

**Testimony Submitted to  
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**Considering the Impacts on Beneficiaries in Medicare Financing**

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Medicare has grown rapidly since its inception in 1966, rising from 0.71 percent of GDP in 1970 to 3.72 percent in 2022, making it a frequent target in discussions about reducing federal government spending.<sup>i</sup> Medicare's total spending growth reflects both expansion in the number of beneficiaries (from 20.4 million in 1970 to 64.9 million in 2022), and increases in the per capita costs of health care. The increase in costs of the program is often cited with alarm, but in many ways, higher costs for Medicare over time signal substantial success: Americans are living longer and receiving better care. It is to be expected that costs would rise.

The solvency of the Part A Trust Fund also garners substantial attention and over the years has periodically faced the prediction of impending insolvency. The most recent projection is that the fund will be depleted by 2031. That provides additional urgency for dealing with Medicare's issues, but it should not be viewed as a judgement about Medicare's success or the need to cut back on the program. The Part A Trust Fund and its projections were essentially put into place to offer an early warning sign for the need for funds to assure that Medicare would continue to function without interruption. It is not a signal of the need for cutting back on services. Social Security and Medicare provide vital support for the most vulnerable of our citizens and should not be dealt with as short term budget issues.

Challenges from the aging of the Baby Boom generation and expanded life expectancies were both anticipated when Medicare passed in 1965, and discussions about the need for increasing tax rates over time were part of the legislative debate and early planning for Medicare's needs.<sup>ii</sup> It was well known at that time that payroll tax revenue would not increase at the same rate as the costs of Medicare and hence rates would need to be raised periodically. Indeed, in the early years of the program, both current and future scheduled rates changed several times. In more recent years, much of the improvement in the solvency outlook of Medicare has come from cost cutting efforts and changes in the way that care is delivered rather than from continuing to increase payroll tax rates.

Substantial cost cutting over the last 30 years has meant that Medicare has not grown faster than other costs of health care. In many years, it has grown at a slower pace than private health insurance. Moreover, as a share of GDP, Medicare has been stable for the last four years despite the challenges of the pandemic. However, this cost cutting also means that Medicare has often lagged behind coverage available to many working Americans. Consequently, Medicare is not an overly generous program,<sup>iii</sup> and studies have documented the unmet needs of these most vulnerable of our citizens.<sup>iv</sup>

Seeking ways to make the program function better or adopting new approaches to provide good care at lower cost certainly needs to be part of any discussion of Medicare's future. And there are some areas (such as payments to Medicare Advantage plans) where reforms could yield important savings. Part D changes made in the Inflation Reduction Act will also help to hold down costs in the future (and help beneficiaries better afford the costs of drugs). But, further limitations on coverage or reductions in provider payments could leave even more beneficiaries at risk for getting good care, and policy debates should keep this in mind. Indeed, there are

strong arguments to be made for increasing benefits—improvements in post hospital and long term care and better protections for those with modest incomes are just two examples. But concerns about financing Medicare have often precluded serious considerations for improving the program. Thus, rather than focusing on further belt tightening as the sole means for keeping Medicare financially strong, it is important to consider additional sources of financing.

### **The Contributions that Medicare Has Made to its Beneficiaries**

When Medicare began, many seniors could not afford mainstream medical care. The program changed that and proved to be remarkably successful from its very start. Suddenly access to mainstream care was available as nearly all hospitals and doctors participated in the program (despite initial skepticism that they would do so), making care available to nearly all persons 65 and over. Further, Medicare is often lauded as having accelerated the integration of hospitals in the U.S., ensuring that minority patients as well as white Medicare beneficiaries would be served. Medicare's initial success continues today as the program remains popular and continues to give seniors (and since 1972 persons with disability) access to lifesaving care.

In 1965, less than 58 percent of Americans age 65 and over had insurance for hospital costs; once Medicare was fully phased in that share jumped to over 97 percent.<sup>v</sup> And while many factors contribute to reductions in life expectancy, growth in life expectancy between 1950 and 1960 was just 0.4 years as compared to an increase of 0.9 years between 1960 and 1970. And by 1975, that number rose by another 0.9 years. Access to lifesaving care certainly contributed to these life expectancy increases, which have continued to rise over the years. By 2016, life expectancy was 19.4 years for those reaching age 65 as compared to 14.3 years in 1960.<sup>vi</sup>

Medicare spending per capita was \$15,727 in 2022—an amount that totals 53 percent of median per capita income for persons 65 and older. Thus, for most older Americans, without Medicare, the costs of health care would be well beyond their means—and it is unlikely that subsidized retiree insurance would defray those costs for many.<sup>vii</sup> It is not hard to understand how much Medicare has contributed to the living standards of older and disabled Americans, undoubtedly reducing poverty substantially.<sup>viii</sup>

Despite the important role that Medicare has played in assuring retirement security for nearly 60 million current Americans—and in providing assurances to younger persons planning for retirement—the substantial costs of healthcare that are not covered by Medicare remain daunting for many. Requirements to pay premiums and cost sharing—and to contribute through taxes to Medicare’s financing mean that many older and disabled Americans are already paying substantial shares of their incomes for the costs of their care.

