



# The Medicare Financing Conundrum

## Revenues, Spending, and Short- and Long-Term Fiscal Challenges

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### Introduction

The Medicare program, which provides health insurance coverage to 64 million elderly and disabled Americans, faces serious short- and long-term financial pressures in each of its two components. The first component, Hospital Insurance (HI) or Part A, helps pay for hospital and most institutional services as well as skilled nursing facility, hospice, and some home health care. It is financed through the HI trust fund, into which receipts from a payroll tax imposed on workers' earnings are deposited. When the inflows of payroll taxes and other receipts, along with accumulated surpluses, are insufficient to cover HI costs, the law requires that payments to providers somehow be reduced to the level of incoming receipts.

The second component, Supplementary Medical Insurance (SMI), has two elements: Part B, which helps pay for physicians' outpatient services, laboratory tests, physician-administered drugs, and durable medical equipment, and Part D, which helps pay for self-administered prescription drugs. Both Parts B and D are financed by beneficiary premiums and federal general revenues deposited into the SMI trust fund. Unlike in the HI trust fund, when the balances in the SMI trust fund run low, they are automatically replenished with general revenues, and beneficiary premiums for Parts B and D are increased.<sup>1</sup>

The HI trust fund is expected to be depleted sometime around 2028 (Medicare Trustees 2022).<sup>2</sup> Were this to occur, Medicare would not be able to make full and timely payments to HI health care providers, creating adverse consequences for patient care. Meanwhile, SMI spending will require ever-larger infusions of funds from general revenues, leading to higher deficit spending and ever-increasing beneficiary premiums, whose growth rate typically will exceed that of beneficiaries' incomes. Given the immediate and visible adverse effects that HI trust fund insolvency would cause, some type of

congressional action is inevitable. Tackling HI insolvency and the growing pressure on the federal budget requires slowing the rate of growth in health or other benefits paid, increased financing, or, most likely, both.

Medicare has multiple sources of financing that are confusing to beneficiaries, analysts, and policymakers alike. These financing sources can be direct or indirect and take the form of various taxes, fees (premiums), copayments, and federal budget deficits (or borrowing) that must be covered by households at some point in the future. As we highlight below, Medicare beneficiaries contribute through premiums, purchases of supplemental plans, and copayments for their health benefits, while higher-income beneficiaries pay premium surcharges and higher income taxes on their Social Security income to help meet the costs of Medicare-covered services, even though they already contributed earlier in life to support other Medicare recipients through a payroll HI tax and possibly an *additional Medicare tax* on their earnings, along with income tax and other taxes. Adding further to the confusion, Medicare has likely also been financed by a little-recognized source: government spending on other programs that is lower than it otherwise may have been. Even if that other spending is not reduced, the choice to increase Medicare's share of government spending still reflects priorities in the sense that the total share spent on everything else declines.

The inescapable fact about Medicare (or any government program) financing is that once debt is included as a means of financing, the total amount of financing at a point in time must equal the total amount of spending. When current revenues fall short of current spending, the resultant shortfall also has implications for the future, even if they remain ambiguous. For instance, we don't know which future taxpayers will cover interest costs, while possible financing sources can include higher taxes, lower benefits in other programs, and inflation acting as a tax on government bondholders.

In this brief, we first examine the sources of financial pressure on the Medicare program overall and the contributions of Medicare's Parts to that pressure. We then describe the complex array of Medicare financing sources, including their size and scope in relation to gross domestic product (GDP), federal spending, and revenue. With Medicare spending growing faster than national income historically, and projected to do so into the future, the nation faces increasingly difficult choices between obtaining additional sources of financing that take money away from other public and private uses and reducing Medicare spending. We focus on the financing side of this issue, though reforms to address Medicare's sustainability also need to consider reductions in Medicare's spending growth.

Several key takeaways emerge from our review of Medicare's financing challenges:

- Taxes are only one means of financing Medicare spending growth. Deficits, premiums, and reductions in other spending are each employed over time.
- Financing and spending issues for Medicare are intertwined. Policies that nominally address one have implications for the other that must be anticipated.

- Because Medicare spending is under the partial control of people who demand services and the providers who supply services, much of the power of Medicare financing is passed from elected officials to individual actors—providers and consumers.
- Although creating a new dedicated financing source could close a given Medicare financing shortfall, it is hard to match future growth in Medicare spending needs exactly with growth in a particular financing source.
- It is easier to enact reforms consistent with the goals of tax or budget policy through general revenue financing than through dedicated financing.
- Dedicated financing via a trust fund can work when it covers all costs and imposes budgetary rigor on matching spending and receipts, but the HI trust fund is not set up to work that way.
- Broadening the base of an existing dedicated tax, such as subjecting employer-sponsored health insurance to the HI payroll tax, would follow the tax policy principle of horizontal equity without necessarily adding to the complex array of Medicare financing sources.
- Addressing HI and SMI financing issues together would help confront longer-term Medicare financial challenges and allow fairer and more efficient financing and spending trade-offs to be made within HI, SMI, and the broader tax system.

