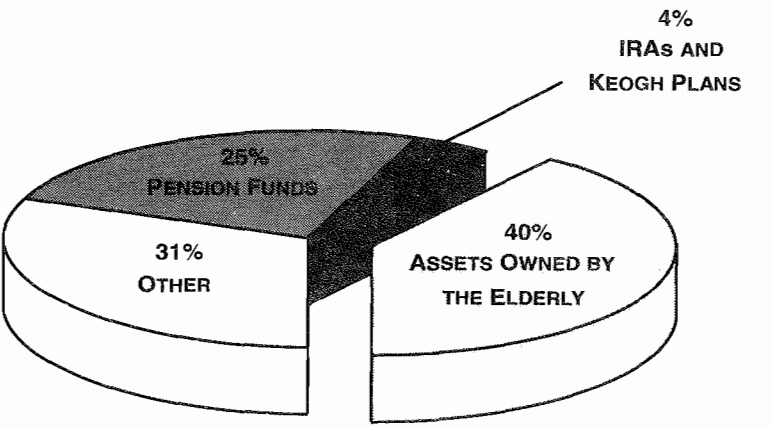
[5]Includes the portion of capital gains income excluded on 1986 tax returns.

[6]Totals show gross income prior to adjustments. The average adjustment is −$8,425 on elderly income tax returns and −$2,024 on nonelderly returns.

low-income taxpayers typically do not report their Social Security income. Nonetheless, evidence from a variety of sources points to the conclusion that, on the average, the elderly have more income than the nonelderly.

The elderly also have more assets. Using three different data sets to estimate the distribution of assets by age, economists Aldona Robbins and Gary Robbins have concluded that although the elderly constitute only 12 percent of the population, they hold about

Figure 14.1
OWNERSHIP OF U.S. CAPITAL ASSETS



SOURCE: John C. Goodman, Aldona Robbins, and Gary Robbins, *Elderly Taxpayers and the Capital Gains Tax Debate,* NCPA Policy Report no. 153 (Dallas: National Center for Policy Analysis, July 1990).

40 percent of all the capital assets in the United States.[8] (See Figure 14.1.) On the whole, the elderly receive about 53 percent of all interest income, 52 percent of all dividend income, 30 percent of all capital gains income, and 32 percent of the income from all other sales of assets.[9]

Far from being a poverty program, Medicare takes taxes from the working poor and pays the medical bills of retired millionaires. It certainly cannot be justified on the grounds that it promotes greater equality of income and wealth.

Medicare Is Unfair to Minorities

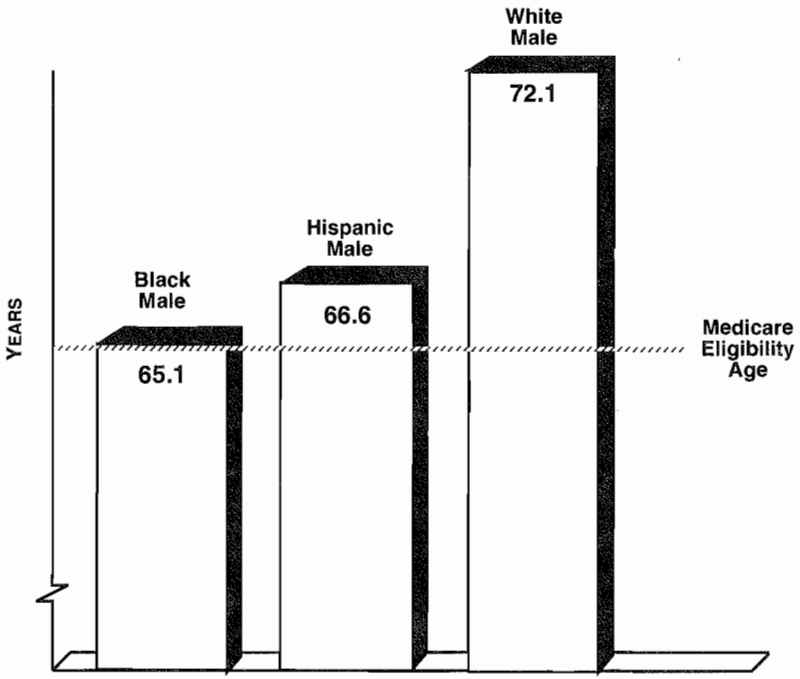
Both Medicare and Social Security discriminate against minorities.[10] That is because black and Hispanic Americans have lower life expectancies than white Americans, and both programs pay

[8]See Aldona Robbins and Gary Robbins, *Taxing the Savings of Elderly Americans,* NCPA Policy Report no. 141 (Dallas: National Center for Policy Analysis, September 1989), appendix B.

[9]Refers to the sale of assets held for less than one year.

[10]John C. Goodman, *The Effect of the Social Security Reforms on Black Americans,*

Figure 14.2
LIFE EXPECTANCY FOR U.S. MALES AT BIRTH



SOURCE: U.S. Bureau of the Census, *Statistical Abstract of the United States, 1990* (Washington: U.S. Government Printing Office, 1990), p. 72; and the National Center for Policy Analysis.

benefits based on age. For example, the life expectancy of a black male at birth is seven years shorter than that of a white male, and the life expectancy of a black female is about five years shorter than that of a white female. Because the eligibility age for Medicare is the same for both races, whites get much the better deal from the program.

As Figure 14.2 shows, a black male at birth has a life expectancy of 65.1 years, a Hispanic male 66.6 years, and a white male 72.1

NCPA Policy Report no. 104 (Dallas: National Center for Policy Analysis, July 1983); and John C. Goodman and Peter Ferrara, *Social Security and Race*, NCPA Policy Report no. 128 (Dallas: National Center for Policy Analysis, June 1987).

years. All three pay the same payroll tax rates. But the white male can expect to receive Medicare benefits five times greater than those received by his Hispanic counterpart, and the black male can expect to die about one month after he becomes eligible for benefits. Even at age 20, the differences between blacks and whites is striking. A 20-year-old white male can expect to receive 47 percent more in Medicare benefits than his black male counterpart. A 20-year-old white couple can expect to receive 35 percent more in Medicare benefits than a 20-year-old black couple.[11]

Black and Hispanic Americans, therefore, tend to be overrepresented among Medicare taxpayers and underrepresented among Medicare beneficiaries. More than 17.7 percent of the population of tax-paying age is nonwhite.[12] Only 13.6 percent of all Medicare beneficiaries are nonwhite.[13]

It is also instructive to look at the representation of minorities in Medicare, in which eligibility is based on age, versus their representation in Medicaid, in which eligibility is based on income. Nonwhites constitute only 13.6 percent of all Medicare beneficiaries, but about 46.8 percent of all Medicaid beneficiaries.[14] Moreover, when the federal government has felt the necessity of slowing the growth of federal spending, it has trimmed Medicaid—not Medicare—more often.

Under the Reagan administration, the Social Security Advisory Council proposed that the eligibility age for Medicare be raised from 65 to 67. If this proposal were adopted, a black male age 20 would lose 100 percent of his expected benefits under Medicare, whereas his white counterpart would lose only 25 percent. A black female age 20 would lose 19 percent of her expected benefits, whereas a white female would lose only 14 percent. Moreover, unlike the recent reforms in the Social Security retirement age, the advisory council's proposal would index the eligibility age for Medicare to gains in life expectancy. The probable effect of this change (which

[11]Goodman and Ferrara, *Social Security and Race,* Table VI (p. 16).

