Solving the Problem of Medicare

by

Peter Ferrara

John C. Goodman

Gerald Musgrave

Richard Rahn

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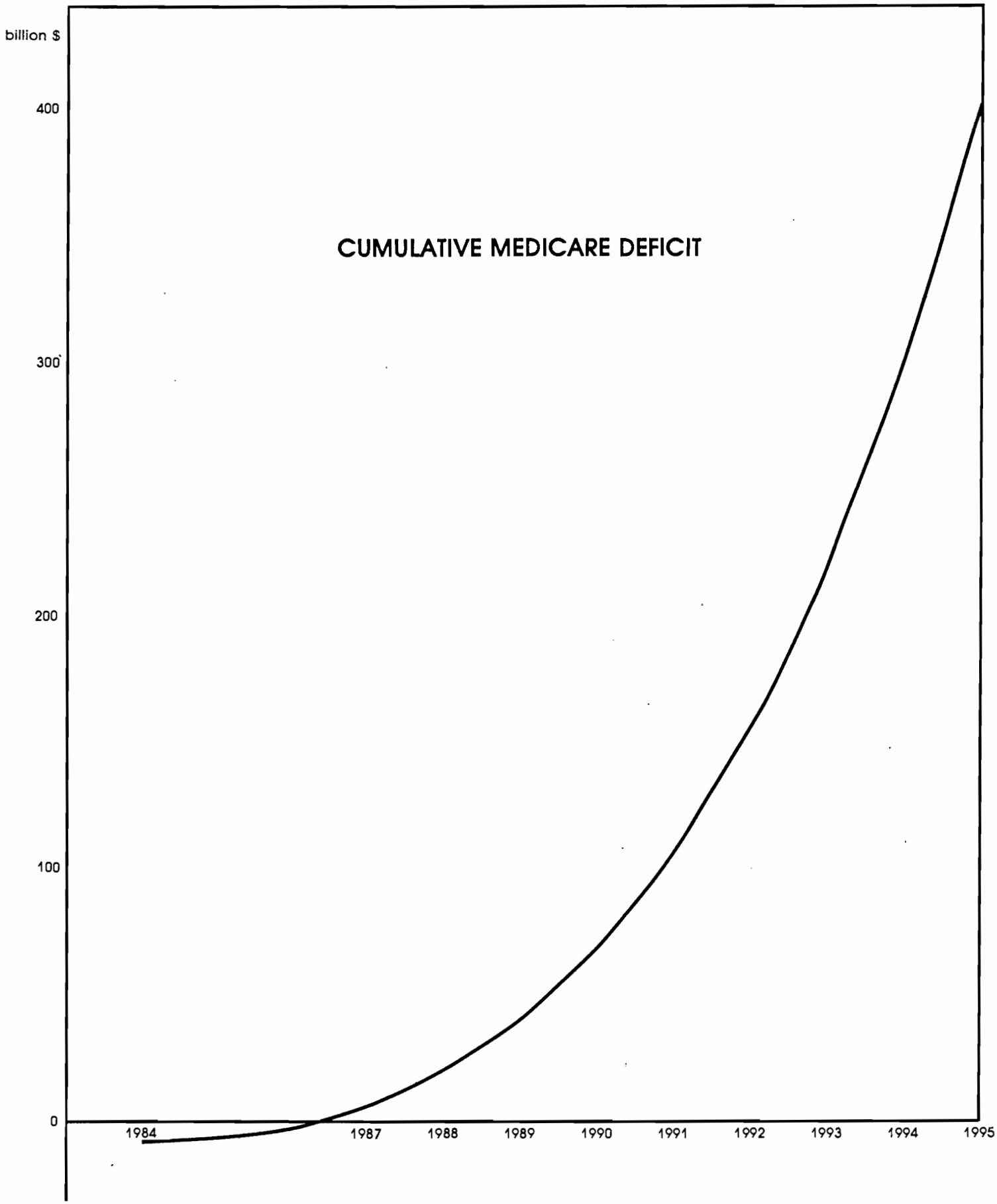
National Center for Policy Analysis
12655 North Central Expressway, Suite 720
Dallas, Texas 75243
(972) 386-6272



SOURCE: National Center for Policy Analysis

THE MEDICARE BANKRUPTCY*

Medicare is bankrupt. At the moment a small surplus exists in Medicare's Hospital Insurance Trust Fund. Yet by any reasonable prediction, that surplus will vanish in a few short years as expenditures quickly outpace tax revenues. We estimate that:

- Between now and 1995 the cumulative deficit in Medicare's HI Trust Fund will be $400 billion.[1]

- This deficit is a liability equal to almost $2,000 for every man, woman and child in the country under the age of 65.

The deficit is only a short-term liability, however. The long-term picture looks much worse. Since 1967, spending on Medicare has grown from $3.4 billion to $57.4 billion--an increase of more than 1,500 percent! Over the last decade, spending on Medicare has grown at an annual rate of 17.7 percent. At this rate of growth Medicare outlays will double every four years. Even if the rate of growth moderates to the 14.4 percent predicted by the Congressional Budget Office, Medicare outlays will grow from seven percent to ten percent of the federal budget by 1988.[2] If this trend continues, Medicare spending will account for one out of every three dollars in the budget 50 years from now.

The crisis of Medicare is much more than a budgetary crisis. It also has a human dimension which is difficult to measure in terms of dollars and cents. Right now, Medicare is making implicit promises to millions of working men and women who are paying taxes into the system. The promise is that in return for the taxes these workers are paying, government will pay for certain medical expenses during their retirement years. Yet it is not at all certain that this promise can ever be met.

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1. This estimate assumes that Medicare outlays increase at an annual rate of 13.7 percent and taxable payrolls increase at an annual rate of 6.8 percent.

2. Congressional Budget Office, Changing the Structure of Medicare Benefits (Washington, D.C.: CBO, March, 1983), p.2.

THE UNEASY CASE FOR MEDICARE

Because of record deficits, the federal budget is receiving unusual scrutiny to determine which programs have merit and which ones do not. As one looks down the list of spending programs, it is clear that various programs exist to meet fairly well-defined objectives. Some programs, for example, exist to help the needy. Some exist to help minority groups. Some are designed to provide for the national defense. Others are presumed to promote the general welfare.

