Policy Analysis

Cato Institute Policy Analysis No. 62: Averting the Medicare Crisis: Health IRAs

October 31, 1985

Peter J. Ferrara

Peter J. Ferrara, a Washington attorney, is author of *Social Security: The Inherent Contradiction* and editor of *Social Security: Prospects for Real Reform,* both published by the Cato Institute.

Executive Summary

Medicare is in shambles. Official government reports indicate that Medicare faces overwhelming long-term financial problems. Recent attempts to control costs through centralized government regulations and controls have led to a deterioration in the quality of care the program provides the elderly. The program is poorly structured for serving both young and old. Now is the time to begin making fundamental reforms to avert looming financial disaster and eliminate the program's other serious problems.

Four innovative congressmen have taken the lead in proposing legislation that would do precisely that in a positive, constructive way. Reps. French Slaughter (R-Va.), Philip Crane (R-Ill.), Mark Siljander (R-Mich.), and David Dreier (R-Calif.) have introduced legislation providing for Health IRAs. Through this legislation, the long-term Medicare financing problem can be solved without benefit cuts for the elderly or payroll tax increases for workers.

The Medicare System

Medicare consists of two components known as Hospital Insurance (HI) and Supplemental Medical Insurance (SMI). HI primarily covers persons aged 65 and over who receive social security retirement benefits and persons under 65 who receive social security disability benefits. HI pays for up to 90 days of inpatient hospital care for each illness, as well as a total of lifetime reserve days for each person. This coverage is currently subject to a deductible of $400 per hospital stay; in addition, the person covered must pay co-insurance fees of $100 a day for the 61st to 90th days of hospital stay and $178 a day for each lifetime reserve day. The deductible and co-insurance fees are indexed to increase each year with hospital costs. HI also pays for up to 100 days per illness of care in a skilled- nursing facility, with a current daily co-insurance fee of $50 after 20 days, 100 home health-care visits per illness, and hospice care.

HI is financed through part of the social security payroll tax, which includes an earmarked HI payroll tax rate of 1.35 percent on both employer and employee, for a combined total of 2.7 percent. This rate is applied to wages up to the maximum social security taxable income ($39,600 in calendar year 1985 and indexed to increase each year with average wages). In 1986 the HI payroll tax rate is scheduled to rise to 1.45 percent, for a combined total of 2.9 percent, remaining at that level indefinitely thereafter.

SMI is available on a voluntary basis primarily to those persons eligible for HI. SMI pays for physician services, out-patient hospital services, home health-care services, and other non-hospital health services. This coverage is subject to a statutorily fixed annual deductible of $75 and co-insurance fees equal to 20 percent of claims. Those who choose coverage must pay a monthly premium, currently $15.50 and indexed to increase each year with medical costs. These premiums now cover about one-fourth of SMI expenses, with general revenues financing the rest. Virtually all of the

elderly eligible for SMI have opted for coverage, and the program now covers over 80 percent of the U.S. elderly population.

Medicare expenditures will total almost $70 billion in fiscal year 1986. By the end of the 1980s annual Medicare expenditures will be almost $100 billion.

Financial Problems

The latest projections of the Social Security Administration indicate that HI will probably run short of funds to pay promised benefits some time in the 1990s. Under the SSA's widely cited, intermediate, Alternative IIB projections, the HI program will be unable to pay promised benefits by 1998.[1] Under the so-called pessimistic, but often more realistic, Alternative III projections, the program will be unable to pay full benefits by 1992.[2]

Under Alternative IIB projections, by the time those now entering the work force retire, HI revenues will be sufficient to cover only 40 percent of HI expenditures; under Alternative III projections, HI revenues will cover only 17 percent of expenditures.[3] Under Alternative IIB projections, to pay all promised benefits to these workers the total employer/employee HI tax rate would have to be raised to 7.4 percent, almost three times the present rate of 2.7 percent.[4] Under Alternative III projections, this rate would have to be raised to 15.4 percent, higher than the current tax rate of 14.1 percent for all of social security.[5] Over the next 75 years, the financing gap projected by SSA under Alternative IIB assumptions for HI alone is one-third greater than the financial gap for all the rest of social security closed by the 1983 legislation to save the system from bankruptcy.[6] Under Alternative III assumptions, the HI gap alone would be almost three times greater than the social security shortfall closed in 1983.[7]

The cost burden of SMI is also out of control. The Office of Management and Budget projects that SMI expenditures beyond those covered by the monthly premiums of beneficiaries will almost double from $14.1 billion in FY 1983 to $27.1 billion in FY 1990. In FY 1990, total Medicare expenditures, net of SMI premiums, will be almost $100 billion, which alone amounts to 8 percent of the entire FY 1990 federal budget.