[12]U.S. Bureau of the Census, *Statistical Abstract of the United States: 1987* (Washington: 1986), p. 17.

[13]U.S. Department of Health and Human Services, *1989 HCFA Statistics* (Baltimore: 1989), p. 7.

[14]Ibid., p. 12.

was not adopted) would be that blacks, especially black males, could always expect to receive virtually nothing from Medicare.

Medicare Is Unfair to the Young

As in the case of a chain letter, those who cash in early benefit disproportionately. The latecomers pay in far more than they can expect to receive. Consider those workers who earned the median wage and retired in 1989. In just two years, they can expect to receive more in Medicare benefits than they paid throughout their working lives in Medicare taxes, and over the remainder of their lives they can expect to receive about $58,000 more than they paid. If a retiree has a dependent spouse, together they can expect to receive more than $100,000 more in benefits than they paid in taxes.[15]

A far different scenario confronts today's young workers. As Table 14.2 shows, a 20-year-old male can expect to pay considerably more in Medicare taxes than he will receive in Medicare benefits. If he is a high-income worker, he can expect to pay from four to eight times more; if he is a median-income worker, he'll pay from three to five times more. If the worker earns only 50 percent more than the minimum wage, he can expect a loss equal to as much as one-third of his current annual income. Table 14.3 shows that a 20-year-old female worker faces similarly dismal prospects under Medicare. Table 14.4 shows that virtually all workers under the age of 50 can expect substantial losses as a result of forced participation in the system.[16] (See Figure 14.3.)

Medicare, then, redistributes a vast amount of wealth from the working population to today's elderly. For current beneficiaries, it is a windfall. For current taxpayers, it is a losing proposition, even if they can convince future taxpayers to shoulder the enormous burden of their benefits.

The Criteria for Medicare Eligibility Are Arbitrary

All an individual has to do to be eligible for Medicare benefits is to reach the age of 65. For a person at 64 years and 11 months old,

[15]Based on estimates made by the U. S. Department of Health and Human Services.

[16]Note that in all these calculations the expected benefits probably are overstated. That is because, unlike Social Security retirement pensions, Medicare benefits are not paid in cash. They are benefits in kind. In many cases, the value that people place on the benefit is much less than the cost to the government of providing it.

Table 14.2
VALUE OF PARTICIPATION IN MEDICARE FOR SINGLE MALES AGE 20 IN 1986 AT REAL RATES OF INTEREST OF 4 PERCENT AND 6 PERCENT*

Category	At 4 Percent	At 6 Percent
Low-income workers		
Expected benefits	+$8,863	+$3,732
Expected taxes	−9,984	−6,784
Past taxes	−598	−616
Net present value	−$1,719	−$3,668
Median-income workers		
Expected benefits	+$8,342	+$3,339
Expected taxes	−24,945	−16,561
Past taxes	0	0
Net present value	−$16,603	−$13,222
High-income workers		
Expected benefits	+$8,068	+$3,134
Expected taxes	−37,003	−24,004
Past taxes	0	0
Net present value	−$28,935	−$20,870

SOURCE: Calculations made by William T. Rule III of Peat, Marwick, Main & Co. Reprinted from John C. Goodman and Peter Ferrara, *Social Security: Who Gains? Who Loses?* NCPA Policy Report no. 153 (Dallas: National Center for Policy Analysis, July 1990), Table II, p. 3.

*Assumptions: (1) Workers' lifetime average annual earnings are equal to 150 percent of the minimum wages ($10,050 per year in 1986) in the case of low-income workers, to the median income earned by adult male workers ($26,605 in 1986) in the case of median-income workers, and to the maximum taxable Social Security wage ($42,000 in 1986) for high-income workers; (2) workers enter the labor market at age 18 for low-income workers, age 22 for median-income workers, and age 24 for high-income workers; and (3) at every age, workers are assumed to have worked continuously since entering the labor market.

Medicare pays nothing. One month later, Medicare pays lavishly. Aside from age, little else matters. The following is a brief discussion of some other Medicare eligibility characteristics.

You don't have to be poor to be covered by Medicare. Medicare is not a poverty program. Several hundred thousand millionaires are either covered or can be if they so choose.

Table 14.3
VALUE OF PARTICIPATION IN MEDICARE FOR SINGLE FEMALES AGE 20 IN 1986 AT REAL RATES OF INTEREST OF 4 PERCENT AND 6 PERCENT*

Category	At 4 Percent	At 6 Percent
Low-income workers		
Expected benefits	$11,495	$4,534
Expected taxes	−10,272	−6,943
Past taxes	−598	−616
Net present value	$625	−$3,025
Median-income workers		
Expected benefits	$10,993	$4,143
Expected taxes	−16,533	−10,921
Past taxes	0	0
Net present value	−$5,540	−$6,778
High-income workers		
Expected benefits	$10,734	$3,941
Expected taxes	−34,180	−24,648
Past taxes	0	0
Net present value	−$23,446	−$20,707

SOURCE: Calculations made by William T. Rule III of Peat, Marwick, Main & Co. Reprinted from John C. Goodman and Peter Ferrara, *Social Security: Who Gains? Who Loses?* NCPA Policy Report no. 153 (Dallas: National Center for Policy Analysis, July 1990), Table II, p. 3.
NOTE: Columns may not add due to rounding.
*Assumptions same as for Table 14.2 except that median-income workers are assumed to earn the median wage paid to adult female workers ($16,472 in 1986).

You don't have to be retired to be covered by Medicare. Unlike Social Security, you do not have to quit work to receive benefits. In principle, the president of a multinational corporation can receive Medicare benefits, courtesy of the taxes paid by other employees. The corporation's private insurance plan would be the payer of first resort, however.

You don't have to pay Medicare taxes to be covered by Medicare. People who are over 89 years of age and are drawing Social Security benefits never paid a dime into Medicare. But they have received tens of thousands of dollars of benefits. Individuals reaching 65

Table 14.4

VALUE OF PARTICIPATION IN MEDICARE FOR SINGLE WORKERS AT DIFFERENT AGES IN 1986 AT REAL RATES OF INTEREST OF 4 PERCENT AND 6 PERCENT

Worker's Age	Single Male		Single Female	
	At 4 Percent	At 6 Percent	At 4 Percent	At 6 Percent
Low-income workers				
20	−$1,720	−$3,668	+$624	−$3,025
25	−2,192	−5,021	+416	−4,217
30	−2,577	−6,433	+407	−5,400
35	−2,592	−7,553	+787	−6,250
40	−1,575	−7,400	+2,244	−5,764
45	+672	−5,555	+5,003	−3,495
50	+3,251	−3,245	+8,202	−633
Median-income workers				
20	−16,603	−13,222	−5,540	−6,778
25	−16,201	−14,602	−4,614	−7,206
30	−17,034	−27,316	−4,524	−8,529
35	−17,802	−20,325	−4,348	−9,957
40	−17,337	−22,118	−3,273	−10,468
45	−14,341	−20,551	−399	−8,618
50	−10,012	−17,022	+3,551	−5,237

(Continued on next page)