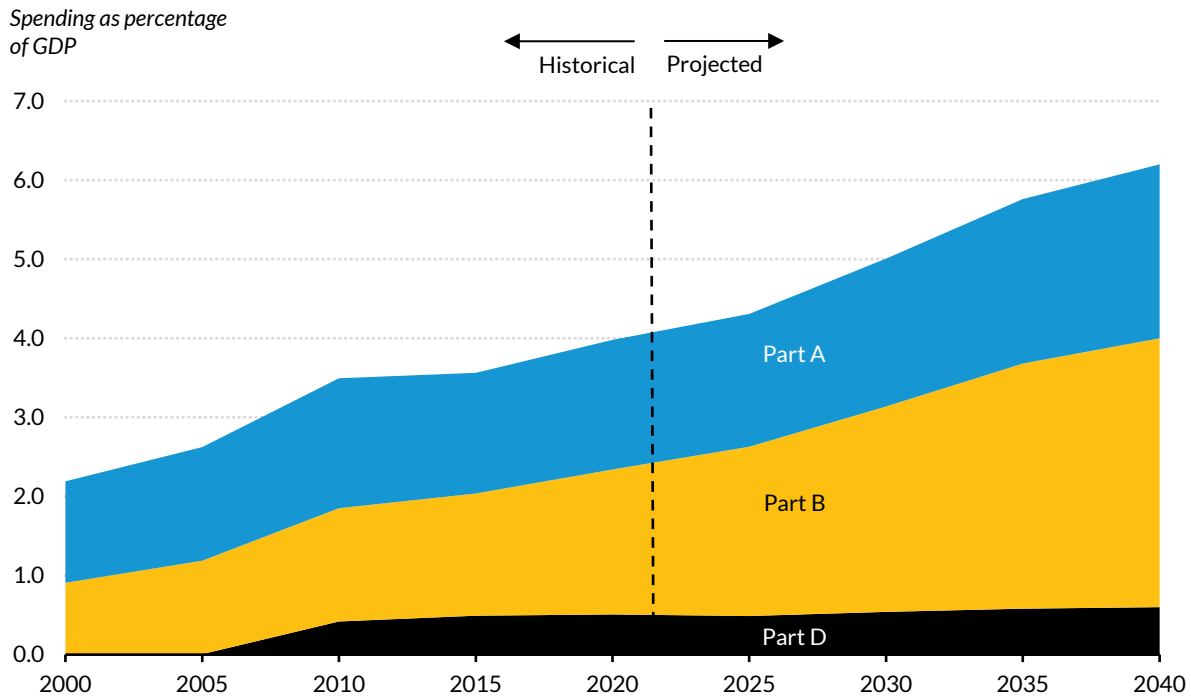
## Short- and Long-Term Financing Issues

The current financing problem facing Medicare can be understood most simply by looking at the growth in total Medicare program spending as a share of GDP, because GDP provides a rough measure of the size of the economy or the amount of resources that government, households, and businesses together produce and can devote to all purposes.

### Medicare Spending Continues to Rise as a Share of GDP

Figure 1 shows the total growth in Medicare program spending from 2000 to 2020 and projected spending to 2040. It also shows how spending is allocated across Medicare Parts A, B, and D. Total Medicare spending increased from just above 2 percent of GDP in 2000 to about 4 percent in 2020 and is projected to be 6 percent of GDP by 2040. When Medicare was enacted in 1965, the program made up significantly less than 1 percent of GDP. The projected spending amounts in figure 1 (after 2020) use the intermediate assumptions of the trustees of the Medicare trust funds, including that adequate financing will be found under HI to pay for those benefits.<sup>3</sup>

**FIGURE 1**  
**Historical and Projected Medicare Spending, by Program Part**



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**Source:** Data from figure II.D1 in Medicare Trustees (Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds), *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Medicare Trustees, 2022).

