1988

Medicare and the Private Sector

Peter J. Ferrara

Follow this and additional works at: https://digitalcommons.law.yale.edu/ylpr

Part of the Law Commons

Recommended Citation
Available at: https://digitalcommons.law.yale.edu/ylpr/vol6/iss1/5

This Article is brought to you for free and open access by Yale Law School Legal Scholarship Repository. It has been accepted for inclusion in Yale Law & Policy Review by an authorized editor of Yale Law School Legal Scholarship Repository. For more information, please contact julian.aiken@yale.edu.
So long as Medicare manages to pay its bills, the program may seem to be working. But just under the surface, Medicare is badly in disarray. The program faces dramatic long-term financing problems that threaten to create untenable payroll tax burdens for workers or draconian benefit reductions for retirees. The program's benefit structure includes broad gaps that leave the elderly unprotected from high medical expenses and resulting financial ruin. Yet payroll taxes are already too high, reducing employment and economic growth. To counter the program's rapidly rising costs, new regulatory burdens have been imposed on Medicare-financed services. But these burdens are producing a decline in the quality of care for the elderly, and threaten to deprive doctors of professional freedoms and authority central to the American medical system. Consequently fundamental reform of Medicare seems long overdue.

Congress adopted Medicare in 1965 as part of the Great Society reforms, and the program became effective on July 1, 1966.1 As enacted, Medicare provided coverage for hospital and medical care primarily for persons aged 65 and over who received Social Security retirement benefits.2 In 1973, Congress expanded the program to provide full Medicare benefits to those under 65 receiving disability benefits for at least two years.3 In 1982, federal employees were required to participate in the program, and in 1983 employees of nonprofit organizations were required to participate as well.4 In 1983, to counter rapidly rising Medicare costs, Congress adopted the Prospective Payment System (PPS) to pay doctors and hospitals under the program,5 as discussed below. Otherwise, the structure and coverage of the program has remained fundamentally the same since its adoption.

* Mr. Ferrara is Associate Professor of Law at the George Mason School of Law and the John M. Olin Distinguished Fellow at the Heritage Foundation.

2. Id.
3. Id.
4. Id.
5. Id.
In fiscal year (FY) 1967, total Medicare net expenditures over and above the premiums paid by the elderly amounted to $2.7 billion. By FY 1970, the program's net expenditures had soared to $6.2 billion, already far exceeding original cost estimates. The program's expenditures have continued to grow rapidly, at least doubling every five years. In FY 1988, net Medicare expenditures are projected to total about $80 billion, approximately 8% of the entire federal budget.

Today, Medicare covers about 28 million people over age 65 and about three million disabled beneficiaries under 65. About 94% of the elderly are now covered by the program. Medicare has become much too large a factor in our economic and social life to remain in such disorder.

This Article will argue that the deep problems of Medicare all could be addressed fruitfully by expanding the role of the private sector in providing health care coverage. Workers and their employers could be allowed to contribute to individual investment accounts, "health IRAs," during working years. In retirement, such accounts would then serve as a reserve of savings and health insurance to cover more routine medical expenses in place of Medicare. Those exercising this private option would still receive coverage through Medicare for catastrophic expenses. The public sector would continue to provide full Medicare coverage for those who may not choose the private option. Government would also provide health coverage to those in need who, because of inconsistent work histories or other reasons, were unable to develop adequate retirement health coverage through the joint private/public systems.


7. 1987 HI Trustees' Rep., supra note 6, at Table 5; 1987 SMI Trustees' Rep., supra note 6, at Table 5.

8. 1987 HI Trustees' Rep., supra note 6, at Table 5; 1987 SMI Trustees' Rep., supra note 6, at Table 5.

9. 1987 HI Trustees' Rep., supra note 6, at Table 5; 1987 SMI Trustees' Rep., supra note 6, at Table 5. The federal budget for fiscal year (FY) 1988 is currently projected to be $1,024.3 billion. Off. of Mgmt. and Budget, Exec. Off. of the President, Budget of the United States Government, 1988, M-4.


11. In 1984, about 26.6 million elderly people in the U.S. were covered by Medicare. Annual Statistical Supp., supra note 1, at Table 148. In that year, the elderly population in the U.S. was about 28.3 million, as calculated from 1987 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Table A1 (1987) [hereinafter 1987 OASDI Trustees' Rep.].
Medicare and the Private Sector

fact, bipartisan legislation has been introduced in Congress to provide for just such reform.\footnote{12}

The analysis will begin with a brief review of the current Medicare system and an examination of the program’s serious problems. Next, the Article will review and analyze pending federal legislation designed to provide catastrophic coverage under the program and add new taxes. Finally, the private sector option, which proposes to cover routine medical expenses with private health care accounts, will be analyzed.

I. The Current Medicare System

Medicare consists of two components—Part A, or hospital insurance (HI), and Part B, or supplemental medical insurance (SMI).\footnote{13} Part A pays for the first 60 days of hospital care for each spell of illness, subject to a deductible that currently requires the patient to pay the first $540 in hospital expenses.\footnote{14} An illness is considered “over” when the patient has spent 60 consecutive days out of the hospital. Consequently, if the patient reenters the hospital after being out for 60 days, Part A will pay for another 60 days of care, subject to another deductible of $540.

Part A will continue to pay for up to 90 days of hospital care for each spell of illness, but after the first 60 days the patient must pay part of the cost each day in a “co-insurance fee.” Currently this co-insurance fee for the 61st to 90th day of hospital care is $135 per day.\footnote{15} For hospital stays beyond 90 days, Part A pays for 60 additional “lifetime reserve days” once during the life of each beneficiary. The patient must pay a co-insurance fee, currently $270, for each of these lifetime reserve days.\footnote{16} Overall, therefore, Medicare provides coverage for up to 150 days of hospital care for each spell of illness, or up to 90 days after lifetime reserve days are used.

Only about 0.5% of all Medicare beneficiaries each year stay in the hospital for between 61 and 90 days. Only about 0.2% experience a hospital stay of more than 90 days and thus use some lifetime reserve days. Running out of lifetime reserve days and exceeding the Medicare coverage limit altogether is extremely rare. Only

\footnote{13} For sources describing the current Medicare system, see Annual Statistical Supp., supra note 1, at 36-40; Health Care Financing Admin., U.S. Dep’t of Health and Human Services, Your Medicare Handbook (1987).
\footnote{15} Id.
\footnote{16} Id.
about 2,000 Medicare beneficiaries, about 0.007% of the Medicare population, do so each year.\textsuperscript{17}

Part A also pays for up to 100 days of care in a skilled nursing facility after discharge from a hospital. After the first 20 days of such care, the patient must pay a co-insurance fee each day currently equal to $67.50 daily.\textsuperscript{18} Part A covers unlimited home health care visits, prescribed by a doctor, to provide skilled nursing care, physical therapy, or speech therapy to those who are confined to their homes. Part A also provides up to 210 days of hospice care for the terminally ill. All Part A deductibles and co-insurance fees are currently indexed to increase each year with rising hospital costs.