Table 14.4—Continued

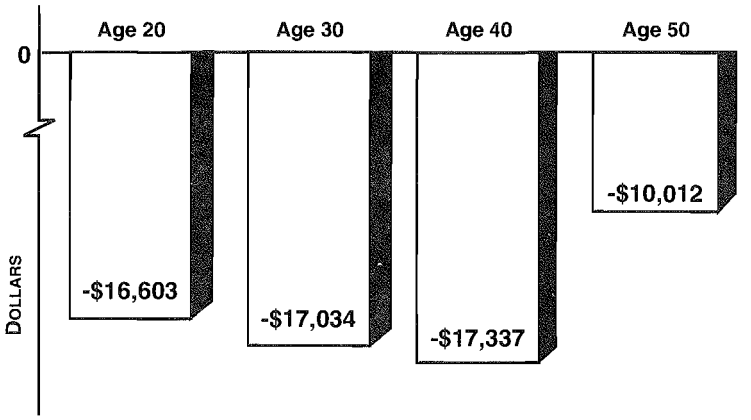
VALUE OF PARTICIPATION IN MEDICARE FOR SINGLE WORKERS AT DIFFERENT AGES IN 1986 AT REAL RATES OF INTEREST OF 4 PERCENT AND 6 PERCENT

Worker's Age	Single Male		Single Female	
	At 4 Percent	At 6 Percent	At 4 Percent	At 6 Percent
High-income workers				
20	−28,935	−20,870	−27,446	−20,708
25	−28,282	−22,756	−26,455	−22,407
30	−29,584	−26,633	−27,271	−26,012
35	−29,327	−29,147	−26,537	−28,228
40	−27,694	−30,280	−24,413	−29,019
45	−24,263	−29,250	−20,427	−27,560
50	−18,361	−24,624	−13,835	−22,352

SOURCE: Calculations made by William T. Rule III of Peat, Marwick, Main & Co. Reprinted from John C. Goodman and Peter Ferrara, *Social Security: Who Gains? Who Loses?* NCPA Policy Report no. 153 (Dallas: National Center for Policy Analysis, July 1990), Table II (p. 3).

NOTE: Assumptions same as for Table 14.2.

Figure 14.3
EXPECTED LOSS FROM PARTICIPATING IN MEDICARE FOR WORKERS AT DIFFERENT AGES*
(Male Workers Earning the Median Wage)



SOURCE: Table 14.3.

*Present value of Medicare benefits minus Medicare taxes. Calculations assume a 4 percent real rate of interest, and the numbers are expressed in 1986 prices. Assumptions behind the calculations are discussed in the appendix to this chapter.

today can also become eligible for benefits, even if they never paid taxes into the program. (They include employees of the federal, state, and local governments, and nonprofit institutions that have elected to get out of Social Security.) They can receive Medicare Part A (hospital insurance) by paying a monthly premium of $177 and Medicare Part B (supplemental medical insurance) benefits by paying a monthly premium of $29.90.[17] These premiums are an exceptionally good deal for elderly individuals with known illnesses who face very expensive medical procedures.

You don't have to be a good citizen to be covered by Medicare. You can break any number of laws and still be covered. According

[17]Source: U.S. Department of Health and Human Services, Health Care Financing Administration.

to federal regulations, the only crime for which an individual is tossed out is plotting an overthrow of the federal government—that is, of the people who give us Medicare.[18]

You don't have to be a citizen to be covered by Medicare. Noncitizens who become permanent residents and remain in the United States or one of its territories for five years can become eligible.[19] Had they lived for a few more years, even the shah of Iran or Ferdinand Marcos could have been covered.

The Long-Term Problem of Medicare: A Crisis in Funding

Like Social Security, Medicare is viewed by most people as a government insurance program, fully comparable in concept to a private insurance plan. This image is encouraged by Department of Health and Human Services publications and by the pronouncements of bureaucrats. The payroll taxes that fund Medicare are called "contributions." The surplus of taxes over expenditures is said to "accumulate" in a "trust fund." People are led to believe that the benefits paid out by Medicare are "in return for" contributions made during their working years. If officials of a private health insurance company made comparable claims, they would be risking imprisonment.

The Medicare "trust fund" is largely a myth. No money is being stored away for later use. Every dollar paid into Medicare is spent by the federal government the moment it arrives. Medicare, like Social Security, is strictly "pay-as-you-go."[20] And no one knows whether the next generation will support a system to which it never consented and from which it can never gain.[21]

[18]Treason is the only crime that disqualifies a person from Medicare coverage. However, Medicare benefits are suspended during any term of imprisonment because penal institutions are obligated to provide medical services for their inmates.

[19]Commerce Clearinghouse, Inc., *Medicare and Medicaid Guide* (Chicago: CCI, 1983), p. 1405.

[20]For a nontechnical discussion of the pay-as-you-go nature of our Social Security system, see John C. Goodman and Edwin Dolan, *Economics of Public Policy*, 2d ed. (St. Paul: West Publishing Co., 1982), ch. 7.

[21]For a more complete discussion of the nature of the Social Security crisis, see Peter Ferrara, *Social Security: The Inherent Contradiction* (Washington: Cato Institute, 1980); and A. Haeworth Robertson, *The Coming Revolution in Social Security* (McLean, Va.: Security Press, 1981).

The real long-term funding problem of Medicare is that it is putting today's children at risk. Prudence demands that we act now to relieve this risk. Chapter 15 looks at a specific way to do so.

Appendix: Assumptions behind the Calculations of the Present Value of Medicare

The statistics on the present value of Medicare benefits used in this chapter were calculated by William T. Rule III of Peat, Marwick, Main & Co. What follows is a discussion of the assumptions behind the calculations.

Labor Market Participation

Workers are assumed to enter the labor market at age 18 (low-income workers), age 22 (median-income workers), and age 24 (high-income workers). They are assumed to work continuously until they reach the age of 65, unless disabled. A computer program calculates the probability that a worker will become disabled sometime in the future, and that a worker, once disabled, will later reenter the labor market.

Expected future taxes and benefits are calculated for workers at different ages. In each calculation, it is assumed that the worker has worked continuously from the time of entry into the labor market until the time the calculation is made. However, the calculation includes the probability of future disability.

Future Wages

Workers enter the labor market at a certain wage. From that point forward, the worker's real income is expected to grow at the same rate as the rate of growth of real wages in the economy as a whole. This rate is 1.5 percent per year, according to the Social Security Administration's intermediate assumptions.

Future Benefits

Only Part A Medicare benefits are included. It is assumed that the benefit formulas currently written into law will remain in effect indefinitely. It is further assumed that the future amount spent per beneficiary will grow according to the intermediate assumptions. Note that individuals under the age of 65 may receive Medicare benefits as a result of disability, in addition to qualifying for normal coverage at the age of 65.

Future Taxes

All calculations are based on the assumption that promises made under Medicare will be kept and will be financed by increases in the payroll tax, whenever necessary, to pay promised benefits. For the purposes of these calculations, the portion of the total payroll tax counted as Medicare taxes is equal to the proportion of all spending from the trust funds allocated to Medicare benefits in any given year.

Expected Values

The computer program calculates the probability that an individual will live to all possible ages up to 105. For each possible lifespan, it calculates the associated costs and benefits. Expected value is the sum of all possible outcomes, each weighted by its probability of occurring. These calculations include the probability of disability and of death at each age. The expected value of participation in Medicare is included in Tables 14.2, 14.3, and 14.4.

15. Privatizing Medicare with Medical IRAs

A major difference between Medicare and Social Security is that under Social Security money is given directly to beneficiaries. As a result, when the beneficiaries spend Social Security dollars on goods and services, they treat the money as their own. By contrast, money spent under Medicare goes to entities other than the beneficiaries—doctors, hospitals, and other health care providers. Thus, when Medicare beneficiaries "spend" a dollar on medical care, it is not a dollar they could have spent on other goods and services. When they make purchases in the health care marketplace, they are spending someone else's money. Small wonder, then, that one hears little about wasteful spending of Social Security benefits but a great deal about wasteful spending of Medicare funds.

