Health Care After Retirement: Who Will Pay the Cost?

by

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EXECUTIVE SUMMARY

Health care spending for the elderly, like Social Security, is financed on a pay-as-you-go basis. Both employees and employers are discouraged from putting aside money during an individual's working years to pay for health care during retirement. As a result, each generation of retirees depends on the next generation of workers to pay its medical bills. Yet if current trends continue, by the year 2050, when today's young children are in their retirement years,

- About one-half of the population will be age 45 or older and one-fourth of the population will be elderly.
- Roughly half of the men who reach age 65 will live beyond the age of 86, and half of the women who reach 65 will live past 91.
- The elderly, who today consume about one-third of all health care resources, will account for two-thirds of the nation's health care bill.

The financial implications of these projections are staggering. In order to honor future commitments to retirees, tomorrow's workers will face financial burdens far beyond their ability to pay. For example,

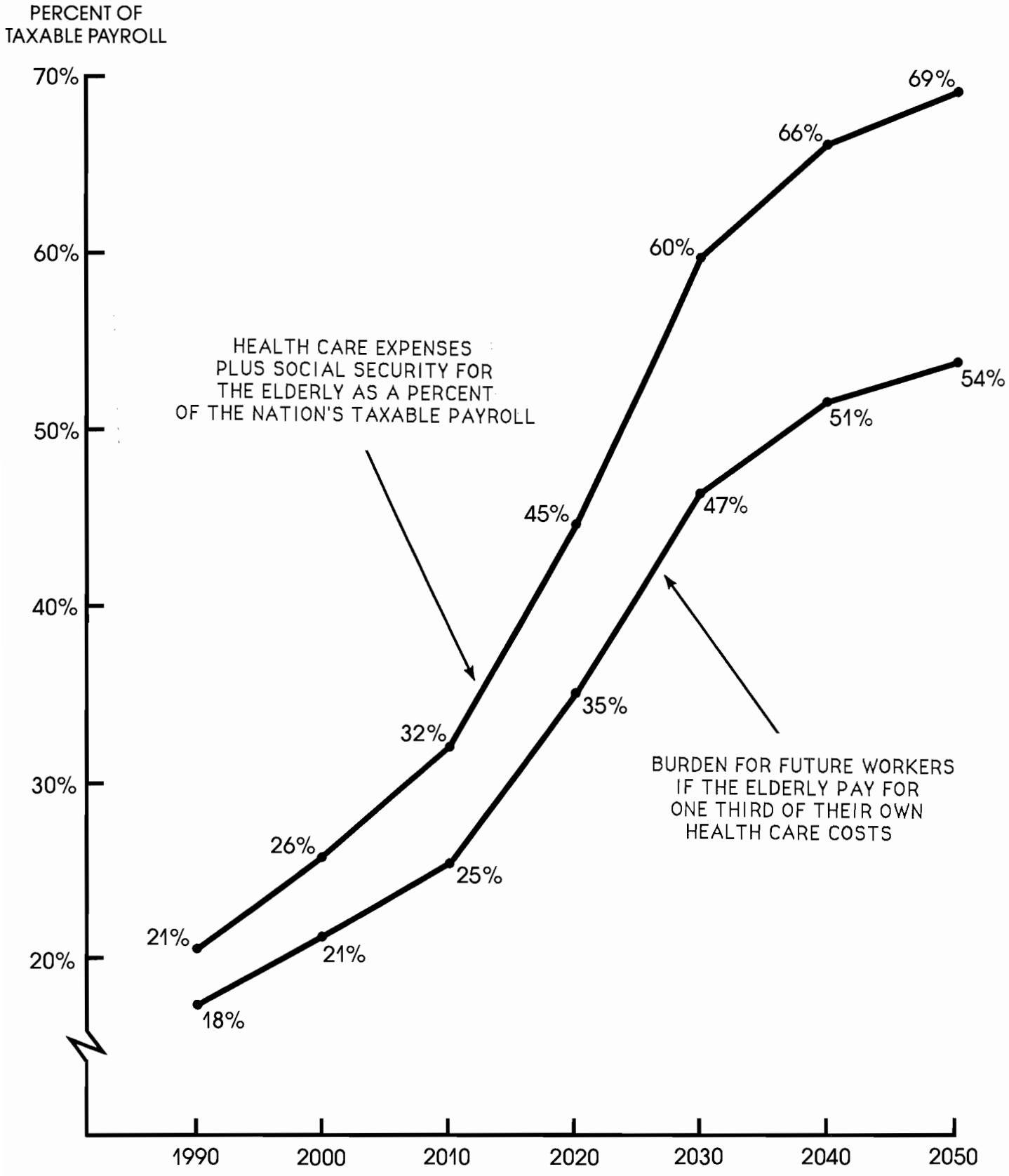
- When Social Security payments are added to total health care spending for the elderly, these two commitments will account for 25 percent of taxable payroll by the year 2000.
- That burden will approach one-third of taxable payroll within two decades and exceed 70 percent of taxable payroll by the year 2060.
- Even if the elderly pay one-third of their health care expenses out of their own pockets, the remaining burden will claim more than one-half of workers' incomes by the year 2040, and will grow continuously thereafter.

The future nightmare we face arises because of federal policy. The tax law discourages both individuals and employers from saving and investing today to pay for future health care. Although one-third of all workers are employed by companies which provide post-retirement health care benefits, Congress has forced these employers to adopt the same pay-as-you-go approach followed by the federal government. As a result,

- Unfunded liabilities for post-retirement health care for U. S. employers are as high as $2 trillion.
- If *Fortune* 500 companies were required to account for post-retirement health care benefits the way they now account for pensions, their annual net income would be reduced by 30 to 60 percent.

The federal government must cease imposing an irresponsible pay-as-you-go policy on individuals and on corporate America. Employers should be allowed to set aside funds today to pay for the post-retirement health care needs of their employees, and individuals should be encouraged to establish medical savings accounts.

NIGHTMARE IN OUR FUTURE



SOURCE: NATIONAL CENTER FOR POLICY ANALYSIS

BASED ON THE SOCIAL SECURITY ADMINISTRATION'S ALTERNATIVE III ASSUMPTIONS

THE NIGHTMARE IN OUR FUTURE

As we move into the twenty-first century, the United States and all other developed countries will face the problem of 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 become staggering. During the latter half of the next century, the annual cost of Social Security plus health spending for the elderly will equal one-half to three-fourths of all workers' wages.

Under our current system of pay-as-you-go financing, each generation depends on the government to tax the next generation to pay its Social Security benefits and most of its health care bills. If we continue this practice, the burden we create for tomorrow's workers will be impossible for them to bear.

The year 2050, the middle of the next century, seems like the distant future -- so distant it is easy to ignore. Yet everyone who will be 65 years of age or older in the year 2050 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 of the Social Security Administration:

Social Security and Medicare. 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" forecast is the most likely. Yet many students of Social Security take more interest in the "pessimistic" projection because they more closely reflect our recent experience.[2] Currently, spending on Social Security and Medicare Hospital Insurance is equal to about 14 percent of the nation's total taxable payroll. 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 I shows, according to the "pessimistic" projection,[3]

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[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 *The Board of Trustees Report*).

[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 "Social Security: Who Gains? Who Loses?", NCPA Policy Report No. 127, pp. 6-8. The assumptions behind all three projections are discussed in greater detail below.

[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.

- By the year 2030, the payroll tax will have to rise to 32 percent of taxable wages to fund benefits promised under current law.

- By the year 2060, the burden of Social Security and Medicare Hospital Insurance will equal 39 percent of the nation's taxable payroll.

Note that this future payroll tax burden is greater than the combined burden of all federal, state, and local personal income taxes today.

Projected Health Care Spending. By far the fastest-rising component of our commitment to the elderly is the commitment to pay for future health care costs. The burden of Medicare Hospital Insurance currently is about 2.56 percent of total taxable payroll. Yet, as Table II shows,

- By the year 2010, the burden of Medicare Hospital Insurance will have doubled.

- The burden will be more than triple its current level by the year 2020, and more than quadruple its current level by the year 2030.

These estimates considerably understate the total magnitude of health care spending for the elderly. Medicare Hospital Insurance (Medicare Part A) today pays about 75 percent of hospital costs for the elderly, and hospital expenses are only 45 percent of total health care spending. As a result, Medicare Hospital Insurance pays for about 30 percent of 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 costs borne directly by the elderly. As Table II shows, if non-hospital medical costs increase at the same rate as projected hospital costs, health care spending for the elderly may exceed 45 percent of the nation's taxable payroll by the year 2050.

Burden for Future Taxpayers. The 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 which 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, to the Veterans Administration, to Medicaid, or to private employers is viewed as reducing future obligations.

This assumption undoubtedly is wrong. If the political marketplace communicates any clear message, it is that of an implicit "contract" with the elderly. Moreover, the political obligation to ensure that all elderly citizens will have access to health care is probably every bit as strong as the obligation to pay Social Security benefits.