The Medicare system itself promotes substantial waste and inefficiency, contributing to this cost explosion. With the government paying for medical bills through Medicare, both doctors and patients tend to lose concern for costs. Consequently, hospital stays may be extended, unnecessary or repetitive tests and procedures may be run, and little or no thought may be given to how treatment can be provided in the least-cost manner. Patients may obtain medical services that they themselves believe are not worth the full costs. Medical consumers have little incentive to seek out the lowest-cost medical-service providers, and consequently competitive pressures for efficiency and the development of low-cost medical-service alternatives are weakened. Doctors and hospitals no longer need to be as concerned about whether their patients can afford the charges, and, as a result, they may charge more than they would otherwise. These perverse incentives permeate the entire medical sector servicing Medicare.

Stifling Regulation

In an attempt to control spiraling costs and reduce waste and inefficiency, the federal government has resorted to a sharp increase in its regulation of the private medical community, through adoption in 1983 of the Prospective Payment System (PPS) for payment of hospital services under Medicare. Under the PPS requirements, the government has established almost 500 categories of illness requiring hospital treatment and has set the amount the government will pay under Medicare in each locality to treat each category of illness. The set fees are based on an average of local hospital costs for treating each illness. If treatment costs for a particular patient turn out to be less than the amount set for that patient's illness, the treating hospital can keep the difference. If the treatment costs more, however, the hospital cannot collect the extra charges from the patient and must absorb the loss.

The PPS requirements follow a typical policy pattern pursued by governments deeply involved in financing costly medical treatment for average citizens--sacrificing quality for cost savings. The PPS creates powerful incentives for medical providers to take shortcuts and shortchange medical consumers in the quality of care. Even if patients want to pay more for less-harried service and more personal attention, they cannot do so. The hospital can maximize income only by processing patients as quickly and cheaply as possible. Patients who are slow to respond to treatment may tend to find themselves icily classified as hopeless in a somewhat peremptory fashion. Indeed, the PPS takes away any

significant power and control that medical consumers may have over medical providers. Once the patient enters the hospital under PPS, the hospital receives a flat fee from the government. Whatever treatment the hospital gives the patient thereafter is basically charity, in effect coming out of the hospital's own pocket. The patient no longer has the power that control over payment brings.

For those hospitals whose legitimate, unavoidable costs are above the government-set PPS payments, the payment system will in effect operate like price controls, leading to a reduction in doctors and hospitals willing to provide service under Medicare--and possibly to shortages and rationing of hospital services for Medicare beneficiaries. Updating the illness categories and their accompanying fees will be subject to bureaucratic delays and political logrolling. Ultimately, it is likely to lead to a regulatory morass and to enhanced prospects for shortages, rationing, and quality deterioration. Indeed, administration and congressional budget cutters have apparently decided already to freeze the PPS payments set for FY 1986..

A report issued by the Senate Special Committee on Aging on September 26, 1985, and hearings held before the committee on the same day, document that consumers are already beginning to suffer from these problems.[8] But this stifling regulatory regime is disastrous not only for medical-care consumers but for doctors and other medical-care providers as well. As a result of this regulation, doctors are being subject to more detailed and centralized restrictions on their choice of medical treatment and to more bureaucratic second-guessing of the choices they are allowed to make. With increased complaints about the quality of medical care, the regulatory trend toward increased regulation is only likely to accelerate. Doctors and other medical professionals are consequently losing the traditional market freedoms enjoyed in other professions and that have always been most important in Medicare.