**Notes:** GDP = gross domestic product. Historical data include 2021; data for 2022 onward are projected.

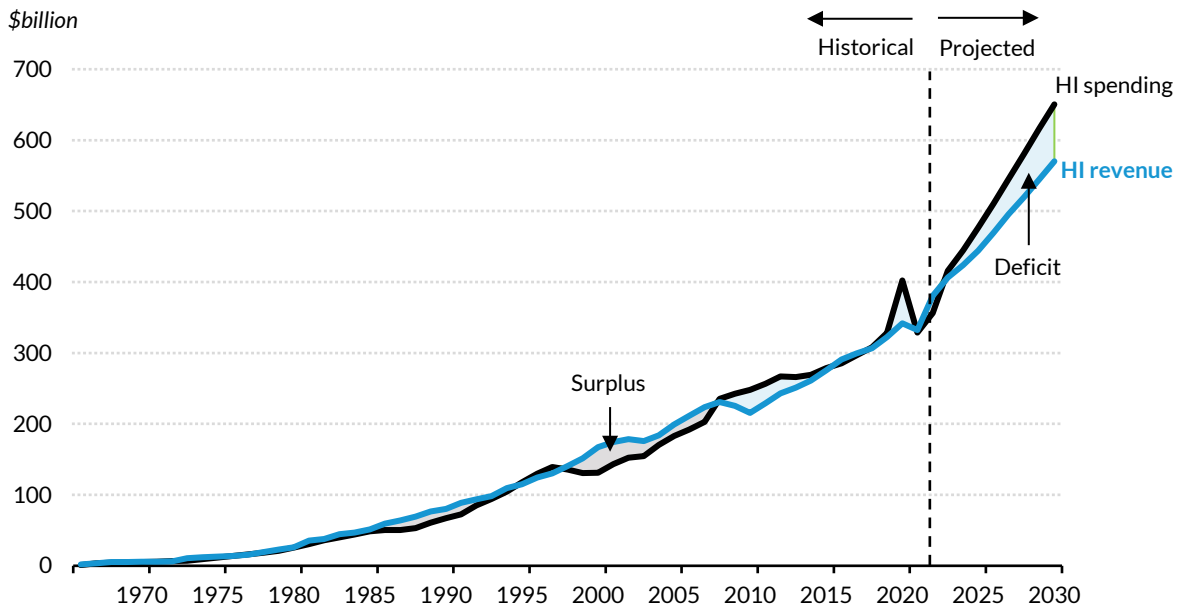
Especially with the movement of more hospital services to an outpatient setting, the largest component of Medicare spending growth has been Part B (mainly covering physician services, hospital outpatient care, and medical supplies), which, as figure 1 shows, is projected to grow substantially as a share of GDP. Medicare Part D (drug coverage) began enrolling Medicare beneficiaries in 2006 and is responsible for a relatively modest share of overall projected program growth to 2040.

### Projected HI (Part A) Spending Increasingly Exceeds HI Revenue

Figure 2 focuses on the HI (or Part A) portion of the program, showing HI spending (in billions of dollars) and corresponding dedicated HI revenues. At various points in the past, the HI trust fund took in more than it spent. With a few exceptions, that period ended during the first decade of this century. Excluding interest payments from past surpluses, which are available only until 2028, recent deficits would be even larger. The HI program is projected to run a deficit from 2023 onward.

FIGURE 2

Historical and Projected Medicare HI (Part A) Spending and Revenues



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Source: Data from figure III.B1 in Medicare Trustees (Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds), *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Medicare Trustees, 2022).

Notes: HI = hospital insurance. Historical data include 2021; data for 2022 onward are projected.

Unlike other Medicare Parts, the HI portion operates like Social Security, under a constraint that Medicare can pay only as much money as it takes in, plus any reserves from past surpluses that are stored and earn interest within the HI trust fund. Those revenues derive mainly from a payroll tax collected on workers' earnings. The HI tax is currently 2.9 percentage points, split equally between workers and their employers. Also, though the earnings base for Social Security's payroll tax is capped, there is no cap on earnings subject to the HI tax. The HI trust fund also receives a dedicated portion of income taxes, as discussed in more depth below.

HI trust fund reserves, including interest payments paid out of general revenues on past surpluses, have been covering recent deficits of current spending over current revenues, but they cannot do so much longer. According to the trustees of the HI trust fund, the HI trust fund reserves are projected to be exhausted in 2028. At that point, only 90 percent of scheduled HI benefits can be paid. Roughly speaking, that means that immediately before exhaustion, about 90 percent of benefits would be covered by current HI tax revenues and other dedicated sources and 10 percent by a final depletion of (or sale of assets from) the reserves in that trust fund.

Two main factors have caused the rapid decline in the ability of dedicated financing sources to cover HI costs: a decline in the number of workers paying Social Security tax in support of each beneficiary and significant cost increases per beneficiary. The former relates to demographics. People

live longer while the age of eligibility for Medicare benefits remains constant. Combined with declines in the birth rate, the share of the population over age 65 has risen sharply (Steuerle and Cosic 2019, figure 1). Of particular note, baby boomers, born between 1945 and 1965, started aging into eligibility for Medicare around 2010. Also, as they retire, a smaller share of adults pays HI taxes. Social Security shares in these demographic pressures, but Medicare uniquely faces significant additional pressures from health cost increases.

## **Containment of Total Medicare Costs Is Needed in the Long Term, but Additional Financing for HI Is Likely Needed in the Near Term**

Though cost-containment measures in theory could eventually bring the HI system into balance, Congress typically implements such measures gradually. As an extreme example, in 2028, when reserves are projected to be exhausted, Congress would not be likely to immediately cut payment rates to providers of HI services by 10 percentage points. Also, cost containment could stretch across all Medicare Parts, with the saving not fully accruing to HI alone.

Accordingly, some additional financing for HI, such as new taxes or borrowing, almost inevitably will be required for the near term, no matter how extensive any cost-containment effort might be over the long term. Unlike for SMI, borrowing for HI would require congressional approval and change HI's current financing structure. Even with significant cost containment, the drop in the ratio of workers to Medicare beneficiaries will continue to provide significant and rising pressure well into the 2030s, as most baby boomers finally get absorbed into Medicare and then move into the higher-age and higher-health-care-need cohorts within Medicare.<sup>4</sup> Recent reductions in the birth and immigration rates, if continued, could also add financing pressures.

