Reforming Medicare with Medical Savings Accounts

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Executive Summary

As currently structured, Medicare pays many small bills which the elderly could easily afford and does not pay the catastrophic expenses that could devastate them financially. Medicare is in need of serious reform.

The National Center for Policy Analysis proposes an alternative: allowing participants to choose among competing, private-sector insurance plans. For example, most Medicare participants could obtain catastrophic insurance to cover all expenses over a high deductible (say $3,000 or $4,000) and set up a Medical Savings Account to help pay expenses below the deductible. To finance the MSA and catastrophic insurance, Medicare would pay the private plan a portion of the funds (say, 90 percent) it otherwise would expect to pay.

To estimate the effects of the Medicare MSA proposal, this study made the following assumptions:

- Forty percent of Medicare spending is reserved for the 5.2 percent of high-risk enrollees; they would continue in the current program.
- Sixty percent of spending is redirected to a combination Medical Savings Account-catastrophic insurance program for the remaining 94.8 percent of enrollees.
- Private plans that accept Medicare enrollees would receive a risk-adjusted premium reflecting expected health care costs.
- The 33 million enrollees would effectively face a doubling of copayments — most of the increase paid out of MSAs, funded by the difference between the costs of the catastrophic policy and the amount paid to beneficiaries.

Because copayments would be effectively doubled, the National Center for Policy Analysis/Fiscal Associates Health Care Model finds that demand for health care would decrease. Because lower demand would ease pressure on medical prices, the rate of increase in health spending would slow.

- By the year 2005, Medicare spending would be 18 percent lower than currently projected spending, and total U.S. health care costs would be 8.7 percent lower.
- Hospital and home care costs — heavily subsidized by Medicare — would decrease by 16.3 percent.
- Spending on drugs and devices — not heavily subsidized by Medicare — would increase by 7.6 percent.

An increase in the production of other goods and services would outweigh the resulting reduction in medical services.

- By the year 2005, annual GDP would be $55 billion (or 0.4 percent) higher than otherwise.
- Although spending on health care would decrease by $186 billion, the output of other goods and services would increase by $241 billion.
- There would be 367,000 more jobs than otherwise, and labor income would have increased by almost one-half trillion dollars between 1997 and 2005.
- Despite improved economic conditions, the stock of U.S. capital would be $179 billion lower due to the switch in demand from the relatively capital-intensive health care sector (e.g., hospitals) to other sectors of the economy.

Introduction

Medicare, the fastest-growing program in the federal budget, is in need of serious reform. The Congressional Budget Office (CBO) projects that Medicare spending will more than double by the year 2000. Since Medicare's annual growth rate of 10.2 percent is almost twice the 5.3 percent for the entire federal budget,[1] any attempt to bring the budget into balance must trim the growth rate of Medicare spending.

Medicare, which came into existence in 1966, consists of two parts. Hospital Insurance, or Part A, pays hospital bills for retired and disabled workers and is financed through a 2.9 percent payroll tax.[2] Supplementary Medical Insurance, or Part B, pays doctor and other outpatient bills. Beneficiaries pay premiums on Part B, but these premiums finance only about one-fourth the costs. The remainder is subsidized from general tax revenues.

Medicare faces financial crises in both the short and long run. The Medicare trustees project that, depending upon economic conditions, the Hospital Insurance program will run out of money in the next six to 11 years.[3] What is worse, left unchecked, Medicare Parts A and B will more than double from 2.6 percent of GDP today to 5.3 percent by 2015.[4]

Medicare Is Badly Designed Insurance

"Medicare pays too many small bills for the elderly, while leaving them exposed for catastrophic expenses."

If Medicare had to compete against other insurance in an open market, it probably could not survive. The reason is that it pays too many small bills which the elderly could pay themselves and leaves them exposed for catastrophic medical expenses that could devastate them financially. Take the Hospital Insurance program, for example:

- After a first-day deductible of $716, Medicare Part A pays inpatient hospital bills based upon predetermined fee schedules.[5]
- According to the schedules, Medicare pays all hospital costs for days 2 through 60.
- Beginning on the 61st day, coinsurance payments are one-fourth of the deductible or $170 per day.
- After the 90th day, coinsurance payments are one-half of the deductible or $358 per day, provided the beneficiary still has "lifetime reserve" days upon which to draw.[6]
- When the lifetime reserve is exhausted, Medicare inpatient hospital coverage during an individual's benefit period ends after the 90th day.