Failing Workers and Retirees

Still another seriously worsening Medicare problem stems from the fact that workers must pay for their retirement HI coverage throughout their working years, yet their payments are not saved and invested to finance their future coverage. Rather, their payments are immediately paid out to finance the benefits of current beneficiaries. Workers consequently lose the market returns on capital investment they would receive each year if their payments were saved in an IRA-type vehicle to finance their own benefits in retirement. This loss is not significant for those retired today, who had to pay HI taxes for only part of their careers (since 1966), and relatively low taxes at that. But workers entering the work force today, along with their employers, will have to pay the full HI tax for their entire careers. These workers could purchase much more coverage and medical service for their money, or the same coverage and service for much less money, if they could receive full capital investment returns on their payments into the system.[9]

In addition, the Medicare benefit structure has always been poorly designed for meeting the most important needs and concerns of the elderly. The chief threat to the financial security of the elderly is the possibility of life-threatening illness requiring overwhelming medical expenses for treatment. Yet, Medicare does not insure against such catastrophic illness. Medicare co-payment fees increase the longer a patient stays in a hospital or skilled-nursing facility, and coverage stops altogether after a certain number of days. Medicare covers only the more routine and less-threatening costs. Consequently, the priorities of the Medicare benefit structure are the reverse of what they should be.

The Health IRA

Solving these many problems of Medicare does not require imposing hardships on the elderly, through benefit cuts, or on the young, through further payroll tax increases. Rather, the answer lies in increasing the role of the private sector in providing and financing medical care for the elderly and in widening the range of consumer choice and genuine market competition and incentives. This can be accomplished through Health IRAs,[10] which have now been proposed in legislation introduced by Slaughter, Crane, Siljander, and Dreier.

Under this legislation, workers would be allowed to establish accounts called Health IRAs, similar to existing regular IRAs. Workers would be allowed to contribute to their Health IRAs each year amounts up to the total of the HI Medicare payroll taxes paid by them and by their employers on their behalf. Instead of the usual IRA income-tax deduction, workers would receive an income-tax credit equal to 60 percent of their contributions to their Health IRAs. Employers could make some or all of the Health IRA contributions for their employees and receive the 60 percent credit accordingly.

Health IRA contributions and investment returns would then accumulate tax free until retirement. Before retirement, workers could not withdraw 60 percent of Health IRA contributions and associated returns, since they have received income-tax credits for these amounts. They could withdraw 40 percent subject to a 10 percent penalty as with a regular IRA.

After retirement, Health IRA funds could be used to purchase medical insurance or finance medical expenses directly. However, to the extent that each worker utilized the Health IRA option over his working years, an added annual deductible would be applied before payment of Medicare benefits, under either HI or SMI, for that worker in retirement. The added deductible would be roughly equal to the amount of health-insurance coverage the retired worker could be expected to be able to buy each year with accumulated Health IRA funds, given the worker's record of past contributions. The calculation of the deductible would assume a modest investment return earned on Health IRA contributions, equal to an average of the returns earned on federal securities. Only 60 percent of accumulated funds would be counted in determining the deductible, corresponding to the percentage of the tax credit the worker received for contributions to his Health IRA.

During their careers, workers could utilize the Health IRA option in some years and not in others, and in differing degrees each year, with each worker's ultimate Medicare deductible automatically adjusted accordingly under the formula for calculating the deductible. Workers already in the work force when Health IRAs are first offered would simply be assumed not to have utilized the option during their prior working years; consequently, their future Medicare deductible would be increased only to the extent that they would utilize Health IRAs during their remaining working years.

Workers utilizing the Health IRA option to the maximum over their entire careers would have an added Medicare deductible of several thousand dollars a year in retirement. However, they would have far more than enough to finance medical expenses below the deductible amount through their accumulated Health IRA funds. Workers utilizing the Health IRA option to a lesser degree during their careers would have proportionally lower deductibles, again with more than enough in accumulated Health IRA funds to cover expenses below the deductible.