Despite the imperative to attend to the HI trust fund, the more substantial short- and long-term problems of Medicare relate to the total cost of the system, whatever its financing sources. In 2000, the total shortfall of Medicare spending over its dedicated sources of funds equaled less than 1 percent of GDP, but it will rise to about 3.5 percent of GDP by 2040 (figure 3). All of this would be covered out of what are called *general* (essentially meaning not dedicated) *revenues*, such as the income tax and increased borrowing.

Elimination of HI shortfalls may do nothing about shortfalls in the total system if, for example, covered services are shifted to outpatient or doctors' offices, as has been done in the past. That would merely convert HI costs to general revenue costs and higher premiums for Part B beneficiaries, unless such transfers lead to additional efficiency or other cost saving to Medicare as a whole.

# The Size and Scope of Financing for Medicare Beneficiaries

In this section, we describe the various sources of Medicare financing, their sizes relative to GDP, and their scopes relative to Medicare and total government spending, revenue, and deficits.

## Medicare Financing Is Largely Pay as You Go

For the most part, Medicare depends upon current financing. When baby boomers were in their peak working years in the 1980s and 1990s, the number of workers per retiree was much higher than today. Yet even the surpluses built up during that time for HI alone were modest. This can be seen in figure 2, in the past correlation between lines for HI spending and HI revenues: money in and, for the most part, money out. When the revenue line was above the spending line, there was a surplus; now that the revenue line falls below the spending line, there is a deficit.

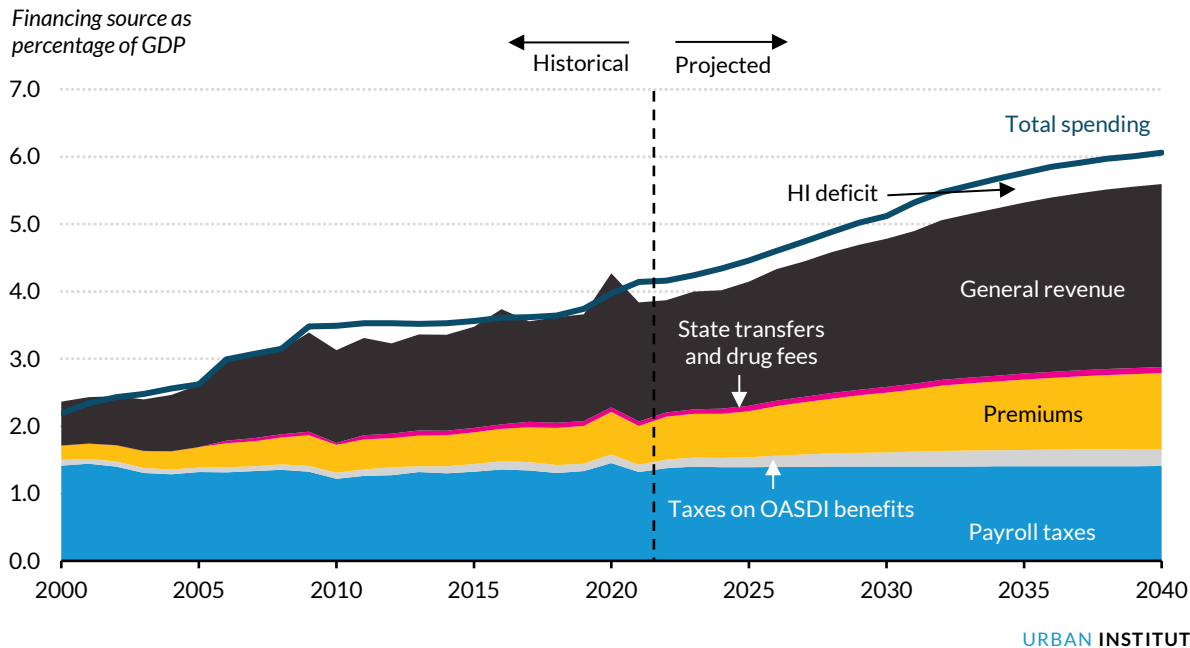
Medicare's SMI trust fund has separate accounts for Parts B and D. The SMI trust fund was not designed to rely on dedicated revenue sources; it is funded primarily through general tax revenues and beneficiary premiums (CRS 2020). Enrollee premiums finance roughly 25 percent of these services and general revenues finance 75 percent. The term *general revenues* is a bit misleading because it includes not only actual revenues but borrowing by the government to cover its own deficits. SMI costs and HI deficits are growing as a share of GDP, as are overall government deficits; the pandemic years also added a temporary boost to all of these deficits.