TABLE I

Patient's Share of Medicare Bills, 1992

Amount of Patient Cost-sharing	Percent Incurring Liability[1]	Percent of Total Medicare Cost-sharing Liability[2]
$1 to $499	62.8%	17.3%
$500 - $999	13.4%	12.8%
$1,000 - $1,999	15.3%	27.3%
$2,000 - $4,999	7.0%	25.4%
$5,000 or more	1.5%	17.2%

[1] An estimated 27.9 million out of 35.6 million Medicare beneficiaries used covered services and incurred cost-sharing liability in 1992.

[2] Deductibles, coinsurance and balance billings paid by people paying this amount.

Source: Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, Baltimore, MD: HCFA Pub. No. 03348, February 1995, Figure 17, p. 45.

"8.5 percent of participants had to pay at least $2,000 themselves."

The Supplementary Medical Insurance program has a similar defect:

- Medicare Part B generally pays 80 percent of approved costs for doctor and other outpatient services after a $100 annual deductible.
- But while providing a good deal of first-dollar coverage for some services, it provides no coverage for others, such as prescription drugs.

As a result, some Medicare enrollees face large out-of-pocket costs:

- Of the 27.9 million participants who experienced some Medicare cost-sharing in 1992, 8.5 percent had to pay at least $2,000 themselves. [See Table I.]
- For the 1.5 percent with cost-sharing of at least $5,000, the average patient liability was $8,657.[7] [See Figure I]

Medicare is probably the only large health insurance plan in the country that has not undergone fundamental change over the past decade. Many employers have increased employees' deductibles and copayments, and most have begun directing employees to lower-cost doctors and actively managing health care costs.

Medicare, however, pays the same fee whatever the quality of care provided, encouraging hospitals to discharge patients earlier than they otherwise would. Medicare also is slow to approve new medical technologies, leaving the elderly without access to the latest and best treatments.

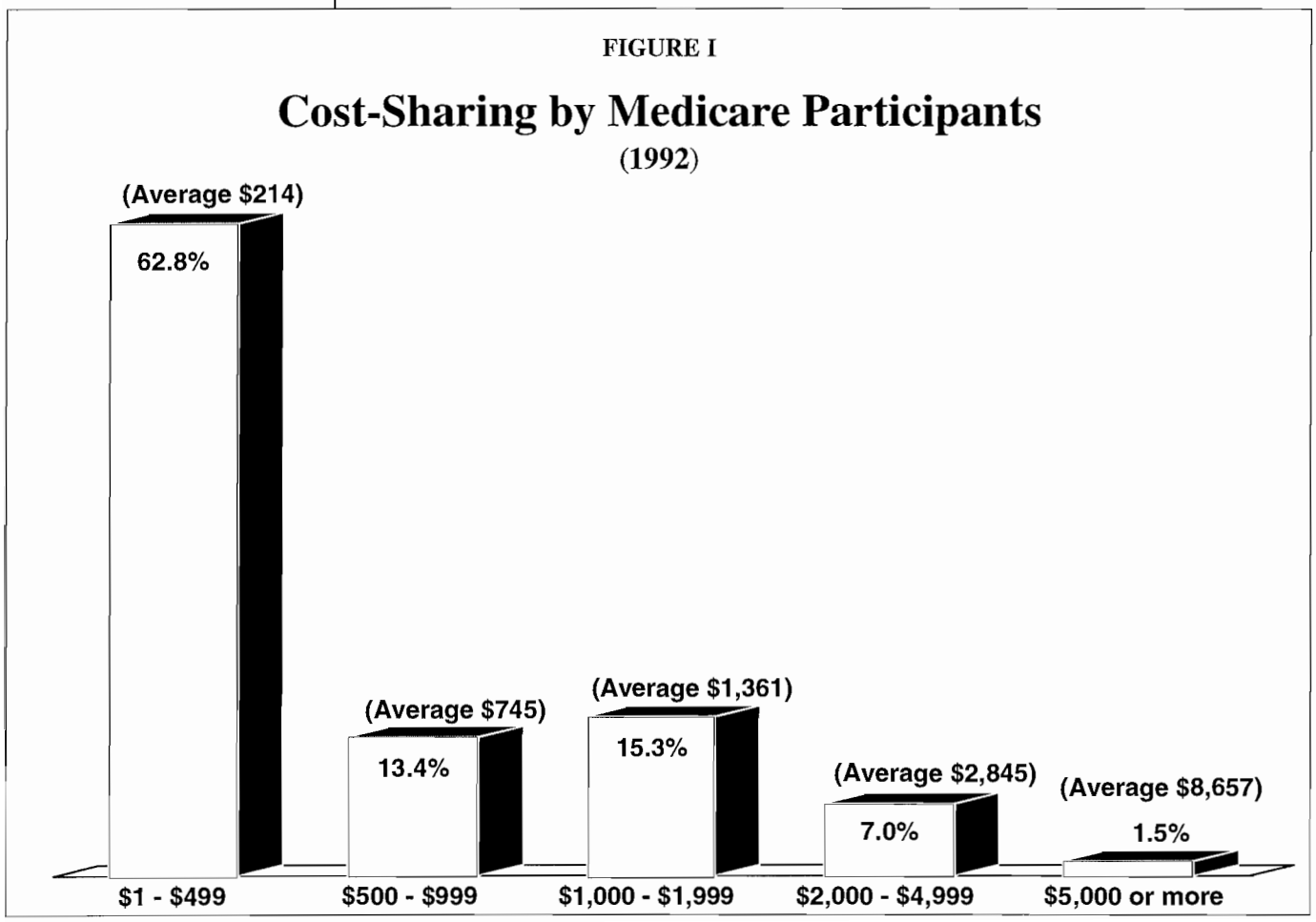
Medicare heavily subsidizes inpatient hospital care, home health care and doctor visits. Prescription drugs receive no subsidy outside the hospital. Medicare recipients and their doctors have adjusted their behavior based on these government subsidies. The result is two major sources of waste. First, Medicare enrollees consume much more health care than they otherwise would. Second, Medicare enrollees tend to consume more of the services that Medicare subsidizes relative to those that it does not.[8]