Even within the category of federal spending on medical care, most programs exist to meet clearly defined social goals. Medicaid exists to provide medical care for the poor. Money spent on the V.A. hospital system presumably is part of our national defense effort. Money spent on medical research presumably promotes the general welfare.

Medicare does not fall within any of these categories. In fact, if one looks carefully at Medicare it is difficult to understand what the rationale is for this program.

1. Medicare Beneficiaries Did Not Pay for the Benefits They Receive.

Medicare is an insurance policy which pays the medical bills of those who qualify as beneficiaries. In any given year, only a small percentage of beneficiaries will have substantial bills paid for by Medicare. On the average, about 78 percent of all Medicare spending pays for medical services used by only 11 percent of Medicare beneficiaries. About 40 percent of all beneficiaries generate no Medicare payments.[3] However, even those beneficiaries who had no medical bills during a given year derived something of value from Medicare. What they received was protection of their assets from unforeseen medical bills. They lived secure in the knowledge that had they generated unforeseen medical expenses, Medicare would have paid a substantial portion of those costs.

3. Ibid, p.17. See also Karen Davis, "Medicare Reconsidered," prepared for the Duke University Medical Center Seventh Private Sector Conference on the Financial Support of Health Care of the Elderly and the Indigent, Durham, North Carolina, March 14-16, 1982. Quoted in The New England Journal of Medicine, May 27, 1982, p. 1310.

One way of thinking about the value of Medicare is to ask: What would a beneficiary have to pay to obtain a similar insurance policy in the private marketplace? Since private insurers have to charge premiums that are roughly equal to expected outlays, the cost of an insurance policy similar to Medicare would be roughly equal to the amount that Medicare spends per beneficiary per year. In 1982 this amount was about $1,819.[4]

A little known fact about Medicare is that the amount which beneficiaries have paid into the program in taxes is only a small fraction of the amount they are receiving and can expect to receive back in the form of benefits. For example, a male worker earning the median income who reaches age 65 today will receive more benefits in two years from Medicare than he paid in taxes over his entire working life.

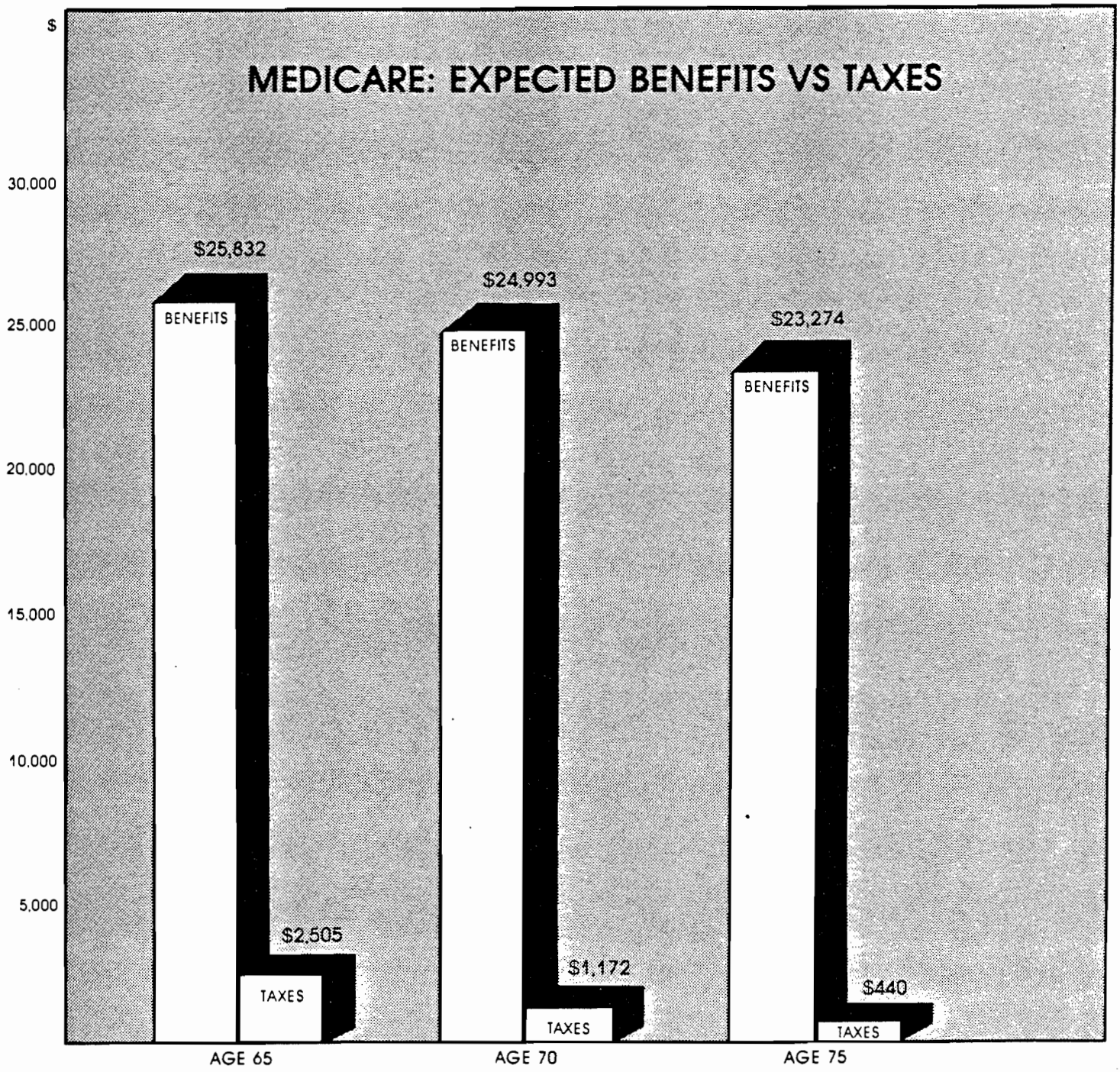
Even if there is no increase in Medicare spending per beneficiary in the future,[5]

- A male beneficiary, age 65, can expect to receive 10 times more in Medicare benefits than he paid in taxes.
- A male, age 70, can expect to receive 21 times more in benefits than he paid in taxes.
- A male, age 75, can expect to receive 53 times more in benefits than he paid in taxes.
- A male, age 80, can expect to receive 291 times more in benefits than he paid in taxes.
- If these beneficiaries have a dependent spouse, the expected benefits relative to taxes will more than double.

