Policy Analysis

Cato Institute Policy Analysis No. 115: Abolish Medicare Taxes on the Elderly

January 25, 1989

Peter J. Ferrara

Peter J. Ferrara is a senior fellow at the Cato Institute and an associate professor of law at the George Mason University School of Law.

Executive Summary

Medicare was adopted almost 25 years ago to carry much of the financial burden of medical care for the elderly. But today the Medicare program itself is increasingly becoming a financial burden on the elderly. The program imposes a monthly "premium" on each elderly beneficiary, which has been soaring in recent years. In addition, starting this year elderly taxpayers will begin paying a stiff income tax surcharge for Medicare. Both the surcharge and the monthly premiums are projected to soar to new heights in future years. In part because of this rapidly rising Medicare tax burden, the elderly today pay at least as much of their income for medical care and coverage as they did before Medicare was adopted. Moreover, increasingly burdensome and complex Medicare regulations threaten the quality of medical care the elderly receive under the program.

The Medicare taxes on the elderly can and should be abolished, with Medicare benefits redesigned to offset the revenue loss. Such changes can be structured to allow the elderly greater choice and control over their own funds, and ultimately substantial savings overall. These changes would also be good health policy, providing major new market incentives to counter rapidly rising health costs. Over the long run, more fundamental reforms should be adopted to allow the elderly even greater choice and control and to introduce greater competition and incentives into medical care for the elderly.

The Medicare System

Medicare consists of two components: Part A, or Hospital Insurance (HI), and Part B, or Supplemental Medical Insurance (SMI). Part A now pays for an unlimited number of days of hospital care, subject to a deductible that requires patients to pay the first $560 of hospital expenses each year. It also pays for up to 150 days of care in a skilled nursing facility each year, subject to a coinsurance fee of $20.50 for each of the first 8 days of such care. Part A further provides for unlimited care in a hospice for the terminally ill.

Part B pays for services of physicians, surgeons, and other health care professionals. It also covers certain medical supplies and equipment and some home health care services. The beneficiary pays the first $75 in such expenses each year under the Part B deductible. Part B then pays for 80 percent of additional charges that are at or below maximum approved fees set by Medicare for each service. The beneficiary pays 20 percent of these charges as a coinsurance fee, plus the full amount of any charges exceeding Medicare's approved maximum fee. In 1990, however, the Part B deductible and 20 percent coinsurance fee (but not the excess of any charges above Medicare-approved fees) will be subject to an annual limit for the first time, which will be $1,370 in that year.

In 1990 Medicare also will begin coverage for prescription drugs. This coverage will be subject to a $550 annual

deductible (leaving each beneficiary responsible for the first $550 in drug costs that year). A coinsurance fee will also be introduced that will ultimately require beneficiaries to pay 20 percent of prescription drug costs above the deductible. The drug deductible, the Part B annual cap on Medicare insured charges, and the Part A deductible and coinsurance fees are all indexed to increase with medical costs each year.

Part A coverage is financed primarily by workers and employers through a portion of the social security payroll tax, called the Hospital Insurance or HI tax. In 1989 the HI tax will be 2.9 percent of wage income up to $48,000, divided equally between employer and employee. The wage cap is indexed to increase each year with average earnings.

General revenues finance about 75 percent of Part B expenses. The remaining 25 percent is financed by monthly Medicare premiums paid by each beneficiary. These monthly charges will also help to finance the new coverage for prescription drugs. Starting this year, all elderly income taxpayers will be assessed an income tax surcharge that will help finance the program. The Medicare premiums and income tax surcharge on the elderly are discussed further below.

Medicare Taxes on the Elderly

The monthly Medicare premiums deducted from each social security check have soared from $17.90 per month in 1987 to $24.80 in 1988 to $31.90 in 1989, an increase of 78 percent in the last two years. An elderly couple is now required to pay $63.80 per month, or $765.60 per year. Moreover, under current trends, by 1993 the premiums will increase to about $50 per month per beneficiary, or $1,200 per year for elderly couples.