"Incorporating Medical Savings Accounts would give the elderly greater control over their health care dollars and decisions."

Reforming Medicare Through Medical Savings Accounts. The National Center for Policy Analysis proposes allowing Medicare participants to choose among private-sector insurance plans as an alternative to traditional Medicare. One private-sector option would incorporate Medical Savings Accounts (MSAs) to give the elderly greater control over their health care dollars and decisions.[9]

Under the proposal, individuals would obtain catastrophic insurance to cover all expenses over a high deductible (say $3,000 or $4,000) and set up a Medical Savings Account to help pay expenses below the deductible. Figure II illustrates how the plan might work. In the example, an elderly beneficiary has a deductible of $4,000 and an MSA balance of $2,000 provided by a private insurer. The first $2,000 of medical expenses would be paid from the MSA and the next $2,000 out of pocket. The insurer would pay all expenses

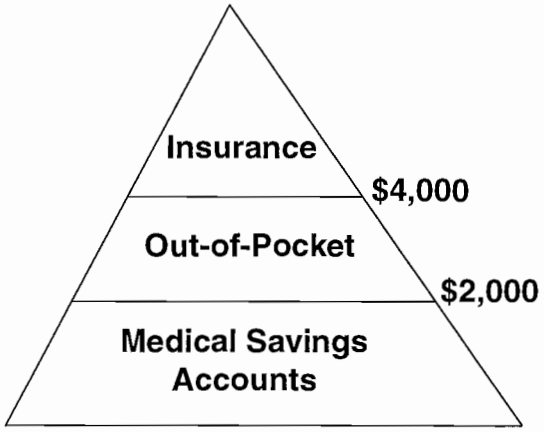
FIGURE I



"As an example, the first $2,000 would be paid from the MSA, the next $2,000 out-of-pocket and all remaining expenses by the insurer."

FIGURE II

Example of Medicare with a Medical Savings Account



above $4,000. In order to limit the out-of-pocket exposure, beneficiaries could deposit additional funds to the MSA, including money they otherwise would have spent on Medigap insurance (about $1,000 per year) and money they would expect to pay out-of-pocket in any case.

A beneficiary could withdraw unspent MSA funds at year-end for any purpose, save them for future medical expenses or use them for long-term care benefits. Investment returns on the MSA funds would be tax free.

To finance the combination of MSA and catastrophic insurance, Medicare would pay the private plan a portion of the funds (say, 90 percent) it otherwise would expect to pay. Because about 10 percent of Medicare participants account for over three-fourths of the spending, Medicare benefits would have to be redistributed on a risk-adjusted basis. [See Table II.] Medicare would pay the private plan more for enrollees expected to generate higher health costs.

Simulating the Effects of the Medicare MSA Proposal

To estimate the effects of the Medicare MSA proposal, we made the following assumptions:

- Forty percent of Medicare spending is reserved for 5.2 percent of enrollees who can readily be identified as high-risk participants and who are expected to have high health care costs; this portion of Medicare would continue to operate as the current program does.
- Sixty percent is redirected to a combination Medical Savings Account-catastrophic insurance program for the remaining 94.8 percent of enrollees.