## Dedicated Payroll Taxes Are the Primary Financing Source for HI

In figure 3, we reproduce a graph from the 2022 Medicare trustees report to show the various financing sources for all of Medicare as a share of GDP. The payroll tax on workers, which is shown at the bottom, is the primary funding source for the HI trust fund and is projected to remain at a roughly constant share of GDP, even as Part A costs rise as a share of GDP. The regular employer-plus-employee Medicare or HI payroll tax of 2.9 percent of earnings is supplemented by an additional Medicare tax of 0.9 percent of earnings for earnings above a high-income threshold.<sup>5</sup>

In addition, a portion of the income tax on Social Security cash benefits, known as the Old Age, Survivors, and Disability Insurance program, is allocated to the HI trust fund. This is technically neither a new separate tax nor a dedicated revenue source; rather, it is a *dedicated transfer* by the US Department of the Treasury of some of the individual income tax paid by taxpayers. When the incomes of beneficiaries exceed a base level, they must add an additional share of their Social Security benefits to their income potentially subject to tax.<sup>6</sup> Congress allocated this new source of income tax revenues to the HI trust fund when it was looking for ways to shore up that trust fund.<sup>7</sup> The level of income below which individuals are exempted is not indexed for inflation or wage growth, so this source of financing grows at a faster rate than the GDP.

**FIGURE 3**  
**Historical and Projected Sources of Medicare Financing**



**Source:** Data from figure II.D2 in Medicare Trustees (Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds), *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Medicare Trustees, 2022).

**Notes:** GDP = gross domestic product. HI = hospital insurance. OASDI = Old Age, Survivors, and Disability Insurance. Historical data include 2021; data for 2022 onward are projected.

### Premiums Paid by Beneficiaries Fund Only a Modest Portion of SMI

Medicare premiums represent fees paid by beneficiaries to help finance Medicare. Though covering less than 25 percent of total Medicare costs, these premiums for coverage under Parts B and D are among the most visible to Medicare beneficiaries. A standard premium for Part B (about \$171 per month in 2022) applies to most beneficiaries. Beneficiaries who opt in to Part D also pay a premium that depends on what plan they buy. For enrollees with low incomes, state Medicaid programs may cover the costs of these premiums.

Congress has assessed two premium surcharges, labeled income-related monthly adjustment amounts (IRMAAs), on a sliding scale for enrollees with higher incomes. Because additional income increases these fees, the fees act as an add-on income tax for Medicare recipients with high incomes. Maximum IRMAAs for SMI and Part D, however, are capped at 85 percent of the average per capita government cost related to those insurance plans. In 2022, these monthly surcharges are capped at \$408 for Part B and \$78 for Part D.<sup>8</sup> IRMAA fees will also tend to rise as Medicare recipients' incomes rise, particularly as wealthier succeeding cohorts of retirees join the program. Indexing all fees to health costs usually causes fees to rise faster than per capita incomes rise. Congress did, however, put a *hold-harmless* limitation on beneficiaries who pay only the basic Part B fee (but not those subject to IRMAAs):



the net nominal amount of each individual's Social Security check cannot be reduced from year to year because of that particular fee increase.<sup>9</sup>

A relatively small amount of funding comes from state transfers and drug fees, generally applying to beneficiaries with low incomes and those who qualify for Medicare through disability. Also called a *state buy-in*, it relieves states from having to make other payments to cover these individuals.

## **Federal General Revenue Is the Largest Source of Medicare Financing**

General revenue transfers (excluding the tax on Old Age, Survivors, and Disability Insurance program benefits) provide the largest and by far the fastest-growing source of Medicare financing. Any increase in the net cost of Part B or Part D automatically increases this source of financing for Medicare, though it simultaneously reduces the amount of tax revenue available for all other government spending. And, of course, these general revenue transfers occur even when the current collection of revenues is insufficient to cover the government's total expenses—that is, when the government runs deficits.

The top of figure 3 shows potential HI deficits separately from the general revenue transfers for other Medicare Parts. One reason for showing this separately is that scheduled (anticipated) benefits cannot be paid in full if the HI trust fund has insufficient money. Also, if Congress keeps this trust fund dichotomy between HI and the rest of Medicare, it could cover shortfalls in HI by legislating authority to the HI trust fund to incur loans eventually to be paid back to general revenues. For that and other reasons, we need to track any HI deficits that might occur separately from other demands on general revenues.

## **Medicare Financing Can Derive Not Just from Taxes but Government-Wide Debt Financing and Reductions in Other Spending**

Who pays for one bill versus another is almost always ambiguous when it comes to general revenue financing. Money is fungible. With simultaneously rising Medicare and total government deficits, the fastest-growing source of financing to cover current total Medicare expenses exceeding dedicated revenue sources might be thought of as bond sales by the government. The payers here include future taxpayers, though which taxpayers and through which funding sources they pay remain unspecified.

Medicare's growth as a *share* of total government spending tautologically means that the share of spending on everything else has been in decline. Relatedly, while aggregate domestic spending (total spending on everything but defense and interest on the debt) on all programs has grown as a share of GDP in almost every decade since the end of World War II, the share of GDP (not just the share of spending) for all domestic programs other than Social Security, Medicare, and other health care in general has also been declining (OMB 2022).<sup>10</sup> This implies that a more-hidden way that government pays for one program is by reducing its support for other programs from what its support otherwise may have been.