### **Contributions to Medicare from Beneficiaries**

Before exploring options for new sources of financing, it is important to examine the status of Medicare beneficiaries since explicitly or implicitly many proposals for reducing the costs of Medicare would adversely affect them. As I have already noted, Medicare is not currently a very generous program, placing considerable burdens on those the program serves. And proposals to further cut benefits, for example, indirectly through premium support proposals (limiting the government’s contribution to Medicare) or raising the eligibility age, or directly via increased premiums or cost sharing would exacerbate the inadequacy of the program. That is particularly important when considering how much individuals now pay out of pocket.

A new study by KFF found that the out of pocket burden of Medicare continues to rise over time—now standing at \$6,557 in 2021—substantially higher than what non-Medicare beneficiaries pay.<sup>ix</sup> In 2010, the amount was \$4,734 and in 2000, \$3,293. Moreover, the burdens are heaviest on those with incomes in the \$20,000 to \$40,000 range. Those beneficiaries do not have low income protections (because of the strict eligibility requirements for such benefits) and often lack the supplemental insurance that higher income people often receive at subsidized rates from former employers. Further, these costs are rising faster than the median incomes of Medicare beneficiaries—and particularly for those with incomes below 300% of the federal poverty level. For example, for those with incomes between 100 and 200% of poverty, the share of income going to out of pocket spending has risen to 26 percent in 2021 compared to 23 percent in 2000. While the expansions in insurance protections for younger families have improved since Obamacare was passed in 2010, Medicare beneficiaries’ situation has not.<sup>x</sup>

In addition, the common view of Medicare is that younger taxpayers fund all but the beneficiary premiums and copayments, resulting in intergenerational burdens. But in fact, beneficiaries also contribute substantially to the taxes that fund Medicare—and these contributions have been growing over time. After many years of Americans retiring early, more people now work past the age of 65 and hence contribute more to both income and payroll taxes. In fact, the shares of these taxes paid by persons over age 65 have increased over time. Seniors now pay about one-third of the income and tax revenues that go into financing Medicare. And if premiums and co-pays are included, young taxpayers were responsible for just 59 percent of the costs of Medicare services while beneficiaries, their families or former employers were responsible for 41 percent in 2016.<sup>xi</sup> And the share that beneficiaries pay is continuing upward.

Thus, policies directed at explicitly increasing burdens on beneficiaries do not represent a good strategy for the future.

### **Financing Options**

Since the last payroll rate increase in 1986, Medicare's share of the population and total spending per capita have nearly doubled. Some of the need for increased revenue has been filled by general revenues (mainly the personal income tax), largely because of changes in the health care system. The shifting of medical care away from inpatient hospital to outpatient settings has meant that Part B—financed by premiums and general revenues--represents a greater share of spending as compared to Part A. The share that payroll taxes cover for all Medicare has fallen from 61.8 percent in 1970 to 36.4 percent in 2019.

To ensure stable future financing for Medicare, payroll taxes and/or personal income taxes will need to be increased. Payroll taxes have always been popular because they are simple, administered by employers with no filing requirements by workers, and dedicated to Social Security and Medicare. Traditionally, economists have criticized the payroll tax because it is assessed only against wages and hence falls disproportionately on lower income persons. Progressivity (the extent to which a tax burden falls more on higher income persons) for Medicare's portion of the payroll tax improved when the taxable wage cap was eliminated and when additional requirements for higher income taxpayers and beneficiaries to pay more were added. But wages have also declined as a share of incomes for Americans over the years, with income from interest and dividends rising particularly for those with higher incomes, making the payroll tax *less* progressive. There is still substantially more room to improve the progressivity of funding for Part A.

A modest increase (for example, a 0.5 percentage point increase each on employers and employees) could raise substantial new revenues for Medicare's Part A Trust Fund, extending its life substantially and keeping the dedicated nature of the tax that funds most of Part A. It would need to be phased in over time and to be paired with other changes to enhance progressivity. And since general revenues by law will naturally increase over time to fund Parts B and D, this approach would mean that both types of taxes will expand to fund Medicare.

Additional approaches would include expanding personal income tax revenues to the funding for Part A. This would mean that there would be no extra burden on individuals whose incomes come mainly from wages, since the burden would be more evenly spread across all income sources, or options could focus on those with higher incomes in general. A variation of this approach could target certain types of income to be devoted to the Part A Trust Fund rather than a general rate increase. Closing various tax loopholes (for both personal and corporate income taxes) and increasing IRS enforcement capabilities are often popular proposals and have been advocated for a variety of purposes.<sup>xii</sup> Further, an increase in the tax on capital gains could be used to explicitly supplement the existing payroll tax and hence enhance the progressivity of Medicare taxation.