Workers in retirement could also receive cash rebates from their Health IRAs. If a retiree conserved on the use of medical resources and spent less than a specified proportion of Health IRA funds on medical expenses or insurance in a year, at the end of the year the retiree could withdraw the difference from the Health IRA and use the funds without restriction. If a worker earned a higher return on Health IRA investments over his career than the modest target return assumed in calculating the deductible, the worker could also withdraw the excess accumulated funds at any point during his retirement years and use them without restriction. The retired worker could also always withdraw up to 40 percent of Health IRA contributions and associated returns for any expense under the same terms as a regular TRA

Workers utilizing the Health IRA option to a minimum degree during their careers would also receive catastrophic coverage under Medicare. For these workers, caps on duration of covered care under Medicare would be eliminated, as would added co-insurance fees for extended coverage. In addition, their SMI co-insurance fees would be capped.

If a worker accumulated an added deductible by retirement through use of the Health IRA option and lacked funds to pay deductible medical expenses, the Medicaid program would provide back-up coverage. If the worker meets all requirements for the Supplemental Security Income program (SSI) and consequently qualifies for SSI benefits, he would automatically receive Medicaid coverage, and the program would pay the expenses. Of course, the SSI asset and income tests mean that workers would have to exhaust their own discretionary resources before receiving Medicaid assistance.

Upon death of the worker, either before or after retirement, any remaining funds in a Health IRA would go to the worker's designated heirs.

The income-tax credit for Health IRA contributions is meant to serve, in effect, as a rebate of payroll taxes to the extent that workers choose to rely on Health IRA funds rather than Medicare. However, because the credit would be taken against income taxes rather than payroll taxes, the payroll tax revenues that finance Medicare would not be reduced. Such revenues would continue to be fully and exclusively available to pay benefits to today's elderly. Health

IRA income-tax credits would simply result in a loss of income-tax revenues (discussed more fully below).

Because the credit is intended in effect to give workers their money back to the extent they reduce reliance on Medicare, ideally the credit should be equal to 100 percent of contributions rather than 60 percent. The 60 percent credit gives workers only 60 percent of their money back. To compensate for this, the proposed legislation bases the added Medicare deductible on only 60 percent of past contributions and associated returns. The worker could withdraw the remaining 40 percent as with a regular IRA. This treatment is essential to maintaining the attractiveness and fairness of Health IRAs, which, in turn, is crucial if workers are to be expected to exercise the Health IRA option.

The 60 percent credit has the virtue of substantially reducing the initial revenue loss as compared with a 100 percent credit. Along with the above-described compensating treatment, legislation based on such a credit is, consequently, a politically judicious starting point for Health IRAs. Later legislation could expand Health IRAs to the full scope of the original concept, by gradually increasing the credit to 100 percent, along with the proportion of Health IRA contributions counted toward the added deductible. Such later expansion would maximize the potential benefits of the Health IRA concept.

The Costs of Health IRAs

The potential income-tax revenue loss from the proposed Health IRA legislation is easy to determine, since it is a function of the amount of HI payroll tax revenues, which is projected annually by the SSA. If Health IRAs became available starting on January 1, 1986, and workers utilized the option in the first year as much as they currently utilize regular IRAs, the income-tax revenue loss in FY 1986 would be $4.0 billion.[11]

In future years, the annual income-tax revenue loss would eventually be offset completely by reduced Medicare expenditures, as workers began relying more on their private Health IRAs and less on Medicare. Long before this point, moreover, the revenue loss would be offset on net by the combination of expenditure reductions and new revenues generated by increased investment through the Health IRAs.

In addition, during the period of temporary net revenue loss there would be increased savings in the Health IRAs probably greater than the amount of the lost revenue because the tax credit, and consequently the revenue loss, would equal only 60 percent of the funds saved in Health IRAs.[12] Consequently, while a small short-term increase in the deficit might result from the proposed Health IRA legislation, the real concern over the budget deficit--the crowding out of private savings--would actually be alleviated through an increase in savings.

The Benefits of Health IRAs

The most immediately important benefit of Health IRAs is that they would sharply reduce and potentially eliminate altogether the long-term financing problems of Medicare, without benefit cuts or payroll-tax increases. As indicated, with Health IRAs, HI payroll taxes would still be maintained in full, while both HI and SMI expenditures would likely be reduced sharply as workers began to rely more and more on their Health IRAs and less and less on Medicare. The extent to which Health IRAs could solve Medicare's long-term financing problems depends on the degree to which Health IRAs are expanded in the future and the degree to which workers utilized them.