Part A coverage is financed through an earmarked portion of the Social Security payroll tax; the HI payroll tax rate is 2.9% split between employee and employer.\textsuperscript{19} This tax is assessed on the employee's wage income up to an annual maximum of $45,000 in 1988. The wage cap is indexed to increase each year with average earnings.\textsuperscript{20} With certain narrow, well-defined exceptions, general revenues may not be used to finance Part A benefits, and the program must rely primarily on payroll tax revenues for funds.

Medicare Part B pays for services by physicians, surgeons, therapists, chiropractors, anesthesiologists, pathologists, radiologists, and psychiatrists; it also covers diagnostic tests, certain medical supplies and equipment, and services related to home health care visits. The beneficiary pays for the first $75 in expenses each year under the deductible for Part B, which is fixed by statute. Part B pays for 80% of remaining charges, unless such charges exceed the maximum approved fees for the services under a schedule maintained by Medicare, in which case Part B will pay only 80% of the maximum approved fees. The beneficiary pays 20% of approved charges as a co-insurance fee and 100% of charges above the Medicare maximums. About 30-50% of Medicare claims each year include doctors' charges above the Medicare set fees.\textsuperscript{21}

Part B is financed in part by a current monthly premium of $24.80,\textsuperscript{22} about $300 per year, paid by each elderly beneficiary.

\textsuperscript{17} Robbins & Hurwitz, Catastrophic Health Insurance is Bad Medicine, Econ. Pol'y Bull. No. 26, 3 (1987) [hereinafter Robbins & Hurwitz].
\textsuperscript{19} 1987 HI Trustees' Rep., supra note 6, at 2-3.
\textsuperscript{21} McMenamin, Mandatory and Other Medicare Assignment Issues and Options, Health Industry Mfrs. Ass'n 6, (Aug. 9, 1987).
\textsuperscript{22} 52 Fed. Reg. 36716-17 (1987).
Medicare and the Private Sector

These premiums cover about 25% of program costs. General revenues finance remaining expenditures. The Part B premium has recently been indexed under law to increase sufficiently each year to finance 25% of projected program costs. But this is not a permanent provision, and Congress may instead index the premium to increase each year with health costs or general inflation.

Neither Part A nor Part B covers long-term care in nursing homes or other institutions. The costs of such care generally are financed from the personal resources of the elderly or their families, or through Medicaid. Medicare also does not cover outpatient prescription drugs, dental care, eyeglasses, hearing aids, and similar items. Most of the elderly have private medical coverage that supplements Medicare. As generally mandated by state regulatory requirements, this insurance covers the Part A hospital co-insurance fee and 90% of the costs for 365 days of hospital care beyond the Medicare limits. As a practical matter, virtually no one ever exceeds this 365-day limit, and many policies simply provide for unlimited hospital coverage. The private insurance also is required to cover the Part B 20% co-insurance fee, after an annual deductible of $200, up to $5,000 per year. Such insurance, plus Medicare, provides coverage of $25,000 per person for Part B expenses, and such health care expenses almost never exceed this amount. Accordingly, some policies cover the Part B co-insurance fees without any annual caps.

About three-fourths of the elderly have such coverage through private insurance or Health Maintenance Organizations (HMOs). 

---

23. 1987 SMI Trustees’ Rep., supra note 6, at Table 5.
24. Medicaid is a means-tested program financed out of general revenues. It pays for all health care expenses of the elderly who have low incomes and little or no saved resources. It also provides health benefits for many of the poor below age 65.
25. About 72% of the elderly have private insurance either purchased directly or paid for by their former employers as part of pension benefits. Robbins & Hurwitz, supra note 17, at 5.
27. About 72% of the elderly have private insurance; see supra note 25. And as of November 1987, another 990,229 elderly persons received much of their medical coverage from HMOs. A recent initiative allows retirees to choose to have their Medicare benefits provided by an HMO. The federal government pays the HMO the average expenditure per beneficiary under Medicare. Federal law also requires the HMO to use some of its net profits to provide supplemental medical benefits to the participating elderly, and HMOs now compete to attract elderly customers by offering such supplemental benefits. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 114, 96 Stat. 329, 341-53 (1982); 42 C.F.R. § 417 (1986); Health Care Financing Admin., TEFRA Risk HMOs/CMPs (Nov. 1, 1987). About 3% of the elderly, consequently,
Another 10% of the elderly are covered for such benefits through Medicaid.\textsuperscript{28} Those with this coverage are protected against catastrophic expenses for acute care, although catastrophic expenses for long-term nursing home care still are not covered for those ineligible for Medicaid. Private insurance is available for nursing home care, prescription drugs, doctor’s charges above the Medicare approved fees, dental care, and other items, although most of the elderly have not purchased such coverage.

\section{II. The Imperative for Reform}

Based on the latest set of annual reports for the Medicare program,\textsuperscript{29} Medicare Part A is unlikely to be able to pay its promised benefits by about the end of the next decade. Under the most widely cited intermediate projections in the reports, Part A will run short of funds by 2002.\textsuperscript{30} Under the so-called pessimistic projections, the program will run short by 1996.\textsuperscript{31}

Moreover, the program's projected financial gap grows wider over the long term. Under 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 emergency 1983 legislation to save that system from bankruptcy.\textsuperscript{32}

By the time those entering the work force today retire, payroll tax

\textsuperscript{28} Annual Statistical Supp., supra note 1, at Table 162, shows 3.1 million Medicaid recipients 65 and over currently live in the U.S. Estimated from 1987 OASDI Trustees' Rep., supra note 11, at Table A1.

\textsuperscript{29} See generally 1987 HI Trustees' Rep., supra note 6; 1987 SMI Trustees' Rep., supra note 6.

\textsuperscript{30} 1987 HI Trustees' Rep., supra note 6, at Table 11.

\textsuperscript{31} Id. The pessimistic projections generally assume an economic performance similar to the experience of the 1970s, with periodic recessions and sustained inflation. The intermediate projections assume more sustained economic growth and lower inflation. Demographically, the intermediate projections assume an increase in fertility, which means more workers in the future paying taxes into the system, and a slowdown in the rate of increase in life expectancy, which means fewer beneficiaries in the future to collect benefits. The pessimistic projections assume a decline in fertility and a sustained improvement in the rate of increase in life expectancy. These demographic assumptions make little difference in the short term, but have a dominant influence on the outlook for the system over the long run.