For example, an area of great potential waste is care given to patients who are near death. A remarkable fact is that 28 percent of all Medicare spending is for the treatment of patients in the last year of their lives and 11 percent is for their final 40 days.[1] If Medicare patients were spending their own dollars, it is not at all clear that they would choose to deplete their estates to prolong their lives so marginally. On the other hand, there is no economic reason not to spend someone else's money to achieve marginal benefits. Moreover, the providers of medical services often find it in their economic self-interest to increase spending under the program.

At the same time, important decisions about the elderly's access to health care are being made by the Medicare bureaucracy. They include apparently arbitrary decisions to underpay rural hospitals, to fail to cover important technological innovations, and to fail to compensate hospitals for the care of expensive-to-treat patients. The right to decide such issues should be transferred from the bureaucrats to the patients themselves.

[1]Data obtained from the U.S. Department of Health and Human Services.

Medical IRAs

The long-term problems of funding and inefficiency in Medicare and the threat of rationing caused by Medicare's reimbursement formulas necessitate radical reform. In designing a plan for such reform, we are guided by two principles. First, given appropriate government policies, most individuals can and should be responsible for paying for their own medical care (either directly or through private insurance) during their retirement years. Second, to most efficiently allocate resources and ensure freedom of choice in the medical marketplace, individuals should bear the costs and reap the benefits of their own decisions whenever possible.

One way to satisfy both principles is by creating a system under which individuals make annual contributions to qualified individual retirement accounts called Medical IRAs (MIRAs).[2] Sufficient funds would accumulate in these accounts to enable individuals to pay for their own medical expenses and/or to purchase private health insurance for their retirement years. These individuals would have partially or completely opted out of Medicare. The choice to opt out of Medicare would be voluntary. However, those doing so would be given tax credits for their MIRA contributions, and the tax credits would be structured so that individuals would find it in their financial self-interest to make MIRA contributions.

The concept behind the Medical IRA proposal is to allow workers to withdraw an amount equal to all, or almost all, of the payroll taxes they now pay into Medicare and to place those funds in a private savings account. The funds would be used to pay for medical expenses and private health insurance in retirement, in lieu

[2]Variously called medical IRAs, health care savings accounts (HCSAs), health bank IRAs, and individual medical accounts (IMAs), savings for postretirement medical care have been included in proposals to supplement, privatize, or replace Medicare. The original proposal to create such accounts was made in John C. Goodman, Peter A. Ferrara, Gerald L. Musgrave, and Richard Rahn, *Solving the Problem of Medicare*, NCPA Policy Report no. 109 (Dallas: National Center for Policy Analysis, January 1984). The proposal received considerable visibility based on the summary that appeared in John C. Goodman and Richard Rahn, "Salvaging Medicare with an IRA," *Wall Street Journal*, March 20, 1984. That same year, Singapore initiated the Medisave account. Another version of the idea was developed in Peter J. Ferrara, *Averting the Medicare Crisis: Health IRAs*, Cato Institute Policy Analysis no. 62 (Washington: Cato Institute, October 31, 1985). Ferrara's version of the proposal became the basis for a bill that has subsequently been introduced in several sessions of Congress.

Table 15.1
SOURCES OF FUNDS FOR POSTRETIREMENT HEALTH CARE*

MIRA Contributions	Value of Medicare Coverage	Total Resources
0	$30,000	$30,000
$10,000	25,000	35,000
20,000	20,000	40,000
30,000	15,000	45,000
40,000	10,000	50,000
50,000	5,000	55,000
60,000	0	60,000

*In 1990 dollars.

of Medicare. The federal government's role would be limited to administering a diminishing Medicare program and providing means-tested benefits through Medicaid. In what follows, we discuss two ways of designing a system that would achieve these objectives.

The National Center for Policy Analysis Proposal

In 1984, a MIRA proposal was developed for the National Center for Policy Analysis by John Goodman, Peter Ferrara, Gerald Musgrave, and Richard Rahn.[3] Under the proposal, people would receive a $1 tax credit for each $2 contributed to a medical IRA. Effectively, for each $2 of personal funds contributed to a MIRA, the federal government would contribute another $1 in the form of reduced income taxes.

Individuals would be able to trade private savings in MIRA accounts for government promises under Medicare in the following way. For each $1 contributed to a MIRA account, an individual would forgo a claim against Medicare of 50 cents. Thus, at the time of eligibility for Medicare, for each $1 in Medicare benefits that individuals do not receive, they would have $2 of private savings in their MIRA accounts or the insurance equivalent of that amount.

Table 15.1 shows how MIRAs would combine with Medicare to provide total funding for postretirement health care needs. As of 1990, lifetime coverage under Medicare is worth approximately

[3]Goodman et al., *Solving the Problem of Medicare.*

$30,000 to an individual at age 65. Medicare, moreover, can be expected to pay about half of a retiree's medical expenses. As Table 15.1 shows, people who choose the MIRA option would have enough to cover their entire expected medical expenses during retirement—about $60,000 (in 1990 dollars). The $30,000 of private savings replacing Medicare coverage would be made possible by federal dollars (income tax credits). Retirees would have the further advantage of an additional $30,000 that would accumulate with tax-free interest.

A person who reached the age of 65 with $60,000 reserved for postretirement medical expenses would have new options in the medical marketplace. For example, a small part of the money could be used to purchase catastrophic hospital insurance and a limited nursing home benefit. The remainder could be kept in the MIRA account, continuing its tax-free buildup, and used for medical expenses at the discretion of the retiree—without the hassles or encumbrances of Medicare.

Refundable Tax Credits

All people under the age of 65 would be allowed to make annual contributions to designated MIRAs and receive a 50 percent income tax credit for those contributions. The maximum annual contribution would be equal to the average Medicare (hospital insurance) payroll tax for all workers, which was $583 in 1989.[4] People could deposit more money in their MIRAs, but they would not receive a tax credit for the additional amounts. To encourage low-income individuals to exercise the MIRA option, tax credits would be refundable. A person with no taxable income would be able to make annual contributions to a MIRA, with 50 percent of the money being provided directly in the form of a tax refund granted by the federal government.

The Disposition and Tax Status of Medical IRA Funds

Because the MIRA is a private alternative to Medicare, funds deposited in this account could be used to purchase only (l) medical care for a worker who has declared retirement after age 59.5; (2) medical care for a person who has reached age 65, whether retired

[4]U.S. Department of Health and Human Services, *Social Security Bulletin Annual Statistical Supplement, 1990.*

or not; or (3) private health insurance to cover medical expenses in these two cases. MIRA funds could be used for these purposes without any tax penalty. Under certain exceptions (for example, the purchase of lifesaving medical technology not normally covered by private insurance), the funds could also be used to purchase medical services without tax penalty prior to retirement.

Until MIRA funds were used to purchase medical care or private health insurance, they would be invested, and the return on such investments would be tax-exempt in accordance with existing IRA rules. The MIRAs of individuals would be part of their estates, and funds remaining at their death would be passed on to their heirs.