- Private plans that receive Medicare enrollees would receive a risk-adjusted premium reflecting expected health care costs.
- On the average, the payments to the private plans would equal only 90 percent of expected Medicare expenditures under the traditional program; the remaining 10 percent represents a saving to the federal government.[10]
- Total payments for the new program are assumed to grow at 7 percent a year, instead of the 10.2 percent projected under current law, because both medical inflation and use of services would grow more slowly.
- The new insurance is structured so that the 33 million covered beneficiaries would effectively face a doubling of copayments; most of that increase would be paid out of MSAs, funded by the difference between the costs of the catastrophic policy and the amount paid to beneficiaries.[11]

We used the National Center for Policy Analysis/Fiscal Associates Health Care Model to assess the effect of the Medicare MSA proposal on the U.S. health care sector and economy. The Health Care Model links to the rest of the economy via the Fiscal Associates Model that explicitly incorporates detailed information on tax policy and how it affects the economy, capital investment, output and jobs.

"The fact that about 10 percent of Medicare participants account for over three-fourths of the spending would require that Medicare benefits be redistributed on a risk-adjusted basis."

TABLE II

Distribution of Medicare Participants and Payments

(1992)

Amount of Program Payments	Percent of Participants[1]	Percent of Medical Expenses
$0	21.6%	0.0%
$1 - $499	33.0%	1.9%
$500 - $1,999	18.9%	5.7%
$2,000 - $9,999	9.9%	9.7%
$5,000 - $9,999	6.8%	14.3%
$10,000 - $24,999	6.8%	31.5%
$25,000 or more	3.0%	36.9%

[1] There were an estimated 35.6 million Medicare participants in 1992, and Medicare paid out an estimated $120.7 billion.

Source: Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, Baltimore, MD: HCFA Pub. No. 03348, February 1995, Figure 11, p. 33.

Prices are an extremely important component of the Health Care Model. The model measures who pays for health care — either consumers out of their pockets, insurance companies or federal, state and local governments. Once prices are accurately measured, the model estimates traditional production and demand relationships as with any other sector or the economy as a whole.

Simulating the economic effects of the Medicare MSA proposal was done in two stages. First, the model produced a *baseline,* based on the Congressional Budget Office's latest projections of economic performance and health care spending under current law.[12] Next, *dynamic* simulations forecast what would happen to the health care sector and the economy as a whole if the proposal were enacted.

Effects on the Health Sector. Much of the rapid escalation in health care costs over the past 30 years can be directly traced to the increase in government spending on health care. In an earlier study, we showed that over the past three decades the share of private health care spending in total U.S. consumption grew at an annual rate of 1.3 percent while the share of government health care spending grew at three times that rate.[13] In other words, consumer out-of-pocket spending on health care has remained steady while government spending soared.