Like Social Security, virtually all 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 the year 2050 only by taking income from people who are alive in the year 2050.

Table III shows the magnitude of our combined commitments to pay Social Security benefits and health care costs for the elderly in future years. As the table indicates,

- The combined burden of Social Security plus total health care expenses for the elderly will reach almost one-third of total taxable payroll in just two decades.

- By the year 2030, the combined burden will be almost 60 percent of the nation's taxable payroll.

- By the year 2060, the combined burden will be more than 70 percent of the nation's taxable payroll.

It is not known precisely what share of their own health care expenses the elderly pay with their own funds. A reasonable estimate is that they currently pay no more than one-third.[4] As our society ages, we will witness an increasing proportion of the "old" elderly -- people 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 to rely on the elderly to pay as little as one-third of their own medical expenses. Nonetheless, Table IV projects the burden for future taxpayers on the optimistic assumption that the working population still will be obligated to pay for only two-thirds.

- If the elderly continue to pay one-third of their own health care costs, in just two decades the remaining burden on the working population will exceed one-fourth of the nation's taxable payroll.

- By the year 2040, that burden will exceed one-half of the nation's total taxable payroll, and will grow continuously thereafter.

[4]The technical issues involved in making this estimate are discussed in the Appendix.

TABLE I

SOCIAL SECURITY AND MEDICARE HOSPITAL INSURANCE AS A PERCENT OF THE NATION'S TAXABLE PAYROLL

Year	Optimistic Projection[1]	Intermediate Projection[2]	Pessimistic Projection[3]
1990	13%	14%	14%
2000	12%	14%	16%
2010	12%	15%	18%
2020	14%	18%	25%
2030	16%	22%	32%
2040	16%	23%	35%
2050	15%	23%	37%
2060	15%	24%	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.

Source: *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, Appendix E, Table E3, pp. 129-130.

Note: These projections do not include the effects of the recently-passed catastrophic health insurance legislation for Medicare beneficiaries.

TABLE II

HEALTH CARE EXPENSES FOR THE ELDERLY AS A PERCENT OF THE NATION'S TAXABLE PAYROLL

(Based on the Social Security Administration's "Pessimistic" Projection)

Year	Medicare Hospital Insurance[1]	Total Medicare[2]	Total Health Care Costs[3]
1990	2.85%	4.14%	9.46%
2000	4.31%	6.47%	14.30%
2010	5.98%	8.97%	19.82%
2020	8.79%	13.19%	29.15%
2030	12.17%	18.26%	40.35%
2040	13.53%	20.30%	44.86%
2050	13.86%	20.79%	45.95%
2060	14.17%	21.26%	46.99%

[1] *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, Appendix E, Table E3, pp. 129-130.

[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.

Note: These projections do not include the effects of the recently-passed catastrophic health insurance legislation for Medicare beneficiaries.

TABLE III

SOCIAL SECURITY PLUS HEALTH CARE EXPENSES FOR THE ELDERLY AS A PERCENT OF THE NATION'S TAXABLE PAYROLL

(Based on the Social Security Administration's "Pessimistic" Projections)

Year	Social Security[1]	Social Security Plus Total Medicare	Social Security Plus Total Health Care Expenses
1990	11.36%	15.64%	20.82%
2000	11.58%	18.05%	25.88%
2010	12.19%	21.16%	32.01%
2020	15.73%	28.92%	44.88%
2030	19.56%	37.82%	59.92%
2040	21.45%	41.75%	66.31%
2050	23.23%	44.02%	69.18%
2060	25.05%	46.31%	72.04%

[1]Includes Old-Age, Survivors, and Disability payments.

Source: *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, Appendix E, Table E3, pp. 129-130; and Tables I and II.

Note: These projections do not include the effects of the recently-passed catastrophic health insurance for Medicare beneficiaries.

TABLE IV

BURDEN FOR FUTURE WORKERS

(Assuming the Elderly Pay for One-Third of their Health Care Expenditures)

Year	Burden as a Percent Of Taxable Payroll
1990	17.67%
2000	21.11%
2010	25.47%
2020	35.97%
2030	48.00%
2040	52.41%
2050	54.48%
2060	56.37%

Source: *The 1988 Annual Report* of *the Federal Old-Age and Survivors Insurance and the Federal Disability Trust Funds,* May 9, 1988, Appendix E, Table E3, pp. 129-130; and Tables II and III.

The Problem of Expanding Medicare Coverage. These forecasts, in all likelihood, considerably understate the magnitude of future health care spending on the elderly because they ignore the political pressure to expand Medicare coverage. For example, they do not take into account the almost certain increase in medical costs that will follow the enactment of the recently-passed catastrophic health care legislation.[5] The forecasts also ignore other medical expenses which Medicare does not now cover and for which there would be considerable demand if price were no object. Take nursing home care, for example:

[5]See Peter Ferrara and Edmund F. Haislmaier, "The Catastrophic Health Tax on America's Elderly," Issue Bulletin No. 132, Heritage Foundation, July 21, 1987.

- Medicare currently pays less than 2 percent of nursing home costs for the elderly.[6]
- Yet among catastrophic, out-of-pocket medical costs born by the elderly, 81 percent goes for long-term care in nursing homes.[7]
- In addition, for every elderly patient in a nursing home, two equally- disabled patients are not in nursing homes.[8]

Political pressure is mounting to expand Medicare to cover nursing home costs. Yet even today, the costs of such coverage would be huge:[9]

- If every elderly person in America spent just one year in a nursing home, the total cost would be about $627 billion.
- This figure alone exceeds 60 percent of the entire federal budget.

One of the prime forces keeping the elderly out of nursing homes today is the high cost. If price were no object (e.g., if Medicare coverage were extended), the percentage of elderly people in nursing homes would increase sharply.

TAKING A CLOSER LOOK AT THE ASSUMPTIONS BEHIND THE PROJECTIONS

Since the Social Security Administration has published different forecasts for the next 75 years, which one should we believe? That depends on which forecast is based on the most realistic assumptions. And the only known way of evaluating such assumptions is to compare them to our recent past experience.

Table V summarizes the key assumptions used in each of the Social Security Administration's projections. The differences in the assumptions appear small. But these small differences today lead to huge differences in taxpayer burdens tomorrow -- differences which are magnified the further we look into the future. Depending on which set of assumptions is correct, the required financial burden of support for the elderly will be only modestly greater than today, or it will be far beyond the ability of future taxpayers to bear. What follows is a brief analysis of some critical assumptions behind current forecasts.

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

[7]Thomas Rice and John Gabel, "Protecting the Elderly Against High Health Care Costs," *Health Affairs*, Fall, 1986, p. 16.

[8]Task Force on Long-Term Care Policies, *Report to the Congress and the Secretary.*

[9]John C. Goodman and Gerald L. Musgrave, "Health Care for the Elderly: The Nightmare in Our Future," NCPA Policy Report No. 130, October, 1987, p. 5.

TABLE V

KEY ECONOMIC AND DEMOGRAPHIC ASSUMPTIONS FOR THE PERIOD FOLLOWING THE YEAR 2012

Assumption	Recent Experience	Optimistic Projection[7]	Intermediate Projection[8]	Pessimistic Projection[9]
Total Fertility Rate	1.81[1]	2.2	1.9	1.6
Real Wages (annual increase)	-0.2%[2]	2.4%	1.4%	0.9%
Consumer Price Index (annual increase)	6.6%[3]	2.0%	4.0%	5.0%
Mortality Rate (annual decrease)	1.6%[4]	0.3%	0.6%	1.1%
Hospital Costs[5] (annual increase)	8.1%[6]	0.0%	1.8%	3.7%

[1]Average fertility rate for the years 1976 to 1986.

[2]Real wages grew at an average annual rate of 0.5 percent from 1967 to 1976 and declined at a rate of 0.2 percent for the years 1977 to 1986.

[3]Average annual increase for the period 1976 to 1986.

[4]Average annual decrease in the age-sex-adjusted death rate for the years 1968 to 1985.

[5]Measured as the annual rate of increase in Medicare Hospital Insurance expenditures minus the annual rate of increase in average wages.

[6]Annual rate of growth of hospital inpatient expenditures (approximately 93 percent of HI spending) minus the rate of growth in wages for the years 1975 to 1986.

[7]Based on the Social Security Administration's Alternative I Assumptions.

[8]Based on the Social Security Administration's Alternative II-B Assumptions.

[9]Based on the Social Security Administration's Alternative III Assumptions.

Source: *The 1988 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Trust Funds*, May 9, 1988; and *The 1988 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, May 10, 1988.