Few of the elderly yet recognize, however, that this year income taxpayers over age 65 will also have to pay a 15 percent income tax surcharge to Medicare. This means that the total income tax bill for the year for these taxpayers will be increased by 15 percent. This surcharge is subject in 1989 to a limit of $800 per beneficiary, or $1,600 per couple. (For those elderly whose income puts them above the cap--earning roughly over $50,000 for couples or $30,000 for singles--the effective income tax surcharge rate will decline below 15 percent as income rises.) Because nothing is currently being withheld for this surcharge, the great majority of elderly taxpayers will be shocked to find next April that they suddenly will have to come up with an extra 15 percent to meet their tax bills.

Moreover, current law provides that this surcharge will increase to 28 percent by 1993, with a cap of $1,050 per beneficiary, or $2,100 per couple. The total income tax bill for each elderly taxpayer will therefore be increased in that year by 28 percent (except for those few whose income causes them to exceed the cap). After 1993, the income tax surcharge is indexed to increase each year with the cost of the new Medicare catastrophic health benefits adopted in 1988.

The Medicare income tax surcharge will raise marginal income tax rates for the elderly above those for everyone else, by the same percentage as the surcharge (that is, 15 percent in 1989 and 28 percent in 1993). Moreover, because the surcharge rate will be increased each year to keep pace with program costs, marginal income tax rates for the elderly will continue to increase each and every year indefinitely.[1] The surcharge effectively reverses tax reform for the elderly, as the central purpose of tax reform was to reduce marginal tax rates as much as possible. The surcharge also discourages savings, because those who save more for their retirement, and consequently have higher retirement income, will bear higher marginal tax rates under the Medicare surcharge.

The total Medicare tax burden on the elderly in fiscal 1990, including monthly premiums and the income tax surcharge, will amount to about $17 billion, an enormous sum to draw from a subgroup of the population. An elderly couple this year will pay as much as $2,365.60 in Medicare premiums and income tax surcharges, and by 1993 this amount will rise to about $3,300. The monthly premiums themselves are becoming a substantial burden for the elderly of modest means, and the income tax surcharge amounts to a harsh, discriminatory tax for millions of elderly income taxpayers.

The Failure of Medicare

In part because of this heavy Medicare tax burden, the elderly today incredibly pay at least as much of their income for medical care and coverage as they did before Medicare was adopted.[2] Medicare therefore has failed to make the

elderly any better off than they were in 1965 when it was enacted.

This lack of overall improvement can be explained by two additional factors besides the heavy Medicare tax burden. First, many medical expenses are not covered by Medicare. As noted above, the program does not pay for the amount by which doctors' charges or other expenses covered by Part B exceed maximum set fees. The program does not pay for long- term intermediate or custodial care in nursing homes or other settings. It does not pay for dental care, hearing aids, eyeglasses, walking aids, and similar items. Benefits added in 1988 will cover prescription drugs after the first several hundred dollars each year and previously uncovered expenses for long hospital stays and extended illnesses. But these benefits are all financed by the elderly through increased premiums and the new Medicare income tax surcharge, so the net burden of medical costs on the elderly will remain unchanged. In the past the program has paid about half the total medical costs of the elderly.[3]

Second, medical costs have soared over the years, imposing higher costs on the elderly for direct medical payments and for Medicare premiums and taxes. Medicare not only has failed to stop this cost spiral, it appears to have been a major contributor to the trend. To the extent that the federal government pays the bills through Medicare, both patient and doctor lose incentives to keep costs down. As a result, unnecessary or marginally useful services, tests, and treatments are pursued. Consumers devote less effort to shopping for the lowest-cost care. Doctors consequently become less interested in devising and adopting more cost-efficient medical treatments. Patients seek medical services when even they would agree the benefits are not worth the costs.

To counter such incentive problems for hospital services under Medicare, the federal government adopted the Prospective Payment System (PPS) in 1983. PPS classifies all illnesses requiring hospital treatment into Diagnostic Related Groups (DRGs) and sets the amount Medicare will pay in each locality for treatment of illness in each DRG. The fees are supposed to be based on an average of local hospital charges for each illness. If a hospital can treat a patient for less than the set fee, it 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.