Medicare, then, is a program which takes billions of dollars out of the pockets of some Americans and pays for the medical bills of other Americans. For those who are on the receiving end, the program has been a bonanza. Medicare beneficiaries are receiving far more in benefits then they ever paid in taxes.

4. Spending per beneficiary under Part A (Hospital Insurance) was $1,364 and net spending under Part B (Supplemental Medical Insurance) was $455.

5. These estimates are based on the latest 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.



SINGLE MALE WORKER

SOURCE: National Center for Policy Analysis

2. 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. This perception is incorrect, however. Not only does Medicare not take from the rich and give to the poor; if anything, it does the reverse.

- The after-tax income of the elderly ($6,300 per person in 1980) is greater than the after-tax income of those under 65 years of age ($5,910 in 1980).[6]

- On the average, people over 65 have considerably more wealth than those under 65.[7]

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

3. Medicare Is Unfair to Minorities.

A recently publicized fact about Medicare and Social Security is that both programs discriminate against minorities. This is because black and Hispanic Americans have lower life expectancies than white Americans. For example, the life expectancy of a black male at birth is six years shorter than it is for a white male. The life expectancy of a black female is about five years shorter than for a white female. Because the eligibility age for Medicare is the same for both races, whites get a much better deal from the program than do blacks and other minorities.

To see how much difference life expectancy makes, consider the following:

- A black male at birth has a life expectancy of 64.8 years. Although he will pay taxes into Medicare throughout his working life, he can expect to die two months before he becomes eligible for benefits.

- A Hispanic male at birth has a life expectancy of 66.6 years. A white male has a life expectancy of 71 years. Both pay the same payroll tax rates. Yet the white male can expect to receive Medicare benefits five times greater than those received by his Hispanic cohort.

6. U.S. Bureau of the Census, Current Population Reports, Series P-23, No. 126, "Estimating After-Tax Money Income Distributions Using Data From the March Current Population Survey," U.S. Government Printing Office, Washington, D.C. 1983, Table 1, pp. 20-23.

7. Wall Street Journal, April 28, 1982, p. 30.

Because black and Hispanic Americans have lower life expectancies than white Americans, members of these minority groups tend to be over-represented among Medicare taxpayers and under-represented among Medicare beneficiaries:

- More than 14.4 percent of the population of tax-paying age is non-white.[8]

- Only 8.6 percent of elderly Medicare beneficiaries are non-white.[9]

It is interesting to compare the representation of minorities in Medicare (eligibility is based on age) with their representation in Medicaid (eligibility is based on income). Although only 8.6 percent of elderly Medicare beneficiaries are non-white, about two-thirds of all Medicaid beneficiaries are non-white.[10] It is also interesting to note that when it came time to slow down the growth of federal spending, it was Medicaid, not Medicare, which took most of the brunt of the belt tightening.

An NCPA study entitled "The Effect of the Social Security Reforms on Black Americans"[11] has documented that the recently legislated increase in the retirement age for Social Security will be devastating for blacks and other minorities. The Social Security Advisory Council has proposed that the eligibility age for Medicare also be raised. The Council has proposed to increase the eligibility age from 65 to 67 by 1990. If this proposal is adopted,

- A black male, age 20, will lose 100 percent of his expected benefits under Medicare. His white counterpart will lose only 25 percent of his.

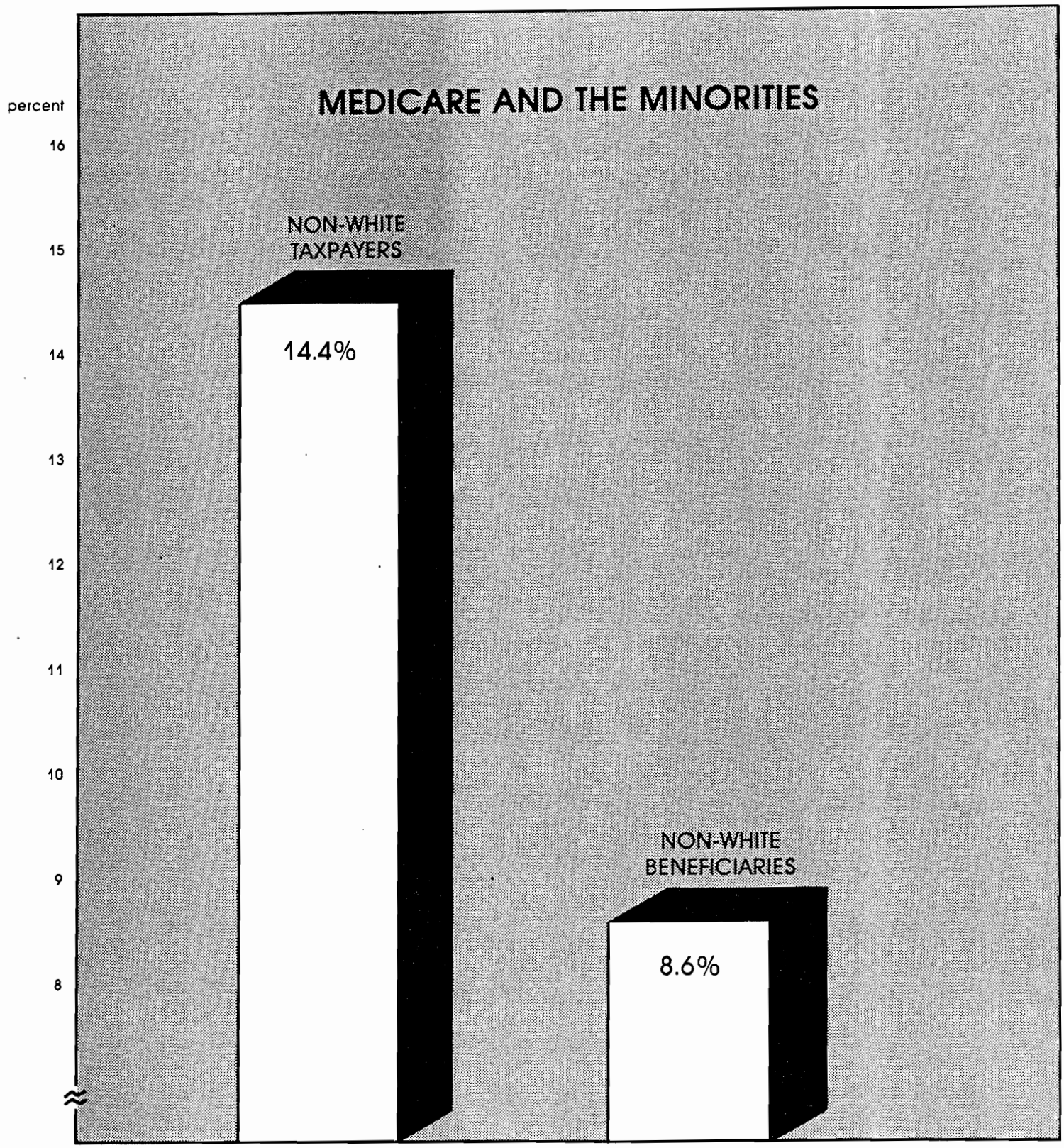
- A black female, age 20, will lose 19 percent of her expected benefits. A white female will lose only 14 percent of hers.