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 lifetimes. In developed countries, a fertility rate of 2.1 is the replacement rate -- the rate necessary to maintain the size of the current population. In other words, each adult man and woman must be replaced by approximately two children in order to keep the total population at its current size.[10]

In 1960, virtually all developed countries had fertility rates in excess of 2.1, and most had rates substantially higher. Yet one of the most striking demographic changes that has occurred throughout the developed world is the dramatic drop in fertility rates over the last few decades. As Table VI shows,

- Since 1960, every developed country has experienced a substantial drop in its fertility rate.
- The U.S., Canada, Iceland, and the Netherlands have experienced more than a 50 percent drop in fertility rates in the last 25 years.
- In Belgium, Austria, Denmark, Australia, Germany, and New Zealand, the decrease has been 40 percent or greater.

As a result of this dramatic change, the vast majority of developed countries today have fertility rates which are substantially below the replacement rate. Specifically,[11]

- The fertility rate is currently 1.3 in Germany, and 1.4 in Italy, Luxembourg, and Denmark.
- Overall, out of 22 western industrial democracies, only three (New Zealand, Ireland, and the Jewish population of Israel) have fertility rates that currently are above the replacement level.

[10]The 0.1 factor accounts for childhood mortality that occurs before reaching childbearing age.

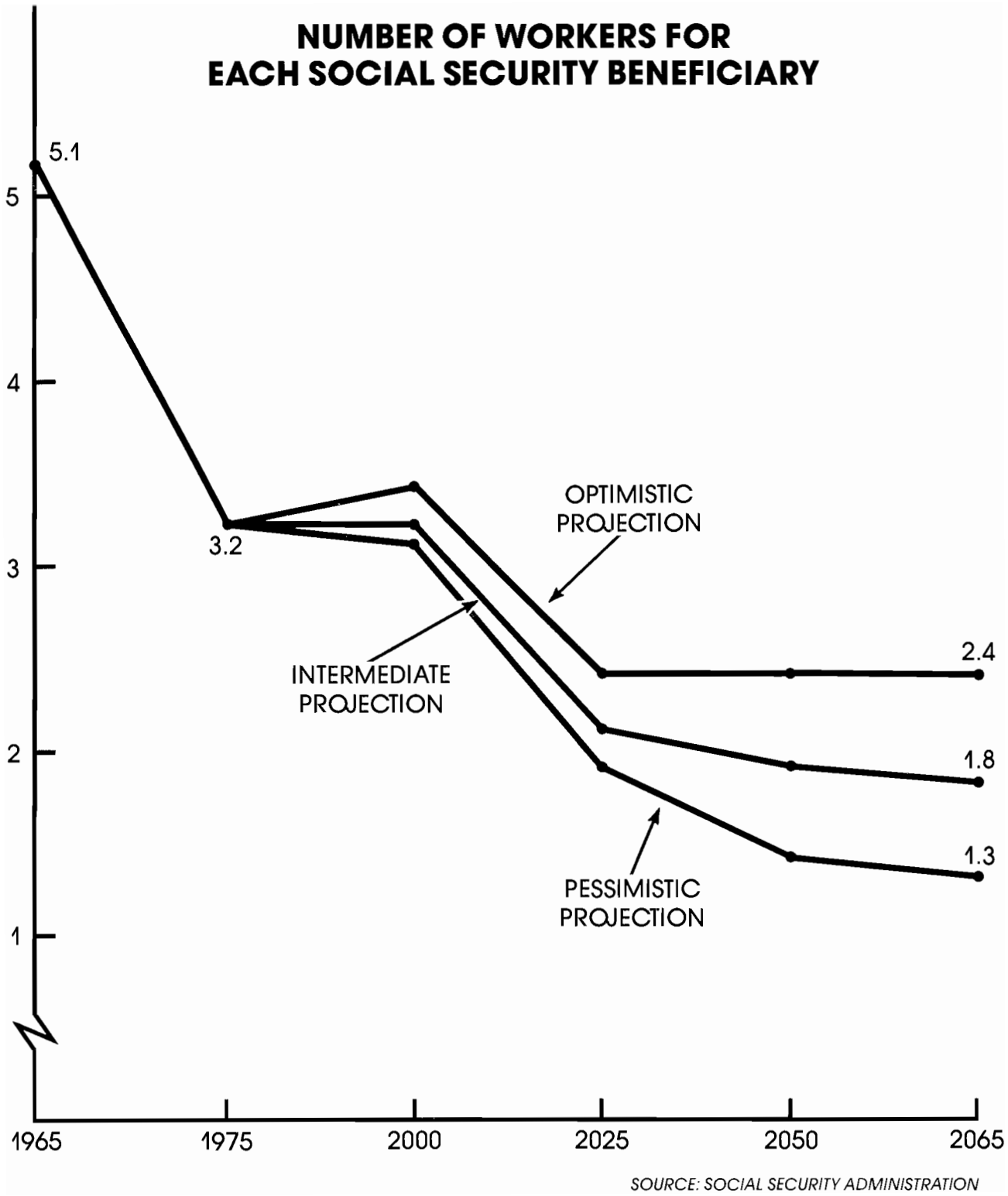
[11]Ben J. Wattenberg, *The Birth Dearth* (New York: Pharos Books, 1987), Chart 2A, p. 173.

TABLE VI

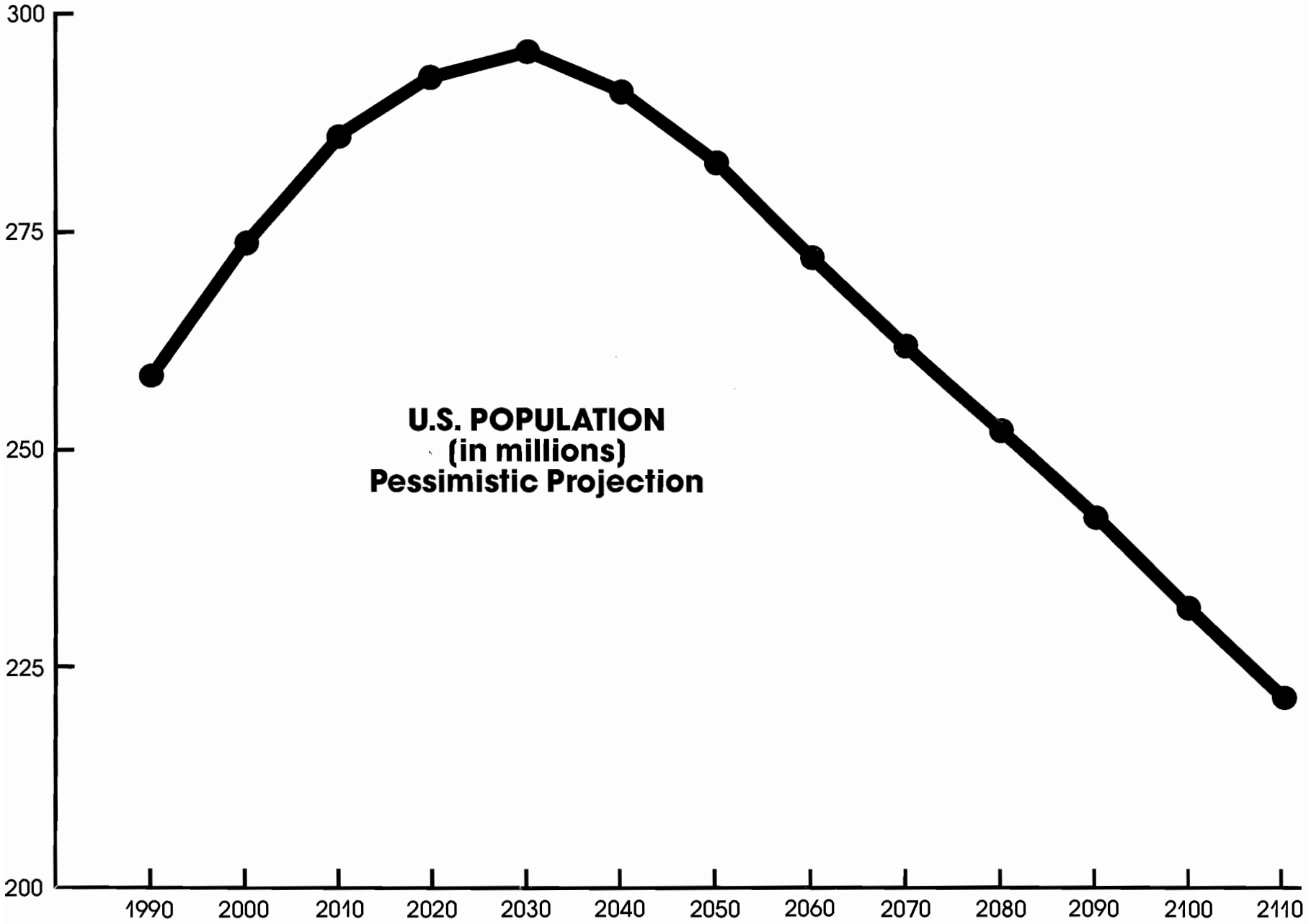
DROP IN FERTILITY RATES
(1960 - 1985)

Country	Change
Australia	-43%
Austria	-42%
Belgium	-40%
Canada	-55%
Denmark	-44%
Finland	-37%
France	-33%
Germany	-44%
Iceland	-56%
Ireland	-34%
Israel (Jewish Population)	-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.