## **Though Not on the Government Balance Sheet, Enrollees Also Pay Out of Pocket for Medicare-Covered Services**

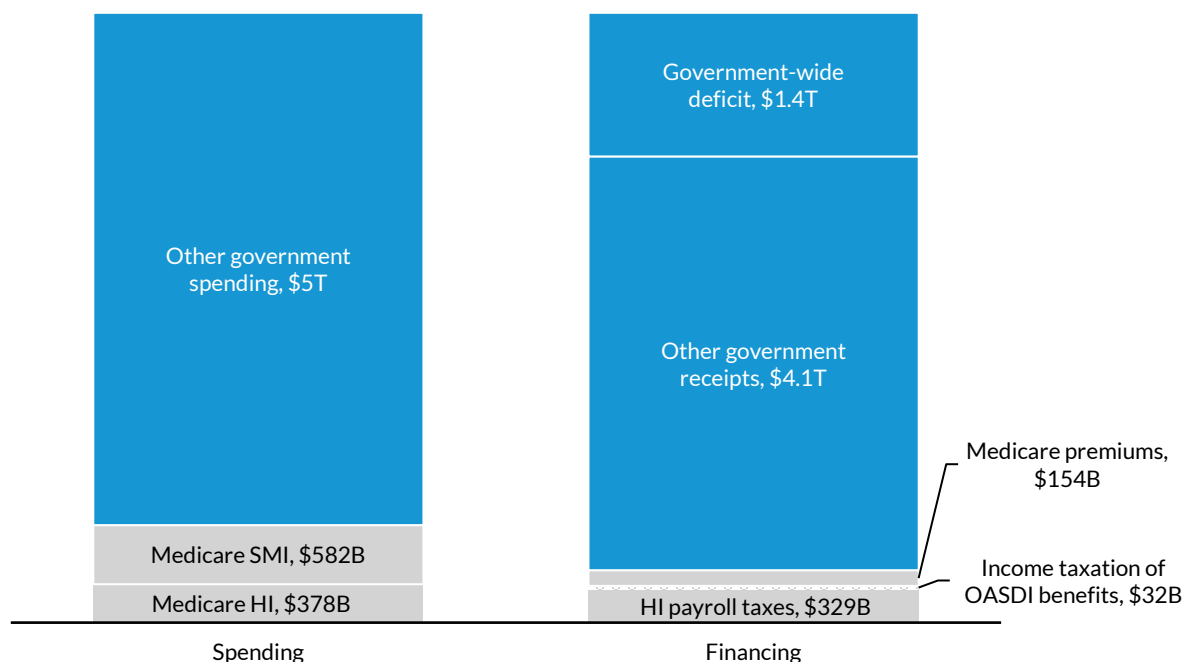
In addition to the funding sources for Medicare program spending shown in figure 3, people pay out of pocket for Medicare-covered services. They pay deductibles, copayments, and coinsurance when receiving treatment under Medicare, and many buy a Medicare supplemental plan to cover various gaps in coverage. In traditional Medicare, cost-sharing rules for Parts A and B vary across services but are the same for all enrollees. In Part D and in Medicare Advantage (Part C), cost-sharing rules vary according to what plans enrollees choose. Enrollees' cost-sharing payments are not represented in total program spending in figure 1, and, accordingly, premiums for supplemental insurance are not shown as a revenue source in figure 3. However, they do represent costs beneficiaries pay when they use Medicare services. One way to reduce government program spending is to finance more of program costs through higher cost-sharing burdens on enrollees. This could lead enrollees to use fewer services (including both beneficial and wasteful care). The recent Inflation Reduction Act passed by Congress went in the other direction and lowered those cost-sharing burdens by capping enrollee annual spending in Part D at \$2,000 and limiting Part D enrollee costs for insulin to \$35 per month.<sup>11</sup>

## **In Fiscal Year 2022 Projections, Medicare Spending Exceeding Dedicated Revenue Is Roughly One-Third the Size of the Federal Deficit**

It is also useful to consider the size and scope of Medicare in relation to the overall federal budget. For government as a whole, just like for Medicare, the level of financing required equals the level of spending undertaken. In figure 4, we provide a simple government income statement that combines both (1) Medicare spending and its dedicated funding sources and (2) total federal spending and financing. Medicare's dedicated funding sources cover a bit more than one-half of its total expenses, while general revenues—here shown as other government financing plus government-wide deficits—cover the remainder. As Medicare costs exceeding dedicated funds increase, other government receipts or deficits must increase or other government spending must decrease, or some combination thereof. Using estimated data for fiscal year 2022, total Medicare spending of \$960 billion (summing HI and SMI) makes up 16 percent of total government spending (sum of all first column amounts) and 21 percent of receipts (sum of all second column amounts less government-wide deficit financing). Medicare spending exceeding program funding (excluding interest) totaling \$445 billion (sum of Medicare spending amounts in first column less the sum of the Medicare financing amounts in the second column) equals about 11 percent of other government receipts (\$4.1 trillion) and 31 percent of the projected government deficit (\$1.4 trillion).

