W.E. UPJOHN INSTITUTE FOR EMPLOYMENT RESEARCH

Employment Research Newsletter

Volume 7 | Number 3 Article 2

2000

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Citation

Rettenmaier, Andrew J., and Thomas R. Saving. 2000. "The Economics of Medicare Reform." Employment Research 7(3): 5–6.
https://doi.org/10.17848/1075-8445.7(3)-2

W.E. Upjohn Institute for Employment Research
Employment Research - October 2000
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The Economics of Medicare Reform

Around the globe, entitlement programs for the elderly are at a crossroads. Without fundamental reform, the rapidly approaching retirement of the post war baby-boom generation will cause another boom in the form of higher tax rates on workers or a bust in the form of reduced benefits to retirees. As in many other developed countries, the United States' elderly entitlements—Medicare and Social Security—are supported by transfers from the young to the old. The question is, how will the United States and other countries prepare for the retirement of the baby boom? Because the programs are financed by taxes, the question is one of crucial importance in terms of public policy.

Reforming Medicare and Social Security go hand in hand. The solutions to Social Security's financing problems are applicable to those of Medicare. Working within the context of transfer-payment financing, the possible solutions involve tax hikes, benefit reductions, reductions in other federal programs, or combinations of all three. Left unchecked, Medicare and Social Security spending will consume 11.7 percent of the nation's gross domestic product by 2030, up 66 percent from their current share. Paying for these elderly entitlements using tax revenues will require a tax rate approaching 30 percent of taxable earnings. Alternatively, balancing the budget at current tax rates would require substantial future benefit cuts.

For some time now, the prepayment of all or some of future retirement Social Security benefits has been discussed in policy circles as an answer to the problems inherent in transfer-payment financing, but regardless of the route taken, one generation or several generations will bear the burden of the system's implicit debt. Future benefit reductions place the burden on future retirees, who are today's workers. Increasing taxes in future years places the burden on future taxpayers who are today's young. Prepayment places the burden on current workers. So, in some ways, benefit cuts in the future and prepayment are equivalent. Further, because transfer-payment financing of retirement expenditures suppresses saving and, as a result, reduces the capital stock, current workers have lower wages than they would have had with a funded program.

In our book The Economics of Medicare Reform, prepayment of retirement health insurance is studied as part of a sweeping proposal to reform the Medicare program. Prepayment of elderly consumption has several advantages over the current unfunded system, the main one being a higher capital stock and higher national income. In addition, while prepayment requires current workers to pay for their own retirement and that of current retirees, it also releases subsequent generations from onerous tax rates.

In contrast to Social Security, which is an unrestricted cash transfer, Medicare provides health insurance coverage. The cost of providing that coverage has grown at rates that have far outpaced the growth in other expenditures. Between 1970 and 1998, real Medicare expenditures per enrollee grew at a rate of 4.8 percent, while real Social Security benefits grew at a rate of 1.7

percent, so an answer to the Medicare funding problems must address both the population bulge and the size of and growth in real expenditures. In our book, we also analyze the benefits of converting Medicare's two-part insurance package to a single higher-deductible policy for future retirees. This type of health coverage makes consumers care what health care costs and can play a major role in restoring competition to the industry. The higher-deductible policy will reduce the cost of the transition to a prepaid system and may well affect expenditure growth.

The strain that Medicare has placed (and will place) on government finances was not lost on those who passed the legislation. Even before its passage, powerful members of Congress predicted that the program would require escalating tax rates and increases in the taxable maximum. Interestingly, reviewing the debates that led up to Medicare's passage also remind us that many of the proposals currently being discussed—including choice, means testing, vouchers, and even prepayment—have historical antecedents.

Unfortunately, we cannot go back to 1965 and choose among the options that were on the table then. The institution of Medicare in 1965 was a boon for members of the original retired generation, who immediately received benefits without paying any taxes. Today, the current working generation must recognize the system's debt in developing a means to finance the program.

We evaluated several transition scenarios that differed by the rate-of-return assumptions and by the benefit package that is prepaid. The common features of the scenarios included moving all baby boomers into the prepaid system of individual retirement health insurance accounts and requiring all individuals to contribute to an insurance account that pays for their medical care during retirement. In the simplest construction, all individuals of a given age engage in a mutual insurance compact that begins when they enter the labor force and lasts through retirement. Contribution rates to the insurance accounts are periodically updated as more information about future health care expenditures is known.

By investing in private accounts, workers can prepay their retirement health insurance at rates that are lower than the implied Medicare tax. Any differential between the current implied Medicare taxes and the cost of prepayment goes toward funding the older cohorts—those born before 1946—who remain in the conventional Medicare system. The younger cohorts' contributions are also used to subsidize the prepayment of most of the baby boomers' retirement health care. A final common feature in each simulated transition is the imposition of a transitional tax to cover its cost.

One of the transition paths we analyzed involves replacing the current Medicare package in full. Figure 1 shows the simulation results for the cost of making the transition to a prepaid system versus the cost of retaining the current pay-as-you-go financing. By the 16th year, workers pay less in taxes and contributions to their retirement health insurance accounts than they would in taxes if the current pay-as-you-go Medicare financing system is retained. In all future years, workers pay lower taxes than would be needed to finance Medicare on a pay-as-you-go basis. As Medicare is replaced with fully funded real investment, the nation's capital stock will increase and provide the resources necessary to fund the retirement medical care of the baby

boomers and protect the rights of older generations to retirement medical care.

Figure 1 Transition Path to Prepaid Medicare