SOURCE: SOCIAL SECURITY ADMINISTRATION


300
275
250
225
200
U.S. POPULATION
(in millions)
Pessimistic Projection
1990
2000
2010
2020
2030
2040
2050
2060
2070
2080
2090
2100
2110

The fact that the fertility rate in this country and in almost every other developed country is well below the replacement rate has generally gone unreported -- both in official publications of the U.S. government and in the publications of independent scholars.[12] Yet even if the U.S. maintains its current fertility rate, the U.S. population will peak in the first half of the twenty-first century and continuously decline thereafter.

The implications of declining fertility rates are devastating for the social security systems of all developed countries. 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.[13]

Aging and Health Care Costs

As a country ages, its health care costs will inevitably rise. And the faster it ages, the faster those costs will rise. At the turn of this century, only 4 percent of the population was age 65 or older. Today that percentage has grown to 12 percent. By the year 2030, one in five; and by the year 2050, almost one in four will be elderly.[14] The elderly comprise the fastest growing segment of the population; and, among the elderly, the "old" elderly are the fastest growing group:[15]

- Although the total population of the U.S. will probably be smaller in the year 2050 than it is today, the elderly population will double, and the "old" elderly population will be almost quadruple its current size.

- Although the "old" elderly represented only 9 percent of the elderly population in 1980, they will represent one-fifth of the elderly by the year 2050.

The aging of the population will continue indefinitely as we look into the future. For example,[16]

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[12]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, *The Birth Dearth*, n. 3, pp. 26-27. 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, Karen Davis and Diane Rowland (both former administrators in the U.S. Department of Health and Human Services) recently published a book on Medicare policy in which all of their forecasts assumed a (replacement) 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. 121-123.

[13]In principle, these countries could attempt to increase their populations through immigration. However, almost all developed countries have very restrictive immigration policies and the trend is toward even more restrictions.

[14]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, D.C.: U.S. Government Printing Office, 1984), lowest series projection, Table E and Table F, pp. 7-8.

[15]*Ibid.*

[16]*Board of Trustees Report,* Table II, pp. 37-38.

- Among 65-year-old retirees, a male today can expect to live to age 80, and a female can expect to live to age 84.

- By the year 2065, about one-half of all 65-year-old men will live beyond age 86.

- About one-half of all 65-year-old women in the year 2065 will live beyond age 91.

It is inevitable that larger numbers of elderly people will increase the demand for health care resources. Elderly patients see physicians 20 percent more often than the non-elderly, and are admitted to hospitals at twice the rate.[17] Once in the hospital, the cost of their care is higher.

- On the average, people today can expect to incur more than half of their lifetime health care costs after they reach age 65.[18]

- In 1984, average health care spending was about four times higher for the elderly than for the non-elderly -- $4,200 compared with $1,100 for each individual under the age of 65.[19]

- Moreover, between 1977 and 1984, health care expenses for the elderly grew at 2.6 times the rate for the non-elderly.[20]

Among the "old" elderly, health care utilization and health care costs are even higher.

- On the average, hospital costs for persons 85 years of age and older are about 67 percent more than for those age 65 to 75.[21]

- Long-term care for the "old" elderly is about ten times more costly than for the "young" elderly.[22]

- Moreover, whereas 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.[23]

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[17]George W. Bush, George B. Swick, Sarita L. Karon, and Marc A. Cohen, "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, N.Y.: Panel, 1986), p. 296.

[18]Estimates of the U.S. Health Care Financing Administration.

[19]Department of Health and Human Services, *Catastrophic Illness Expenses: Department of Health and Human Services Report to the President* (Washington, D.C.: DHHS, November, 1986), p. 8.

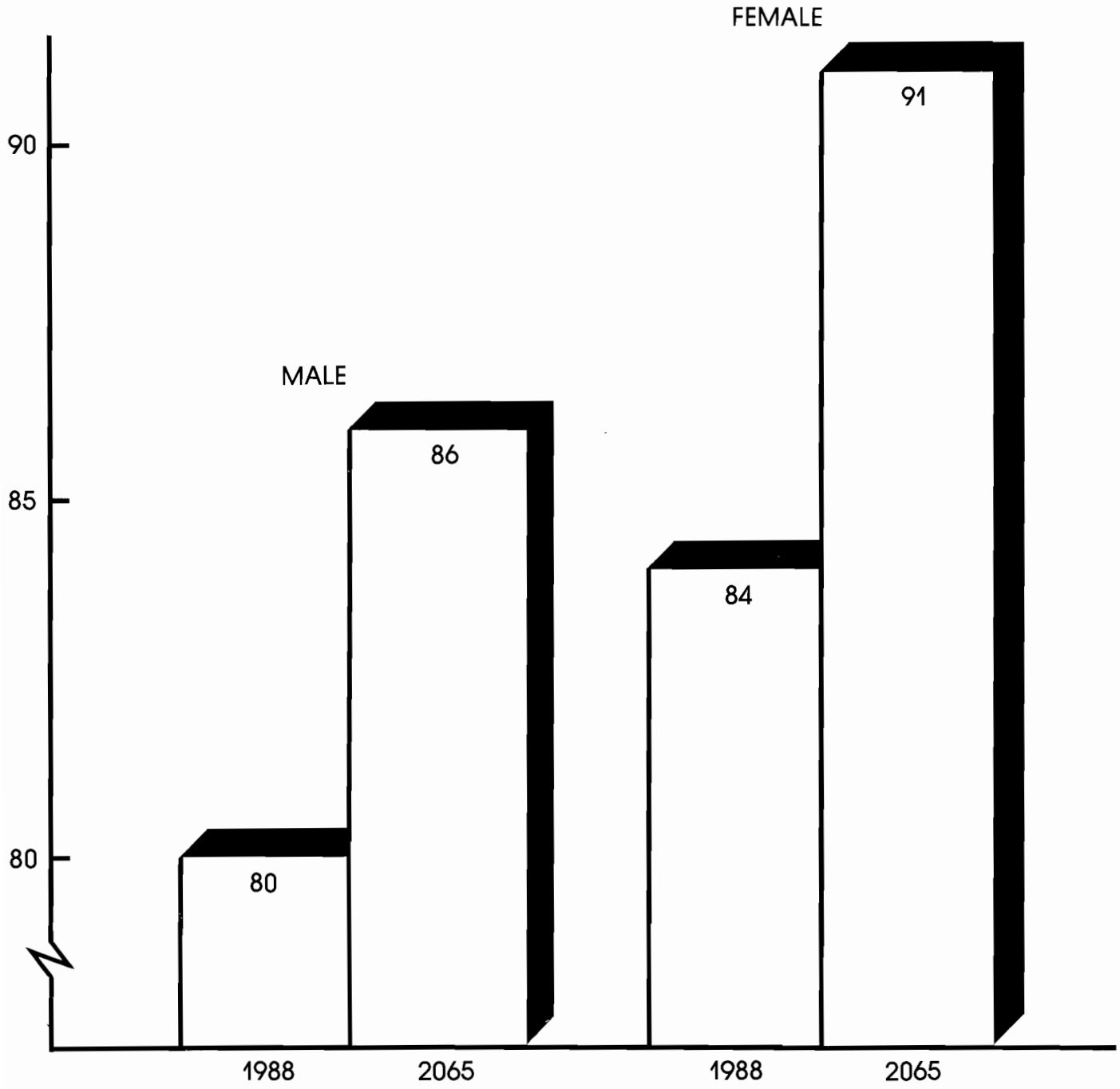
[20]Deborah J. Chollet and Robert B. Friedman, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," in Frank B. McArdle, ed., *The Changing Health Care Market* (Washington, D.C.: Employee Benefits Research Institute, 1987), p. 206.

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

[22]*Ibid.*

[23]Phillip Longman, *Born to Pay: The New Politics of Aging in America* (Boston: Houghton Mifflin Co.,

EXPECTED AGE OF DEATH FOR 65-YEAR-OLDS



SOURCE: SOCIAL SECURITY ADMINISTRATION

BASED ON THE PESSIMISTIC PROJECTION

Although the elderly today represent only 12 percent of the U.S. population, they consume almost one-third of all U.S. health care services.[24] 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 breakthroughs on the part of medical science, the aging population will create impossibly burdensome costs.

TABLE VII

U.S. POPULATION GROWTH
1990-2050

Population Group	Percent Increase
Total Population	**-6%**
Ages 65-74	**51%**
Ages 75-84	**78%**
Ages 85+	**246%**

Source: Based on the U.S. Bureau of the Census lowest series projection. 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, D.C.: U.S. Government Printing Office, 1984), Table 6.