PPS, however, seems to create powerful incentives for hospitals to shortchange medical consumers in the quality of care. Hospitals can maximize income under this system only by processing and discharging patients as quickly as possible with the minimum of services and treatment. Even if patients want to pay more for less-hurried service and more careful and thorough care, they are prohibited from doing so. Indeed, once a patient enters the hospital under PPS, the hospital automatically receives a flat fee from the government and thereafter faces the same economic incentives in treating the patient as it would if it were providing charity. Any expense a hospital incurs for treatment in effect comes out of its own pocket.

News media reports and congressional hearings have already begun to echo complaints of early hospital exits and other forms of inadequate treatment attributable to PPS.[4] Medicare promises patients coverage for unlimited days of hospital care but then will usually only pay the hospital for a few days of treatment based on the PPS-set payments. The hospital is then expected to provide whatever additional days are necessary for free. Under such a system, patients are likely to be discharged soon after PPS payments run out and given a nifty medical rationale as to why nothing further can be done.

For those hospitals whose legitimate costs are regularly above the PPS payments set by the government, PPS effectively operates as a price control. Indeed, the entire system is headed in this direction, as the government regularly adopts freezes or arbitrary, systemwide cuts in scheduled fee in- creases, and as bureaucratic red tape delays the updating of fees and illness categories. Such price controls will naturally tend to reduce the quality and supply of care for Medicare patients. Recent news reports have suggested that some rural hospitals have had to close because of inadequate Medicare payments for services provided for their local population.[5]

To the extent that PPS has reduced the quality of medical care for the elderly, Medicare may actually have been counter- productive.

Tax Relief for the Elderly

Medicare taxes on the elderly, including the monthly premiums and the income tax surcharge, should be abolished.

The resulting revenue loss could be offset by readjusting Medicare benefits. Under Part B, the current annual deductible of $75 could be raised to $900 (indexed to medical inflation), and the current 20 percent coinsurance fee could continue to apply to all expenses after the deductible, without the cap of $1,370 per year now scheduled to go into effect in 1990. A coinsurance fee of 10 percent could also be added to all covered expenses under Part A. These changes should be deficit-neutral overall. Other possible combinations of benefit adjustments could be adopted instead.

Under this package the elderly would retain the significant catastrophic benefits added last year. These include coverage for unlimited days of hospital care, elimination of high coinsurance fees for longer hospital stays, repeal of the application of the Part A deductible (currently $560) to second and later hospital visits each year, coverage for prescription drugs, extended home health care benefits, longer and less-restricted skilled nursing facility care subject to more limited coinsurance charges, and other benefits.

The package would also provide major tax relief for the elderly, amounting to about $17 billion per year. It would remove the harsh, discriminatory Medicare income tax surcharge, which would otherwise ultimately cost millions of elderly families thousands of dollars per year. It would restore to the elderly the same marginal income tax rates as everyone else, eliminating a tax policy that would increase marginal income tax rates on the elderly every year. It also would remove the discouraging effect of the surcharge on private savings. Eliminating the monthly premiums would provide important relief for the elderly of more modest means who are finding the premiums increasingly burdensome. Siphoning funds from the elderly under Medicare and then in effect giving the money back to them through the same program is not going to provide any net overall improvement for the elderly, as experience under the program has already shown.

Such changes would allow the elderly greater choice and control over their own funds, as well as the opportunity for substantial savings overall. While gaining greatly from the tax relief, the elderly could minimize their costs under the proposed deductible and coinsurance fees by shopping for the most efficient, lowest-cost care, avoiding unnecessary services and treatments, and seeking to maintain good health. They could also purchase coverage for most of the deductible and coinsurance fees from private insurers, Health Maintenance Organizations (HMOs), or others. Most of the elderly could purchase such coverage for less than they are now paying to Medicare in premiums and income tax surcharges, in many cases quite a bit less. Most would likely continue to have some private coverage in the future as they have had in the past, and adding such coverage to policies the elderly will buy anyway would involve little overhead and lesser additional net cost as a result. Such coverage should involve especially low cost if added to more general coverage already provided by an HMO or other system with prearranged, lower-cost doctors' charges. Moreover, at what should be a quite modest charge, the elderly should be able to purchase coverage that would simply cap their potential coinsurance fee liability at a level sufficient to protect against high cost from such fees, since the extended illnesses or treatments that would cause such fees to build up to large amounts are relatively rare.