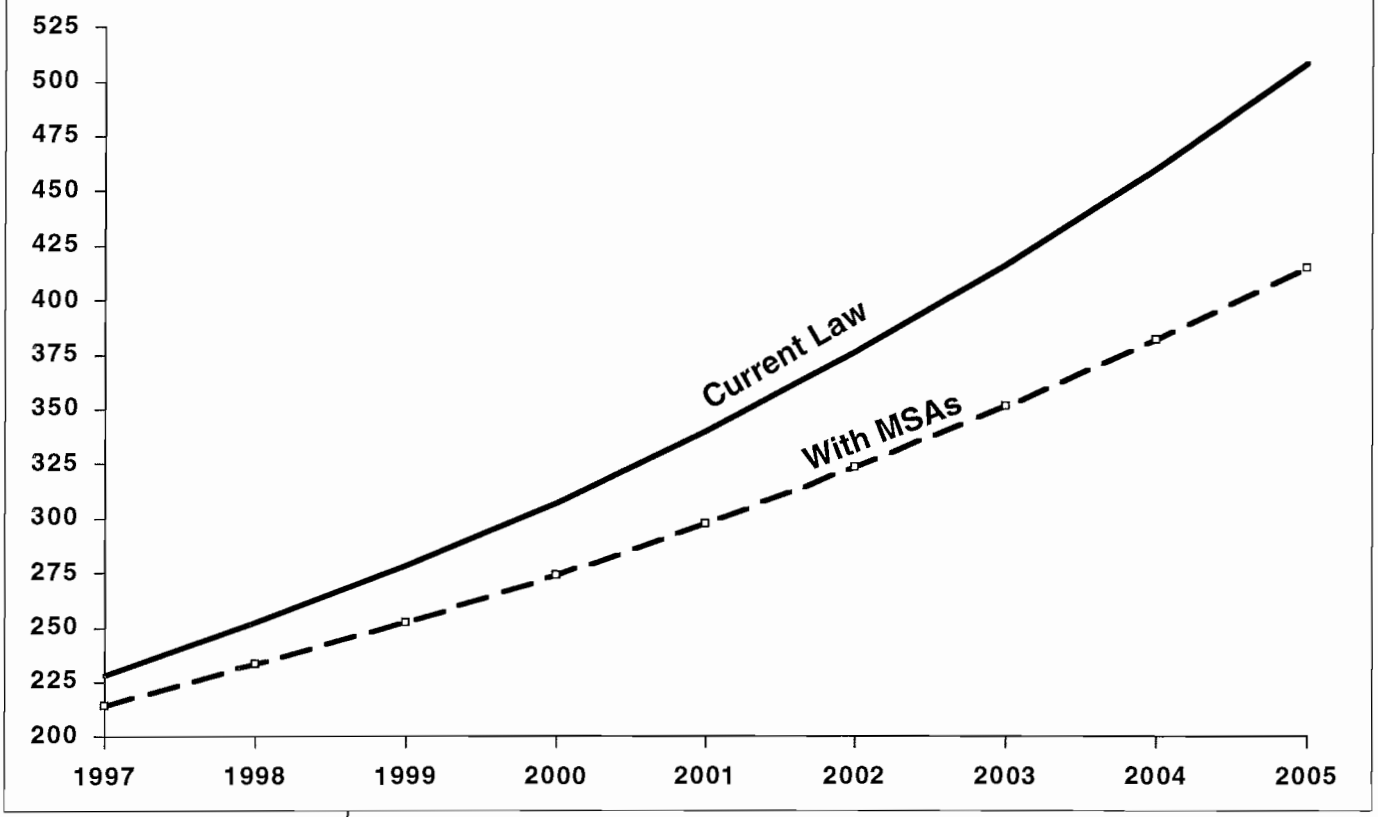
The reason for this rapid growth in government-subsidized health care is demand and supply. On the demand side, government programs such as Medicare lower the price of health care to beneficiaries who, in turn, use more medical services than they otherwise would.[14] On the supply side, the resulting escalation in health care spending pushes against an inelastic supply of health care services. Increased spending in most industries is met with an almost equal increase in the amount of real product and little price inflation. For example, spending another dollar on highways yields about 99 cents in new real highway product and a one cent price increase. Health care, however, is quite different. Every extra dollar spent on health care today yields less than 43 cents in additional real product or service. The remaining 57 cents is eaten up in higher prices for medical care. This is why medical inflation continues to increase at twice the rate of general inflation.

"Because of an inelastic supply, every extra dollar spent on health care today yields less than 43 cents in additional real product or service and about 57 cents in higher prices."

Because the Medicare MSA proposal would effectively double copayments for 33 million participants, their demand for health care would decrease. Because lower demand would ease pressure on medical prices, the rate of increase in health spending would slow. Thus:

FIGURE III

Medicare Spending — Current Law vs. MSA Reform



"By the year 2005, Medicare spending would be 18 percent lower than projected under current law."

- By the year 2005, as Figure III shows, Medicare spending would be 18 percent lower than projected under current law.[15]
- The reduction in Medicare usage would lead to a decrease in total U.S. health care costs of 8.7 percent.
- Hospital and home care costs — heavily subsidized by Medicare — would decrease by 16.3 percent.
- Spending on drugs and devices — not heavily subsidized by Medicare — would increase by 7.6 percent.

[See Table A-I.]

Effect on the Economy. Moving workers and capital from health care into other sectors of the economy would lead to an increase in the production of other goods and services that outweighs the reduction in medical services. Because of increased economic efficiency [see Table A-II]:

- By the year 2005, annual GDP would be $55 billion (or 0.4 percent) higher than otherwise.
- Although spending on health care would decrease by $186 billion, the output of other goods and services would increase by $241 billion.

- There would be 367,000 more jobs than otherwise, and labor income would have increased by almost one-half trillion dollars between 1997 and 2005.
- Despite improved economic conditions, the stock of U.S. capital would be $179 billion lower due to the switch in demand from the relatively capital-intensive health care sector (e.g., hospitals) into other sectors of the economy which have a higher labor mix.

Effects on Government and Household Budgets

Estimates of budgetary effects show that the Medicare MSA proposal would significantly reduce government spending on health care. Most savings would accrue to the federal government.

"Although health care spending would decrease by $186 billion, the output of other goods and services would increase by $241 billion."

Federal budget savings would come primarily from lower spending on health programs. By the year 2005, direct spending on government health programs would be lower by $305 billion. Subtracting the $212 billion in Medicare spending that would be redirected to catastrophic insurance and MSAs leaves net savings of $93 billion. The spending reduction would occur because beneficiaries in the private-sector plans would voluntarily reduce their use of health care services and because of a shift to more efficient treatment patterns, such as less hospital care and more pharmaceuticals and other outpatient treatments. These savings plus higher tax revenues from faster economic growth would decrease the federal deficit by $232 billion between 1997 and 2002. [See Table A-III.]