\textsuperscript{32} The long-term gap for Part A, or HI, under the intermediate assumptions is 2.30\% of taxable payroll. 1987 HI Trustees' Rep., supra note 6, at Table II. The 1983 Social Security amendments reduced the long-term gap for that program by 2.09\% of taxable payroll. 1983 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds (1983) [hereinafter 1983 OASDI Trustees' Rep.].
Medicare and the Private Sector

revenues under these projections would be sufficient to pay only 43% of promised Part A benefits.\footnote{33} Paying all such benefits for workers entering the labor force today would require a 130% increase in the total Medicare payroll tax rate, from a 2.9% rate today on employers and employees combined to a rate of 6.7% in 2040.\footnote{34} By comparison, the combined employer/employee tax rate for all other components of Social Security was only 11.4% in 1987.\footnote{35}

Under the pessimistic projections, the long-term financing gap for Medicare Part A is over twice as large as the long-term deficit reduction provided for all of Social Security in the 1983 legislation.\footnote{36} Under such projections, current payroll taxes would be sufficient to pay only 21% of promised Part A benefits for workers entering the labor force today.\footnote{37} Paying all benefits to these workers would require an increase of almost 400% in the total Medicare payroll tax rate, from 2.9% to 13.6%.\footnote{38} The payroll tax rate for Medicare Part A alone would be higher then than the total tax rate for all of Social Security today.\footnote{39}

And these figures do not tell the whole story. The long-term projections for Medicare Part A imply that equivalent fiscal difficulties will face Part B.\footnote{40} The required increase of 130% to 400% in Medicare payroll tax rates discussed above suggests that general revenue

\footnote{33. Under these projections, in 2040, the total cost of the HI program will be 6.73% of taxable payroll. 1987 OASDI Trustees' Rep., \textit{supra} note 11, at Table E3. The total HI payroll tax rate on employer and employee is 2.9%, as noted, amounting to 43% of the projected cost rate.}

\footnote{34. \textit{Id.}}

\footnote{35. The total combined payroll tax rate for employers and employees for the Old-Age, Survivors and Disability Insurance programs (OASDI) is 11.4% for 1987. This tax rate will be increased under current law to 12.12% in 1988. 1987 OASDI Trustees' Rep., \textit{supra} note 11, at Table 1.}

\footnote{36. The long-term gap for Part A, or HI, under the pessimistic assumptions is 6.65% of taxable payroll. 1987 HI Trustee's Rep., \textit{supra} note 6, at Table II. The 1983 Social Security amendments reduced the long-term gap for that program by about 3.2% of taxable payroll. Calculated from 1982 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds 70 (1982) and 1983 OASDI Trustees' Rep., \textit{supra} note 30, at 80-81.}

\footnote{37. In 2040, the total cost of the HI program will be 13.59% of taxable payroll. 1987 OASDI Trustees' Rep., \textit{supra} note 11, at Table E3. The total HI payroll tax rate on employer and employee is 2.9%, amounting to 21% of the projected cost rate.}

\footnote{38. \textit{Id.}}

\footnote{39. See note 33.}

\footnote{40. Since Part B is financed mostly by general revenues rather than an earmarked payroll tax, technically it cannot run short of funds to pay benefits. Congress is expected to appropriate whatever general revenue contributions are needed to pay benefits. Consequently, the federal government does not publish regular long-term projections of the financial outlook for Part B. But the discussion above indicates that long-term financial burdens on the general taxpayer and the elderly may be expected under the current system.}
contributions to Medicare Part B also will have to increase by 130% to 400% in order to pay all promised benefits to workers now entering the labor force. With current general revenue contributions at $25 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 of $60 to $125 billion in today's terms. In addition, annual Part B premiums paid by the elderly would have to increase by 130% to 400%.

None of the program's revenue sources—payroll taxes, general revenue contributions, or premiums on the elderly—are promising candidates for providing increased revenues to meet future program costs. Indeed, payroll taxes are already far too high. Total Social Security and Medicare payroll taxes for an individual worker, including the employer's share, can be as high as $6,759 in 1988. With the payroll tax rate increases scheduled under current law, the maximum annual payroll tax is projected to reach $7,574 by 1990. This figure compares with a maximum total payroll tax of $348 in 1965, $189 in 1958, and $60 in 1949. The total payroll tax for average workers has soared from 2.0% of income in 1949 to 4.5% in 1958, 7.25% in 1965, and 15.02% in 1988. For most workers, the total employer/employee payroll tax is more than each pays in federal income tax. Indeed, the payroll tax is now approaching the personal income tax in total amount of revenues generated. By

41. 1987 SMI Trustees' Rep., supra note 6, at Table 5.
42. The total payroll tax rate for 1988 is 15.02%. 1987 OASDI Trustees' Rep., supra note 11, at Table 1; 1987 HI Trustees' Rep., supra note 6, at Table I. With a maximum taxable income for the year of $45,000 (see supra note 20), this means the maximum annual tax for an individual worker, including both the employer and employee shares, is $6,759.
43. The total payroll tax rate for 1990 will be 15.3%. 1987 OASDI Trustees' Rep., supra note 11, at 1; 1987 HI Trustees' Rep., supra note 6, at Table I. Under intermediate assumptions (Alternative IIb projections), the maximum taxable income in 1990 will be $49,500, making the maximum tax for the year $7,573.50. 1987 OASDI Trustees' Rep., supra, at 39.
44. P. Ferrara, Social Security: The Inherent Contradiction, Table 2 (1980).
45. Calculated from 1987 OASDI Trustees' Rep., supra note 11, at Table 1; 1987 HI Trustees' Rep., supra note 6, at Table I.
46. The total payroll tax rate for 1988, including employee and employer shares, is 15.02%; see supra note 40. Under the new tax reform legislation, 80% of workers either have no income tax liability or are in the 15% tax bracket. S. Rep. No. 99-313, 99th Cong., 2d Sess. 36 (1986). Moreover, income taxes are reduced by the standard deduction and personal exemptions, while payroll taxes are not. So for the great majority of workers, total payroll taxes, including employer and employee shares, are greater than individual income tax liability.
Medicare and the Private Sector

FY 1990, the payroll tax is projected to raise $358 billion, compared with the $450 billion raised by the personal income tax.\(^47\)

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, for a total payroll tax burden of $1,502 on this worker's low-income job.\(^48\) Since the payroll tax is basically a tax on the act of employment, this huge tax burden limits employment opportunities for the unskilled.\(^49\) The tax discourages employers from hiring and discourages workers on the margin from working as much as otherwise, since the return from such work is reduced. The overall result is fewer jobs and reduced economic growth. Here, as in other sectors of the economy, 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 produced a loss of 500,000 jobs per year by 1982.\(^50\) In another study, Robbins estimated that the payroll tax rate increases from 1985 to 1990 would eliminate as many as 900,000 U.S. jobs and ultimately reduce gross national product by as much as $25 billion per year.\(^51\) In a


\(^{48}\) With a total payroll tax rate for 1988 equal to 15.02% split between employee and employer, the payroll tax liability on $10,000 in income would be $751 each for the employee and the employer. See supra note 40.

\(^{49}\) In theory, the payroll tax could be changed to make it progressive, reducing the tax burden on lower-income workers and increasing it on higher-income workers, and focusing any future increases on higher-income workers as well. But this would fundamentally change the nature of the Social Security and Medicare systems, which are supposed to be contributing systems in which workers and their employers generally finance their own benefits. Consequently, such a change has not been considered a policy option in the past.

Moreover, avoiding a major increase on average-income workers through such progressive restructuring would require a dramatic tax increase on the relatively small number of higher-income workers, quite possibly requiring intractable payroll tax rates of 50% or more on such workers, considering needed future tax increases. This progressive restructuring and the associated higher marginal tax rates on average- and/or higher-income workers would also be contrary to the recent trend of federal tax policy, which has been to reduce and flatten marginal tax rates.