Under the catastrophic health legislation passed last year, all states are now required to phase in coverage under Medicaid for all Medicare deductible and coinsurance fees. This coverage will be provided to all elderly and disabled individuals with incomes below the federal poverty line and with limited savings (currently less than about $8,000). Under this requirement, Medicaid would provide coverage to the poor for the proposed additional Medicare deductible and coinsurance fees, and consequently these fees would not be a burden to them.

Perhaps most important, the proposed reform package would also be good health policy, providing major new market incentives to counter rapidly rising health costs. While Medicare coverage would be retained for high or catastrophic expenses, the elderly would be directly responsible for more routine medical expenses. They would consequently have strong incentives to shop for the least expensive care and to avoid unnecessary services and treatment. This in turn would put new market pressure on health care providers to develop more cost-effective methods of care. The extension of coinsurance fees for Part A and Part B benefits would maintain significant incentives to avoid unnecessary care or overutilization throughout the full range of Medicare coverage, a change that most health policy analysts would consider to be highly desirable.

While these incentives would be strongest without private insurance covering the deductible and coinsurance charges, the elderly would still have strong incentives to seek coverage from low-cost insurers such as HMOs. This in turn

would create additional market pressures for development of new cost- saving insurance systems and the extension of existing ones. Retirees would also have economic incentives to purchase only low-cost private coverage, providing relatively high caps on their potential coinsurance liability. This would allow them to retain control over their funds for more routine expenses.

Ultimately, adopting such market incentives in an environment structured to maximize their effectiveness is the only way to counter rapidly rising health costs without undermining the quality of care.

Long-Term Reform

In addition to its other problems, Medicare is still facing dramatic long-term financing difficulties. Based on the government's own projections, Part A is likely to be unable to pay its promised benefits within the next 10 to 15 years. Under the most widely cited intermediate projections, Part A will run short of funds by 2005.[6] Under the so- called pessimistic projections, the program will run short by 1999.[7]

Moreover, the program's projected financial gap grows wider and wider over the long term. Under the intermediate projections, the long-term financing gap for Part A alone is larger than the long-term deficit reduction package for all of social security that was enacted in the emergency 1983 legislation to save the system from bankruptcy.[8] Paying all promised benefits in retirement to those entering the work force today would require a 130 percent increase in the total Medicare payroll tax rate, from 2.9 percent today to 6.6 percent in 2035.[9] This 6.6 percent rate would be more than half today's total 12.12 percent tax rate for all other social security programs.

Under the supposedly pessimistic projections, the long- term financing gap for Part A is more than twice as large as the long-term deficit reduction provided for all of social security in the 1983 legislation.[10] Paying all promised benefits in retirement to today's young workers would require an increase of almost 400 percent in the total Medicare payroll tax rate, from 2.9 percent to 13.6 percent, more than the total tax rate for all other social security programs today.[11]

Those long-term projections for Part A imply equivalent fiscal burdens under Part B. The required increase of 130 percent to 400 percent in Part A payroll tax rates suggests that general revenue contributions to Part B will have to increase an equivalent amount to pay all promised benefits to workers now entering the work force. With current general revenue contributions at about $30 billion per year, this means that paying all benefits to today's young workers would require a total annual general revenue contribution to Part B equivalent to $70 to $150 billion today. Moreover, annual Part B premiums and income tax surcharges paid by the elderly would have to increase by 130 percent to 400 percent as well. Today's young workers could therefore look forward to monthly premiums alone per couple equivalent to between $200 and $400 today, and total maximum annual premiums and income tax surcharges equivalent to between $8,000 and $13,000.