8. U.S. Bureau of the Census, Statistical Abstract of the United States: 1982-83, Washington, D.C., 1982, p. 26.

9. Department of Health and Human Services, The Medicare and Medicaid Data Book, 1981, (Baltimore, Md., 1982), pp. 16-17.

10. Ibid, p. 19.

11. Staff Report, "The Effect of the Social Security Reforms on Black Americans," National Center for Policy Analysis, July, 1983.



SOURCE: National Center for Policy Analysis

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 will be that blacks, expecially black males, can always expect to receive, on the average, virtually nothing from Medicare.

4. Medicare Is Unfair to the Young.

Medicare, we have noted, has been a bonanza for those who are currently covered by the program.

- A male worker earning the median income who reaches age 65 today can expect to receive $23,327 more in benefits than he paid in taxes.

- If he has a dependent spouse the couple together will receive $56,982 more in benefits than they paid in taxes.

The enormous benefits received by today's Medicare beneficiaries are made possible by the taxes being paid into the system by the working population. Yet young workers who are paying Medicare taxes will never receive anything like the "deal" the elderly are receiving today. In fact, most young workers entering the labor force right now will pay considerably more into Medicare than they can expect to receive in return.

We have calculated the present value of Medicare for workers at different age levels under the conservative assumption that Medicare spending per beneficiary will grow no faster than the rate of growth of nominal wages. Under conservative assumptions:[12]

- A white male, age 20, can expect to pay about $8,500 more in taxes than he will receive in benefits.

- A black male, age 20, can expect to pay about $14,000 more in taxes than he will receive in benefits.

Moreover, almost anything that Congress is likely to do to relieve the financial crisis of Medicare--raise the payroll tax, raise the eligibility age, raise deductibles or co-insurance rates, etc.--will lower the expected benefits to young workers and make the return on their Medicare investment even lower than it is now.

12. Present value calculations were made based on a rate of interest equal to the rate of growth of the average wage.

For example, under current law, the combined payroll tax on employers and employees is scheduled to rise from the current 2.6 percent to 5.08 percent by 1995. If, in order to reduce the Medicare deficit, Congress also raises the eligibility age to 67, the penalty imposed on young workers will be substantial:

- With a 5.08 percent Medicare payroll tax and an eligibility age of 67, a white male, age 20, can expect to pay about $33,171 more in taxes than he will receive in benefits.

- Under the same conditions, a white female worker, age 20, can expect to pay about $6,685 more in taxes than she will receive in benefits.

5. The Criteria for Eligibility Are Arbitrary

Medicare, as we have seen, provides enormous benefits to those who currently qualify for coverage--benefits which far exceed the value of taxes paid. In view of this fact, it is interesting to consider what an individual has to do in order to be eligible for the lavish benefits which Medicare confers.

The basic requirement for eligibility is to reach 65 years of age. At 64 years 11 months, one gets nothing from Medicare. One month later, Medicare starts paying the medical bills. Aside from age, little else seems to matter.

You don't have to be poor to be covered by Medicare. As we have seen, Medicare is not a poverty program. There are about 254,000 millionaires who are either covered by Medicare, or who can be covered if they choose to do so.[13]

You don't have to be retired to be covered by Medicare. Unlike Social Security, you do not have to quit earning a living in the labor market in order to receive Medicare benefits. In principle, the president of Exxon can receive Medicare benefits--courtesy of the taxes paid by other Exxon employees.

You don't have to pay Medicare taxes in order to be covered by Medicare. People over 83 years of age who are drawing Social Security benefits never paid one dime into Medicare. Yet these individuals have received thousands of dollars of benefits from the program.

13. Based on estimates made in U.S. News and World Report, October 3, 1983, p. 65.

Individuals reaching 65 today can also become eligible for benefits, even if they never paid taxes into the program. (These include federal workers, and employees of state and local governments and non-profit institutions which have elected to get out of Social Security.) They can receive Part A (Hospital Insurance) by paying a monthly premium of $113 and Part B (Supplemental Medical Insurance) for a monthly premium of $12.20.[14] 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. Amazing as it may seen, you can break any number of laws and still be covered by Medicare. According to federal regulations, the only crime which gets an individual tossed out of Medicare is plotting an overthrow of the federal government, i.e. the people who give us Medicare.[15]

You don't have to be a citizen at all to be covered by Medicare. Non-citizens who become permanent residents and remain in the United States or one of its territories for a period of five years can become eligible for Medicare.[16] For example, had he lived for a few more years the Shah of Iran could have been covered by Medicare!

