

Issue Brief MAY 2016

Who Pays for Medicare?

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In the debate over Medicare's future, one key question that's nearly always at least implicit when reform comes up is who should pay. More specifically, how should the burden be split between taxpayers and beneficiaries?

Medicare is financed as a pay as you go system rather than a funded system even though individuals pay payroll taxes over many years to "contribute" to Part A of the program. Medicare's financial status is always based on the notion of ability to pay benefits from resources on hand in a given year.¹ Thus, we look at what taxpayers under the age of 65 pay each calendar year and what beneficiaries incur as their contributions toward the costs of Medicare in that same year.

Proposals to increase premiums or cut benefits to recipients suggest that the balance should change and that a greater share of the costs of health care for the elderly and persons with disabilities should be borne by Medicare's beneficiaries. But of the changes proposed, few would actually reduce health care's overall costs and though greater efficiencies should certainly be pursued, proposals that essentially just shift cost burdens from taxpayers to beneficiaries shouldn't be construed as "savings" for Medicare. Here, we need to look hard before we leap.

One way to judge whether the current balance is appropriate is to scrutinize the health care cost burdens that these two groups actually bear. Too often, people assume that this is a straightforward question and that most costs are borne by taxpayers aside from the premiums that individuals must pay. In fact, the actual burdens are more complicated to estimate: many older Americans continue to work and pay payroll taxes and they pay income taxes on both wages and retirement income.

To calculate these relative health care cost burdens more accurately, we estimate the shares of the burden borne by taxpayers and elderly beneficiaries and how they are likely to change over time. Taxpayers contribute to Medicare via payroll taxes that fund the bulk of Part A (covering hospital and post-acute care) revenues and via the income taxes that largely finance Parts B and D (covering physician and ambulatory services and prescription drugs). But Americans over the age of 65 also contribute to these two tax sources so those contributions must be subtracted from the total attributed to younger taxpayers.

Let's also remember that because older Americans are remaining in the labor force longer, they are paying a greater share of the payroll and income taxes that fund Medicare than ever before. In particular, the share of income taxes paid by seniors is substantially higher than it was just a decade ago (while the share paid by taxpayers under 35 has fallen substantially). Also, taxing Social Security benefits (some of which fund Part A) brings in a substantial contribution from higher income seniors each year. Finally, beneficiaries pay premiums on Parts B and D of the program.

¹In another paper, we look at the issue of lifetime contributions and benefits for Medicare and Social Security. See the third brief in this series, Jing Guo and Marilyn Moon, "A Lifetime Measure of Medicare's Value."

Methodology

We begin with estimates for 2015 and calculate the increases in burdens that will occur through 2035 after all Baby Boomers have been absorbed into the system. The Medicare and Social Security Trustees Reports for 2015 are our main data, but projections from other sources supplement this information.² For example, we use IRS data on income taxation and data from the Labor Department on labor force projections for older workers.³

We treat as young taxpayers all persons between the ages of 20 and 64, allocating among them payroll and income taxes net of that paid by those aged 65 and older. Since some of the tax revenues from taxing Social Security benefits fund Part A, and beneficiaries are assessed premiums for Parts B and D—including relatively new income related premiums—beneficiaries' burdens arise from a range of sources.

To examine future burdens, we make some simplifying assumptions. First, we assume that payroll taxes will be increased one way or another to cover the costs of future benefits, even though the payroll tax rate currently is set too low to fund the program beyond 2030.

Second, we take a conservative approach to projecting what older Americans will pay in payroll and income taxes. Over the past twenty years, the elderly have worked longer—increasing the payroll tax contributions seniors make each year as a share of the total. And, the share of personal income taxes paid by persons 65 and over has risen substantially over this period. Although we expect these contributions to keep rising relative to younger taxpayers, we use projections available from the Labor Department through 2020 to increase these shares and then assume an increase that reflects only the rise in the share of the population aged 65 and above after 2020. In fact, contributions from older taxpayers are likely to be higher than that.

A third simplifying adjustment attributes the costs of the premiums on a per beneficiary basis but attributes the share of taxes across all persons aged 65 and over. A full calculation of tax contributions limited to Medicare beneficiaries would require omitting contributions from the approximately 2 percent of people aged 65 and above who do not participate in Medicare and adding contributions from the disabled population. Since the focus here is on the elderly, this simplifying assumption only modestly affects the results. It underestimates what beneficiaries contribute since we did not calculate or include payroll and income tax contributions from disabled beneficiaries.

Finally, we estimate the shares paid by taxpayers and beneficiaries in two different ways. The first limits the allocation to benefits paid by the federal government. That essentially understates the amount that beneficiaries actually pay because it does not include required cost sharing by beneficiaries for covered services. Adding cost sharing to the estimate substantially increases the share attributable to beneficiaries.⁴ For that reason, we provide two alternative estimates.

The Results

For 2015, per capita costs of Medicare total \$12,174. Although the burdens on younger taxpayers get most of the attention in debates over Medicare costs, our estimates indicate that beneficiaries pay a substantial portion of the costs of their own care. In 2015, the average burden per young taxpayer is estimated to be \$2,334, compared to \$3,824 for elderly beneficiaries (Table 1). Since the number of workers paying into the system substantially exceeds the number of beneficiaries, the proportional *shares* of how much each group pays require an additional calculation. As Figure 1 shows, the elderly pay essentially 32 percent of the total federal costs of the program while younger taxpayers pay 68 percent.