1987), p. 88.

[24]Frederic D. Wolinsky, Ray R. Mosely, II, and Rodney M. Coe, "A Cohort Analysis of the Use of Health Services by Elderly Americans," in *Journal of Health and Social Behavior*, Vol. 27, No. 3, 1986, p. 209.

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 eliminate whole categories of life-threatening diseases or that slow the aging process and cause a significant increase in life expectancy for the elderly. Yet such developments are not merely possible. They are, over a 75-year time span, almost inevitable.

Seventy years ago, no one could have imagined medical procedures which are commonplace today. Similarly, we cannot possibly predict what medical science will achieve over the next 70 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 R & D industry will work hard at producing new inventions and discoveries that will cost us more money.

Second, unlike our counterparts of seventy years ago, today we have a fairly good idea of the direction in which progress in medical science will go. For example, it is virtually inevitable that scientists will someday produce a complete mapping of the genetic code. The question is not *if* it will happen, only *when*. Since a great 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.

Take 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. Yet some people, partly because of their genetic endowment, resist exposure better than others.[25] 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,[26]

- 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.

If we could costlessly eliminate all three of these diseases, we would also eliminate three major categories of health care spending. But it is not clear that our total financial burden

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[25]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, Mark H. Skalnick, Timothy Bishop, Randall G. Lee, and Randall W. Burt, "Common Inheritance of Susceptibility to Colonic Adenomatus Polyps and Associated Colorectol Cancers," *New England Journal of Medicine*, Vol. 319, No. 9, September 1, 1988, pp. 533-537.

[26]Bush, et. al., "Prefunding of Postemployment Health Care," pp. 303-304.

would go down. Freed of the three leading causes of death, 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 -- forecasts which invariably underestimated their 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 projection is forecasting.

OUR CHAIN-LETTER APPROACH TO FUNDING RETIREMENT NEEDS

America is a country in love with chain letters. At the federal level, we have Social Security, Medicare, federal civil service retirement, and Veterans Administration 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 the chain-letter approach to retirement security, each generation avoids making the sacrifice necessary to pay its own way, and instead hopes the next generation will pay. Using this approach, there are only three sources of funds available to pay retirement benefits: (1) the income and assets of the elderly themselves; (2) the income and assets of private companies which have promised to pay; and (3) federal government taxes on the income and assets of the general public.

Table VIII shows the current sources of health care funding for the elderly for expenses incurred outside of nursing homes. Throughout the 1980s, there has been considerable activity -- in both the public and private sectors -- attempting to shift costs among these various sources of payment. For example, state governments pay Medicare Part B premiums for elderly Medicaid patients in an attempt to shift medical costs from state governments to the federal government.[27] State governments also have stepped up their efforts to make Medicaid the "payor of last resort" by collecting wherever possible from Medicare and private insurance. Almost all employer-provided insurance is integrated with Medicare, and designed to pay for expenses not paid for by Medicare.[28] However, Congress recently made employers the "payor of first resort" for employees who continue to work after they qualify for Medicare at age 65.[29] 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 are veterans who can escape these higher payments by turning to "free" care made available by the Veterans Administration.[30]

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[27]Although Medicaid is partially funded by the federal government, each state administers the programs within its jurisdiction and pays roughly one-half of the costs.

[28]For a description of the types of employer plans, see Jonathan C. Dopkeen, "Post-retirement Health Benefits: Pew Memorial Trust Policy Synthesis, 2, Health Services Research, Vol. 21, No. 6, February, 1987, pp. 803-804.

[29]*Ibid.*, p. 583.

[30]Timothy M. Smeedling and Lavonne Straub, "Health Care Financing Among the Elderly: Who Really Pays

TABLE VIII

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

Medicare[2]	60.4%
Out-of-Pocket Expenses Plus Medigap Insurance Purchased by the Elderly	22.1%
Employer or Union-Provided Health Insurance[3]	7.4%
Medicaid	6.0%
Veteran's Medical Care	4.0%

[1] Excludes payments for nursing home care.

[2] Includes Supplemental Medical Insurance (SMI) premiums paid by the elderly for coverage under Medicare Part B.

[3] Includes premiums paid by the elderly.

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*, Vol. 12, No. 1, Spring, 1987, Table 1, p. 39 and Table 3, p. 43.

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the Bills?", *Journal of Health Politics, Policy and Law*, Vol. 12, No. 1, Spring, 1987, p. 37.

For our purposes, it is important to note that the net result of these activities is simply to shift costs back and forth among pay-as-you-go funding sources. In other words, none of these cost control attempts comes to grip with the reality that post-retirement health care is not being pre-funded 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 expenses of the elderly, and employer-provided post-retirement health insurance.

The Myth of the Social Security Trust Funds

Partly in response to growing public concern over the future of Social Security, Commissioner of Social Security Dorcas Hardy recently sent a letter to all Social Security recipients assuring them that the Social Security 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 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 Social Security 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 the government writes to itself. In order for Social Security to pay future benefits, the government will have to levy additional taxes at the time the payments are due.

As a practical matter, annual Social Security surpluses (the excess of Social Security revenue over Social Security expenditures) 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.[31]

- Projected annual surpluses will never exceed .85 percent of 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.

The projections on the accompanying graph are based on the Social Security Administration's "intermediate" assumptions. When the more realistic "pessimistic" assumptions are used, the future looks far bleaker:[32]

- Based on 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 -- about $350 billion in current dollars.

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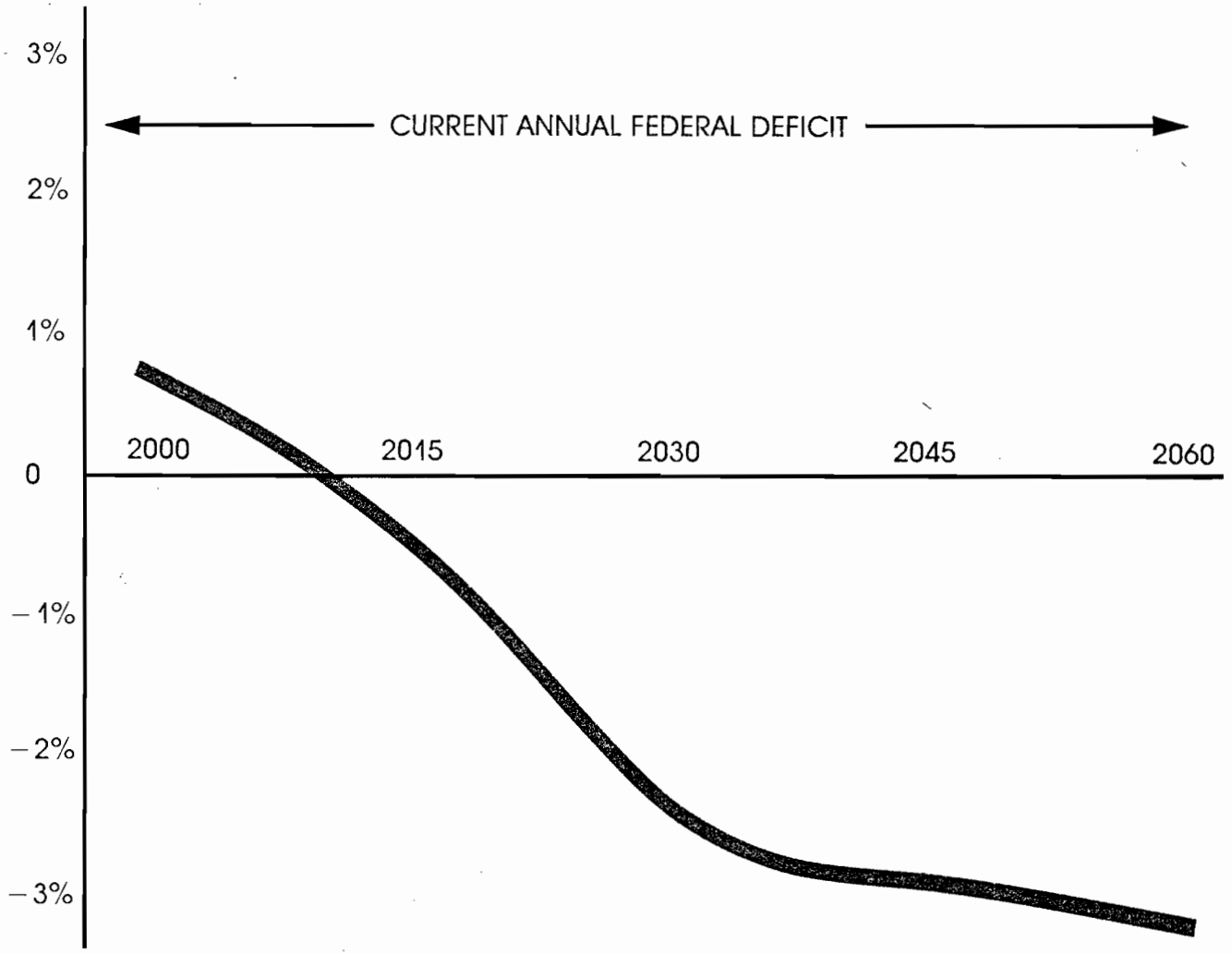
[31]Peter Ferrara, "The Great Social Security Hoax," Heritage Backgrounder No. 662, July, 1988.

