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HOW TO AVERT THE MEDICARE CRISIS

INTRODUCTION

Medicare faces staggering financial problems. The Hospital Insurance (HI) portion of the program is projected to run short of funds by the end of the decade. By the time today's young workers retire, currently scheduled tax rates will pay for only one-fourth to one-third of promised benefits. If these benefits are to be paid, the total HI payroll tax rate may have to be raised from today's 2.6 percent to 11 percent. Expenditures for the Medicare program are projected to soar to $103.3 billion by fiscal year 1989. The program is also plagued with waste and inefficiency, a pay-as-you-go method of financing that imposes unnecessary cost burdens on today's young workers, and a benefit structure that discriminates against minorities while failing to meet the greatest needs and concerns of the elderly.

Fundamental reform of Medicare is needed. Such reform should be based on the concept of Health Bank IRAs. Workers and their employers under such a program would be allowed dollar-for-dollar tax credits for contributions to these new Individual Retirement Accounts (IRAs), where the funds would accumulate tax-free investment returns until retirement. The funds would then be used to pay for medical insurance and health expenses during retirement years. Workers who did not opt for the Health Bank IRAs would instead receive vouchers in retirement to meet these expenses. Under the plan, the federal government would provide health insurance for retirees to cover catastrophic medical expenses. The government would also provide means-tested supplemental benefits for those who were unable to meet their retirement medical expenses from any of these or other sources. This new system, phased in over several years, eventually would completely replace the current Medicare system.

This reform would eliminate both the short-term and long-term financing problems of the current system, without any benefit cuts for the elderly or payroll tax increases for workers. It would reduce waste and inefficiency by increasing competition and improving incentives. It would also allow workers to pay for their retirement medical insurance coverage with substantially lower payroll contributions, thanks to the investment returns that workers would earn on such contributions over the years through the Health Bank IRAs. Retirees would have increased control and choice over their retirement coverage, discrimination against minorities would be ended, the poor would be protected, and the catastrophic coverage included in the program would address the greatest needs and fears of the elderly. In short, the Health Bank IRA plan would enable the country to avert the growing threat of Medicare bankruptcy by using the tried and tested private sector IRA system to provide retirees with the means for their hospital bills--ending their dependency on the political climate in Congress.

THE CURRENT MEDICARE SYSTEM

The Structure of the System

Medicare comprises two components--Hospital Insurance (HI) and Supplemental Medical Insurance (SMI). HI primarily covers persons over 65 receiving Social Security benefits, and those under 65 receiving Social Security disability benefits. It pays for up to 90 days of in-patient hospital care for each illness, and a total 60 additional days during the retiree's lifetime (known as "lifetime reserve days"). This coverage is currently subject to a deductible of $356 for each hospital stay, plus co-insurance fees of $89 per day for the 61st to 90th days of hospital stay, and $178 for each lifetime reserve day. These deductible and co-insurance fees are indexed, so that they increase each year with hospital costs. HI also pays for up to 100 days of skilled nursing facility care per illness (currently with a daily co-insurance fee of $44.50 after 20 days), a total of 100 home health care visits per illness, and hospice care.

HI is financed by part of the Social Security payroll tax. This consists of an earmarked portion of the payroll tax amounting to 1.3 percent each on the employer and employee, which is applied to wages up to the maximum Social Security taxable income ($37,800 in 1984 and indexed to increase each year with average wages). In 1986, the HI tax rate is scheduled to rise to 1.45 percent, for a combined employer-employee total of 2.9 percent, and to remain at that level thereafter.

SMI is available on a voluntary basis, primarily to those eligible for HI. SMI pays for physician services, outpatient hospital services, home health care services, and other non-hospital services. Coverage is subject to a statutorily fixed annual deductible of $75 and a co-insurance fee equal to 20

percent of claims. Those who choose coverage are charged a monthly premium, currently $14.60 and indexed to increases in medical costs. These premiums cover about one-fourth of expenses, with general revenues financing the remainder. Virtually all of the elderly eligible for SMI have opted for coverage, and the program covers over 90 percent of the elderly population.