State and local governments also would spend less on health programs. Most of this reduction would come from the almost 9 percent reduction in national health care costs. State and local government spending on health programs would be $26 billion lower in 2005, while tax revenues from faster economic growth would be $11 billion higher. On net, the Medicare MSA proposal would lower annual state and local deficits by $37 billion in 2005. [See Table A - VI.]

American households also would win. Because of higher effective prices, Medicare beneficiaries would demand less health care and more of other goods and services. Out-of-pocket costs would change very little and premiums for private insurance would be lower by $91 billion in the year 2005. Because of favorable supply conditions, the $241 billion more in other goods and services produced would more than offset the $186 billion less of health care, leaving consumers better off by $55 billion. [See Table A - V.]

Conclusion

The current Medicare system is badly designed insurance. Almost 10 percent of Medicare enrollees who get sick face substantial out-of-pocket costs, one-fifth of participants receive no Medicare benefits and another one-third receive less than $500.

"The key to controlling Medicare costs is a shift in emphasis so that people are truly free to choose."

The key to controlling the cost of Medicare is to subtly shift its emphasis. People must be free to choose health care rather than forced to use what Medicare determines is "free." Reforming Medicare to help fund Medical Savings Accounts and catastrophic insurance is one way to provide such a choice.

Notes

[1] Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1996-2000*, Washington, DC, January 1995, Tables 2-6 and 2-7.

[2] Nominally, employer and employee each pay a tax rate of 1.45 percent. Until 1990, the Medicare wage limit was the same as that of Social Security. The 1990 tax bill raised the base to $125,000 and the 1993 tax bill removed the limit altogether.

[3] *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, Washington, DC: U.S. Government Printing Office, April 1995, pp. 26-27.

[4] 1995 Hospital Insurance Report, Table III.B.1, p. 66.

[5] The Prospective Payment System, which came into existence in 1984, pays hospitals on the basis of about 500 diagnostic related groups (DRGs). Before that, Medicare usually paid whatever hospitals billed.

[6] A beneficiary has a nonrenewable lifetime reserve of 60 days.

[7] Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, Baltimore, MD: HCFA Pub. No. 03348, February 1995, p. 44.

[8] This effect is mitigated to the extent that some Medigap policies provide benefits not covered by Medicare (beyond the copayments).

[9] Peter J. Ferrara and John C. Goodman, "Medical Savings Accounts for Medicare," National Center for Policy Analysis, Brief Analysis No. 60, April 17, 1995.

[10] This amounts to an initial 6 percent reduction in Medicare spending (10 percent of the 60 percent going to private plans), reflecting the anticipated lower demand for medical services.

[11] For example, a $4,000 payment from Medicare could purchase a catastrophic policy with a $4,000 deductible and leave $2,000 on MSA deposit.

[12] Congressional Budget Office, "Projections of National Health Expenditures: 1993 Update," CBO Memorandum, Washington, DC, October 1993; and Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1996-2000*, Washington, DC: U.S. Government Printing Office, January 1995.

[13] Gary Robbins, Aldona Robbins and John C. Goodman, "How Our Health Care System Works," National Center for Policy Analysis, NCPA Policy Report No. 177, February 1993, p. 13.

[14] For the health care system as whole, we estimate that a 10 percent decrease in the price of medical care results in a 4 percent increase in demand.

[15] Sixty percent of current expenditures redirected to catastrophic policies and MSAs would increase at 7 percent a year instead of 10.2 percent.

Appendix

TABLE A-I

Effect of Medicare MSA Proposal on Health Care Spending

Baseline (in $ billions)

Year	All Health[1]	Hospitals	Doctors	Dentists	Other Prof. Services	Home Care	Drugs and Devices	Vision Products	Nursing Home Care
1997	1,103	470	244	57	78	35	92	19	108
1998	1,201	511	267	61	88	39	98	20	117
1999	1,305	555	290	65	99	43	105	22	127
2000	1,418	604	315	69	110	47	112	23	138
2001	1,542	657	342	73	123	52	120	24	150
2002	1,674	715	370	78	138	57	128	26	162
2003	1,818	778	401	83	153	62	137	28	176
2004	1,974	847	434	89	169	67	147	30	191
2005	2,143	921	470	94	187	72	157	33	208

Difference From Baseline (in $ billions)