[32]*Ibid.*

ANNUAL SOCIAL SECURITY SURPLUS/DEFICIT

(Percent of GNP)



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, there was considerable pressure on Congress to relieve the elderly of the financial responsibilities of health care. Yet the elderly today spend a *larger* share of their out-of-pocket income on health care than they did before the programs came into existence.[33]

- In 1962, before the enactment of Medicare and Medicaid, the elderly spent less than 8 percent of their own income for health care.

- Despite the phenomenal growth in Medicare and Medicaid spending, the elderly now spend 15 percent of their household income on medical care.

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 without Medigap insurance, and spend 15 percent more out-of-pocket.[34] In general, health insurance does not replace money the elderly would otherwise have spent on health care; it adds to the total spent.[35]

Nonetheless, there clearly is a limit to the amount 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.

- Among elderly families age 65 to 69, out-of-pocket expenses for health equal only four percent of income.[36]

- Among those 85 years of age and older, out-of-pocket expenses equal 38 percent of income.[37]

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[33]Smeedling and Straub, "Health Care Financing Among the Elderly: Who Really Pays the Bills?", p. 36.

[34]Davis and Rowland, *Medicare Policy*, p. 36.

[35]Prior to the passage of catastrophic health insurance legislation in 1988, it was widely believed that the legislation would reduce, or even eliminate, the market for Medigap insurance. However, the American Association of Retired People (AARP) -- the nation's largest marketer of Medigap policies -- now expects that premiums for its policies will remain the same or even increase due to an expected increase in the use of health care services. See Deborah Rankin, "Is 'Medigap' Insurance Still Needed?", *The New York Times*, August 7, 1988, p. 9-F.

[36]Anne M. Rappaport and Robert W. Kalman, "Financing Postretirement Medical Benefits: Assuring Economic Security for Retirees," in *The Sourcebook on Postretirement Health Care Benefits*, p. 271.

[37]*Ibid.*

- Yet the "old" elderly have only two-thirds as much income as the "young" elderly.[38]

Since the "old" elderly are the fastest growing segment of our population, our ability to extract greater out-of-pocket payments from retirees will become increasingly limited in the future.

Commitments of Private Employers

Just as almost all large companies provide private pensions, most now pay certain post-retirement health care expenses as well. Currently, about 95 percent of all large firms and a significant number of smaller ones provide post-retirement health care benefits.[39] Among retirees, about one in four is now covered by employer- or union-provided health insurance.[40] About one-third of all workers[41] and two-thirds of workers with employer-provided insurance[42] work for an employer who provides coverage for post-retirement health care. The cost of this commitment is soaring.[43]

- In 1974, when many companies began covering post-retirement medical expenses, *Fortune* 500 companies averaged twelve employees for every retiree.

- Today, there are only three workers for every retiree.

- As a result, for many companies retiree health plans are more costly than retiree pension benefits.

Some companies have been especially hard hit by the burden of post-retirement benefits. For example,

- Bethlehem Steel Corp has only 33,000 active employees but supports 70,000 retirees and their spouses.[44]

- Among companies reporting post-retirement health care expenses, the annual expense is equal to 57 percent of net income at USX, 44 percent at Bethlehem Steel, and 23 percent at General Motors.[45]

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[38]Bush, et. al., "Prefunding of Postemployment Health Care: The Pension Analogy, the Insurance Need," p. 321.

[39]Dopkeen, "Post-retirement Health Benefits," p. 809-810.

[40]*Ibid.*, p. 831.

[41]*Ibid.*, p. 810.

[42]Chollet and Friedman, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," p. 210.

[43]See *America's Health Care Challenge: New Directions for Business, Government and Individuals*, (Minneapolis: Northwestern Life Insurance Co., 1986).

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

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

- Post-retirement health care expenses also are considered a major factor in some corporate bankruptcies, including Allis-Chalmers Corp. and LTV Corp.[46]

What is the total magnitude of post-retirement health care commitments for U.S. companies? The estimates vary widely:[47]

- The Department of Labor estimates that employer liabilities are $98 billion for workers over age 40.

- Other estimates place the liability as high as $2 trillion if all workers are considered.

In general, almost all of this liability is unfunded:

- A study by Coopers & Lybrand and Hewitt Associates found that only nine out of 4,000 companies surveyed were setting aside funds for retiree health benefits.[48]

- Other studies have placed the number of companies which pre-fund these obligations at less than 2 percent.[49]

- If *Fortune* 500 companies were required to account for post-retirement health care benefits the way they now account for pensions, their net income would be reduced by 30 to 60 percent.[50]

At one time it was thought that employer promises to provide post-retirement health care benefits were not legally binding. Thus, an employer who faced financial problems could simply cease providing the benefit. A series of court rulings have altered that assumption. In many cases, the courts have ruled these promises legally binding, and soon the Financial Accounting Standards Board will require corporations to show these liabilities on their formal balance sheets. This is one reason why Joseph Califano, former Secretary of the Department of Health and Human Services, described the problem as "one of the world's greatest time bombs."

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

[47]Employee Benefit Research Institute, *Measuring and Funding Corporate Liabilities for Retiree Health Benefits* (Washington, D.C.: EBRI, 1988), p. xv.

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

[49]Dopkeen, "Postretirement Health Benefits," p. 832.

[50]EBRI, *Measuring and Funding Corporate Liabilities for Retiree Health Benefits*, p. xvi.

It is worth noting that the funding of post-retirement health 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.[51]

Unlike federal policy toward private pensions, the government either prohibits or discourages the pre-funding of post-retirement medical benefits. As a result, this mounting liability not only threatens the financial health of corporate America, it virtually ensures that employers will turn to the federal government -- and therefore to taxpayers -- to pick up a larger share of post-retirement health care costs.

TABLE IX

RETIREE HEALTH CARE COSTS AS A PERCENT OF NET EARNINGS[1]

Company	Percent
USX	57.0%
Bethlehem Steel	44.0%
General Motors	23.0%
McDonnell Douglas	22.0%
Gould	10.4%
Pillsbury	8.3%
Ford	7.0%
Ingersoll-Rand	6.9%

[1]Figures are for 1987.

Source: *Business Week*, September 12, 1988, p. 94.

[51]Dopkeen, "Postretirement Health Benefits," p. 802. Note that individuals become eligible for Medicare at age 65.

GOVERNMENT BARRIERS TO PRE-FUNDING POST-RETIREMENT HEALTH CARE EXPENSES

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

Federal government policy toward health care expenses approaches the bizarre. We subsidize and encourage health care spending today. At the same time, we discourage needed savings for health care expenses during the retirement years. In 1984, tax subsidies to current health care expenditures totaled $25 billion.[52] Yet with few exceptions, the federal government allows no tax deduction for the pre-funding of future health care expenses, and prohibits or severely penalizes the use of tax-deductible retirement savings to pay for medical bills or to purchase post-retirement health insurance. A summary of the major elements of this perverse policy follows.

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 may not deduct funds set aside to pay medical expenses during retirement. The one exception is that individuals are allowed to use funds in 401(k) savings plans to pay large medical bills. Because of the set-up cost of these plans, however, they are effectively 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 IRAs, Keough plans, and 401(k) plans to encourage retirement savings, tax law forbids using these funds to obtain post-retirement health insurance prior to retirement.

Congress also has restricted the ability of individuals to save. The IRA deduction, for example, has been greatly limited despite research which concludes that 97% of every dollar put into an IRA account adds to total personal savings.[53]

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[52]Dopkeen, "Postretirement Health Benefits," p. 798.

[53]Steven F. Vinti 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.

Restrictions on Employers

As individuals are discouraged from saving for post-retirement health care expenses by federal policy, so are companies.

Prior to 1984, employers could use several vehicles to pre-fund post-retirement health care expenses for their employees. "Tax reform," however, has severely limited the employers' ability to do this -- despite a liability that is as much 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. There is a limit to the amount of funds that may be set aside, however, and employer self-insurance appears to be prohibited from pre-funding health costs incurred in the distant future.[54]

Under current law, the most effective way for employers to pre-fund post-retirement health insurance is by purchasing corporate-owned life insurance policies on their employees, and companies are increasingly turning to this option.[55] Corporate-owned life insurance is a funding vehicle that Congress overlooked.

The status of common methods used by employers to fully or partially pre-fund post-retirement medical expenses for their employees is summarized below.