The Need for Reform

Medicare faces a disastrous financial future. The Social Security Administration (SSA) projects that HI will probably run short of funds to pay promised benefits by the end of this decade.[1] By 1995, HI under current law will likely have run a cumulative deficit of $200 to $400 billion.[2] Over the next 75 years, SSA projects that, under its widely used (Alternative IIB) assumptions, HI alone faces a deficit twice as large as the long-term financial gap for all the other parts of Social Security addressed by the legislation passed in 1983 in an effort to save the system from bankruptcy.[3]

By the time those now entering the workforce reach retirement, HI revenues under current law will only cover one-third of expenditures, based on Alternative IIB assumptions.[4] Under the so-called

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1 See 1984 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Funds (Washington, D.C.: April 5, 1984), (hereinafter referred to as 1984 Trustees Report (HI)). Under the report's supposedly intermediate Alternative IIA and IIB projections, HI runs short of funds in 1991. Under the so-called pessimistic but probably more realistic Alternative III assumptions, HI runs short of funds in 1989. Under the optimistic, and truly unrealistic, Alternative I assumptions, HI still runs short of funds by 1995.

2 Calculated from 1984 Trustees Report (HI); Harry C. Ballantyne, Chief Actuary, Social Security Administration, "Long-Range Projections of Social Security Trust Fund Operations in Dollars," Actuarial Note 120, Social Security Administration, (May 1984). The cumulative deficit for HI by 1995 would be about $200 billion under Alternative IIB projections and over $400 billion under Alternative III projections..

3 The 1983 legislation reduced the financing gap over the next 75 years by about 2 percent of taxable payroll under the Alternative IIB assumptions in the 1983 Social Security Trustees reports, which are basically the same as the Alternative IIB assumptions in the 1984 Trustees reports. Yet the 75-year HI deficit under the 1984 Alternative IIB assumptions is 4 percent of taxable payroll. See 1984 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds (Washington, D.C.: April 5, 1984), (referred to hereafter as 1984 Trustees Report (OASDI)), especially Appendix F of the report.

4 By 2030, HI expenditures under Alternative IIB projections will equal 8.65 percent of taxable payroll, while revenues will equal only 2.9 percent. See 1984 Trustees Report (HI), Appendix B.

pessimistic, but more plausible, Alternative III assumptions,[5] HI revenues would cover only one-fourth of HI expenditures.[6] In order to pay all the HI benefits promised to these young workers, the total HI payroll tax rate under Alternative IIB assumptions would have to be raised to 8.65 percent, more than three times the current 2.6 percent.[7] Under Alternative III assumptions, the rate would probably have to be raised to 11 percent--four times today's HI rate, and about the same as that now levied to finance all the other elements of Social Security such as retirement income, spousal benefits, and disability insurance.[8]

The cost of SMI is out of control. The annual general revenue contribution to supplemental insurance is projected by the Office of Management and Budget (OMB) to double from $14.2 billion in fiscal 1983 to $28.2 billion in fiscal 1989. The total annual cost of Medicare for Fiscal Year 1985, including HI and SMI, is estimated by OMB at $69.7 billion (net of SMI premium payments), rising to $103.3 billion net in Fiscal Year 1989. In that year, Medicare alone will account for 9 percent of all federal expenditures.

Contributing to this cost explosion is the substantial waste and inefficiency built into the current system. With the government paying medical bills through Medicare, both doctors and patients cease to pay close attention to costs. Consequently, hospital stays tend to be extended, repetitive, or unnecessary; tests and procedures are conducted with little or no thought given to how treatment could be provided in the least costly manner. Patients have little incentive to seek out the lowest cost providers of quality medical services, and this weakens competitive pressures for efficiency and the development of low-cost medical service alternatives. Doctors and hospitals, in turn, need not worry about whether their patients can afford the charges, and consequently there is little pressure on them to keep costs down.

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5 For a comparative discussion of the Alternative IIB and Alternative III sets of assumptions used by SSA, see Peter J. Ferrara, "Rebuilding Social Security: Part 1, The Crisis Continues," Heritage Backgrounder No. 345, April 25, 1984; Peter J. Ferrara, Social Security: The Inherent Contradiction (Washington, D.C.: Cato Institute, 1980), Chapter 5; Peter J. Ferrara, Social Security: Averting the Crisis (Washington, D.C.: Cato Institute, 1982), Chapter 5.

6 Though Alternative III projections for HI are not published past 2005, in that year HI expenditures for Alternative III are already running 2.53 percent of taxable payroll higher than under Alternative IIB. If we assume that at least this margin is present in 2030, and it would surely be greater, then in that year expenditures under Alternative III projections will equal 2.53 percent of payroll plus the 8.65 percent under Alternative IIB in that year, for a total of 11.18 percent, compared to tax revenues of 2.9 percent. See 1984 Trustees Report (HI).