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 numerous publications of the Department of Health and Human Services and by the public pronouncements of leading politicians and bureaucracts.

14. Commerce Clearinghouse, Inc., Medicare and Medicaid Guide, (Chicago, Illinois, 1983), p. 739 and p. 3050.

15. Treason is the only crime which disqualifies a person from Medicare coverage. However, any imprisonment will suspend Medicare benefits during the term of imprisonment because the institutions are obligated for the medical services of their inmates.

16. Commerce Clearinghouse, Inc., Medicare and Medicaid Guide, (Chicago, Illinois, 1983), p. 1405.

Payroll taxes which 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 claims about their policies which were as inaccurate as the claims routinely made by government officials about Medicare, the private officials would be violating numerous laws and would risk possible imprisonment.

In fact, the Medicare "trust fund" is largely a myth. There is no money being stored away in bank vaults for use during some later period. Every dollar paid into Medicare is spend by the federal government the very hour of the very day that it arrives.

Private insurance companies, by contrast, are required to keep an actual fund of assets from which to pay claims. They cannot simply write IOUs to themselves and spend the money elsewhere. Moreover, the benefits paid by private insurance companies are financed by the premiums paid by the policyholders.

By contrast, money paid into Medicare by today's workers is not invested in assets and kept there until those workers reach the age of 65. Money paid into Medicare by today's workers is spent immediately on benefits provided to today's beneficiaries. Today's workers, then, are not paying for their own benefits. They are paying for someone else's benefits. Any benefits which today's workers hope to get from Medicare during their retirement years will have to be paid for by the next generation of workers. It is for this reason that Medicare, like Social Security, is properly referred to as a "pay-as-you-go" system.[17]

17. For a non-technical discussion of the pay-as-you-go nature of our Social Security system, see John Goodman and Edwin Dolan, Economics of Public Policy, (St. Paul, Minnesota: West Publishing Co., 1982) 2d. ed.

One of the inherent problems of any pay-as-you-go pension or health care system is that each generation of workers depends on the ability and willingness of the next, yet-unborn generation of workers to pay its benefits. Yet no one really knows how many members of the next generation there will be or what type of burden they will be asked to bear. More important, no one knows what the next generation of workers will be willing to pay. Medicare, as we have seen, has been a bonanza for workers who are 65 years and older today. But each new generation of workers can expect to pay more in taxes than they will receive in benefits. Why should the next generation of workers support a system which they never consented to and from which they can never realize a positive gain?[18]

Just how bad things can get in the future is shown in the calculations recently made by Haeworth Robertson, former Chief Actuary of the Social Security Administration. Robertson calculated the potential burden of Social Security and Medicare for future generations of taxpayers using three sets of assumptions used by the Social Security Administration: optimistic, intermediate and pessimistic. Since Social Security's pessimistic assumptions historically have been far closer to reality than the two other sets of assumptions, Robertson's predictions based on these is the most interesting.

Robertson estimated that under pessimistic assumptions, in order to pay for Social Security and Medicare benefits 70 years from now the government will have to collect between 40 and 50 percent of income in the form of payroll taxes.[19] Moreover, the pessimistic assumptions are by no means the worse thing that can happen. These assumptions, for instance, ignore the possibility of major breakthroughs in slowing down the process of aging.

Some scientists are now predicting that the average life span may be extended from the current level of 74.5 years to 150 years by the turn of the century.[20] If life extension occurs by increasing productive years relative to

18. For a more complete discussion of the nature of the Social Security crisis see Peter Ferrara, Social Security: The Inherent Contradiction (San Francisco: Cato Institute, 1980), and A. Haeworth Robertson, The Coming Revolution in Social Security (McLean, Virginia: Security Press, 1981).

19. Robertson, The Coming Revolution in Social Security, p. 90. Robertson's calculations were based on an eligibility age of 65.

20. See, for example, the interview with Dr. Roy Walford, UCLA Medical School, in U.S. News and World Report, July 4, 1983, pp. 73-74.

retirement years, the long-term problems of Social Security and Medicare will ameliorate. If, on the other hand, life extension occurs largely by increasing the retirement years, the problems of Social Security and Medicare will become much worse. We could face a situation in which as much as 60 or 70 percent of taxable payroll is needed to pay promised benefits.

The real long-term funding problem of Medicare, then, is that by continuing the pay-as-you-go system we are putting children today at great risk. We have no real assurance that when these children reach the age of 65, the working population will be willing or able to pay promised benefits.

Prudence demands that we act now to relieve this risk.

THE LONG-TERM PROBLEM OF MEDICARE:

WASTE AND INEFFICIENCY

A major difference between Medicare and Social Security is that under Social Security money is given directly to beneficiaries. This means that when Social Security beneficiaries spend their Social Security dollars on goods and services, the money they spend they treat as their own.

By contrast, money spent under Medicare goes to someone other than the beneficiary--doctors, hospitals, and other health care providers. Medicare beneficiaries do not have the option of taking their benefits in cash and putting them in the bank. Thus, when Medicare beneficiaries spend a dollar on medical care, that is not a dollar that they could have spent on other goods and services. This means that Medicare beneficiaries are not spending their own money when they make purchases in the health care marketplace. Instead, they are spending someone else's money.

This difference between Medicare and Social Security has a substantial impact on the incentives faced by the elderly. If an elderly person is frivolous and wasteful in spending his Social Security dollars, he bears the full cost of that waste. If he is thoughtful and careful he bears the full benefit of that care. When spending Medicare dollars, however, things are very different. If a beneficiary is frivolous and wasteful in spending Medicare dollars, that cost is born by someone else. If he is frugal and careful, the benefit of that care is realized by someone else. Small wonder, then, that one rarely hears much about wasteful spending of Social Security benefits, while one hears a great deal about wasteful spending in Medicare.