401(h) Trusts. Primarily designed for pension plans, Congress has restricted the use of these trusts for pre-funding health care benefits. Contributions for medical benefits cannot exceed 25 percent of total contributions to the plan.[56]

501(c)(9) Trusts. Prior to 1984, tax-qualified trusts known as voluntary employee beneficiary associations (VEBAs) were ideal vehicles for pre-funding post-retirement health care benefits. Since tax reform, among other restrictions, allowable contributions cannot take into account projections of 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.[57]

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[54]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, September, 1985.

[55]See *Institutional Investor*, May, 1988, pp. 108-109.

[56]For a summary of the restrictions on the use of 401(h) trusts to pre-fund post-retirement health care benefits, see Chollet and Friedland, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," pp. 211-214.

[57]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 pre-fund post-retirement health care benefits, see Chollet and Friedland, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," pp. 211-214.

Over-funded 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 medical benefits during retirement.[58] Although the Reagan Administration proposed this option, so far Congress has not agreed.[59]

Company-Owned Life Insurance. As mentioned above, companies can use this vehicle to pre-fund medical expenses. Under this method, the employer pays the policy premium and is the beneficiary. If an employee dies, the employer receives the death benefit tax free. While the employee lives, the cash value in the policy continues to accumulate tax free. Under either contingency, funds accumulate and 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 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.[60]

In its desire to remove tax deductions and increase federal revenues, Congress has closed off virtually every option available to pre-fund post-retirement health care expenses. To make matters worse, the few opportunities that do remain are being met with increasing Congressional hostility.

BUILDING A NEW APPROACH TO FUNDING HEALTH CARE AND RETIREMENT NEEDS

Currently, there is no coherent federal policy designed to promote saving today to meet the income maintenance and health care needs of tomorrow's elderly retirees. The few policies that do encourage retirement savings appear randomly throughout the tax code; these provisions 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 which now exist. Much more can be done, however. To avert the financial nightmare in America's future, we can adopt the following policies today.

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[58]See Dopkeen, "Postretirement Health Benefits," p. 824.

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

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

Saving for Post-retirement Health Care Costs Through Medical IRAs

The concept of Medical IRAs (MIRAs), first proposed by the National Center for Policy Analysis in January 1984,[61] 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 U.S. Department of Health and Human Services Otis Bowen, numerous public policy groups, and members of Congress whose views span the ideological spectrum -- from Claude Pepper (D-Fla) to Philip Crane (R-Ill). 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 post-retirement health care benefits.[62]

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 other versions, MIRAs would be used to pay for medical expenses not covered by Medicare. In all versions, MIRA legislation would establish an explicit federal policy of encouraging individuals to save for future health care needs.

Integrating Lifetime Choices Through Medical Savings Accounts

Medical IRAs would be an enormous improvement over our pay-as-you-go Medicare program. However, MIRAs share with Medicare two principal defects. Most MIRA proposals create an artificial dividing line (e.g., age 65) beyond which individuals would pass from one method of health care finance to another. Yet the health status of individuals is partly the result of a lifetime's decisions and rational health care finance requires an integrated plan extending over the course of an individual's life. 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 age 65.

An age limitation on the use of MIRA funds also discriminates against blacks and other minorities who have below-average life expectancies.[63] For example, according to current life expectancy tables, 42.1 percent of all black males will die before age 65.[64] Under many MIRA proposals, these individuals would not have access to their MIRA funds to pay medical bills which arise near the time of their death.[65]

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[61]Peter Ferrara, John Goodman, Gerald Musgrave and Richard Rahn, "Solving the Problem of Medicare," NCPA Policy Report No. 109, National Center for Policy Analysis, January, 1984.

[62]"Introduction and Survey Highlights of the EQUICOR Health Survey VI: Looking to the Future of Retiree Health Benefits," *The Sourcebook on Postretirement Health Care Benefits*, p. 108.

[63]See "Social Security and Race," NCPA Policy Report No. 128, June, 1987.

[64]*Statistical Abstract of the United States, 1987* (Washington, D. C.: U. S. Government Printing Office, 1986), Table 119, p. 79.

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

A better approach -- an approach we have advocated for many years -- is to create medical savings accounts which could be used over the course of a lifetime, not merely after retirement. This approach has now been officially adopted in Singapore.

Case Study: Medical Savings Accounts in Singapore. Beginning in 1984, the government of Singapore extended its program of forced savings to require employer and employee contributions to "Medisave accounts" to fund hospitalization expenses.[66] Currently, six percent of an employee's salary is placed in a Medisave account until the balance reaches approximately $7,500. Once that total is reached and maintained, additional contributions are automatically placed in an individual's ordinary savings account.

In Singapore, this sum of money would be sufficient to cover most hospitalization expenses except in very rare catastrophic cases.[67] In 1986, for example, 145,000 employees (out of a total Singapore population of 2.6 million) made Medisave withdrawals averaging about $300 per person. After withdrawals are made, individuals must continue to contribute to their Medisave accounts until the amount again reaches $7,500.

Funds in a Medisave account are self-insurance for hospitalization throughout the employee's life. For example, retirees are required to leave about $3,250 in the Medisave account to cover medical expenses after they reach age 65.

The Singapore approach has important advantages as well. Funds which accumulate in Medisave and retirement savings accounts provide capital to finance investment within the country and promote economic growth.

Integrating Personal Choices With Employee Benefit Plans

Under current tax law, health insurance premiums and health care expenditures are not included in employees' taxable incomes (and, therefore, are effectively deductible) if paid by employers. 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.

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[66]These funds may not be used for outpatient care. Funds used for hospitalization may be used for treatment at a government hospital or at an approved private hospital.

[67]The Singapore government currently is engaged in negotiations with private health insurance companies, and it is possible that in the future some portion of the Medisave account funds will be allocated to catastrophic health insurance coverage.

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, life-long financial plans.

In order to achieve these objectives, however, it is necessary to make major changes in the employee-benefit 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. Yet in many corporations the value of fringe benefits is only loosely related -- even unrelated -- to the workers' productivity. Since 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. Yet the most common form of pension is a defined-benefit plan. Under this arrangement, pension benefit formulas are "back end loaded" -- full benefits are paid only if the employee remains with the firm for the whole of the employee's worklife. As a result, even fully vested employees lose thousands of pension benefit dollars if they leave employment prior to retirement. For example, under representative defined-benefit pension plans, [68]

- A worker earning a moderate income can lose up to $45,000 in pension benefits as a result of one job change in mid-career.
- If the worker changes jobs three times over a career, the loss of pension benefits can reach $68,000.

Numerous studies have shown that defined-benefit pension plans lead to considerable redistribution of income.[69] Funds are redistributed from those who leave the firm to those who stay, from young workers to old workers, and from those with shorter to those with longer life expectancies.

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[68]Dennis G. Logue, "Pension Plans at Risk: A Potential Hazard of Deficit Reduction and Tax Reform," NCPA Policy Report No. 119, October, 1985, pp. 6-9.

[69]*Ibid.* See also, Edward J. Harpham, "Private Pensions in Crisis: The Case for Radical Reform," NCPA Policy Report No. 115, January, 1984.

Like the defined-benefit pension, post-retirement health care benefits are defined benefits. They involve even more redistribution of income among employees than typical pension plans.

1. **Post-retirement Health Care Benefits Usually Offer the Same Benefits to All Retirees, Regardless of Final Salary**. As Table X shows, in a representative post-retirement health care benefit plan, there is no relationship between employees' salaries, or their productivity, and the benefit offered. For example, among 55-year-old retirees, the benefit is equal to about 55 percent of salary for a $100,000-a-year worker and equal to about 336 percent of salary for a $15,000 a year worker.

2. **Unlike Defined-Benefit Pensions, Post-retirement Health Care Benefits are Indexed.** Because the benefit is a service rather than cash benefit, its cost rises with medical inflation and increased utilization of health care services. For this reason, post-retirement health care benefits are usually more valuable than pension benefits for low-income employees. In a representative plan,[70]

   - Among 55-year-old retirees earning $25,000 a year, post-retirement medical benefits are almost twice as valuable as pension benefits.

   - Among $15,000 a year employees, medical benefits are more than 3-1/2 times more valuable than pension benefits.

3. **The Value of Post-retirement Benefits is Unrelated to Years of Service to the Firm.** Unlike pension benefits, post-retirement medical benefits are all-or-nothing. Employees receive either the full benefit, or they receive nothing. Moreover, the benefit is usually totally unrelated to the worker's lifetime service to the firm. In one survey of 250 large companies,[71]

   - At the normal retirement age, 43 percent of the companies provide the benefit with no years-of-service requirement.

   - An additional 43 percent of the companies offer the benefit to employees who have spent five years or less with the firm.

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,[72]

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[70]Dopkeen, "Postretirement Health Benefits," p. 814.

[71]*Ibid.*, p. 805.