Year	All Health[1]	Hospitals	Doctors	Dentists	Other Prof. Services	Home Care	Drugs and Devices	Vision[1] Products	Nursing Home Care
1997	-91	-68	-2	0	-2	-6	4	-1	-17
1998	-99	-75	-2	0	-3	-6	5	-1	-18
1999	-108	-82	-1	0	-3	-7	6	-1	-20
2000	-119	-91	-1	0	-3	-8	7	-1	-22
2001	-130	-101	-1	1	-4	-8	7	-1	-24
2002	-142	-111	0	1	-4	-9	8	-1	-26
2003	-156	-123	1	1	-5	-10	9	-1	-28
2004	-171	-136	1	1	-5	-11	11	-1	-31
2005	-186	-150	2	2	-6	-12	12	-1	-34

Percent Change from Baseline

Year	All Health[1]	Hospitals	Doctors	Dentists	Other Prof. Services	Home Care	Drugs and Devices	Vision Products	Nursing Home Care
1997	-8.2%	-14.5%	-0.7%	-0.1%	-2.8%	-16.6%	4.8%	-3.7%	-15.6%
1998	-8.3%	-14.7%	-0.6%	0.1%	-2.9%	-16.5%	5.2%	-3.4%	-15.6%
1999	-8.3%	-14.9%	-0.5%	0.3%	-2.9%	-16.4%	5.4%	-3.5%	-15.7%
2000	-8.4%	-15.1%	-0.3%	0.5%	-2.9%	-16.4%	5.8%	-3.5%	-15.8%
2001	-8.4%	-15.3%	-0.2%	0.7%	-2.9%	-16.2%	6.1%	-3.1%	-15.9%
2002	-8.5%	-15.6%	0.0%	0.9%	-3.0%	-16.2%	6.5%	-3.0%	-16.0%
2003	-8.6%	-15.8%	0.2%	1.1%	-3.0%	-16.3%	6.8%	-2.9%	-16.1%
2004	-8.6%	-16.1%	0.3%	1.4%	-3.0%	-16.3%	7.2%	-2.8%	-16.2%
2005	-8.7%	-16.3%	0.5%	1.6%	-3.0%	-16.3%	7.6%	-2.6%	-16.3%

National Center for Policy Analysis/Fiscal Associates Health Care Model.

[1] U.S. personal health expenditures.

TABLE A-II

Economic Effects of the Medicare MSA Proposal

Baseline (in $ billions)

Year	GDP	Non-Health Output	Health Output	Capital Stock[1]	Employment[2] (in thousands)	Labor Income
1997	7,322	6,219	1,103	17,333	126,798	5,313
1998	7,817	6,616	1,201	17,707	128,581	5,651
1999	8,345	7,039	1,305	18,069	130,390	6,011
2000	8,908	7,489	1,418	18,442	132,223	6,394
2001	9,508	7,966	1,542	18,827	134,083	6,801
2002	10,149	8,474	1,674	19,223	135,968	7,236
2003	10,832	9,014	1,818	19,632	137,880	7,697
2004	11,560	9,587	1,974	20,053	139,819	8,189
2005	12,337	10,194	2,143	20,488	141,785	8,712

Difference From Baseline (in $ billions)

Year	GDP	Non-Health Output	Health Output	Capital Stock[1]	Employment[2] (in thousands)	Labor Income
1997	2	93	-91	-136	56	22
1998	7	106	-99	-137	109	28
1999	12	121	-108	-138	158	34
2000	18	137	-119	-142	201	41
2001	24	154	-130	-147	238	49
2002	30	173	-142	-154	267	58
2003	38	193	-156	-162	298	67
2004	46	216	-171	170	331	78
2005	55	241	-186	-179	367	90

National Center for Policy Analysis/Fiscal Associates Health Care Model.

[1] Amounts are cumulative.

[2] Each job represents 2,040 labor hours annually. Amounts are cumulative.

TABLE A-III

Effect of the Medicare MSA Proposal on Federal Budget

($ Billions)

Year	Direct Spending	New Insurance Subsidies	Other Tax Subsidies	Net Taxes	Deficit Impact
1997	-137	123	-3	0	-17
1998	-151	132	-3	2	-25
1999	-167	141	-3	4	-32
2000	-184	151	-3	5	-42
2001	-204	161	-2	7	-52
2002	-226	173	-2	9	-64
2003	-250	185	-1	11	-78
2004	-276	198	-1	14	-93
2005	-305	212	0	16	-110
				Sum 1997-2002	-232

National Center for Policy Analysis/Fiscal Associates Health Care Model.