FIGURE 4

**Projected Medicare Spending and Financing in Relation to the Overall Federal Budget, Fiscal Year 2022**



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Source: Data from tables S-1 and S-4 and historical tables 13.1 and 15.1 in White House Office of Management and Budget, *Budget of the U.S. Government, Fiscal Year 2023* (Washington, DC: US Government Publishing Office, 2022).

Notes: T = trillion. B = billion. SMI = supplementary medical insurance. HI = hospital insurance.

## Discussion

With the impending insolvency of Medicare's HI trust fund projected in 2028, congressional action is inevitable, involving additional sources of revenue, spending cuts, or both. Congress could take a minimalist approach that only pushes out the date of HI insolvency, or it could take more comprehensive steps to address Medicare's broader financial challenges. The magnitude of the long-term challenge is daunting.

With the complex mix of funding sources for Medicare described above, it might simplify things to ask: What tax rate from a single source would be required to support projected government spending on the Medicare program (Parts A, B, and D) at 6 percent of GDP, as scheduled by the end of the 2030s? Using the current tax bases for Social Security and the individual income tax, it would take about a 15 percent Social Security tax rate (essentially all of the payroll tax currently devoted to both Social Security cash and HI health benefits) just to cover that cost. Or it would take a 12 percent average individual income tax rate—that is, about three-quarters of individual income tax revenues.<sup>12</sup> Of course, beneficiaries must also cover supplemental plan premiums and out-of-pocket payments. Because it is

difficult to imagine the public accepting taxes of such a size simply to support one program, Medicare cost containment almost certainly also needs to be part of the solution.

Some relevant broader lessons for reform emerge from this overview:

- First, taxes are only one means of financing Medicare and its growth. Deficits, premiums, and reductions in other spending each are employed over time.
- Second, the financing and spending issues for Medicare are inexorably intertwined, as several financing sources adjust automatically to the level of Medicare cost incurred and some Medicare costs adjust to the means of financing. Policies that nominally address one have implications for the other that must be anticipated. Relatedly, Medicare is unique among government programs in that its spending is under the partial control of people who demand services and the providers who supply the services. As we have written elsewhere, Congress has effectively passed on a significant power of appropriations to the private sector (Steuerle 2020). Every time a hospital administrator figures out how to add a chargeable item to a Medicare bill, or a beneficiary decides to purchase services of a specialist instead of a primary care physician, they essentially add to government “appropriations” (though, technically, Congress no longer appropriates the money but instead mandates that the bills be paid even in the absence of any new appropriations). While this occasionally happens in other programs, as when more people access a benefit for which they become newly eligible, in almost no cases do individuals and businesses have such authority over the amount to be spent. In turn, much of the power of Medicare financing, not just spending, also is passed from elected officials to individual actors—providers and consumers.<sup>13</sup>
- Third, creating a new dedicated revenue source would add to an already confusing system. Although a new source could close an existing shortfall, it is hard to match future growth in Medicare spending needs exactly with growth in particular financing sources. In general, the public finance literature suggests general revenue financing (through receipts but not deficits) is superior to dedicated financing. It is easier to enact reforms consistent with the goals of tax or budget policy without tying them tightly to health policy considerations in future years.
- Fourth, as an exception to the preference for general revenue financing, dedicated trust fund financing can work when it covers all costs and imposes budgetary rigor on matching spending and receipts. But as it currently operates, the HI trust fund performs that function only minimally by forcing occasional congressional action on the Part of the Medicare program that is not even the fastest growing.
- Fifth, broadening the base of an existing dedicated tax (e.g., subjecting nonwage forms of employee compensation like health benefits to the HI payroll tax) would be consistent with the tax policy principle of horizontal equity without necessarily adding to the complex array of Medicare financing sources.

- Finally, addressing HI and SMI together not only helps confront longer-term Medicare issues but allows financing and spending trade-offs to be made more fairly and efficiently within HI, SMI, and the tax system.