These financial burdens are clearly untenable. The Medicare financial burden on the elderly is already too high, and the federal budget has no room for massive growth in general revenue contributions to Medicare. The payroll tax burden on workers also is already too high. The maximum total payroll tax for an individual worker, including the employer's share, is $7,209 this year, and it will continue to grow each year indefinitely. By 1990 the payroll tax will be generating 80 percent as much revenue as the personal income tax. Few have noticed the heavy burden that the sharply increased payroll tax now places on low-income jobs. A married worker with two children earning below-poverty wages of $10,000 this year will pay $751 in payroll taxes, with another $751 from his employer (which probably comes out of the worker's earning capacity as well), for a total tax burden of $1,502 on this worker's low-income job.

The payroll tax is essentially a tax on jobs, and here, as elsewhere, the result of taxing something is that there is less of it. A study by the Congressional Budget Office estimated that the payroll tax rate increases from 1979 to 1982 would produce a loss of 500,000 jobs by 1982.[12] Another study recently estimated that the payroll tax rate increases from 1985 to 1990 would eliminate another one-half million jobs and ultimately reduce GNP by as much as $25 billion per year.[13] In a society deeply concerned with employment opportunities, the current payroll tax burden on employment is ludicrous.

Medicare is quite simply deteriorating into a fiasco. Long-term fundamental reform is clearly needed. In the last Congress, Rep. French Slaughter (R-Va.), along with 40 bipartisan cosponsors, offered such reform, carefully tailored to address all of the major problems in health care for the elderly today.

Their proposal would allow workers and their employers to contribute to individual Health Care Savings Accounts (HCSAs) for each worker up to the amount of employer/employee Medicare payroll taxes for that worker. Contributors would an income tax credit equal to 60 percent of the amounts paid into the accounts. The contributions and investment would accumulate tax-free until retirement. To the extent each worker chose to utilize this option during his or her working years, an added Medicare deductible would apply to that worker in retirement, leaving him responsible for payment of more of his initial medical costs each year. Someone who exercised the option for a few years before retirement would bear a relatively small added deductible. The retired worker would then use the HCSA funds to purchase insurance covering medical expenses below the added deductible or to pay such expenses directly.

The proposal is designed so that by retirement workers would likely have accumulated more than enough in their accounts to cover private insurance for the increased deductible. They could then use the excess for long-term care or other expenses not covered by Medicare, or to supplement retirement income. In addition, if a retiree were to spend less than a specified proportion of HCSA funds on medical expenses each year, he or she could withdraw the difference at the end of the year for any purpose.

Workers and employers who contributed to HCSAs would continue to pay their Medicare payroll taxes in full. But the income tax credits for HCSA contributions are designed to offset these taxes, and in effect give workers their tax money back to the extent they choose to rely on their private HCSA funds rather than on Medicare. Because the credits are taken against income taxes rather than payroll taxes, Medicare payroll tax revenues would not be reduced. They would continue be fully available to finance benefits for today's elderly. As a result, the HCSA option would sharply reduce and potentially eliminate the long-term financing problem of Medicare. While Medicare payroll tax revenues would be maintained, the added deductible resulting from the exercise of the HCSA option would sharply reduce the program's expenditures over the long run. With revenues maintained and expenditures reduced, the long-term Medicare financing gap would shrink.

The HCSA option would also strengthen the market incentives needed to counter rapidly rising health costs. Those exercising the private option would purchase medical care and coverage with funds from their own private accounts. The less they spent from those accounts the more they would retain to pay for future expenses, to supplement their retirement income, or to leave to children or other heirs. Consumers with such accounts would, therefore, be likely to devote far greater efforts to shopping for the lowest-cost service. They would be far more likely to seek care and coverage through HMOs or insurers with networks of assigned doctors who follow efficient and low-cost practices, or through insurers who otherwise are able to pressure service providers into keeping costs down. Consumers also would be more likely to favor low-cost insurance covering only large unexpected costs, keeping control over their own funds and costs for more routine expenses. Moreover, consumers with these accounts would have greater financial incentive to devote more attention to preventive measures that would save medical costs over the long run.