\(^{51}\) Robbins, Social Security: At What Price? 6-7 (1986) (on file with author). The total combined employer/employee payroll tax rate increased from 14.0% in 1984 to 14.10% in 1985, 14.3% in 1986, 15.02% in 1988, and is scheduled to increase to 15.3% in 1990. 1987 OASDI Trustees’ Rep., supra note 11, at Table 1; 1987 HI Trustees' Rep., supra note 6, at Table 1.
more recent study, Robbins and Robbins estimated that the payroll tax rate increases in 1988 and 1990 would eliminate 500,000 jobs per year.\textsuperscript{52}

In a society deeply concerned about employment opportunities, the growing payroll tax burden on employment is already intolerable. Yet without fundamental reform of Medicare, the future holds further major payroll tax increases, unless the program's benefits are cut sharply.

Yet current Medicare benefits already are inadequate to protect the elderly from financially ruinous medical expenses. For basic hospital coverage, the Medicare Part A deductible and co-insurance fees can add up to almost $21,000 for a single hospital stay,\textsuperscript{53} excluding the costs of the 20% Part B co-insurance fee for physician services, inpatient drugs, special tests, therapy, and other treatment services. Medicare coverage also runs out altogether after a certain number of hospital days. Moreover, the program provides no significant coverage for long-term, intermediate, or custodial care in nursing homes or other settings. Yet long-term nursing home expenses, which averaged almost $18,000 per year for basic care in 1985, can rapidly deplete the life savings of most elderly.\textsuperscript{54} Medicare also does not pay for doctors' charges above maximum set fees, leaving the elderly to pick up the difference when doctors charge more, as many do. Also, as noted above, the program does not provide coverage for dental care, hearing aids, eyeglasses, outpatient prescription drugs, walking aids, and similar items.

As a result of these many gaps in the program's benefit structure, Medicare currently pays for only about 45% of the medical expenses of retirees.\textsuperscript{55} Indeed, the elderly pay as much or more of

\textsuperscript{52} Robbins & Robbins, The Effects of 1988 and 1990 Social Security Tax Increases (forthcoming in IRET Econ. Rep.). The total combined employer/employee payroll tax rate increased from 14.3% in 1987 to 15.02% in 1988, and is scheduled to increase to 15.3% in 1990. 1987 OASDI Trustees' Rep., supra note 11, at Table 1; 1987 HI Trustees' Rep., supra note 6, at Table 1.

\textsuperscript{53} Calculated as follows: the Part A deductible of $540, the $135 per day co-insurance fee for the 61st to 90th days of hospitalization, and the $270 co-insurance fee for each lifetime reserve day.

\textsuperscript{54} The average per diem rate for intermediate nursing home care in 1985 was $48.09 per day, amounting to $17,552.85 per year. Strahan, Nursing Home Characteristics, Preliminary Data from the 1985 National Nursing Home Survey, Nat'l Center for Health Statistics, No. 131, 7 (1987).

Medicare and the Private Sector

their income for medical expenses as they did before Medicare was adopted. Moreover, from the perspective of the elderly, the priorities of the Medicare benefit structure are inverted. The chief concern of the elderly is coverage for necessary but financially overwhelming "catastrophic expenses," such as those arising from long hospital and nursing home stays. But Medicare does not consistently provide such catastrophic coverage. The program's coverage is instead heavily skewed toward more routine and less threatening costs that nevertheless add up to a heavy financial burden on the federal government.

In an attempt to control spiraling Medicare costs and reduce waste and inefficiency, the government adopted the Prospective Payment System (PPS) in 1983 for payment of hospital services under Medicare. Under PPS, the government has classified illnesses requiring hospital treatment into almost 500 categories, and set the amount it will pay under Medicare in each locality for treatment of illness in each category. The set fees are based on an average of local hospital charges for treating each illness. If the hospital can treat the patient for less, 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.

The idea was to give hospitals new incentives to reduce costs and improve efficiency. But actually, the PPS seems to create powerful incentives for hospitals to take short cuts and to shortchange medical consumers in quality of care. The hospital can maximize income by processing patients as quickly and cheaply as possible. Even if patients want to pay more for less hurried service and more personal attention, they are prohibited from doing so. Under PPS, the hospital cannot accept extra payments from the patient for services covered by Medicare. Indeed, once the 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 expenses the hospital incurs for treatment in effect come out of its own pocket. Consequently, services provided during each hospital stay tend to be minimized, and hospitals may discharge patients sooner

56. See, e.g., Harvard Medicare Project, Div. of Health Pol'y Res. and Educ., Center for Health Pol'y and Mgmt., Medicare: Coming of Age 1 (1986). Robbins & Hurwitz, supra note 17, at 5.
57. See supra text accompanying notes 53-55.
than objective medical judgment would suggest. Patients who are slow to respond to treatment may find themselves icily classified as hopeless in a somewhat peremptory fashion. Media reports and Congressional hearings have in fact already begun to echo complaints of early hospital exits and other forms of inadequate treatment attributable to the new payment system.59

For those hospitals whose legitimate, unavoidable costs are above the payments set by the government, the system effectively operates as price controls. Indeed, the whole system is headed in this direction; the government has started to adopt freezes on the set fees while the fees and illness categories already have become outdated and ill-suited to varying local conditions. Such price controls naturally tend to reduce the quality and supply of care provided under Medicare.

As a result of this regulation, hospital bureaucracies, peer review groups, and government auditors are effectively imposing more detailed, centralized restrictions on the medical treatments doctors can choose to provide, and engaging in more bureaucratic second-guessing of the choices doctors are allowed to make. Hospital bureaucracies are now much less willing to allow doctors to freely pursue their medical judgment because of concern over whether reimbursement can be collected under PPS. Doctors in the U.S. have traditionally had the freedom and authority to choose a course of medical treatment based on their own best judgment and the preferences of the patient. Such freedom has created a highly flexible, innovative, and decentralized system of medical care. These features have in fact been central to the American medical system and may be a key factor in its generally high quality of care. The trend towards more centralized restrictions and bureaucratic second-guessing is undermining those features, again resulting in a reduced quality of care for the elderly under Medicare.

Overall, therefore, Medicare faces overwhelming short- and long-term financing problems that must be addressed. Doing so within the confines of the present system would require either dramatic payroll tax increases or draconian benefit reductions. Yet, payroll

59. See, e.g., The Effects of PPS on Quality of Care for Medicare Patients: Hearings Before the Special Comm. on Aging, 99th Cong., 2nd Sess. (1986); Quality of Care under Medicare's Prospective Payment System: Hearings Before the Special Senate Comm. on Aging, 99th Cong., 2nd Sess. 313-37 (1985); Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries. Staff of the Special Comm. on Aging, 99th Cong., 2nd Sess. (1985). See also Robbins & Hurwitz, supra note 17, at 3-4.
Medicare and the Private Sector

taxes are already so high as to reduce job opportunities, and the
program's benefits are already inadequate to protect the elderly
from high medical costs. New regulatory restrictions and payment
systems that were adopted to reduce costs now also threaten the
quality of care for the elderly. Consequently, Medicare is badly in
need of reform.