One example of an area where there is great potential for waste is in care given to patients who are near death. Of course, we do not always know in advance what the effects of medical treatment will be. Still, one cannot help but be amazed by the fact that:[21]

- Twenty-eight percent of all Medicare spending is for the treatment of patients in the last year of their lives.

- Eleven percent of all Medicare spending is for the treatment of patients in the last 40 days of their lives.

If Medicare patients were spending their own dollars, it is not at all clear that they would choose to deplete their estates by spending enormous sums of money to prolong life only marginally. On the other hand, if one has the opportunity to spend someone else's money to achieve marginal benefits, there is no economic reason not to do so.

The Medicare program leads to a great deal of waste and inefficiency because the purchasers of medical services do not bear the costs or reap the benefits of their decisions. There also is waste and inefficiency because the providers of medical services find it in their economic self-interest to increase spending under the program.

Much has been said about the way in which Medicare's cost-based reimbursement systems gives the providers of medical care incentives to increase their costs. Some believe that the new diagnostic related groups (DRG) system will give greater incentives to the providers to curtail the growth of Medicare spending.

Space does not permit an evaluation of these issues here. We do feel compelled, however, to make a general observation. Any Medicare reimbursement scheme, no matter how it is structured, will always be defective because consumers will always be spending, and the providers will always be receiving, someone else's money. The inherent defect in Medicare is that the decision makers can never be made to bear the full costs of their bad decisions.

THE HEALTH BANK IRA

The long-term problems of funding and inefficiency in Medicare necessitate radical reform. In designing a plan for such reform, we are guided by two principles:

Principle One: Given appropriate government policies, most individuals can be and should be responsible for paying for their own medical care during their retirement years.

21. Data obtained from the U.S. Department of Health and Human Services.

Principle Two: In order to achieve an efficient allocation of resources in the health care marketplace, individuals whenever possible should bear the costs and reap the benefits of their own decisions.

We propose a system in which individuals will be allowed to make annual contributions to qualified individual retirement accounts called Health Bank IRAs. After a 30-year period, sufficient funds would accumulate in these accounts to allow individuals to pay for their own medical expenses and/or to purchase private health insurance for their retirement years. These individuals will have opted out of the basic Medicare program. They will rely on Medicare only in case of very large, catastrophic medical expenses.

The choice to opt out of Medicare is voluntary. However, individuals who choose the IRA option will be given tax credits for their Health Bank IRA contributions. We calculate that a tax credit of $500 per person will be sufficient to encourage all members of each new generation of workers to choose the private, IRA alternative to Medicare.

We propose to make these tax credits refundable. This means that individuals with no earnings will be able to get an income tax refund equal to the amount of the allowed tax credit. The refund will be placed in their Health Bank IRAs. This will give individuals with little or no income, living in poverty, a source of funds from which to purchase their own medical care during their retirement years.

Money deposited in a Health Bank IRA is the private property of the individual who creates the account. Moreover, this money is part of the individual's estate and can be passed on to his heirs. As a result, when individuals spend their Health Bank IRA money, they will be spending their own money, not someone else's.

The full details of this proposal are included in the Appendix to this report.

BENEFITS OF THE HEALTH BANK IRA PROPOSAL

This proposal eliminates for each new generation of workers the risk that succeeding generations will refuse to pay, or will inadequately pay, for their medical care during their retirement years. It allows all individuals to provide for their own medical care later in life from income earned during their working years. This proposal, therefore, solves the long-term funding problem which Medicare faces.

In addition, under this proposal individuals will be spending their own money for medical care. This means that individual IRA owners will have ideal incentives to weigh carefully the costs against the benefits of purchases of medical services and to avoid wasteful and inefficient spending.

Finally, because this proposal will lead to the phasing out of Medicare (except for catastrophic coverage) it will reduce the size of government income transfers which go from the working population to the elderly. This development should do much to improve the self-esteem of elderly citizens, most of whom do not relish being a burden on the young, and to reduce the economic and political tensions between generations.

On the average, workers today are paying about $464.10 per year into Medicare. This money is not kept in separate accounts for the workers who pay it. Instead, this money is spent on the medical care of other people. And the fact that it is spent no change means that there is no way to assure that today's workers will have their medical expenses paid for during their retirement years.

Table I shows what would happen if a 20 year-old worker were allowed to invest his Medicare taxes in a private IRA account rather than pay the money into Medicare.

- By the time the worker reached the age of 65, his IRA account would contain $476,519.

- By the time the worker reached the proposed eligibility age of 67, his IRA account would contain $575,419.

This fund should be more than adequate to pay for medical care and/or private health insurance during the retirement years.

January, 1984

TABLE I

WHAT MEDICARE TAXES WOULD GROW TO IF THEY WERE INVESTED IN AN IRA ACCOUNT

	YEAR	AMOUNT DEPOSITED	TOTAL ACCUMULATED
Worker enters the labor market at age twenty →	1	$464.10*	$505.86
	2	487.31	1,081.35
	3	511.70	1,731.09
	4	537.25	2,478.29
	5	564.12	3,318.31
	6	592.32	4,265.07
	7	621.94	5,323.22
	8	653.04	6,520.60
	9	685.68	7,857.21
	10	719.97	9,346.97
	11	755.97	11,013.09
	12	793.77	12,869.49
	13	833.46	13,704.87
	14	875.13	15,895.42
	15	918.89	18,327.30
	16	964.83	21,028.37
	17	1,013.07	24,021.81
	18	1,063.73	27,340.13
	19	1,116.91	31,020.44
	20	1,172.76	35,090.60
	21	1,231.40	39,592.37
	22	1,292.97	44,567.52
	23	1,357.61	50,057.82
	24	1,425.49	56,114.33
	25	1,496.77	62,792.73
	26	1,571.61	70,162.63
	27	1,650.19	78,279.74
	28	1,732.70	87,209.03
	29	1,819.33	97,038.66
	30	1,910.30	107,856.84
	31	2,005.81	119,747.00
	32	2,106.10	132,820.00
	33	2,211.41	147,189.00
	34	2,321.98	162,973.00

	35	2,438.08	180,298.00
	36	2,559.98	199,317.00
	37	2,687.98	220,192.00
	38	2,822.38	242,942.00
	39	2,963.50	267,887.00
	40	3,111.67	295,232.00
	41	3,267.26	325,194.00
	42	3,430.62	358,029.00
	43	3,602.15	393,997.00
Worker reaches	44	3,782.26	433,385.00
age 65 →	45	3,971.37	476,519.00
Worker reaches	46	4,169.94	523,736.00
age 67 →	47	4,378.44	575,419.00

Assumptions: Amount deposited grows at five percent per year. Rate of interest equals nine percent.