The Quid pro Quo

In general, for each $1 contributed to a MIRA, an individual would forgo 50 cents of Medicare benefits, which would be reduced in the following way. At the time of eligibility for Medicare, an individual's contributions to a MIRA in different time periods would be converted to a present-value figure based on what those funds would have earned if invested in government securities. The expected value of Medicare benefits for people reaching retirement age that year would also be converted to a present-value number. An individual's claim against Medicare in the case of a Medicare-covered medical expense would be equal to the present value of MIRA contributions divided by the present value of Medicare benefits multiplied by the normal Medicare reimbursement for the medical expense.

Table 15.2 shows how these calculations would be made in 1990 dollars. As the table shows, individuals with $20,000 of MIRA contributions would have their expected Medicare benefits reduced from $30,000 of lifetime benefits to $20,000. In the case of a medical expense, they would be entitled to two-thirds of the normal Medicare reimbursement, and the retirees (or their private insurer) would be responsible for the remaining one-third. Similarly, individuals with $30,000 in a MIRA would have expected Medicare benefits reduced from $30,000 to $15,000. In the case of a medical expense, they would have a claim against Medicare equal to one-half of what Medicare ordinarily pays.

Incentives to Choose the MIRA Option

The purpose of the MIRA option is to encourage workers to save the money they will need to fund their own medical expenses

Table 15.2
CALCULATION OF A RETIREE'S CLAIM AGAINST MEDICARE FOR MEDICAL EXPENSES*

MIRA Contributions	Value of Claim against Medicare	Claim against Medicare as a Fraction of Normal Medicare Benefits
0	$30,000	1
$10,000	25,000	5/6
20,000	20,000	2/3
30,000	15,000	1/2
40,000	10,000	1/3
50,000	5,000	1/6
60,000	0	0

*In 1990 dollars.

during retirement. Workers will be financially encouraged to exercise the MIRA option in three ways. First, of every $2 contributed to a MIRA account, $1 is contributed by the federal government in the form of a tax credit, and this $1 replaces a $1 claim against Medicare. This allows people to take $1 in cash from the government to replace a $1 promise. Second, for each $1 of personal money contributed to the MIRA account, individuals will realize a tax-free buildup of funds for postretirement medical expenses not covered by Medicare—expenses likely to be incurred if the individual reaches retirement age. Third, workers who have exercised the MIRA option at any time during their working years will have an opportunity to buy back into Medicare.

The Buy-Back Option

Every individual making contributions to a MIRA will have the opportunity to reenter Medicare at the age of 65 by making a lump sum payment to Medicare. The payment will be at least equal to the amount that the person's MIRA balance would have grown to (if invested in Treasury bonds) and perhaps will include a penalty as well.

Medicare Taxes

Because contributions to MIRAs earn income tax credits, the payroll tax (including that portion of the payroll tax designated for

Medicare) will be unaffected. That means that the payroll tax can continue to serve as the major (or even exclusive) source of funds for Medicare. As individuals exercise their MIRA options, however, the total amount of Medicare spending will gradually fall. Thus, in principle, the payroll tax can be progressively lowered through time.

The extension of tax credits for this purpose will cause the federal deficit to be larger than otherwise, unless other taxes are increased. However, studies show that about 80 percent of all deposits to IRA accounts represent new savings.[5] For every $1 of revenue lost by the government, an extra $1.60 will be added to the supply of loanable funds in the credit market through the use of MIRAs. As a consequence, the introduction of the MIRA program will not cause interest rates to rise or create additional inflationary pressures on the economy. To the contrary, it will add to the supply of credit available in private capital markets. Even if larger deficits resulted, funds would be available to finance them without crowding out private investment.

The Slaughter Proposal

Since the original NCPA proposal was made in 1984, a bill has been introduced in every session of Congress not only to privatize Medicare but also to provide for medical expenses not covered by Medicare—including long-term care. These bills have received support from both conservative and liberal members of Congress. Led by Rep. French Slaughter (R-VA), the bill was introduced in the 101st Congress as H.R. 1080.

Under the Slaughter proposal, workers and their employers would be able to make annual deposits to MIRAs up to the amount of their annual Medicare payroll tax (currently 2.9 percent of taxable income).[6] Workers would receive a tax credit equal to 60 percent of the amount contributed. At retirement, 60 percent of the funds in the account would replace Medicare coverage, and the remaining

[5]Steven F. Venti and David A. Wise, "The Determinants of IRA Contributions and the Effects of Limit Changes," in *Pensions and the U.S. Economy*, Zvi Bodie, John Shoven, and David Wise, eds. (Chicago: University of Chicago Press, 1988).

[6]These deposits are in addition to, not a replacement for, the Medicare Part A payroll tax. In the Slaughter bill, Medical IRAs are called health care savings accounts (HCSAs).

40 percent could be used for medical expenses not covered by Medicare.

One way to think of the Slaughter proposal is to see the government as paying people now to reduce their claims against it in the future. For each $1 contributed to a Medical IRA, the federal government would be providing 60 cents (through tax credits). At the time of retirement, the government would assume the contributions grew at the real rate of interest paid on long-term government securities (about 2 percent). The government would also calculate how much annual private health insurance coverage could be purchased with these funds for Medicare-covered expenses, assuming that 40 percent would be required for the administrative costs of the insurance. This annual insurance coverage would become an added deductible under Medicare. In this way, 60 cents of every $1 contributed to a MIRA would replace 60 cents of Medicare coverage.

For example, consider a middle-income couple where each spouse earns the average wage and makes the maximum contribution to a MIRA each year. As Table 15.3 shows, under the Slaughter bill, the couple would be able to make an annual private health insurance premium payment of $4,672 beginning at age 65. In today's market, such a premium would buy an elderly couple coverage equal to about $25,970 per year (assuming 40 percent of the premium were used for administrative costs). Thus, the couple would have an added Medicare deductible equal to $25,970.

Under the Slaughter bill, the government's method of calculation is very generous to individuals. The bill assumes that funds will grow at a 2 percent real rate of interest per year, whereas a conservative, diversified portfolio of stocks and bonds should be able to net 4 or 5 percent, possibly more.[7] The bill assumes that insurance administrative costs will be 40 percent of premiums, whereas most people will be able to obtain group coverage through an employer for administrative costs that are 10 percent or less. Thus, almost everyone who takes advantage of the MIRA option should be able to make a handsome profit on the part that relates to Medicare.

The rest of the Slaughter bill is even more attractive. The 40 percent of contributions designed to supplement Medicare coverage will also grow over time, tax free. Unlike the 60 percent paid

[7]See Peter A. Ferrara, *A Market for Medicare* (Washington: Cato Institute, forthcoming).

Table 15.3
THE SLAUGHTER PROPOSAL: OPTIONS FOR COUPLES AT AGE 65[1]

Category	Savings and Deductibles[2]	Net Gain[2]
Low-income couple		
Total funds in MIRA	$ 79,876	
Added annual Medicare deductible	12,924	
Hypothetical annuity that could be purchased with health care savings		$ 6,314
Annual private insurance premiums for the first $12,924 of Medicare-covered expenses		−2,102
Annual private insurance premium for high-quality, long-term care		−4,082
Remaining annual income		$ 130
Middle-income couple		
Total funds in MIRA	$177,504	
Added annual Medicare deductible	25,970	
Hypothetical annuity that could be purchased with health care savings		$14,030
Annual private insurance premiums for the first $25,970 of Medicare-covered expenses		−4,672
Annual private insurance premium for high-quality long-term care		−4,082
Remaining annual income		$ 5,276
Higher income couple		
Total funds in MIRA	$349,314	
Added annual Medicare deductible	59,800	

(Continued on next page)

Table 15.3—Continued
THE SLAUGHTER PROPOSAL: OPTIONS FOR COUPLES AT AGE 65[1]

Category	Savings and Deductibles[2]	Net Gain[2]
Hypothetical annuity that could be purchased with health care savings		$27,608
Annual private insurance premiums for the first $59,800 of Medicare-covered expenses		−9,252
Annual private insurance premium for high-quality, long-term care		−4,082
Remaining annual income		$14,274

SOURCE: Peter Ferrara, *A Market for Medicare* (Washington: Cato Institute, forthcoming). Calculations were made by Lewin/ICF.