III. Pending Catastrophic Coverage Legislation

Legislation now pending before Congress seeks to provide new
catastrophic coverage under Medicare. Both the House and Senate
bills\textsuperscript{60} would provide for an unlimited number of days of hospital
coverage under Medicare and the elimination of the current co-in-
urance fees applying after 60 days. The House bill would cap the
beneficiary's liability under the Part B co-insurance fee to $1,043
per year and charge only one Part A hospital deductible per year
(currently $540), for a total $1,583 cap on Medicare deductible and
coinsurance fees in the first year. The Part B annual cap would be
indexed to increase with general inflation, while the Part A deducti-
ble would continue to be indexed to increase with hospital costs.
The Senate bill would cap both the part A deductible and Part B co-
insurance fees at $1,850 per year, indexed to increase with rising
health costs.

Both the House and Senate bills would increase coverage for care
in a skilled nursing facility to 150 days per year from the current 100
days, and eliminate the current co-insurance fees that apply after 20
days. The House bill would apply a co-insurance fee equal to 20% of
average daily approved costs for the first seven days of such care
each year. This fee would be $23.50 in 1988, compared with a daily
coincidence fee under the current law of $67.50 after 20 days of
nursing facility care.\textsuperscript{61} The Senate bill would apply a co-insurance
fee for the first 10 days of such care each year, equal to 15% of
average daily approved charges ($18.00 in 1988\textsuperscript{62}). In the Senate
but not in the House, these co-insurance fees would be subject to
the annual cap of $1,850.

Both the House and Senate bills would also provide coverage for
prescription drugs, subject to a deductible of $500 per year in the

\textsuperscript{60} H.R. 2470, 100th Cong., 1st Sess. (1987); H.R. Rep. No. 105, 100th Cong., 1st
Sess. (1987). The original Senate bill has now been superseded by H.R. 2470, 100th

\textsuperscript{61} CBO, A Comparison of House and Senate Catastrophic Bills 8 (1987).

\textsuperscript{62} Id.
House bill and $600 per year in the Senate bill (both indexed to increase with drug costs) and a co-insurance fee of 20% of drug expenses after the deductibles. These deductible and co-insurance fees would not be subject to the annual caps on costs to the beneficiary under either bill. The two bills include minor additional benefits as well, which are beyond the scope of this discussion.

Such benefits would be financed in part by a huge income tax increase exclusively on the elderly. Under the House bill, 58 supplemental tax brackets would be added to the income tax tables for the elderly, starting at an adjusted gross income of $6,000 per year. In 1989, the tax would climb to a maximum of $730 per year for single elderly taxpayers with a $14,900 income and to $1,460 per year for an elderly couple with a $29,800 income; this would be in addition to regular income tax payments. As a result of this tax increase, the 15% marginal tax rate would be increased for the elderly to 22% until the tax cap was reached.

Under the House legislation, the new taxes would automatically increase each year to meet the costs of the new Medicare expenditures. By 1992, the maximum supplemental tax would be $993 for a single elderly person and $1,986 for an elderly couple. The Treasury Department estimates that 13 years later the maximum annual supplemental tax would be $3,000-$4,000 for a single elderly person and $6,000-$8,000 for an elderly couple, in constant 1988 dollars. Along with these yearly tax increases, effective marginal tax rates on the elderly would increase each year as well. The Treasury estimates that by 1992 the 15% marginal tax rate would be increased to 25% for the elderly, up to the amount of the supplemental tax cap.

The total income tax increase on the elderly would amount to $5 billion per year to start and about $36 billion over the first five full years (1989-93). The Treasury estimates that 12 years later, the
total added income tax burden on the elderly would amount to $20 billion per year in constant 1989 dollars.\textsuperscript{69}

In addition, a new flat monthly premium for each beneficiary would be added to the monthly Part B premium to finance part of the new benefits, again automatically increasing to pay benefit costs over the years. By 1992, this extra premium is projected to be $5.70 per month.\textsuperscript{70} The regular Part B premium already increased $6.90 per month last year alone,\textsuperscript{71} and is projected to increase to $29.70 per month by 1992.\textsuperscript{72} This rise would result in a total flat monthly premium by 1992 of $35.40, or $424.80 per year for each beneficiary, in addition to the income tax increases noted above. The total income tax and Medicare premium increases for an elderly couple by 1992 could total $2,835.60.

The Senate bill would impose a similar tax increase on the elderly, based on an income tax surcharge of about 8.7\% for single persons and 17.4\% for married couples. An income tax surcharge is a flat increase in income tax liability by the percentage of the surcharge. A new flat premium of $4 per month per beneficiary also would be added to the current Part B premium in 1988. Both the income tax surcharge and new monthly premium again would be increased automatically each year to meet program costs.

The two bills are currently in conference, having passed their respective houses. Even if a version of this legislation is enacted, major gaps in the Medicare benefit structure will remain. Neither proposal offers new coverage for long-term care in nursing homes or for doctors’ charges above the Medicare-set fees. Dental care, eyeglasses, hearing aids, and similar items still would remain uncovered.

In fact, the legislation merely expands Medicare to provide coverage that a great majority of the elderly already have through other sources. The major focus of the bills is reduction of Medicare’s current deductible and co-insurance fees and coverage for additional days of hospitalization. But as noted, this is precisely the coverage that about three-fourths of the elderly already have through private

\textsuperscript{69} Mentz letter, supra note 62, at 2.
\textsuperscript{70} CBO, A Comparison of House and Senate Catastrophic Bills, supra note 59, at Table 3.
\textsuperscript{72} CBO, A Comparison of House and Senate Catastrophic Bills, supra note 59, at Table 3.
insurance and/or HMOs, and another 10% have through Medicaid.73

Outpatient prescription drugs are the one major area to which the new legislation would extend coverage not already provided to most of the elderly. But such drug expenses usually do not represent the kind of catastrophic costs that can overwhelm a family’s resources. The new drug coverage would merely provide a couple of hundred dollars per year in additional income redistribution to some Medicare recipients who happen to utilize drugs more heavily during a year. Insurance coverage for drug expenses has been available in the private sector for some time, but the elderly have chosen not to purchase it on as widespread a basis as they have coverage in other areas.74 This suggests that the elderly do not find such coverage as worthwhile as they do other types of coverage. Indeed, insurance for drugs may be undesirable since it could induce substantial and unnecessary overutilization of drugs, which are a relatively easy and painless form of medical care, but not always most appropriate.

The proposed legislation consequently imposes a harsh, discriminatory tax burden on the elderly for the wrong benefits and fails to provide benefits in the crucial areas where the elderly now have no coverage. The new tax burden would reverse tax reform for the elderly. While everyone else would enjoy a simplified tax system with just two tax brackets and relatively low marginal tax rates, the elderly would face a different system with up to 58 brackets and higher marginal rates. The legislation also does not address the long-term financial problems of the program, and indeed would make those problems worse if the new taxes fail to keep up with program costs. Nor does the legislation address the other major problems of Medicare discussed above. This legislation, therefore, fails fundamentally to reform Medicare as is necessary to address its deep problems.

IV. A Private Sector Option

A more comprehensive approach to the problems of Medicare is now pending before Congress in legislation that would create a private sector option.75 Spearheaded by Representative French Slaughter (R-Va), the legislation has 40 co-sponsors, including Democrats and Republicans.