7 See discussion in footnote 4.

8 See discussion in footnote 6.

The government has recently attempted to address this problem by adopting the "Diagnostic Related Group" (DRG) system of payment for hospital services under Medicare. Under this new system, the government has established almost 500 categories of illness requiring hospital treatment, setting the amount it will pay under Medicare in each locality for hospital care to treat each illness. These figures are based on an average of hospital costs for each illness in the local area. If treatment costs for a particular patient turn out to be less than the set amount for that patient's illness, the treating hospital can keep the difference. If the treatment costs more, however, the hospital cannot collect the extra charges from the patient and must absorb the loss.

This system may improve incentives for hospitals to keep costs down, and reduce opportunities for overcharging, but it contains many loopholes, such as the hospital's discretion in deciding illness categories, which may eventually undermine its effectiveness. At best it will touch only the surface of the problems and disincentivies permeating the Medicare system. Updating the categories and payments will be subject to bureaucratic politicking, ultimately leading to a regulatory morass. In those hospitals whose legitimate costs are above the government-set payments, the system will, in effect, operate like price controls, leading to a reduction in doctors and hospitals willing to provide service under Medicare--and possibly to shortages and rationing of hospital services to Medicare beneficiaries.

Still another major problem with Medicare stems from the fact that workers must pay for their retirement HI coverage throughout their careers, yet their payments are not saved and invested to finance their future coverage. Rather, the money is paid out immediately to current beneficiaries. Workers consequently lose the market returns on investment they would receive each year if their payments were saved instead in an IRA-type vehicle to finance retirement health benefits. This loss is not significant for those now retired, who paid low HI taxes for only part of their careers (since the program began in 1966). But those who will have to pay the full HI tax for their entire careers could purchase far better coverage and medical services for their money--or the same coverage and service for much less money--if they could receive full capital investment returns on the payments into the system.[9]

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[9] In a steady state, money paid into HI would receive a return equal to the rate of growth in payroll tax revenues, which would be equal to the rate of growth in wages and population. But this is not likely to be nearly as large as the return on capital investment, particularly with the unfavorable population trends of today. See Ferrara, Social Security: The Inherent Contradiction, Chapters 4 and 9; Ferrara, Social Security: Averting the Crisis, Chapters 4 and 9.

The Medicare benefit structure is also not well designed to meet the chief threat to the financial security of the elderly--the possibility of an illness that is life-threatening and requires enormous medical expenses. Medicare does not insure against such "catastrophic" illnesses. Indeed, Medicare co-payment fees increase the longer the patient stays in the hospital or skilled nursing facility, and coverage eventually ceases altogether. Instead, Medicare covers the more routine and less threatening medical costs, which could be met by most of the elderly out of their own resources. The priorities of the Medicare benefit structure, in other words, are the inverse of those required to deal with the principal concern of the elderly.

The Medicare benefit structure also discriminates against blacks and other minorities. Although everyone has to pay the same HI payroll taxes while working, many minority group members receive less in benefits because, on average, they have lower life expectancies and therefore live fewer years in retirement receiving benefits. A black male born today, for instance, has a life expectancy of 64.8 years, and so typically will not live long enough to receive Medicare coverage for a single day.[10] A Hispanic male at birth has a life expectancy of 66.6 years, compared to 71 years for white males. Consequently, other white males can expect to receive up to 5 times the Medicare benefits received by Hispanic males.[11]

FUNDAMENTAL REFORM OF MEDICARE: THE HEALTH BANK IRA

Solving the problems discussed above requires fundamental reform of the Medicare system. Such reform could be structured around the concept of a "Health Bank IRA." A similar proposal was first advanced in a paper published by the National Center for Policy Analysis in Dallas, Texas, written by this author, U.S. Chamber of Commerce Chief Economist Richard Rahn, Dallas University Professor John Goodman, and University of Michigan Professor Gerald Musgrave.[12]

Under this plan, workers would be allowed to establish a special tax-free savings account, called a Health Bank IRA, analogous to today's Individual Retirement Accounts. They would be allowed to contribute each year to their Health Bank IRAs an amount equal to one percent of their Social Security taxable income (currently wage earnings up to $37,800). Workers could also direct their employers to match these contributions.

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10 Peter J. Ferrara, John C. Goodman, Gerald Musgrave, and Richard Rahn, Solving the Problem of Medicare (Dallas, Texas: National Center for Policy Analysis, 1984).