[72]*Ibid.*, p. 806

- Among retirees with individual coverage, 55.8 percent make no premium payment.
- Among retirees with coverage including their spouse, 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 these cases, the "full premium" is the average premium paid by all employees -- not the actuarially fair premium.

TABLE X

THE RELATIONSHIP BETWEEN FINAL SALARY AND THE PRESENT VALUE OF POST-RETIREMENT HEALTH CARE BENEFITS

Age 65

Final Salary	Present Value of Health Care Benefits	Percent of Final Salary
$100,000	$32,000	32%
$50,000	$32,000	64%
$25,000	$32,000	128%
$15,000	$32,000	213%

Age 55

Final Salary	Present Value of Health Care Benefits	Percent of Final Salary
$100,000	$55,000	55%
$50,000	$55,000	110%
$25,000	$55,000	220%
$15,000	$55,000	336%

Source: Martin J. Zigler, *Post-Retirement Health Care Benefits*, Tillinghast, Nelson and Warren, Inc., 1985, pp. 25 ff. Cited in Johnathan C. Dopkeen, "Post-retirement Health Benefits: Pew Memorial Trust Policy Synthesis, 2," *Health Services Research*, Vol. 21, No. 6, February, 1987, Table 2, p. 814.

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 employer-provided health 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, employees cannot integrate personal financial planning for their retirement years with employer-provided benefits.

It is not clear why employee benefit policies have evolved to their current state. What is clear is that many corporate managers are prepared to change:[73]

- In a recent survey of corporate benefits officers, 80 percent favored tax-deductible or tax-exempt medical IRAs.

- These accounts would be funded by contributions of employees and their employers, would grow in value over the worklife of employees, and would be the property of the worker.

Creating Equity and Fairness in the Tax Law. As noted above, the tax law creates artificial distinctions between individuals who receive fringe benefits from employers and individuals who purchase identical benefits on their own. As a practical matter, the law discriminates against employers of small firms, the self-employed, and the unemployed. When the tax law is combined with the fringe-benefit policies which it subsidizes, individual planning for the retirement years becomes almost impossible.

A better way is to allow all individuals -- regardless of employment status -- to retain a certain portion of their earned income (say 10 or 15 percent) tax free, provided that income is used for certain well-defined purposes. Under this proposal, the cash value of every qualified fringe benefit would be attributed to 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 medical IRA 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 is to maximize individual and company freedom of choice in planning for income security and health care needs. This will permit individual preferences and market forces -- rather than the tax law -- to determine retirement choices.

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

Integrating Choices Between Medical and Non-Medical Goods and Services

One way to achieve the complete privatization of Social Security, Medicare, and Survivors and Disability Insurance is through "Super IRAs."[74] In its various versions, this proposal is 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 insurance, disability insurance, 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 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: the purchase of a house, income maintenance during retirement, and medical expenses both before and after retirement.[75]

Singapore's system implicitly recognizes the fact that individual preferences and circumstances differ. The system also implicitly recognizes that health care is only one of a great many goods and services which people desire, and gives individuals considerable freedom to match their spending decisions to their own needs and preferences.

CONCLUSION

The current system of providing for the income maintenance and health care needs of elderly retirees is a pay-as-you-go system with 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.

Yet like private sector chain letters, those who are latecomers face a much bleaker future. Not only will today's young workers pay considerably more in taxes than they can expect to receive in benefits, future benefits are increasing uncertainty.

Today's young people are being placed at great risk. Promises are being made without any 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.

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

[75]For a description of the social security systems of Chile, Britain, and Singapore, see John C. Goodman and Peter J. Ferrara, "Private Alternatives to Social Security in Other Countries," NCPA Policy Report No. 132, April, 1988.

APPENDIX

HOW MUCH DO THE ELDERLY PAY FOR THEIR OWN HEALTH CARE EXPENSES?

An estimate of the sources of payment for the noninstitutional health care expenses for the elderly in 1979 was presented in Table IX in the text. Those estimates are reprinted as follows:[1]

Noninstitutional Health Care Expenses For The Elderly

Source of Payment	Percent of Total
Medicare	**60.4%**
Out-of-Pocket Expenses Plus Medigap Insurance Purchased by the Elderly	**22.1%**
Employer or Union-Provided Health Insurance	**7.4%**
Medicaid	**6.0%**
Veteran's Medical Care	**4.0%**

Beginning with these estimates, we must adjust for Supplemental Medical Insurance (SMI) premiums paid by the elderly for Part B Medicare insurance. Since one-third of Medicare spending is through the SMI trust fund, and since 22 percent of SMI spending is financed by premiums,[2] approximately 4.4 percent of noninstitutional spending is represented by SMI premiums. From that total, however, we must deduct the premiums state governments pay in order to buy Medicaid patients into the Medicare program. Assuming that 11.4 percent of the elderly who qualify for Medicaid have their SMI premiums paid for by state governments,[3] then 3.9 percent of noninstitutional health care spending for the elderly is paid for by the elderly themselves in the form of SMI premium payments. That brings the total amount paid by the elderly to 26 percent.

Still unexamined is the amount the elderly pay in premiums for employer-provided or union-provided health insurance coverage. While this figure is unknown, it is certainly not large.

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[1]Smeedling and Straub, "Health Care Financing Among the Elderly: Who Really Pays the Bills?", Table 1, p. 39 and Table 3, p. 43.

[2]Davis and Rowland, *Medicare Policy*, p. 48.

[3]*Ibid.*, p. 50.

As reported in the text, more than 55 percent of retirees with individual coverage and more than 46 percent of retirees with dependent coverage make no premium payment at all.[4]

A larger and therefore more difficult issue is spending for nursing home care, which represents about 23.3 percent of total health care spending for the elderly.[5] According to the Health Care Financing Administration (HCFA), sources of payments for nursing home expenditures in 1984 were as follows:[6]

Nursing Home Expenses for the Elderly

Source	Percent
Out-of-Pocket	**49.4%**
Private Insurance	**0.9%**
Medicare	**1.9%**
Other Government Programs	**4.1%**
Medicaid	**43.4%**
Other	**0.6%**

These estimates have been disputed by Rice and Gabel, who maintain that out-of-pocket costs are only 41.3 percent (considerably lower than HCFA's estimate) and private insurance pays 2.8 percent (considerably higher than HCFA's estimate).[7]

Quite apart from the question of which estimates are correct, there is the question of which out-of-pocket payments for nursing home care the elderly make out of their own income and assets and which came from their children.[8] It is not unusual for the elderly to rely on their children to help pay medical bills. But nursing home care is a special case. Because it generally is not covered by Medicare, it is the most common source of catastrophic health care expenditure. For example, among out-of-pocket expenses for the elderly in excess of $2,000 per year, 81.2 percent goes for nursing home care.[9] The degree to which the elderly rely on their children for help with

[4]Johnathan C. Dopkeen, "Postretirement Health Benefits," Figure 3, p. 806.

[5]Davis and Rowland, *Medicare Policy*, p. 35.

[6]Task force on Long-Term Care Policies, *Report to the Congress and the Secretary*, p. 69.

[7]Rice and Gabel, "Protecting the Elderly Against High Health Care Costs," p. 16.

[8]For a survey of research on the degree to which children and other relatives provide financial and other support for long-term care for the elderly both inside and outside of nursing homes, see Pamela Doty, "Family Care of the Elderly: The Role of Public Policy," in *The Sourcebook on Postretirement Health Care Benefits*, pp. 521-551.

[9]Rice and Gabel, "Protecting the Elderly Against High Health Care Costs," p. 16.

such expenses will become increasingly important as the number of children per elderly person decreases and more "children" of the elderly become retirees themselves.

If we stick with the higher estimates of out-of-pocket expenses made by HCFA, and if we ignore the degree to which these funds come from their children, the percent of total health care expenses paid by the elderly rises to 32.5 percent. If we further assume that all payments made by insurance for nursing home care are exactly offset by insurance premium payments made by the elderly,[10] the figure rises to 33 percent. Because of the generosity of the assumptions made, however, this must surely be an upper bound on the actual percent paid.

To this point we have said nothing about taxes paid by the elderly, whether in the form of Medicare payroll taxes or income taxes which subsidize Medicare, Medicaid, the Veterans Administration, and other health care programs. Nor have we mentioned other government payments to the elderly, such as SSI payments, which undoubtedly subsidize medical bills. These omissions are in keeping with our original purpose: to estimate the size of the probable transfer payments that must take place in the next century in order to support Social Security and health care for the elderly. It is known in advance that in the future some of the elderly will be among the taxpayers funding those transfer payments, just as they are today.

NOTE: Nothing written here is to be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder passage of any bill before Congress.

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[10]This assumption is undoubtedly incorrect. Medigap policies purchased by the elderly typically cover only those types of services covered by Medicare. Thus, it seems likely that most insurance payments for nursing home care are made by employer-provided plans.