Workers exercising a fully expanded Health IRA option to the maximum throughout their careers would be financing 80 percent or more of their retirement medical expenses on their own, greatly reducing the cost burden on Medicare.

If eventually most workers did this, the remaining, primarily catastrophic, role of Medicare could be covered by HI payroll tax revenues at the currently legislated HI payroll tax rate of 2.9 percent. Potential increases in this rate to the range of 7 to 15 percent, as discussed above, would be avoided completely. The general-revenue contributions now provided to SMI may also no longer be necessary to finance Medicare's remaining obligations.

Further cost savings would result from the increased market competition, improved incentives, and enhanced consumer choice resulting from Health IRAs. The Health IRA option would allow private medical-care providers and insurers to compete for coverage of retirees, rather then maintaining exclusively the current Medicare monopoly. Private medical-care providers would compete to develop medical institutions with better cost control, such as health maintenance

organizations (HMOs), and they would offer retirees the option of purchasing their insurance and medical coverage through such institutions. In addition, when setting fees, they would have to recognize that funds for payment are not inexhaustible. Private insurers would compete to keep their own costs down by monitoring health providers closely and rooting out wasteful, unnecessary expenditures. The competition would also increase pressure for the development of lower-cost medical-care technologies.

Complementing this increased competition would be improved incentives for consumers, since they would be purchasing services with their own funds in their Health IRAs. Avoiding unnecessary or overly expensive charges would allow consumers to retain greater Health IRA reserves and even pay themselves cash rebates from the Health IRAs. Consumers would consequently devote more effort to seeking out the lowest-cost service providers. They would seek to avoid unnecessary medical care or care that they themselves feel is not worth the cost. They would devote greater attention to preventive measures that could save medical costs over the long run. Health IRAs would be a means of bringing natural market incentives back into medicine, not in a harsh way that could deprive some people, but in a positive way that would result in enhanced benefits and rewards for people responding to market incentives.

The Health IRA option offered to workers would be highly attractive. To the extent that workers earned a higher return on their Health IRA investments than the modest return assumed in calculating the added deductible, they would be able to pay themselves cash rebates out of their Health IRAs, increasing their retirement incomes. Easily available, broadly diversified investments, such as mutual funds, routinely offer common investors higher returns. Stocks across the whole New York Stock Exchange going back to before the Great Depression have earned an average real return greater than 6 percent.[13] With such returns, workers utilizing Health IRAs could increase their retirement incomes by several times the value of the increased deductible.

To the extent the worker's medical expenses in any given year fall below a specified proportion of Health IRA funds, the worker could choose to take a cash rebate equal to the difference at the end of the year from his Health IRA, further increasing retirement income. The more the worker can hold down medical expenses by avoiding the unnecessary use of medical resources, the more retirement income can be increased through such rebates. Moreover, through working and retirement years, Health IRA assets would also serve a life insurance function, since they could be passed on to heirs.

These advantages would result largely from the opportunity for workers to earn full market returns on their Health IRA investments over their working years, as opposed to the present pay-as-you-go Medicare system in which essentially no returns are accumulated. The earned market returns on Health IRA investments would represent a new source of funds for medical care.

Workers exercising the Health IRA option to a substantial degree over their working years would also enjoy catastrophic coverage under Medicare, which is precisely the coverage retirees need and want, but which Medicare does not now provide. The Health IRAs also would provide a new source of funds available to finance long-term care in nursing homes and other institutions. Mechanisms for financing such care are a major concern for health-care policymakers today.

If, despite all these benefits, some workers did not want to exercise the Health IRA option and wanted to continue to rely entirely on Medicare, they would be perfectly free to do so, without penalty. Workers already in the work force would receive complete credit for past taxes paid into Medicare and would bear increased deductibles only to the extent that they exercised the Health IRA option in the future.