[1]Assumptions used in calculations: (1) workers enter the labor market at age 22; (2) low-income workers earn 45 percent of the average wage of workers covered by Social Security ($9,235 in 1989); (3) middle-income workers earn the average wage covered by Social Security ($20,522 in 1989); (4) higher income workers begin working at the average wage but then exceed the average wage by following an earnings profile over their work life; (5) couples are able to combine their health care savings, which are assumed to grow at a 4 percent real rate of interest; (6) each year, workers and their employers contribute an amount equal to the Medicare payroll tax, which grows from 2.9 percent in 1989 to 8.3 percent near the time of retirement.

[2]In 1989 dollars.

for by tax credits, the 40 percent can be withdrawn before age 65, provided that taxes and penalties are paid. After age 65, the 40 percent (plus any "profit" on the other 60 percent) could be spent on medical care without taxes or penalties. The funds also could be withdrawn and spent for other purposes, provided that ordinary income taxes were paid on the withdrawals.

Table 15.3 presents three examples of what we could expect to happen under the Slaughter proposal. In each case, people are assumed to enter the labor market at age 22 and make the maximum

contribution to MIRAs throughout their working lives. In all three cases, Medicare would become a catastrophic policy only, covering expenses exceeding about $13,000 a year for a low-income couple and about $60,000 a year for a higher income couple. Moreover, in all three cases, people would be able to afford high-quality, long-term health insurance, paying up to $100 per day (in 1989 prices) of nursing home care up to four years after the first 90 days of coverage (provided under Medicare). The policy would also pay up to $50 per visit for home health care for up to two years. And both reimbursement amounts would increase by as much as 5 percent per year in future years.

After paying for these benefits (and taking into account the overly conservative assumption that 40 percent of private insurance would be needed for administrative costs), most people would still have considerable funds left over. Each year, after financing all of their own health care, a middle-income couple would have more than $5,000 to use in any way they wanted, and a higher income couple more than $14,000.

Benefits of the MIRA Proposals

The proposals discussed in this chapter eliminate for each new generation of workers the risk that succeeding generations will refuse to pay, or will underpay, for their postretirement medical care. By allowing all individuals to provide for their own retirement medical care, they would solve Medicare's long-term funding problem. Because these proposals also would lead to the phasing out of Medicare, they would reduce the size of government income transfers from the working population to the elderly. This development should do much to improve the self-esteem of seniors and to reduce the economic and political tensions between generations.

Under these proposals, individuals would be spending more of their own money for medical care to the extent that they selected high-deductible private health insurance during the years of retirement. This means that MIRA owners would have ideal incentives to weigh carefully the costs against the benefits of medical services and to avoid wasteful and inefficient spending. Moreover, when they entered the medical marketplace, elderly patients would be the principal buyers. As a result, the quality of care and the efficiency of its delivery should improve greatly.

Finally, these proposals would allow most elderly patients to escape Medicare's restrictions on access to new medical technology. With substantial private resources, the elderly would be able to avoid health care rationing imposed through the Medicare DRG (diagnosis-related group) system and other schemes. Decisions governing access to and use and continuation of lifesaving medical interventions would be made by the patients themselves.

Workers today pay an average of $583 per year into Medicare, and this money is spent on the medical care of others. There is no assurance that today's workers will have their medical expenses paid during their retirement years. Only if individuals can contribute an equivalent amount of money to their own private savings accounts can they be free from the uncertainty of doubtful promises by politicians.

Integrating Medical IRAs with Other Policy Proposals

In this book we have proposed a general program of Medical Savings Accounts to allow people to save for small medical bills. We also have proposed giving employees and employers tax incentives to save for postretirement medical expenses and allowing private insurers to repackage Medicare benefits. Now we will briefly consider how these proposals can be combined to form an integrated national approach to postretirement health care policy.

Medical IRAs and Medisave Accounts

The principal goal of Medical Savings Accounts is to enable individuals to purchase medical services with their own funds rather than through wasteful first-dollar health insurance. Over a person's work life, the amount that accumulates in a Medisave account could approach the amount that accumulates in a Medical IRA—thus effectively doubling the funds available for postretirement medical care. The strategy behind both concepts is to encourage lifetime planning for health care contingencies and to provide the resources for meeting those contingencies.

MIRA and Medisave funds could be combined, provided that the financial institution managing them kept an accounting distinction between the two balances. For the most part, MIRA funds could be used only for postretirement medical expenses. But there would be important exceptions. For example, MIRA funds might be available

to pay for organ transplants or other expensive, lifesaving technology not normally covered by private insurance prior to the age of 65.

Medical IRAs and Postretirement Medical Liabilities of Employers

Just as individuals would be entitled to a $1 tax credit for each $2 contributed to a MIRA account, so employers would receive these tax credits for contributing to MIRAs on behalf of their employees. Employers exercising this option could manage MIRA and Medisave accounts and (acting as agents for the employees) purchase group health insurance for their employees' postretirement medical care. But the funds would belong to the individual employees.

Medical IRAs and Privately Repackaged Medicare Insurance Policies

The purpose of allowing private insurers to repackage Medicare benefits (discussed in chapter 3 and at greater length in the appendix to this chapter) is to extend the advantages of competition and private-sector efficiency to the Medicare program. A private market in Medicare insurance would arise with a diverse product line; each product would be tailored to the special needs of different groups of senior citizens. Medical IRAs represent a natural extension of this idea. Depending on the amount contributed to a MIRA, a retiree could purchase private insurance with the amount owed to the individual by Medicare and the amount accumulated in the individual's MIRA. Substantial private funds added to public funds would greatly expand the range of choices. Ultimately, almost all funds used to purchase postretirement health insurance would come from privately owned MIRAs.

Adopting a New Philosophy of Health Care Finance

National health insurance enjoys widespread popularity in other countries partly because it institutionalizes certain assumptions that are widely held by politicians, the medical community, and the general public. These assumptions also have heavily influenced public policy toward health care in this country. Yet each of them is false.

One false assumption is that ill health is a random event, unrelated to individual behavior. From this assumption, the conclusion is drawn that it is unfair to ask individuals to bear the cost of events over which they have no control. A second false assumption is that it is wrong to ask individuals to choose between health care and

money. From this assumption, the conclusion is drawn that no one should be forced (or even be given the opportunity) to forgo health care services because of an unwillingness to pay. A third false assumption is that the profit motive is inappropriate, if not unethical, in the medical marketplace. From this assumption, the conclusion is drawn that we should forbid doctors, hospitals, and insurance companies to compete by offering services that differ in quality and price. To avert the painful choice of health care rationing caused by mounting health care costs, these false assumptions must be replaced by ones that are consistent with reality.