## Notes

- <sup>1</sup> There is also a Medicare Part C, called Medicare Advantage, which provides Parts A and B services through private health care plans that operate as or somewhat like health maintenance organizations (often called HMOs). Medicare makes payments on behalf of Medicare Advantage enrollees through the HI and SMI trust funds in proportion to its estimates of respective shares of Parts A and B services incurred by Part C plans.
- <sup>2</sup> Other projections in this report also rely upon estimates from the 2022 Medicare trustees report. They do not include changes that might derive from the Inflation Reduction Act of 2022, though such changes are modest relative to the total costs and revenues shown here.
- <sup>3</sup> In budget parlance, *scheduled benefits* under HI relate to what is promised to individuals, assuming adequate revenues. *Payable benefits* refer to what would be paid if current law were strictly applied, and at the time of trust fund exhaustion, benefit payments were suddenly cut back to a level commensurate with the revenues flowing into the HI trust fund on a current basis. The Medicare trustees also show a scenario where various current practices and the payment system in current law are maintained and costs rise toward 8 percent of GDP in the two decades after 2040. This alternative scenario arose when the actuaries at the Centers for Medicare & Medicaid Services feared that the assumptions of current law implied that Medicare pricing would continually fall below private-insurance pricing for the same goods and services. To limit the degree of divergence, they came up with an alternative scenario. In practice, all scenarios are limited by an assumption that currently scheduled benefits can continue, even though it creates unrealistic deficits in the budget for the future. Put another way, the actuaries do not project the interaction between these pressures and how Congress will react.
- <sup>4</sup> Some baby boomers will postpone retirement until after age 65, thus adding to the Medicare population well into the early 2030s.
- <sup>5</sup> Adding further to the confusion, the additional Medicare tax was enacted as part of the Affordable Care Act in 2010 to help pay for the cost of that bill. The additional Medicare tax was then devoted to the HI trust fund, though it obviously cannot pay for both the Affordable Care Act and Medicare. At the same time, a 3.8 percent net investment income tax—sometimes also called a Medicare tax—was levied and not dedicated to the Medicare trust fund.
- <sup>6</sup> Up to 50 percent of Social Security benefits are included in adjusted gross income that might be subject to tax for taxpayers with incomes above \$25,000 (\$32,000 for couples). Up to an additional 35 percent of benefits are potentially subject to tax for taxpayers with incomes above \$34,000 (\$44,000 for couples). The latter item is then transferred to the HI trust fund, and the former is transferred to the Old Age, Survivors, and Disability Insurance trust fund. In sum, a total of up to 85 percent of an individual's benefits may be taxed, and the Treasury calculates that additional tax (over and above the tax otherwise owed if those benefits were not subject to tax) to determine the amount to transfer to the HI trust fund.
- <sup>7</sup> For all intents and purposes, it amounts to “dedicating” a portion of general revenues to the HI trust fund (even though “general” is usually thought to mean “undedicated”).
- <sup>8</sup> “Premiums: Rules for Higher-Income Beneficiaries,” Social Security Administration, accessed August 8, 2022, <https://www.ssa.gov/benefits/medicare/medicare-premiums.html>.
- <sup>9</sup> Another source of support for Medicare beneficiaries, which we will not examine further here, is the nontaxation within the individual income tax of their government-provided Medicare benefits. Were this provided in the form of a direct expenditure credit, it would be listed as a spending item in the budget.
- <sup>10</sup> Authors' estimates based on OMB (2022) historical tables. Domestic spending is defined as total spending less spending on defense, foreign affairs, and interest on the debt.

- <sup>11</sup> Lovisa Gustafsson and Sara R. Collins, “The Inflation Reduction Act Is a Milestone Achievement in Lowering Americans’ Health Care Costs,” Commonwealth Fund blog, August 15, 2022, <https://www.commonwealthfund.org/blog/2022/inflation-reduction-act-milestone-achievement-lowering-americans-health-care-costs>.
- <sup>12</sup> Roughly speaking, the Social Security tax base is about 40 percent of GDP, and the income tax base (as measured by taxable income) is about 50 percent of GDP. Hence, to support spending on Medicare alone at 6 percent of GDP would require a Social Security tax rate of about 15 percent or an individual income tax rate of 12 percentage points. Here are the finer numbers: In the 2021 Old Age, Survivors, and Disability Insurance trustees’ report (SSA 2021), tables VI.G1 and VI.G4 show the rate of tax on Social Security (excluding Medicare or HI) as a share of taxable payroll to equal 12.4 percent, but as a share of GDP in a presumed fuller recovery year like 2028, the tax rate equals 4.78 percent. So that tax base equals about 39 percent of GDP. As for the income tax, total adjusted gross income in 2018 equaled \$11.64 trillion and taxable income equaled \$8.94 billion (according to “SOI Tax Stats: Individual Statistical Tables by Size of Adjusted Gross Income,” IRS, updated December 9, 2021, <https://www.irs.gov/statistics/soi-tax-stats-individual-statistical-tables-by-size-of-adjusted-gross-income>). GDP in 2018 equaled \$18.69 trillion. Thus, the income tax base, as measured by taxable income, equaled about 48 percent of GDP (less if one reduces the tax base by credits that further reduce tax liabilities, more if one thinks that something closer to adjusted gross income would represent a reformed tax base). Total individual income tax of \$1.54 billion equaled 17.8 percent of taxable income.
- <sup>13</sup> For instance, consider that when a drug company invents a new drug, it goes through a long process to get approval from the Food and Drug Administration and Centers for Medicare & Medicaid Services and be included in a formulary. Yet at the end of this process, any net cost increases for drugs generally trigger an automatic increase in the basic fee charged to individuals under Medicare Part D, an increase in IRMAA payments, and, largest of all, an increase in financing through government deficits, unless the government legislates an increase in taxes or other receipts or a cut in other spending.

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