*Average combined employee and employer tax in 1983.

APPENDIX

THE NCPA PROPOSAL

The concept behind the Health Bank IRA proposal is to allow workers to withdraw an amount equal to all or almost of the payroll taxes they now pay into Medicare and place those funds into a private savings account. These funds would be use to pay for medical expenses and private health insurance in retirement, in lieu of Medicare. The federal government's role would be limited to providing catastrophic health insurance, through Medicare, and means-tested benefits, through the Medicaid program.

I. Changes in the Long-Term Structure of Medicare

Catastrophic Coverage

Medicare will be restructured so that two types of benefits are provided: basic health insurance and catastrophic health insurance. Catastrophic health insurance will apply to very large medical bills. The size of medical expense deemed to be catastrophic will grow through time in a manner described below.

Basic Coverage

In order to insure that money spent on health care for the elderly bears some reasonable relationship to spending on other goods and services which people also desire, the amount spent on basic Medicare health insurance will be about $1,500 per beneficiary in 1982 prices, and will be allowed to grow through time in line with annual increases in the average wage in the economy. In order to keep Medicare spending from rising above this maximum, deductibles and co-payments will be increased when necessary.

II. The Health Bank IRA

Refundable Tax Credits

All workers under the age of 65 will be allowed to make annual contributions to designated Health Bank IRA accounts and receive a 100 percent income tax credit for these contributions. The annual contribution will be a fixed sum of money called an "allowable contribution." Any worker who chooses the IRA option must deposit the entire allowable contribution in his IRA account. Workers may place additional funds in their Health Bank IRAs, but they will not receive a tax credit for these additional amounts.

In order to encourage low-income workers to exercise the Health Bank IRA option, tax credits for allowable contributions will be refundable. This means that a worker with no taxable income will be able to make annual contributions to a Health Bank IRA with a tax refund granted by the federal government.

The Disposition of Health Bank IRA Funds

Since the Health Bank IRA account is created in order to provide a private alternative to Medicare, funds deposited in this account may be used to purchase only (1) medical care for a worker who has declared retirement at any time after age 59½, (2) medical care for a worker who has reached the age of 65, whether or not retired, or (3) private health insurance to cover medical expenses for cases (1) and (2).

Until Health Bank IRA funds are used to purchase medical care or private health insurance, these funds may be invested, and the return on such investments will be tax-exempt in accordance with existing IRA rules. Moreover, an individual's Health Bank IRA is part of his estate, and any funds remaining in a Health Bank IRA at the time of an individual's death may be passed on to his heirs.

The Quid Pro Quo

For the first 30 years of contributions under this program, each year that a worker makes an allowable contribution to his Health Bank IRA he will give up the right to 1/30th of the Medicare benefits that he otherwise would have been entitled to. Thus, if a worker contributes only once to an IRA account, when he reaches age 65 he will be entitled to 29/30ths of whatever Medicare pays for basic medical expenses. A worker who makes 15 contributions to an IRA will be entitled at age 65 to one-half of whatever Medicare pays. A worker who makes 30 contributions to an IRA will give up all claims against Medicare for basic medical expenses.

Table A-I illustrates expected annual benefits from Medicare for workers who participate fully in Medicare and for workers who make contributions to their IRAs at every opportunity. The table assumes that the portion of Medicare allocated to basic medical coverage will be about $1,500 per beneficiary in 1982 prices.

The Allowable Contribution

The purpose of the Health Bank IRA option is to encourage workers to engage in a savings program which will furnish them with a sum of money from which they can fund their own medical expenses during their retirement years. In order to assure that this purpose is achieved, it is important to structure the program so that workers find it in their financial self-interest

TABLE A-I

EXPECTED ANNUAL BENEFITS

FROM MEDICARE DURING THE THIRTY-YEAR

PHASE-IN PERIOD

(In 1982 Prices)

Worker Reaches 65 After:	Full Participation	Health Bank IRA Participants
5 years	$1,500	$1,250
10 years	1,500	1,000
15 years	1,500	750
20 years	1,500	500
25 years	1,500	250
30 years	1,500	-0-

to exercise the IRA option. Workers will be financially encouraged to exercise the IRA option in two ways. First, the allowable contribution to a Health Bank IRAs will be an amount which is greater than the discounted present value of the Medicare benefits which the worker will forego as a result of exercising the option. Second, workers who have exercised the IRA option at any time during their working years will have an opportunity to buy back into Medicare.

Table A-II shows what the allowable contributions must be in order to make IRA deposits financially attractive to different individuals at different ages, under the current eligibility age of 65. The table also shows what the allowable contribution must be under the eligibility age of 67, proposed by the Advisory Council on Social Security.

As the table shows, each new generation of male workers entering the labor market can be encouraged to opt out of Medicare (with eligibility at 65) for an allowable contribution of $267. With an eligibility age of 67, each new generation of male workers can be encouraged to opt out with an allowable contribution of $191.

Table II-A also shows that if the allowable contribution is set sufficiently high to induce white male workers to opt out of Medicare, this amount will be considerably greater than the minimum amount needed to induce black male workers to opt out of Medicare. Thus, unlike Medicare which discriminates against blacks and other minorities with low life expectancies, the Health Bank IRA option benfits blacks and other minorities relative to whites. In fact, as we have seen, with an eligibility age of 67, black males can expect to gain nothing from Medicare.