Mounting evidence suggests that ill health is not a random event, an "act of God," or a result of uncontrollable circumstances. Rather, individual health and life expectancy are heavily influenced by choices made over a lifetime. The central concept behind the idea of the MIRA account is that health status over an individual's lifetime is a consequence of that individual's choices. No one is in a better position than the individuals themselves to predict what choices they will make, to plan for probable adverse contingencies, and to gauge their ability to draw on personal savings and family help in case of illness. MIRAs are designed to give freedom of choice to those best suited to exercise that choice.

A free society is one in which individuals are allowed to make lifestyle, occupational, and other choices that involve varying degrees of risk. But a responsible society is one in which individuals bear the costs and reap the benefits of their choices. That means that individuals who take greater risks must be prepared to pay more—in terms of direct health care expenditures from personal savings and higher health insurance premiums.

Not only is it desirable to ask people to bear the full costs of their decisions, but failure to do so subsidizes and encourages risky behavior. When people are forced to assume the costs of their risks, they take fewer risks. Conversely, when they change their behavior and benefit from doing so, they are likely to make more behavioral changes. In both cases, health care costs are lowered.

Full freedom of choice means the freedom to choose whether or not to purchase health care services at all. That freedom is now greatly restricted. Imagine giving every candidate for surgery a choice: undergo the operation or forgo it and receive a sum equal to its cost. Such an option might reduce U.S. surgery rates by 25 or

even 50 percent. Or imagine giving every Medicaid patient in a nursing home a choice: remain in the nursing home or leave with an annual income of $25,000 per year. The Medicaid population in nursing homes likely would be cut in half.[8]

The argument for freedom of choice is that health care is only one of many things that people value. We eliminate waste when we allow people to choose between health care and other goods and services. That ensures that the money spent gives people maximum satisfaction.

In only one area do we routinely offer a choice between money and health care—nursing home care for the nonpoor elderly. In principle, any elderly person may enter a nursing home and spend down his or her resources. Once the patient is impoverished, Medicaid picks up the tab. No one is denied care, but people are forced to choose between the value of government-provided care and other uses of their money. However, for every individual in a nursing home, there are two other, equally disabled individuals who are not in nursing homes (see chapter 13). Clearly, when people are asked to choose between health care services and other uses of their money, health care is not always the first choice.

By allowing individuals to build up private savings in Medical Savings Accounts and MIRAs, we enable them to make their own choices. Patients, rather than third-party institutions, become the principal buyers of medical care, and the suppliers of medical services become increasingly responsive to patients' wants and needs. The result will be not only a more economically efficient system but a more humane one as well.

Appendix: A Short-Term Privatization Solution

Using Medical IRAs to privatize Medicare is a long-term solution, one that would take years before noticeable and major changes would be observed. In the meantime, however, there are important structural problems in Medicare that could be addressed with a short-term privatization program.

Problem: Defects in Medicare Coverage

If insurance is to serve any useful social purpose, it should protect people against catastrophic losses. Most people can pay their own

[8]For example, four people could pool their resources and live quite well on an aftertax annual income of $100,000.

small medical bills. Even if they have difficulty making relatively small payments, purchasing insurance coverage for them is almost always uneconomical. Insurance should be reserved for very large medical bills that would deplete the insured's assets if they were paid out of pocket. As an insurance policy, however, Medicare has always been fundamentally flawed. From its inception, Medicare has always paid too many of the small bills and left elderly enrollees at risk for very large ones.[9] The following is a brief summary.

Medicare coverage for hospital expenses is bizarre. For patients who have hospital stays of only a few days, Medicare pays all expenses beyond a small deductible. For patients with lengthy stays, however, Medicare pays much less of the bill and patients pay much more. In other words, the sicker the patient, the longer the hospital stay, and the larger the health care expense—the greater the proportion of the bill the patient pays. Currently, Medicare patients are "insured" for hospital expenses in the following way:[10]

- Following an initial deductible of $628, a Medicare patient faces no additional costs for a hospital stay of up to 60 days.
- Beginning on the 61st day, the patient is charged $157 per day.
- After the 90th day, the patient's cost rises to $314 per day.
- After the 150th day, the patient is responsible for the full cost of each hospital day.

Medicare is designed so that those with the most severe health problems face the greatest financial burdens—just the opposite of private hospital insurance.

Coverage for physician expenses under Medicare also violates fundamental principles of sound insurance. After a deductible of $100, Medicare pays 80 percent of all remaining physician bills, no matter how small or large. That means that Medicare pays 80 cents of the 101st dollar spent on physician fees in any given year, an amount almost all elderly patients could easily pay out of pocket. Yet, if additional fees soar to $100,000, the patients are responsible

[9]For an analysis of the political pressures that led to this result, see John C. Goodman and Gerald L. Musgrave, *Health Care for the Elderly: The Nightmare in Our Future*, NCPA Report no. 130 (Dallas: National Center for Policy Analysis, October 1987), pp. 27–33.

[10]Health Care Financing Administration. Dollar amounts are for 1991.

for 20 percent, or $20,000—an amount many would have difficulty paying.

As in the case of hospital coverage, coverage for nursing home expenses is structured so that the patient's share of the bill rises as the stay becomes longer and the expense greater. A Medicare patient entering a skilled-nursing facility (following a hospital stay of at least 3 days) pays nothing for the first 20 days. On the 21st day, the patient begins paying $78.50 per day.[11] After the 100th day, the patient pays 100 percent of the cost.

In response to the gaps created under Medicare, a thriving market emerged for Medigap insurance—private insurance designed to pay for hospital and physician expenses not covered by Medicare. Yet the Baucus Amendments, passed by Congress in 1980, required Medigap policies to cover certain benefits. And the amendments directed Medigap policies, like Medicare itself, to cover a great many small medical bills while leaving the coverage of large bills discretionary. For example, a Medigap policy that meets the minimum standards of federal law must have the following features:[12]

- The policy pays the 20 percent of physician fees not covered by Medicare, subject to a $100 deductible.[13]
- The Medigap policy pays for hospital expenses not paid by Medicare up to the 150th day in the hospital.
- On the 151st day, however, the patient begins paying 10 percent of the cost of the hospital stay; after 516 days, the patient is responsible for the entire cost of hospitalization.

Genuine catastrophic health insurance is rather inexpensive to provide because very few patients stay in the hospital beyond 150

[11]A patient staying at a nursing facility that costs less than $78.50 per day pays the amount the facility charges, not $78.50.

[12]See U.S. Department of Health and Human Services, *Guide to Health Insurance for People with Medicare* (1990), pp. 10–21.

[13]Under the 1987 law, which was in effect at the time of the passage of the Medicare Catastrophic Coverage Act, insurance companies were required to cover only the first $25,000 of doctor bills. Currently, if the doctor charges more than the reimbursement allowed under Medicare, Medicare will pick up only 80 percent of the normal assessed value, with the remaining amount to be covered by the insurance company and the patient. Some insurance policies will cover the entire billing gap, but others cover only the 20 percent they normally would have covered, leaving the rest for the patient.

days, and a stay in excess of 516 days is extremely rare. However, by forcing private insurance companies to offer wasteful and inefficient first-dollar coverage, Congress caused Medigap insurance to be needlessly expensive and thereby discouraged genuine catastrophic coverage.

Failed Solution: The Medicare Catastrophic Coverage Act

In the summer of 1988, Congress passed the Medicare Catastrophic Coverage Act in order to address some of the problems described above. By the spring of 1989, however, elderly voters were looking at the fine print and protesting. To appreciate the strength of that protest consider that an April 1989 Senate amendment urging the Senate Finance Committee to hold hearings to reconsider the Medicare Catastrophic Coverage Act was passed by a vote of 97 to 2.[14] The same amendment passed by a vote of 408 to 0 in the House of Representatives. Before Congress adjourned in the fall of 1989—after a lengthy, agonizing, unsuccessful attempt to find a compromise proposal—the act was repealed.