Increased competition would complement these consumer incentives because Medicare would no longer have a monopoly on medical coverage for the elderly. Private insurers and medical care providers would be able to compete to provide the coverage that Medicare now preempts. This competition and the heightened cost awareness by consumers with HCSAs would further increase market pressure on health care providers to develop less-costly services, treatments, and medical technologies. Insurers as well would face increased market pressures to develop and extend innovative institutional arrangements to keep costs down.

HCSAs could, therefore, strongly counter rapidly rising health costs without undermining the quality of care. Indeed, the increased competition resulting from HCSAs might improve the quality of care.

Rather than impose increasingly costly financial burdens on the elderly, HCSAs offer the prospect of making the elderly substantially better off, which Medicare seems to have failed to do. Through accumulation of the returns to HCSA funds during working years and the savings resulting from improved incentives, retirees would likely have additional funds to finance medical expenses not covered by Medicare or to supplement retirement income. These

additional funds could in particular finance coverage for nursing home services or home health care, or help to pay such expenses directly.

Ultimately, HCSAs would greatly increase freedom of choice of the elderly and control over their own funds. They could each choose the pattern and type of health care coverage that best suits their personal needs and preferences. They could exercise more direct control over expenses and pursue alternatives for minimizing those costs. They could choose to spend less on marginal medical care and more on other priorities. They could indeed choose how much to rely on Medicare and how much to rely on private insurance. Those workers who preferred to rely entirely on Medicare for their retirement and forgo the HCSA option completely would be free to do so. Moreover, there would be absolutely no cuts in Medicare benefits for the elderly. Indeed, the strengthened financial prospects of Medicare resulting from the HCSAs would benefit everyone relying on the program.

The HCSA income tax credits would result in some substantial loss of income tax revenue, depending on the degree to which workers exercised the option over the years. Initially, the revenue loss would likely be $5 to $10 billion per year. Over the long run this revenue loss would be offset by reduced Medicare spending as retirees relied less on the program and more on their HCSAs. In the interim there should be increased savings through the HCSAs at least equal to the amount of revenue loss, so there would be no net increase in the government borrowing drain on private savings, which is the real concern behind the deficit. Such borrowing in any event would be nothing more than an explicit recognition of the implicit debt that already exists in the unfunded liabilities of Medicare. To the extent the temporary net revenue loss was financed by means other than borrowing, such as reductions in government spending, sales of underutilized government assets, or new revenues, total savings would be increased, enhancing economic growth and increasing national wealth. The increase in savings would result in increased revenues from taxes on the investment returns to such new capital, particularly through the corporate income tax. This increased revenue would combine with the Medicare spending reductions resulting from the HCSAs option, offsetting the initial net revenue loss more quickly.

Conclusion

The Medicare status quo is not working. The program seems to have failed to make the elderly better off than they were when it was adopted and has itself become an increasing financial burden on retirees through its premiums and taxes. The new Medicare income tax surcharge on retirees going into effect this year will raise marginal tax rates for the elderly substantially above the rates for everyone else, reversing tax reform for those over 65. Instead, the surcharge is indexed to increase marginal income tax rates on the elderly each year indefinitely. Meanwhile, increasingly burdensome and complex Medicare payment regulations designed to counter rapidly rising costs threaten the quality of care the elderly receive under the program.

The Medicare premiums and income tax surcharge should be abolished and Medicare benefits restructured to offset the revenue loss. This would provide major tax relief to the elderly, restoring to them the promise of tax reform with the same marginal income tax rates as everyone else. Such reform would also be good health policy, introducing market incentives to counter rapidly rising health costs while maintaining important catastrophic benefits. This reform would allow the elderly greater choice and control over their own funds and the opportunity for substantial savings overall.