²Board of Trustees. 2015. *2015 Annual Report of the Boards of Trustees of the Federal Hospital and Federal supplementary Medical Insurance Trust Funds*. US:GPO.

³More specifics on data sources and the formulas for allocating burden shares are contained in a technical version of this paper. [ADD LINK HERE](#)

⁴ And, if we had estimates of services such as vision and dental services and long term care services that are not covered by Medicare, that would increase even further the share that beneficiaries pay toward the costs of their own care.

Table 1. Per Capita Amounts of Medicare Borne by Taxpayers and Beneficiaries

	Young Taxpayer Burden	Beneficiary Burden	Total cost sharing for Beneficiaries
2015	\$2,334	\$3,854	\$2,138
2025	\$3,307	\$5,440	\$2,689
2035	\$4,423	\$6,975	\$3,304

As Figure 2 shows, the largest portion of seniors’ burden comes from Medicare premiums, but they also contribute a substantial amount in income taxes that fund Parts B and D. Together, the income tax and premium liabilities mean that Medicare beneficiaries pay for over 43 percent of the costs of B and D.

The beneficiary burden of \$3,824—32 percent of the program’s federal per capita costs—is the more modest estimate of burden because only the premiums and taxes that the elderly pay for their Medicare are counted. If the amount paid for cost sharing

Figure 1. Per Capita Share of Medicare Borne by Taxpayers and Beneficiaries, With and Without Cost Sharing

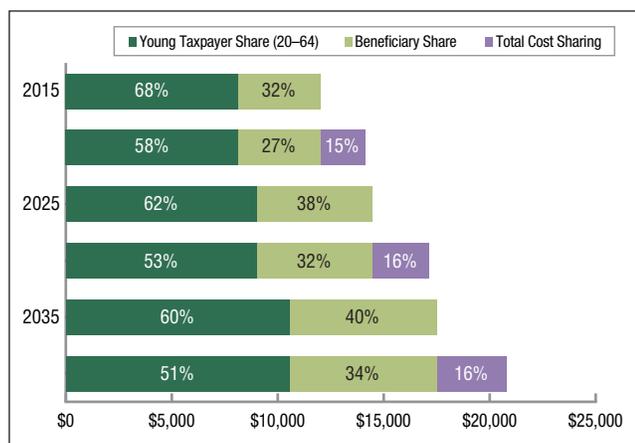
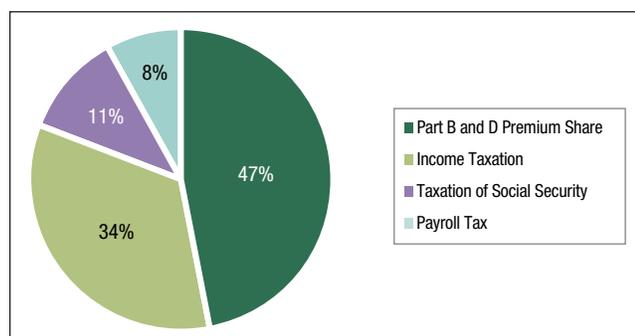


Figure 2. Components of Beneficiary Share of Medicare Cost, 2015



(the deductibles and co-payments) assessed on Medicare-covered services is added to the total, Medicare costs rise to \$14,312, with beneficiaries responsible for \$5,992. This increases their share to 42 percent—or, in the case of B and D, to 55 percent—since the cost share is very high for physician services and prescription drugs.

Medicaid helps some very low-income individuals pay their share of cost sharing. Also, employer-subsidized retiree insurance often picks up some of the cost sharing. Even so, many beneficiaries still shoulder substantial responsibility for deductibles or co-pays. And, for those who buy supplemental insurance (Medigap) on their own, spending may be even higher since they are bearing the full actuarial burden of cost sharing plus relatively high administrative costs. A more fully developed estimate of this burden should make some further adjustments for contributions from other payers, so this estimate that includes cost sharing liabilities is best thought of as an upper bound on Medicare-related costs.

Since Medicare growth is projected to be greater for Parts B and D and because more seniors are remaining on the job and paying income and payroll taxes, the burdens on the elderly will grow as a proportion of total benefits over time even with no change in policy.⁵ As Figure 1 indicates, by 2035, the lower estimate of beneficiary contributions is projected to be 40 percent, assuming that current policy remains in place.

Conclusion

When people debate Medicare’s future and ask whether beneficiaries should pay more, it is important to understand that they already contribute substantially to Medicare and that these burdens will rise over time as a share of the program’s total costs, even with no change in policy. Health care costs are rising faster than incomes for the young, and the same holds true for older Americans.

Whether these growing burdens are affordable also needs to be examined relative to each group’s command on resources which is the subject of a companion paper in this series.

⁵ And, our estimates of tax contributions are likely to be on the conservative side for seniors as noted above.

ABOUT THE AUTHORS

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FUNDING

The Center on Aging is funded by American Institutes for Research.