A special problem arises as a result of the different life expectancies of men and women. On the average, white females entering the labor market today can expect benefits from Medicare which are almost two times larger than the expected benefits for white males. Black females have expected Medicare benefits which are more than five times larger than those of their male counterparts. Under the IRA option, if all workers are given the same allowable contribution, regardless of sex, then the allowable contribution must be roughly equal to $500 to induce women as well as men to opt out of Medicare with the current eligibility age.

The Buy-Back Option

Every worker who makes contributions to a Health Bank IRA will have the opportunity to re-enter Medicare upon reaching the age of 65. In order to buy back into Medicare and obtain full Medicare coverage, the worker must make a lump sum payment to Medicare. This payment will be at least equal to the amount that his Health Bank IRA would have grown to (with prudent investments) and perhaps an additional penalty as well.

Table A-II

AMOUNT OF ANNUAL TAX CREDIT NEEDED TO MAKE OPTING OUT FINANCIALLY ATTRACTIVE.

Eligibility Age: 65

	MALE		FEMALE	
AGE	White	Black	White	Black
20	$ 267	$ 67	$ 493	$ 350
30	$ 373	$ 141	$ 647	$ 471
35	$ 455	$ 205	$ 765	$ 565

Eligibility Age: 67

	MALE		FEMALE	
AGE	White	Black	White	Black
20	$ 191	$ 0	$ 409	$ 271
30	$ 272	$ 53	$ 531	$ 365
35	$ 333	$ 98	$ 623	$ 436

Note: The tax credit grows at the rate of growth of the average wage. It is assumed that the rate of interest paid on IRA accounts is equal to the rate of growth of the average wage. This is a very conservative assumption. Under more realistic assumptions about the rate of interest, the amounts above would be much lower.

Medicare will provide catastrophic health insurance coverage for all workers who reach the age of 65, including those workers who have opted out completely of Medicare's basic insurance plan. The level which medical expenses must reach before they become classified as catastrophic will rise through time and will be related to the size of the fund being accumulated in a representative Health Bank IRA. For example, if an individual makes $500 annual contributions to an IRA account, and if the allowable contribution grows by five percent per year, and the account earns interest return of nine percent, after 30 years it will have grown to $116,200. Since these funds are expected to cover basic medical expenses, the catastrophic level of expenses at this point would probably be in excess of $100,000.

Under Medicare's catastrophic health insurance program there will be co-payments in order to give individuals an incentive to avoid wasteful expenditures. In addition, there will be a recapture provision for those who use Medicare's catastrophic insurance. The recapture provision will allow the government to charge the estate of the deceased the amount of money which the deceased used for catastrophic care prior to death. A provision will have to be made to allow certain transfers to a spouse before the government's claim is paid.

III. The Evolution of Medicare and Medicaid.

Medicare Taxes

Since contributions to Health Bank IRAs earn income tax credits, the payroll tax, including that portion of the payroll tax designated for Medicare, will be unaffected. This means that the payroll tax can continue to serve as the major (or even exclusive) source of funds from which to fund Medicare expenditures.

As individuals exercise their IRA options, however, the total amount of Medicare spending will began to fall through time, relative to what it otherwise would have been. This means that, in principle, the payroll tax can be progressively lowered through time.

Medicare Benefits

This proposal is structured to encourage every member of each new generation of workers to opt out of Medicare. Even low-income workers will be able to build up a fund from which to finance their own health care expenditures during their retirement years.

A small percentage of the population may remain in Medicare because of ignorance of, or indifference to, the IRA option. In addition, because of the "buy back" option, some individuals may choose to buy back into Medicare at the age of 65. Because of the adverse selection problem associated with the "buy back" system, however, Medicare will look very unattractive to young workers. In addition, it is unlikely that those who do buy back into Medicare will gain much by doing so.

As a result, the Health Bank IRA program will ultimately lead to a virtual phasing out of the basic medical insurance part of Medicare. Ultimately, Medicare will become almost exclusively a catastrophic health insurance plan.

Medicaid

Under this proposal, Medicaid will continue in some form to pay for the medical expenses of individuals with few assets and little or no money income. It is anticipated, however, that there will be little need for Medicaid for people 65 and older. Even those who live below the poverty level during their working years should have sufficient Health Bank IRA funds to make Medicaid unnecessary during their retirement years.

IV. Short-Term Financial Effects on the Federal Budget

If no other changes are made in government spending or taxation, tax credits given for funds placed in Health Bank IRA accounts will decease federal revenues and, therefore, increase the size of the budget deficit. However, for each one-dollar increase in the deficit there is a corresponding one-dollar increase in the supply of credit (through IRA accounts). This means that for every extra dollar the government needs to borrow as a result of this program there will be one extra dollar added to the supply of loanable funds in the credit market through Health Bank IRAs.

As a consequence, the introduction of this program will not cause interest rates to rise, or create any additional inflationary pressures in the economy. Even if larger deficits result, funds will be available to finance these deficits without "crowding out" private investment.

ABOUT THE CONTRIBUTORS

PETER FERRARA is the author of Social Security: The Inherent Contradiction, a book which was widely acclaimed for its penetrating analysis of the crisis of Social Security and which advocated an IRA alternative to the Social Security system. A graduate of Harvard Law School, Mr. Ferrara recently left his post as a senior staff member at the White House Office of Policy Development and is currently a member of Shaw, Pittman, Potts and Trowbridge, a Washington law firm.

JOHN GOODMAN is the author of four books, including Social Security in the United Kingdom: Contracting out of the System, a study of a social security system which allows partial opting out. Dr. Goodman is President of the National Center for Policy Analysis and Director of the Center for Health Policy Studies at the University of Dallas.

GERALD MUSGRAVE is the author of over 30 publications, including work on "The Effect of Social Security on Saving and Capital Formation," health economics and computational econometrics. He is the Associate Editor and Book Review Editor of Business Economics, the journal of the National Association of Business Economists. Dr. Musgrave is leaving his position as Adjunct Professor of Economics at the University of Michigan to become President of Safeware Computer Systems.

RICHARD RAHN served as a member of the 1982-83 Social Security Advisory Council. Dr. Rahn is Vice-President and Chief Economist of the U.S. Chamber of Commerce and is the former Executive Director of the American Council for Capital Formation.

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