73. See supra text accompanying notes 25-28.
74. Health Insurance Ass’n of America.
The bill would allow workers and their employers to contribute to individual Health Care Savings Accounts (HCSAs) for each worker, up to the amount of employee/employer Medicare payroll taxes. Contributors would receive an income tax credit equal to 60% of the amounts paid into the accounts. The contributions and investment returns would accumulate tax-free until retirement. Workers could not withdraw 60% of the contributions and returns before retirement, since they already would have received income tax credits for those amounts. They could withdraw the remaining 40%, however, subject to a penalty, as with a regular IRA.

To the extent each worker chose to utilize this option over his or her working years, an added annual deductible would be applied before the payment of any Medicare benefits to that worker in retirement. The added deductible would be calculated under a formula roughly determining the amount of health insurance coverage the worker would be able to buy each year with accumulated HCSA funds, given his or her record of past contributions. This calculation would assume a modest investment return earned on such contributions, equal to an average of the returns earned on federal securities (historically around 1-1.5% in real terms). Only 60% of contributions would be counted in determining the deductible, corresponding to the percentage of the tax credit the worker would receive for contributions to the HCSA. After retirement, the worker would use HCSA funds to purchase insurance covering medical expenses below the added deductible, or to pay such expenses directly.

Workers could choose to exercise the HCSA option in some years and not in others and in differing degrees each year, and their ultimate added deductible would be adjusted accordingly under the formula. The more workers contributed over their careers and the earlier they contributed, the higher their added Medicare deductibles would be because they would accumulate more in their accounts. Workers already in the workforce when the HCSA option was enacted would simply be assumed not to have exercised the option during prior working years. Consequently, they would bear an added Medicare deductible only to the extent they exercised the HCSA option during their remaining working years.

Workers exercising the HCSA option to the maximum over their entire career would bear an added Medicare deductible of several thousand dollars per year in retirement, possibly $5,000 to $10,000 or more. But they would likely have far more than enough money in
their HCSAs to finance insurance covering medical expenses below the deductible, given the deliberate design of the added deductible formula and the investment returns workers could earn on their HCSA funds over the years.\textsuperscript{76} Workers who exercised the HCSA option to a lesser degree during their working years would have proportionally lower deductibles, again with more than enough in their HCSAs to finance coverage for expenses below the deductible.

Workers who exercised the HCSA option over their careers to a minimum degree would also receive catastrophic coverage under Medicare for acute care by doctors and hospitals related to a specific illness. For these workers, Medicare would pay for unlimited days of hospital care after the added deductible was satisfied, and all co-insurance fees for hospital days covered by Medicare would be eliminated. The 20\% co-insurance charge for Medicare Part B would be subject to an annual cap of $1,000 per worker. HCSA funds also could be used to finance long-term care in nursing homes, or to pay for insurance to cover such expenses.

Workers in retirement also could make certain cash withdrawals from their HCSAs. If during the year a retiree spent less than a specified proportion of HCSA funds on medical expenses or insurance, at the end of the year the retiree could withdraw the difference and use it without restriction. If a worker earned a return on his or her HCSA investments over his or her career higher than the modest target return assumed in the added deductible formula, the worker could also withdraw the excess accumulated funds in cash at any point during retirement. The worker could always withdraw up to 40\% of HCSA contributions and returns in retirement without penalty as with a regular IRA.\textsuperscript{77} Any cash withdrawal from an HCSA

\textsuperscript{76} Even if a worker earned on his or her HCSA funds just the modest return that government securities do, since that is the return assumed in the added deductible formula and only 60\% of contributions are counted in computing the deductible, workers would have two-thirds more than is necessary to finance insurance for the deductible. At the higher market returns available on corporate bonds, mutual funds, blue chip stocks, and other investments, workers would have several times the amount necessary to finance the added deductible. For a discussion of the market returns earned by various investment vehicles, see P. Ferrara, Social Security Rates of Returns for Today's Young Workers 14-16 (1986).

\textsuperscript{77} For example, assume that a worker retired with $500,000 in his HCSA account, but with the modest return earned on federal securities, 60\% of his contributions each year would equal $200,000. The worker would be able to withdraw $300,000 without restriction, subject to income taxation. The $200,000 should be sufficient to cover the added deductible expenses, given the design of the added deductible formula; allowing the worker to withdraw the excess would make the HCSA option even more attractive, increasing the degree to which workers would exercise it. Moreover, if we assume that $200,000 would support an annuity of $10,000 per year for the life of the retired worker, that $10,000 would be the annual medical expense target. If the worker spent
Medicare and the Private Sector

would be included in taxable income, however. But any withdrawal for medical expenses or health insurance would be free from tax.

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. Since the credits are taken against income taxes rather than payroll taxes, the payroll tax revenues that finance Medicare are not reduced. Such revenues would continue to be fully and exclusively available to pay benefits to today's elderly.

V. Advantages of the Private Option

The HCSA option could sharply reduce and potentially eliminate altogether the long-term financing problems of Medicare, without cutting benefits for the elderly or increasing payroll taxes on workers. This is possible because, while Medicare payroll taxes still would be levied at current rates, the added deductibles resulting from the exercise of the HCSA option would sharply reduce the program's expenditures. With revenues maintained and expenditures reduced, the long-term Medicare financing gap would shrink.

The extent to which the private option ultimately would reduce the Medicare financing gap depends on the degree to which workers would contribute to the HCSAs. Workers contributing the maximum throughout their careers would be privately financing the great majority, possibly 80% or more, of retirement medical expenses otherwise chargeable to Medicare, greatly reducing the cost burden on the program. Potentially, total Medicare spending could be reduced by as much as 80% on net as a result of workers exercising the private option. This would eliminate the long-term financing problems of Medicare by the time today's young workers retire, even under the pessimistic projections. Consequently, the need to raise the Medicare payroll tax 130-400% or, alternatively, to reduce benefits 50% or more would be avoided. Indeed, under intermediate projections, Medicare spending potentially could be reduced to only $4,000 on insurance and medical expenses during the year, he could withdraw $6,000 at the end of the year.

78. As noted, under intermediate assumptions, the current tax rates would raise sufficient revenues by the time today's young workers retire to pay 43% of promised benefits. See supra note 31. If expenditures were reduced by 80%, payroll taxes would need to finance only 20% of currently projected expenditures.
such a degree that the program's current total payroll tax rate of 2.9% could be cut in half.\textsuperscript{79}

The net savings to Medicare from the increased deductibles would begin slowly and grow over the years as more workers retired having contributed to HCSAs for more years and therefore accumulated greater added deductibles. The early cost savings would delay the date that the Medicare program runs short of funds, but are unlikely to accumulate quickly enough to avoid some interim years during which the program would be unable to pay promised benefits. During these years, interfund borrowing from the Old-Age and Survivors Insurance and Disability Insurance Trust Funds of the Social Security system still could prevent benefit cuts or tax increases, just as these Social Security trust funds borrowed from Medicare when they were in trouble in the 1980s. As it happens, the Social Security trust funds are likely to accumulate substantial reserves from 1990 to 2020 and, under intermediate assumptions, could easily cover the remaining Medicare shortfalls, without threat to Social Security benefits, until the HCSA option completely eliminated the gap.\textsuperscript{80} Under pessimistic assumptions, the Social Security trust funds are unlikely to be able to cover interim Medicare shortfalls completely.\textsuperscript{81} Absent such interfund borrowing, or to the extent such available borrowing is inadequate, some combination of benefit cuts or tax increases would be required during these interim years, but on a vastly lower scale than otherwise would be required. To the extent workers did not exercise the HCSA option sufficiently, some permanent benefit reductions or tax increases would be necessary to completely close the financing gap.