11 Ibid.

12 Ibid.

Both employee and employer would receive a dollar-for-dollar income tax credit for such contributions. In effect, this option would allow workers to withdraw up to 2 percentage points of the 2.9 percent HI tax, scheduled for 1986, to save instead in a Health Bank IRA. But since workers receive a full credit for these IRA payments against income taxes, rather than payroll taxes, revenues flowing into Social Security would not be reduced. The tax revenues would continue to be fully and exclusively available to pay the benefits for today's elderly. The Health Bank IRA funds would be invested and accumulate tax free income until retirement.

Under the reform plan, all workers would also be covered by catastrophic health insurance provided by the federal government, paid for by the 0.9 percent payroll tax they would not be allowed, in effect, to place in the IRA (that is, 2.9 percent minus the 2 percent they could withdraw). The catastrophic coverage would pay for medical expenses beyond a high deductible limit--with a modest co-payment fee simply to ensure the integrity of claims. The deductible and co-payment fees would be set based on the amounts workers could be expected to accumulate in their Health Bank IRAs over their working careers, and would be lower for Americans with lower lifetime incomes.[13]

Workers in retirement would then use their Health Bank IRA funds to purchase private medical insurance to cover expenses below the catastrophic limits. They could also "self-insure" by paying their medical expenses directly out of the Health Bank funds. Or they could choose any combination of these options. In order to register to sell insurance purchased by Health Bank funds, companies would have to allow purchases by any workers at uniform premiums within a year after their retirement, or upon reaching the age of 70, and continue to insure those people for the rest of their lives as long as premiums continue to be paid. Any funds remaining in a Health Bank IRA upon the death of the worker, during his career or in retirement, would pass to the worker's designated heirs.

To the extent a worker did not utilize the Health Bank IRA option during his working years, he would receive upon retirement a voucher from the government for the purchase of private medical insurance or the direct payment of medical expenses--whichever the workers preferred. The amount the worker and his employer paid in HI payroll taxes over the course of his career, minus the 0.9 percentage points paid each year for the catastrophic coverage, would be added together with imputed interest equal to the

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[13] The deductible could be a lifetime deductible, say the first $50,000 or $100,000 in post-retirement medical costs, set roughly equal to the amount a worker could expect to accumulate in his Health Bank IRA or to the maximum amount he could insure for with the annual premiums which could be financed by his expected Health Bank IRA assets.

average Treasury bill rate each year. The government would calculate the annuity such a lump sum could pay, and the worker's voucher would be set at that amount. Workers who had used the Health Bank IRA option to some extent, but not completely, over their working years would have a combination of Health Bank funds and government vouchers to provide for their medical expenses below the catastrophic limits.

Strictly means-tested medical benefits would be paid by the government to cover expenses below the catastrophic limits that Health Bank funds and/or government vouchers could not meet for some reason. Before relying on such government benefits, workers would be expected to use any of their personal assets not essential to daily living and any of their income beyond that needed to maintain a minimum decent standard of living.

Workers could declare their retirement and be eligible to use their Health Bank funds and receive their government vouchers at any time after age 59½. But the government-funded catastrophic coverage and means-tested supplements would not start until the normal Social Security retirement age, as in the case of the existing Medicare system.

This new system of coverage would replace totally the current Medicare system. The catastrophic insurance and government vouchers would be financed exclusively out of payroll tax revenues, which would continue at 2.9 percent of taxable payroll. The means-tested supplemental benefits would be financed out of general revenues, utilizing the general revenue funds now used to subsidize SMI. Under the new system, the elderly would not have to pay monthly premiums to the government for their Medicare coverage, as they do today. These funds would be considered available for the purchase of private medical insurance, or for the direct payment of medical bills, and taken into account in setting the catastrophic insurance deductible and co-payment fees.

Under the new system, the government would provide the benefits that most Americans want--the catastrophic coverage perhaps the most difficult to deliver through the private sector. Thus workers and the elderly would be freed of their greatest fear--overwhelming medical expenses arising from a life-threatening illness or accident. The government would also provide means-tested benefits as a last resort for those who lacked the resources to purchase insurance. But the great bulk of medical expenses between these two extremes would be financed through the private sector, under a system that enabled Americans to accumulate the resources necessary to purchase adequate insurance.

GETTING FROM HERE TO THERE

The first step in the transition to such a system requires a solution to the short-term financing problem of Medicare. As

noted above, HI is now projected to run out of funds to pay all the promised benefits by 1990. If this looming crisis is ignored, another major payroll tax increase is virtually inevitable. The reason: It is politically impossible to solve an imminent financial crisis in any part of Social Security with benefit cuts, because they would have to be precipitous and would fall harshly on those already retired, leaving them without time to make up for the cuts through other means.