More fundamental long-term reform is needed to address the overwhelming problems of the system. Through the proposed Health Care Savings Accounts, the program's dramatic long-term financing gap can be eliminated by inducing workers to rely more on private savings and insurance and less on Medicare. Such reform would as a result avoid the soaring, untenable tax increases on both young and old or the draconian benefit cuts that would otherwise be necessary. It offers the prospect of making the elderly substantially better off overall, enabling workers to accumulate additional funds to finance long-term care or other expenses not covered by Medicare or to supplement retirement income. It would also powerfully extend market incentives and competition to counter rapidly rising health care costs without threatening the quality of care. Through the HCSA option, the elderly would ultimately have much greater freedom of choice and control over their own funds. Such an attractive long-term reform deserves the active support of the most ardent advocates of elderly.

Footnotes

[1] Current law provides that the income tax surcharge rate cannot increase by more than one percentage point per year

after 1993. This would still be a significant annual increase. But, in addition, it will probably not be sufficient to finance rising benefit costs. In that event, the monthly premiums are to be raised more rapidly to cover the benefit payments. But this would lead to such a heavy burden on modest income retirees that it probably will not be carried out. The income tax surcharge is likely to be increased more rapidly instead, unless promised benefits are cut.

[2] See Harvard Medicare Project, Division of Health Policy Research and Education, Center for Health Policy and Manage- ment, Medicare: Coming of Age (Cambridge, Mass.: Harvard Uni- versity, Center for Health Policy and Management, 1986), p. l; Aldona Robbins and William E. Hurwitz, "Catastrophic Health Insurance Is Bad Medicine," Economic Policy Bulletin, no. 26, Institute for Research on the Economics of Taxation, Washing ton, March 18, 1987, p. 3.

[3] Before enactment of these new benefits, Medicare paid about 45 percent of the medical costs of retirees. Donald R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the U.S.: 1977-1984," Health Care Financing Review (Fall 1984), Table 13; Statement of Nancy M. Gordon, assistant director for human resources and community development, Congressional Budget Office, before the Subcommittee on Health and the Environment, Committee on Energy and Commerce (March 26, 1986), p. 13.

[4] See, for instance, The Effects of PPS on Ouality of Care for Medicare Patients: Hearings Before the Special Committee on Aging, 99th Cong., 2d sess., Ouality of Care Under Medicare's Prospective Payment System: Hearings Before the Special Senate Committee on Aging, 99th Cong., 2d sess., 1985; "Impact of Medicare's Prospective Payment System on Quality of Care Received by Medicare Beneficiaries," Staff of the Special Committee on Aging, 99th Cong., 2d Sess., 1985; Robbins and Hurwitz, pp. 3-4.

[5] See, for instance, "CBS Evening News," November 27, 1988.

[6] 1988 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, Washington, May 1, 1988 (here- after 1988 HI Trustees' Report), Alternative IIB projections.

[7] Ibid.

[8] The long-term gap for Part A under these assumptions is 2.30 percent of taxable payroll. 1988 HI Trustee's Report, Table 9. The 1983 social security amendments reduced the long-term gap for that program by 2.09 percent of taxable payroll under intermediate assumptions. 1983 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Washington, June 1983 (hereafter "1983 OASDI Trustees' Report").

[9] 1988 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Washington, May 1, 1988 (hereafter "1988 OASDI Trustees' Report"), Table E3.

[10] The long-term gap for Part A under these projections is 6.63 percent of taxable payroll. 1988 HI Trustees' Report, Table 9. The 1983 social security amendments reduced the long-term gap for that program by about 3.2 percent of taxable payroll under pessimistic projections. 1983 OASDI Trustees' Report.

[11] 1988 OASDI Trustees' Report, Table E3.

[12] Congressional Budget Office, "Aggregate Economic Effects of Changes in Social Security Taxes," Washington, August, 1978.

[13] Aldona Robbins and Gary Robbins, "Effects of the 1988 and 1990 Social Security Tax Increases," Economic Report no. 39, Institute for Research on the Economics of Taxation, Washington, February 3, 1988.