What went wrong? The 1988 act was designed to create benefits for the elderly that were to be solely financed by the elderly. The sources of funds were higher Medicare premiums and a special Medicare surtax levied on elderly incomes. When they compared the costs with the benefits, the majority of elderly voters discovered that the program made them worse off, not better off. There were four major reasons why.

First, when economists Aldona and Gary Robbins compared the average expected benefits with the average expected costs for the first five years under the program, they discovered that the costs exceeded the benefits for elderly individuals with annual (non–Social Security) incomes in excess of $5,000 and couples in excess of $10,000.[15] One of the reasons the cost exceeded the benefits for so many people was that a large portion of revenues collected

[14]See Spencer Rich, "Bentsen Backs Health Care Premium Cut," *Washington Post*, April 21, 1989.

[15]Aldona Robbins and Gary Robbins, *The Insurance Value of Medicare's Catastrophic Benefits*, Economic Report no. 47 (Washington: Institute for Research on the Economics of Taxation, February 24, 1989).

from the elderly was destined to be spent on nonelderly disabled people, including AIDS patients.[16]

Second, the burden of paying for the new program was imposed in a highly regressive way. For example, the net cost (cost minus benefits) would have equaled 3 percent of the (non–Social Security) income of someone with an annual income of $30,000, but only 1.5 percent of a $60,000-a-year individual.

Third, the Medicare surtax was one of the worst possible ways of raising revenue to fund the program. Although the surtax would have raised only a small amount of money from the elderly, it was imposed in a way that had devastating effects on their marginal tax rates. The surtax would have increased the marginal income tax rate for the elderly by as much as 5.3 percentage points in the first year under the program and by 10.8 percentage points in the fifth year. According to one study, if the Medicare surtax were combined with other taxes, some elderly taxpayers would have faced marginal tax rates in excess of 100 percent.[17]

Fourth, although the program did limit hospital expenses and physician fees, it gave little help to elderly patients faced with a catastrophic nursing home expense. Since more than 80 percent of all out-of-pocket expenses in excess of $2,000 for the elderly are for long-term care, the Medicare Catastrophic Coverage Act focused on the least likely catastrophic expenses and ignored those that are most likely. Continuing Congress's predilection for creating small benefits for the many rather than real protection for the few who need it, the act created a mammography benefit but did nothing to help those who face the enormous expenses associated with Alzheimer's disease.

The Medicare Catastrophic Coverage Act was the first major piece of federal welfare legislation repealed in 100 years.[18] The repeal

[16]People who qualify as disabled under the Social Security program are also eligible for Medicare benefits.

[17]John C. Goodman and A. James Meigs, *The Elderly: People the Supply-Side Revolution Forgot*, NCPA Policy Report no. 139 (Dallas: National Center for Policy Analysis, February 1989). See also, Aldona Robbins and Gary Robbins, *Taxing the Savings of Elderly Americans*, NCPA Policy Report no. 141 (Dallas: National Center for Policy Analysis, September 1989).

[18]The previous case was the abolition of the Freedman's Bureau after the Civil War.

meant major embarrassment for the congressional leadership on both sides of the aisle. Given that almost everyone agrees that the Medicare insurance program is defective, that virtually all enrollees want catastrophic coverage, and that most are willing to pay for it, what was the problem? We believe it was another defect in Medicare—the fact that a one-size-fits-all program cannot meet the needs of a diverse elderly population. In a normal insurance market, one expects to find diverse products, tailored to the needs of different consumers. In Medicare, no such diversity is allowed. There is no way to change the structure of Medicare to meet the insurance needs of one group of elderly citizens without at the same time changing it for all others. This defect of Medicare needs to be addressed before a solution can be found to the problem of catastrophic coverage.

To see how their insurance needs differ, consider two groups of elderly families, an upper-middle-income group with substantial assets and a lower income group with few assets. Catastrophic coverage is most important for the first group's members, and most of them would gladly trade higher deductibles and copayments for routine medical expenses for catastrophic hospital and nursing home coverage. On the other hand, elderly families with low incomes and few or no assets do not need genuine insurance. If faced with a very large medical bill, they would quickly spend down their assets and be covered by Medicaid. For them, the effect of a medical bill of $20,000 and one of $100,000 would be much the same. Understandably, this second group is far more interested in payments for small medical bills than in catastrophic insurance designed to protect assets they do not have.

Extending an approach that is already being taken by some pilot projects, private insurers should be able to compete for Medicare enrollees by offering privatized Medicare insurance policies.[19] For each enrollee in a privatized insurance plan, the insurer would receive an amount of money from Medicare equal to about 95 percent of the actuarially fair value of Medicare coverage. Private insurers would be entitled to reimburse hospitals and physicians at the same rate that Medicare pays, although they could voluntarily pay higher rates to avoid health care rationing.

[19]We thank Dr. Phil Gausewitz for helping us develop this solution.

Competition would primarily take the form of creating different packages of benefits. The only requirement would be that the insurer provide catastrophic hospital coverage. Beyond that, insurers would have complete freedom to repackage existing Medicare benefits, and Medicare enrollees would be free to choose their packages. For example, a private insurer might offer a package with a $2,000 hospital deductible, a $2,000 physician deductible, and a combined deductible of $3,000. In return for these higher deductibles, the insurer might offer immediate nursing home coverage for certain illnesses, such as Alzheimer's disease.[20] The nursing home benefit might grow, depending on the number of years that a policyholder stayed with the policy.

Building on Current Innovations in Medicare

Medicare currently contracts with HMOs and competitive medical plans (CMPs) that serve Medicare patients who voluntarily join the plans.[21] The amount paid to the HMO or CMP is about 95 percent of the actuarial Medicare cost, based on the age, sex, and geographic location of the patient population. HMOs and CMPs are required to provide all services covered by the conventional Medicare fee-for-service program, but they can offer more services, such as no or low cost-sharing and no- or low-cost prescription drugs. HMOs attempt to control cost by managing care. Physicians and financial managers work together to provide adequate care using fewer resources. In effect, they are gatekeepers and often ration care at the point of delivery. Decisions are made by general physicians and specialists who attempt to care for and treat patients within the financial constraints of the HMO. If the HMO is to succeed, it must cut costs by reducing the volume of services. However, an HMO has an incentive not to reduce quality to a level that would cause patient dissatisfaction, although about one-third of new enrollees do opt out of the Medicare HMO within two

[20]To take full advantage of the strengths of private-sector competition, insurers would have to have the freedom to alter the package, depending on the age, health condition, and other attributes of the potential policyholders. That is, we could not require an insurer to provide immediate insurance coverage for Alzheimer's disease to someone who already had been diagnosed as having the disease.

[21]CMPs are capitated plans and, while not officially designated as HMOs, for all practical purpose they are HMOs.

years.[22] Another incentive to maintain quality is the threat of malpractice litigation.

If private contractors could repackage Medicare benefits, they would have incentives to reduce costs in innovative ways. Specifically, they could offer high-deductible plans under which the elderly would pay small-dollar medical expenses and get more insurance coverage for truly catastrophic expenses.

[22]"Disenrollment Experience in the Medicare Health Maintenance Organization and Competitive Medical Plan Risk Program," *Health Care Financing Review* (Winter 1990): 162.