Fortunately, there is another alternative for solving the short-term HI problem. The rest of Social Security is now projected to start accumulating a significant surplus by the end of the decade. These surplus funds could be used to finance the projected HI shortfall, simply by providing that any surpluses in the rest of Social Security's trust funds could be used to pay for HI benefits. Under the SSA's Alternative IIB assumptions, this would allow HI benefits to continue to be paid in full for the next 35 years.[14] Under the more pessimistic Alternative III assumptions, HI will be able to continue paying benefits until 1995.[15] But even under these assumptions, only modest additional adjustments would be necessary to permit full benefits to be paid until the new system described above could be phased in.[16]

Phasing In the Health Bank IRA

To begin phasing in the new Health Bank IRA system, all workers would be allowed to establish such IRAs and take the accompanying tax credits starting on a specified date, say January 1, 1988. Benefits would not be changed in any way for those already retired. But for new retirees, the Medicare deductible would be increased slowly each year. These new retirees, however, would also start receiving benefits from accumulated Health Bank IRA assets or government vouchers. The yearly deductible increase would be geared to the amount of such IRA benefits retiring workers would receive in their remaining years to avoid net benefit reductions.

Benefits for catastrophic illness would also be increased gradually each year for new retirees, while monthly SMI premiums would be reduced each year to compensate for the reduced SMI coverage in effect resulting from the deductible increase. These

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14 Calculated from Ballantyne, op. cit.

15 Ibid.

16 To avoid any further financial problems in the rest of Social Security, exacerbated to some extent by using short-term surplus funds to finance HI, long-term reform will be needed here as well. Indeed such reform is necessary and desirable for many other reasons as well. Such reform should be based on allowing workers the option of substituting expanded Super-IRAs for their Social Security coverage, as described in Peter J. Ferrara, "Rebuilding Social Security, Part 2: Toward Lasting Reform," Heritage Backgrounder No. 346, April 25, 1984.

shifts would continue steadily until today's young workers reached retirement age, at which point the new system would be completely phased in. The means-tested supplemental benefits would be fully available from the beginning of the phase-in period, to ensure that no one suffered hardship during the transition, but the demand for these benefits by retirees would grow only slowly over time as the current system was phased out.

Cost of the Reform

If the Health Bank IRA option were in effect in the current fiscal year (FY 1985), and workers utilized it at twice the rate they currently utilize IRAs, there would be an income tax revenue loss from the Health Bank tax credit for the year equal to about $12.5 billion.[17] Over time, this loss of revenue would be offset by reduced Medicare expenditures as workers began relying more and more on their Health Bank IRA funds. Long before this point, however, the tax revenue loss would be significantly offset by new tax revenues paid by businesses resulting from the increased investment in the Health Bank IRA.

During the period of net tax revenue loss, there would also be an increase in savings, thanks to the Health Bank IRAs. This would be equal to the amount of the tax loss, since the credit would only be allowed for such specialized IRA savings.[18] Consequently, even if the government has to increase its borrowing by the full amount of the loss, there would be no net increase in the government's borrowing drain on private savings.

BENEFITS OF THE REFORM

The benefits of the reform would be considerable. Both the short-term and long-term financing problems of the current HI system would be eliminated. The surplus funds from the other components of Social Security, plus net savings from the increased deductible, over time would bridge the short-term HI problem. Over the long term, an entirely new system would be phased in to eliminate the HI deficit that will occur under current law. This would be accomplished, moreover, without any payroll tax increases for workers or cuts in benefits for today's elderly. At the same time, today's young workers would have their future medical security protected through the establishment of an improved and soundly based system.

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17 Calculated from 1984 Annual Trustees Report (OASDI); 1984 Annual Trustees Report (HI).

18 Workers would not be allowed to withdraw Health Bank IRA funds for any purpose except the payment of medical expenses in retirement. This would avoid the danger of any shifting of existing savings into such IRAs, since the savings could not be used for any other purpose, and new savings would in fact be needed by the worker to replace lost Medicare benefits.

Lower Cost: Young workers would be able to obtain retirement medical coverage under the new system for much less than under the current system. This is because the contributions of workers and employers to their Health Bank IRAs would earn the market return to capital over the worker's lives, adding to the funds available for their retirement years. No such market returns are earned under the current system, since the taxes paid are not saved and invested but immediately paid out to finance the benefits of current beneficiaries. With a lifetime of accumulated capital returns under the new system, workers and their employers could pay much less each year than they do under the current system to have sufficient funds in retirement to purchase health care coverage that is superior to Medicare.