The HCSA option also would provide new incentives for consumers to counter rapidly rising health costs. Those exercising the private option would purchase medical care and coverage with funds from their own private accounts. Consumers who avoided unnecessary or overly expensive charges could retain greater reserves in their accounts to pay for future expenses or to leave to their chi-

\textsuperscript{79} Under the pessimistic assumptions, by the time today's young workers retired, payroll tax revenues would be sufficient to finance only 21% of promised benefits. See supra note 35.

\textsuperscript{80} Under intermediate assumptions, the Social Security trust funds could finance the entire present Medicare shortfall from 1990 to 2020 without any threat to Social Security benefits, but the funds would need to be paid back in later years to continue meeting benefit obligations over ensuing decades. Calculated from 1987 OADSI Trustees' Rep., supra note 11, at Table E3; 1987 HI Trustees' Rep., supra note 6, at Table 11. See also Ballantyne, Long-Range Estimates of Social Security Trust Fund Operations in Dollars, Social Security Admin. Actuarial Note 130 (Apr. 1987).

\textsuperscript{81} Calculated from the sources cited in supra note 80.
Medicare and the Private Sector

dren. They also could make cash withdrawals to supplement their retirement income. Consumers, therefore, would be likely to devote more effort to seeking out the least costly service providers. And they would be likely to seek care and coverage through institutions with greater efficiencies, such as HMOs or insurers with networks of assigned doctors who follow efficient and low-cost practices, or insurers who otherwise are able to pressure service providers into keeping costs down. Consumers also would be more likely to favor insurance covering only large unexpected costs, keeping control over their own funds and costs for more routine expenses. Additionally, consumers would have greater interest in avoiding unnecessary medical care or services that they felt were not worth the cost. Moreover, the HCSA option would provide consumers an incentive for devoting greater attention to preventive measures that could save medical costs over the long run.

Increased competition would complement these consumer incentives, since Medicare would no longer have a monopoly on providing most medical coverage for the elderly. Private insurers and medical care providers would be able to compete to provide the coverage and services that Medicare now preempts. These private competitors could be expected to monitor health care providers closely and root out wasteful, unnecessary expenditures and fraud in order to keep their own costs down. They are likely to improve and expand institutional arrangements that lower costs, such as HMOs or networks of assigned doctors. Finally, the increased competition and consumer cost sensitivity also should increase pressure for development of lower-cost medical technologies.

Consequently, the HCSA option would operate as a means of bringing natural market incentives back into medicine, not in a harsh way, threatening deprivation, but in a positive way, by providing enhanced benefits and rewards in response to market incentives. Such market incentives might be able to halt the trend toward ever higher health costs, without the burdensome cost control regulations and rationing that ultimately would reduce the quality of care for the elderly.82

Through the HCSAs, workers would receive catastrophic coverage for acute care under Medicare only after they had taken respons-

---

82. Through the HCSAs, consumers would face market incentives more nearly reflecting the true economic costs of their health care. This would not create a "disincentive" to seek health care, or quality care, but rather it would allow consumers to evaluate the degree and quality of health care they desire based on their own preferences and the true costs. Consumers would be able to make the judgment, based on their own prefer-
sibility for substantial front-end costs commensurate with their ability to meet such costs; this would sharply reduce the total burden on Medicare. The inverted priorities of the current Medicare benefits structure would be reversed. The private sector would be responsible for the bulk of routine, less threatening, front-end costs, and the government would play a back-up role by covering catastrophic health care expenses. Medicare would not be simply expanded to take over the catastrophic coverage now provided through the private sector, as is proposed in the pending catastrophic illness legislation. Moreover, even after financing the costs of the added deductibles, HCSAs, contributed to regularly over a worker's career, would likely still contain sufficient funds to cover most long-term care, if not directly, at least through private insurance mechanisms. Thus the HCSAs would foster the development of additional private savings to finance the high costs of long-term care. These private savings are the only real potential source of new funds to meet such costs.

The HCSA option would be highly attractive and beneficial to workers as individuals. Workers would likely accumulate through the HCSAs substantially more than is necessary to handle the increased deductibles, giving them large net gains. Workers would have much greater control and freedom of choice regarding their retirement medical coverage and medical care. With the opportunity for cash withdrawals from the accounts during retirement, workers could substantially improve their retirement income and would have a new means of coverage for catastrophic and long-term nursing home care.

If, despite all these benefits, a worker did not want to exercise the HCSA option and preferred to continue to rely entirely on Medicare, he or she would be perfectly free to do so. Indeed, this worker

ences, as to the value of additional health care or higher quality care versus alternative goods and services they could purchase with unspent HCSA funds.

Doctors and health care providers would, of course, have to accommodate consumer demands for cost efficiency in the market revived by HCSAs. But doctors would be able to try out and determine on a decentralized basis the best means and systems for meeting those economic realities, now better reflected in the market. Doctors would face the same market demands and enjoy the same freedom to respond as other professionals. This decentralized, flexible market process would determine what balances between competing considerations are preferred by consumers, with different systems reflecting different balances likely to be available to serve varying consumer preferences. This process would maximize the positive features of our decentralized doctor/patient relationships to the extent they are valued by consumers, within a cost-economizing framework.

83. See supra note 73.
84. Id.
Medicare and the Private Sector

would receive the advantage of the improved financial outlook for Medicare, and thus more secure benefits. Similarly, the private account option would not result in any benefit cuts for the elderly. Rather, the elderly also would benefit from the improved financial strength of Medicare. At the same time, the reduction in Medicare spending resulting from exercise of the private option would reduce federal spending by as much as $60-65 billion per year in today's terms.

The HCSA legislation addresses every one of the current major issues in health care for the elderly—catastrophic care, long-term care, the Medicare financing crisis, and new incentives for controlling ever-spiraling health care costs. Moreover, the legislation does so in a positive manner that does not threaten the elderly or add to the payroll tax problem already burdening workers.

VI. Concerns Over the Private Option

While the HCSA option could stabilize the finances of Medicare without increasing payroll taxes, it also could entail a significant cost in terms of lost income tax revenue due to the tax credits given for contributions to the accounts. This revenue loss would be relatively small at first, however, since fewer workers would be expected to exercise a new and unfamiliar option right away. If the option became effective at the start of FY 1988, and 10% of the workforce exercised it maximally in that very first year, the revenue loss would be $3.6 billion. When regular IRAs reached full bloom, about one-fifth of the workforce contributed to them each year; eventually about one-third held IRAs to which they contributed at some point. If 20% of the workforce exercised an HCSA option effective in FY 1988, the revenue loss in that year would be $7.2 billion.