The legislation involves no benefit cuts of any kind for the elderly. Indeed, the Medicare system on which they are relying would be financially strengthened, thereby benefiting them directly. The elderly would also favor the new opportunities Health IRAs would offer their children and grandchildren to enjoy a secure and prosperous retirement future as well.

For doctors and other medical professionals, the plan offers the advantage of depoliticizing medical care to a degree, by moving more of the financing of such care into the private sector. Medical professionals would consequently have greater opportunity to work under the same market freedoms as people in other disciplines, rather than as targets of government scapegoating campaigns and increased government regulations.

For the federal government, the Health IRA plan would likely produce a permanent, substantial reduction in federal spending, as workers chose over the years to rely more on their private Health IRAs and less on public Medicare. Potentially as much as 80 percent or more of Medicare spending could be moved to the private sector, depending on how much workers utilized the Health IRA option and how much the option was ultimately expanded. Under such a system, the government would be paying for the catastrophic benefits most voters really want and backing up workers who lacked sufficient, minimal revenues through the means-tested Medicaid program. But the great bulk of routine retirement medical expenses for the great majority of people would be funded through their own private resources, which they would have been empowered to accumulate through their Health IRAs.

Conclusion

Health IRAs allow advocates of greater economic freedom and prosperity to transcend traditional benefit cut/tax increase dilemmas by offering workers a better deal in the private sector. They solve the overwhelming problems of Medicare in a purely positive manner, offering enormous advantages to the young and a strengthened program with unreduced benefits to the elderly. There is consequently no reason why the reform should be anything but wildly popular.

FOOTNOTES

[1] 1985 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, March 28, 1985.

[2] Ibid.

[3] See 1985 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, March 28, 1985. Appendix E of the report reveals that in 2035, HI expenditures are projected under Alternative IIB assumptions to equal 7.36 percent of taxable payroll, whereas revenues will equal 2.9 percent. Under Alternative III assumptions, HI expenditures in 2035 will equal 15.4 percent of taxable payroll, with revenues remaining at 2.9 percent.

[4] Ibid.

[5] Ibid.

[6] Ibid. Appendix E of the report reveals an HI financing gap over the next 75 years under Alternative IIB assumptions of 2.75 percent of taxable payroll. The 1983 social security rescue legislation was projected, under Alternative IIB assumptions, to reduce the program's financing gap over the following 75 years by about 2.1 percent of taxable payroll.

[7] Ibid. Appendix E of the report reveals an HI financing gap over the next 75 years under Alternative III assumptions of 7.8 percent of taxable payroll. The 1983 social security rescue legislation was projected, under Alternative III assumptions, to reduce the program's financing gap over the following 75 years by about 2.7 percent of taxable payroll.

[8] Senate Special Committee on Aging, Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries, staff report, September 26, 1985; idem, Hearings on Medical DRGs: Challenges for Quality Care, September 26. 1985.

[9] In a steady state, money paid into HI would receive a return equal to the rate of growth in payroll tax revenues, which would be equal to the combined rates of growth in wages and the working population. However, this is not likely to be nearly as large as the return on capital investment, especially with the unfavorable population trends of today. See Peter J. Ferrara, Social Security: The Inherent Contradiction (Washington: Cato Institute, 1980), chaps. 4 and 9. See also idem, ed., Social Security: Prospects for Real Reform (Washington: Cato Institute, 1985, chap. 1.

[10] The Health IRA concept was first advanced in a paper by Peter J. Ferrara, U.S. Chamber of Commerce chief

economist Richard Rahn, University of Dallas professor John Goodman, and University of Michigan professor Gerald Murgrave. See Peter J. Ferrara, Richard Rahn, John Goodman, and Gerald Murgrave, Solving the Problems of Medicare (Dallas: National Center for Policy Analysis, 1984).

[11] Calculated under the Alternative IIB projections in the 1985 Annual Report for HI.

[12] Because workers would not be allowed to withdraw 60 percent of Health IRA contributions before retirement, the danger of any shifting of existing savings into such IRAs would be largely avoided, in that such savings could no longer perform the functions of preexisting savings.

[13] Stocks, Bonds, Bills and Inflation: 1984 Yearbook (Chicago: R.G. Ibbotson Associates, 1984).