Workers and their employers would enjoy further substantial savings because the new system would sharply reduce the waste and inefficiency of the current system. One reason for this is that the Health Bank IRA system would dramatically increase competition in the health care industry by allowing private insurers to compete for coverage of retirees, thereby displacing the current Medicare monopoly. Private providers would likely develop new medical institutions with better cost controls, similar to Health Maintenance Organizations (HMOs), and offer retirees the option of purchasing their insurance and medical coverage through such institutions. Private insurers would also have to compete to keep their own costs down by monitoring health providers closely and rooting out wasteful, unnecessary expenditures.

Consumer Incentives: Complementing this increased competition would be improved incentives for consumers under the new system. They would be purchasing coverage with their own Health Bank IRA funds, and consequently they would seek out the lowest cost insurers and service providers that met their quality and service requirements. Workers who chose to self-insure by paying medical costs directly out of their Health Bank IRA assets would have the most powerful incentives to question charges, and the greatest potential for obtaining substantial cost savings. This desire to economize would lead to general reductions in medical prices and costs by reducing unnecessary demand.

Rather than HI payroll tax rates of 9 to 11 percent that would eventually be required under the current system, the cost saving resulting from this new approach would require no increase in the scheduled "permanent" tax rate of 2.9 percent. Indeed, even lower tax rates eventually could be required. Since workers could accumulate substantial sums in their Health Bank IRAs, the need for federal catastrophic insurance could be quite limited. And if virtually all workers opted for the Health Bank IRAs, as seems likely, the tax revenue needed to finance government vouchers would also be modest.

The new system would expand the role of the private sector by enabling most workers to place funds in Health Bank IRAs, which would, in turn, be invested in private industry. This

enhanced role would sharply reduce projected government spending. Not only would HI costs financed by payroll taxes be reduced dramatically, but the new general revenue financed and means-tested supplemental program likely would cost far less than the existing SMI program. This is because even minimum wage workers should be able to develop enough resources in their Health Bank IRAs to avoid the need for such means-tested supplements.

Catastrophic Coverage: Many of the inadequacies of the benefit structure under the current system would be corrected under the new system. Unlike Medicare, the government would protect retirees against the potentially devastating expenses of catastrophic illness, which is precisely the protection the elderly most need and want.

A Better Deal for Minorities and the Poor: All workers would earn approximately the same market returns on their Health Bank IRA contributions. If a minority worker died earlier than most workers, as is statistically likely, the worker would be able to leave more of his Health Bank IRA funds to his heirs. Medicare's discrimination against minorities, in other words, would be eliminated under the IRA plan. In addition, the poor would be thoroughly protected under the new system through the means-tested supplements. But those workers who wished to continue to rely completely on the government for retirement health care financing would be free to do so by opting for the government vouchers rather than the Health Bank IRAs.

Control and Choice: Under the new system, workers would have much greater control and choice over their retirement medical coverage. The new system would be diverse and flexible, allowing workers to choose from the myriad of options in the private marketplace the coverage best suited to their needs. They would be free to choose their retirement age with no benefit penalties for late retirement.

Boost to Savings: The new system potentially could increase national savings by tens of billions of dollars each year, through the new funds saved in Health Bank IRAs each year. Such increased savings would result in increased capital investment, jobs, and economic growth.

CONCLUSION

Everyone recognizes that Medicare is in deep trouble. Congress should act now to address the system's problems before the crisis becomes acute. Experience with the latest Social Security crisis in 1982-1983 shows that, if Congress waits until the last minute to act, the options available to solve the problem become limited to benefit cuts and tax increases. Public hysteria makes rational consideration of meaningful long-term reform impossible by that stage of a crisis.

The proposed Health Bank IRA system gives Congress a plan to enact now, which will solve Medicare's enormous structural problems without benefit cuts for the elderly or tax increases for workers. Instead, the proposed reform would replace Medicare with a new private sector system which would serve both the elderly and workers far better than Medicare. The new system would enable workers to develop their own resources to meet their retirement medical service needs, but it would retain the option of government-financed medical service vouchers for retirement if the worker so desired. Government would also retain its crucial role in providing catastrophic medical insurance for all elderly Americans and supplemental medical benefits for those retirees who were otherwise unable to develop adequate private resources for their retirement medical expenses.

The proposed new system would meet the major concerns of Americans regarding their retirement health care. Instead of waiting until the Medicare problem becomes a major crisis, Congress should move quickly to consider the Health Bank IRA.

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