As discussed further below, more workers could be expected to exercise the option over time, leading to a greater loss of income tax revenue. But at the same time, increased deductibles from exercise of the private option would begin to reduce Medicare spending and offset some of the revenue loss. Even workers close to retirement would have a strong incentive to exercise the option because their

85. Total Medicare payroll tax revenues under intermediate assumptions are projected to total $60.5 billion in FY 1988. 1987 HI Trustees Rep., supra note 6, at Table 5. If 10% of workers exercised the option maximally in that year, $6 billion would be contributed to HCSAs. A 60% income tax credit for such contributions would total $3.6 billion in lost revenue.
86. Ferrara, Deductible IRAs are Best for Workers, Cato Pol'y Analysis No. 3, 5 (1986).
added deductibles would be commensurately smaller, reflecting contributions made to the HCSAs during the few years before retirement. Spending reductions from the added deductibles for these workers would begin to accrue relatively rapidly. While the spending reductions would be relatively small at first, over time the reductions would grow substantially and eventually would be at least as great as the revenue loss from the tax credits.\footnote{On the simplest level, if taxes and spending under a Medicare-type system were equal, and workers withdrew the taxes to provide for their future benefits through the private sector, spending in retirement would fall to offset the revenue loss as the benefits would be provided through private savings and insurance rather than through Medicare. Under the proposed HCSA option, with future Medicare spending reduced by an increased amount due to the presumed private investment returns on HCSA contributions, spending might be reduced by more than the revenue loss over the long term.}

Moreover, even during the temporary period of net revenue loss, increased savings would be accumulating in the HCSAs and would at least equal the amount of revenue loss.\footnote{Increased savings would at least equal the revenue loss because the 60% tax credit is given for contributions to HCSA savings, so on its face the option should result in a revenue loss equal to only 60% of the savings increase. Potentially some existing savings would be shifted into HCSAs, and the resulting savings increase would be commensurately reduced. But few workers have fluid savings to shift into an HCSA. For further discussion of this issue in the context of IRAs, see Ferrara, Deductible IRAs, supra note 83, at 6-7.} So even if the deficit simply increased by the full amount of the revenue loss and the government just increased borrowing by that amount, there would be no net increase in the government borrowing drain on private savings, which is the real concern about the deficit. Increased savings in the HCSAs would offset the increased borrowing. Indeed, even if the government simply borrowed to cover the net revenue loss for the entire transition period, such borrowing would involve the explicit recognition of the implicit government 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, through the corporate income tax in particular. This increased revenue would combine with the Medicare spending reductions resulting from the HCSA option to offset the revenue loss more quickly.

The significance of the revenue loss from the HCSA option ultimately must be weighed against the benefits of the reform. The private option would create a new system with more comprehensive
Medicare and the Private Sector

coverage and carefully structured, rational roles for the private and public sectors and replace a current, jerry-built system overwhelmed with intractable difficulties. The need for dramatic increases in payroll taxes and general revenue contributions to the current program, or for dramatic reductions in health coverage for the elderly, would be avoided. New incentives would be created to address the root problem in health care policy: rapidly rising medical costs. Considering the benefits of the private option and the enormity of the problems addressed, the reform seems to be well worth the costs.

Some may question whether the private option would be exercised by only a small proportion of workers, particularly those who earn higher incomes and have more resources to contribute to the HCSAs. While millions of workers contributed to regular IRAs, as noted, the total contributing still amounted to significantly less than half the workforce. But a much larger proportion of the workforce ultimately should contribute to HCSAs. As discussed, the private option would be highly attractive to workers, offering large net gains as well as substantial new resources for retirement and new catastrophic care coverage under Medicare. Moreover, exercising the private option would involve a much smaller burden on workers than contributing to IRAs. Workers would receive a 60% tax credit for contributions to HCSAs, not the simple deduction received with IRAs. A worker contributing $1,000 to an HCSA, for example, would reduce his or her income taxes by $600, while a worker in the 15% income tax bracket contributing $1,000 to an IRA would reduce his or her income taxes by only $150. Moreover, workers could withdraw the remaining 40% if needed, subject only to a 10% penalty. This penalty, amounting to 4% of total contributions, is the only net out-of-pocket cost that is necessary to exercise the private option. Even if they regularly withdrew 40% of contributions each year, workers would still have more than enough money to cover the added deductibles in retirement, so long as their HCSA investments earned more than the modest target investment return assumed in the added deductible formula, which is likely. Such withdrawals during working years, however, would leave workers with less funds in their HCSAs to meet nursing home expenses and other costs.

The HCSA option is also designed so that employers play a major role. Employers can make some or all of their workers' contributions and receive the 60% income tax credit accordingly. With this
high tax credit and the benefits of the private option to workers, employers should find contributing to HCSAs a highly attractive means of compensating their workers. Accordingly, worker participation in the private option through employer-sponsored programs may be widespread.

Overall, therefore, participation in the private HCSA option would be practical and feasible for virtually all regularly employed workers. Given the attractiveness of the private option for workers, there is reason to expect that the great majority ultimately will exercise the option.

Low-income individuals who work only intermittently will surely not have sufficient funds to contribute to HCSAs. But those who do not work do not contribute to or become eligible for Medicare either. A contributory system in either the public or private sectors will not help intermittent workers who do not earn enough to contribute. For such individuals, a pure income redistribution program such as Medicaid is needed. Medicaid currently provides comprehensive coverage to those elderly who are sufficiently poor to qualify. But in many states, an elderly person can be very poor and still not be poor enough to qualify for Medicaid.

As part of reform providing for an HCSA option, Medicaid should be reevaluated and updated to ensure that it can perform essential, complementary functions for the new system. Medicaid should cover those who are unable to work regularly during pre-retirement years and who fail to develop adequate retirement health coverage through HCSAs, Medicare, or other means. Modifications to Medicaid may also be necessary to ensure that medical costs do not have to deplete the essential assets of an elderly couple or individual, such as the family home or a basic cushion of savings, before Medicaid eligibility becomes effective. The issue of asset depletion is particularly acute for elderly couples, for whom one spouse’s illness depletes the family’s resources before Medicaid steps in, leaving the remaining spouse without adequate support. Medicaid would also serve as a back-up to those who exercised the HCSA option, ensuring access to essential medical care if they experienced some extreme misfortune with their funds. Medicaid would need to be reevaluated and updated as well to ensure that it could perform this function.
Medicare and the Private Sector

Conclusion

Under the proposed private option, a highly attractive, rationally designed system would be established, with workers and their employers saving during their working years for the more routine medical expenses in retirement, and the government providing back-up catastrophic health care coverage. The government would also cover those in need who were unable to develop the resources and coverage to provide for themselves under the HCSA option. Both private and public health care coverage would be more comprehensive than current Medicare coverage for the elderly.

The Medicare system is now a basic, essential feature of American life. But it is in such disarray that it seriously threatens the financial and physical health of both old and young. The proposed Health Care Savings Account would provide an opportunity for the elderly and current workers to join together in support of fundamental Medicare reform and address the current system’s intractable problems by providing an expanded role for the private sector in meeting the health care needs of the elderly. The possible alternatives—tax increases, benefit cuts, or perhaps even regulatory health care rationing—all seem to pose serious problems that the HCSA option could avoid.