To further protect modest income Medicare beneficiaries, another approach would explicitly target those with higher incomes to achieve increases in revenues. We have already moved in that direction with the requirement that individuals with incomes above \$200,000 (and couples with incomes over \$250,000) to pay an income tax surcharge of 3.8 percent. This amount could be increased for those with even higher incomes. For example, the Biden administration has proposed raising the rate to 5 percent on those with incomes above \$400,000. (And, revenues from the existing high income tax and any expansion should be directly credited

to the Part A trust fund.) Estimates from the Medicare Actuaries indicate that this option for improving revenues would extend the solvency of the Part A Trust Fund indefinitely.

Expanded contributions from those with higher incomes can be justified on a number of grounds. Although the cap on wages subject to tax was eliminated a number of years ago, improving the progressivity of the payroll tax, burdens on higher income individuals are still substantially smaller than on middle-income taxpayers because higher income people receive a much greater share of their incomes from sources other than wages and salaries. This trend has been going on for some time and will likely continue. It is one of the reasons why payroll taxes are declining as a share of GDP (and why the share of income going to the wealthiest Americans is increasing). Bolstering the Part A Trust Fund in this way would help to offset the decline in revenues coming into the fund because of the shift away from wages and towards greater inequality in Americans' incomes.

## **Conclusion**

Whatever choices are made for financing Medicare for the future, protecting Medicare's viability in ensuring the health and security of those it protects should be the guiding principle in considering how to proceed. Beneficiaries are already making strong contributions toward the costs of Medicare and the program's benefits remain modest, so they should not be expected to bear unusual burdens for protecting its future. Rather, it is appropriate to consider broader financial contributions from all Americans in the form of additional revenues. Medicare remains one of the most popular and successful programs of the federal government and a commitment to maintaining it over time deserves nothing less.



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<sup>i</sup> Unless otherwise noted, most of the statistics reported here come from Board of Trustees, *2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, 2023, Washington, D.C.: U.S. Government Printing Office.

<sup>ii</sup> Robert Myers, *Medicare*, Irwin Press, 1970.

<sup>iii</sup> Kaiser Family Foundation, “How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans? A 2012 Update,” by Frank McArdle, Ian Stark, Zachary Levinson, and Tricia Neuman, April 2012. <https://www.kff.org/health-reform/issue-brief/how-does-the-benefit-value-of-medicare/>.

<sup>iv</sup> Kaiser Family Foundation, “How Much is Enough: Out of Pocket Spending Among Medicare Beneficiaries: A Chartbook,” July 2014; “Problems Getting Care Due to Cost or Paying Medical Bills Among Medicare Beneficiaries,” by Juliet Cubanski, Tricia Neuman and Anthony Damico, April 2, 2020. [www.kff.org/coronavirus-covid19/issue-brief/problems-getting-care-due-to-Cost-or-paying-medical-bills-among-medicare-beneficiaries](http://www.kff.org/coronavirus-covid19/issue-brief/problems-getting-care-due-to-Cost-or-paying-medical-bills-among-medicare-beneficiaries).

<sup>v</sup> Marilyn Moon, “What Medicare has Meant to Older Americans,” *Health Care Financing Review*, Medicare Advancing Towards the 21<sup>st</sup> Century 1966-1996, Vol. 18, Winter 1966, pp.49 - 59.

<sup>vi</sup> Centers for Disease Control and Prevention, *Health, United States*, National Center for Health Statistics; [www.cdc.gov/nchs/hus](http://www.cdc.gov/nchs/hus).

<sup>vii</sup> Even though employer retirement health subsidies only cover what Medicare does not, still only a minority of employers offer such coverage and that number has been declining over time.

<sup>viii</sup> Measures of poverty that include the value of Medicare routinely reduce the share of seniors in poverty substantially although these estimates are to some extent still considered “experimental.”

<sup>ix</sup> Kaiser Family Foundation, “Medicare Households Spend More on Health Care than Other Households,” July 2023, by Nancy Ochieng and Juliette Cubanski.

<sup>x</sup> These numbers are reflective of out of pocket spending for those in traditional Medicare. The Medicare Advantage program is often touted as helping to lower these costs but data are not reliably reported and in some cases, out of pocket spending would not be lower. These protections also come at other costs such as lack of access to certain provider and more restrictions on care. Much more analysis needs to be undertaken before concluding that expanding Medicare Advantage would readily be a “solution” to the costs of care for older and disabled Americans. See, for example, Marilyn Moon,

<sup>xi</sup> Marilyn Moon and Jing Guo, “Who Pays for Medicare?” Center on Aging at American Institutes for Research, Issue Brief Series.

<sup>xii</sup> See for example, Paul Van de Water, “President Biden’s 2024 Budget Would Strengthen, Improve Medicare,” May 3, 2023, Center on Budget and Policy Priorities.