TABLE A-IV

Effect of Medicare MSA Proposal on State & Local Budgets

($ Billions)

Year	Direct Spending	Other Tax Subsidies	Net Taxes	Deficit Impact
1997	-13	0	0	-14
1998	-14	0	1	-16
1999	-15	0	2	-18
2000	-17	0	4	-21
2001	-18	0	5	-24
2002	-20	0	6	-26
2003	-22	0	8	-30
2004	-24	0	9	-33
2005	-26	0	11	-37

National Center for Policy Analysis/Fiscal Associates Health Care Model.

TABLE A-V

Effect of Medicare MSA Proposal on Household Spending

($ Billions)

Year	Out-of-Pocket Costs[1]	Insurance Costs Net[2]	Net Health Costs[3]	Aftertax Income	Other Goods[4]	Total Value of Health[5]	Value of Goods[6]
1997	-6	-61	-67	0	93	-91	2
1998	-5	-64	-69	2	106	-99	7
1999	-4	-68	-72	4	121	-108	12
2000	-3	-71	-75	7	137	-119	18
2001	-2	-75	-77	10	154	-130	24
2002	0	-79	-79	12	173	-142	30
2003	2	-83	-81	15	193	-156	38
2004	4	-87	-83	19	216	-171	46
2005	7	-91	-84	23	241	-186	55

National Center for Policy Analysis/Fiscal Associates Health Care Model.

[1] Expenses paid by individuals after payments from MSAs and catastrophic insurance.

[2] Cost of new catastrophic insurance less government payments toward purchase of insurance. Changes result from lower demand for medical services and lower medical prices.

[3] Paid by individuals.

[4] Change in output of nonhealth goods and services.

[5] Net health costs plus change in government spending on health.

[6] Other goods plus total value of health.

About the Authors

Aldona Robbins, an NCPA Senior Fellow and Vice President of Fiscal Associates, has extensive experience with public and private retirement programs. Dr. Robbins served as senior economist in the Office of Economic Policy, U.S. Department of the Treasury from 1979 to 1985 and has developed a model to project Social Security benefits and tax revenues. Recent publications include NCPA Reports entitled "What A Canadian-Style Health Care System Would Cost U.S. Employers and Employees" and "Taxing the Savings of Elderly Americans"; an NCPA and Institute for Policy Innovation Report entitled "Paying People Not To Work: The Economic Cost of the Social Security Retirement Earnings Limit"; a book entitled *The ABCs of Social Security* , published by the Institute for Research on the Economics of Taxation Economic Report; and an article entitled "Encouraging Private Provision for Long-Term Care" in *Compensation and Benefits Management.* Her articles on Individual Retirement Accounts and Medicare have appeared in the *Wall Street Journal.*

Gary Robbins is an NCPA Senior Fellow and President of Fiscal Associates. Mr. Robbins has developed a general equilibrium model of the U.S. economy that specifically incorporates the effects of taxes and government spending. Before joining the private sector, he was Chief of the Applied Econometrics Staff at the U.S. Treasury Department from 1982 to 1985, Assistant to the Under Secretary for Tax and Economic Affairs from 1981 to 1982, and Assistant to the Director of the Office of Tax Analysis from 1976 to 1981. Recent publications include NCPA Reports entitled "Taxes, Deficits and the Current Recession," "A Pro-Growth Budget Strategy: Vision for the 1990s" and "Elderly Taxpayers and the Capital Gains Tax Debate"; an IPI Report entitled "Will Raising Taxes Reduce the Deficit?"; and a report for the U.S. Chamber of Commerce entitled "Adding to the S&L Solution: A Case for Lower Capital Gains Taxes." His articles on various tax policy issues have appeared in the *Wall Street Journal.*

About the NCPA

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute, funded exclusively by private contributions. The NCPA originated the concept of the Medical IRA (which has bipartisan support in Congress) and merit pay for school districts (adopted in South Carolina and Texas). Many credit NCPA studies of the Medicare surtax as the main factor leading to the 1989 repeal of the Medicare Catastrophic Coverage Act.

NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. Its forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The NCPA also has produced a first-of-its-kind, pro-free enterprise health care task force report, written by 40 representatives of think tanks and research institutes, and a first-of-its-kind, pro-free enterprise environmental task force report, written by 76 representatives of think tanks and research institutes.

The NCPA is the source of numerous discoveries that have been reported in the national news. According to NCPA reports:

- Blacks and other minorities are severely disadvantaged under Social Security, Medicare and other age-based entitlement programs;
- Special taxes on the elderly have destroyed the value of tax-deferred savings (IRAs, employee pensions, etc.) for a large portion of young workers; and
- Man-made food additives, pesticides and airborne pollutants are much less of a health risk than carcinogens that exist naturally in our environment.

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