

Issue Brief

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Can We Afford Medicare?

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Measuring the contribution that Medicare and Social Security make to seniors is central to the debate over entitlement reforms. Baked into the fabric of the financial status of families, these complicated programs are major determinants of the well-being of older Americans. People count on both in retirement and plan accordingly. Younger families are affected too because they assume they do not have to put aside as much as they would if the programs were substantially smaller. Further, these programs are progressive, protecting those with low incomes over their lifetimes or during major shocks such as periods of illness and unemployment. Understanding the role that these programs play is essential to understanding the impacts of various reform proposals.

In discussions about entitlement reform, the programs' "value" frequently comes up—often, the question is “do I get my money’s worth?” When the privatization of Social Security was debated in the late 1990s, many people got excited about whether they could do better by privately investing what they would otherwise have to pay into Social Security through FICA taxes. Analysts cautioned that any such gains amount to but one dimension of the program; besides paying retirement benefits, Social Security is also a disability insurance program, and by design, it provides downside protection for those facing various misfortunes across their lifetimes—something that private investments certainly do not do. Many people have periods in their work lives in which their incomes dip or major expenses make it difficult to put aside savings each year. Still, it was very popular to claim that one could do much better in the private market—often assuming a rate of return over an entire lifetime that existed for only a few high-flying years before the market crashed early in the new century. That crash and another at the end of the past decade sobered many people who thought that returns of 10 percent or more on private investments were guaranteed over time.

Ironically, the debate has now shifted to a different issue: can we as a society afford these programs and are their costs unduly burdening younger families? To answer this question, a different set of measures is needed—or at least new interpretations around the program’s costs and benefits. And much of the discussion has shifted from Social Security to Medicare, partly because talk of downsizing Medicare has traditionally gotten more political traction than any attempted encroachment on Social Security has.

For Medicare, the challenge often centers on the predicted funding imbalance for Part A of the program over time: revenues are not growing as fast as outlays. The potential depletion of the trust fund in the future is taken as “proof” that benefits must be reduced. The possibility of greater funding for the program is ignored or rejected, making Medicare’s unaffordability a self-fulfilling prophecy. With no new revenues, the trust fund established to protect Part A will be depleted unless benefits are cut. In reality, necessary changes to Medicare over time will likely require either benefit cuts or new revenues—a choice fraught with value judgments and political sensitivities. Advancing the debate requires a candid discussion of who should pay for medicare: taxpayers or beneficiaries.

In discussions of this choice, two different concepts are often used to describe Medicare’s affordability. One is based on whether taxpayers now bear an inordinate burden of costs and whether that onus will become unaffordable over time. Another common way that Medicare is currently judged is through estimates of the lifetime contributions to the program compared to the lifetime benefits expected by various groups of beneficiaries. These two different approaches each have their merits and shortcomings. In practice, it is useful to consider both measures and contrast the findings since they take different perspectives on the issue. And both are often distorted to support various arguments about Medicare’s future. This paper contrasts these two measures—which have been treated separately in earlier issue briefs in this series—and explores the appropriate interpretations of each.

Lifetime Contributions and Benefits

The measure cited most often in recent presentations and discussions has been what various cohorts of Americans have paid into the Medicare program over their working lives as payroll taxes (that fund Part A of the program) compared to what these cohorts can expect to draw out of the program. The general approach is to choose a particular year in which beneficiaries reach age 65 (the Medicare eligibility age) and estimate what people at varying levels of wages will have paid into the system over time. Since the tax rate is fixed (and since 1987 there is no upper bound limit on wages subject to tax), contributions rise steadily with wages.

The more controversial part of the measure is how to deal with benefits. Two sets of assumptions critically affect what the results look like and what they “show” about contributions vs. benefits. First, typically all Medicare benefits are included in the estimates even though payroll taxes fund only Part A.¹ And since Part A now represents just 44 percent of all Medicare’s benefits, this approach exaggerates

benefits relative to contributions. Parts B and D of Medicare are funded by general revenue contributions—mostly income taxes—and premiums from beneficiaries. Findings calculated on the basis of the higher benefit amounts are essentially guaranteed to show that beneficiaries have not “fully paid” for their benefits. Thus, we estimate only benefits for Part A.

The second assumption affects the outcome more subtly. To generate estimates in “real” (inflation adjusted) dollars, analysts have traditionally used the consumer price index (CPI) for both wages and health benefits. But since health care prices have risen much faster than other prices, this tack makes it appear that benefits are going up over time when in fact, they have been quite stable. The Part D drug benefit added in 2006 has been the program’s main benefit expansion; other changes over the years have modestly increased benefits (the addition of hospice, for example) or cut benefits (through increased co-pays such as the Part B deductible). Using the standard CPI measure this way makes it appear that future cohorts of beneficiaries will be better off—when, in fact, they will have to pay *more* out-of-pocket to receive the same level of care over time. For our estimates, we use the general CPI to adjust wages but the CPI for medical care to adjust benefits. Fine tuning this way instead of using the inflation adjustments that others have adopted has a large impact on the findings—particularly in comparing earlier to later cohorts of individuals.

For a male turning 65 in 2030, we estimate the benefit is \$82,000 in 2015 dollars. For women, it’s slightly higher (\$87,000) since they have longer life expectancies. Since wage contributions (also expressed in 2015 dollars) range from \$51,000 for low-wage workers to \$186,000 for those at the Social Security taxable maximum, the net impact would be split: low-wage workers would receive positive net benefits relative to wage contributions, and the net impacts would fall as wages rise resulting in negative net benefits for those with higher wages.

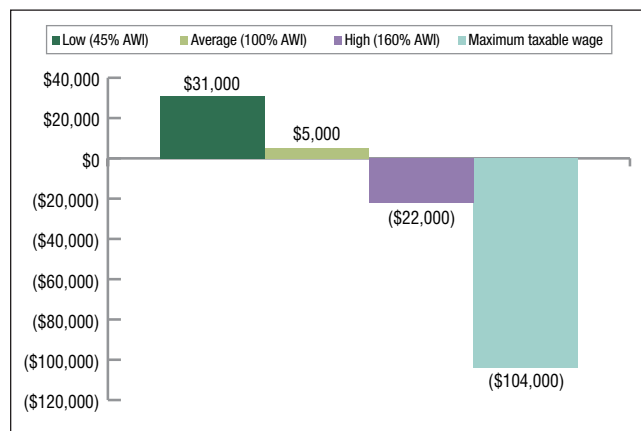
The faulty assumptions often used to estimate benefits would yield totals nearly three times higher than our estimates—\$300,000 instead of \$82,000.

¹ See, for example, Eugene Steuerle and Caleb Quakenbush, “Social Security and Medicare Taxes and Benefits over a Lifetime: 2015 Update,” The Urban Institute.

Taking out benefits from B and D drops the estimated level to \$120,000. And the different inflation adjuster accounts for much of the rest of the difference.

Our findings indicate that many beneficiaries will have contributed substantially toward their benefits and the Medicare program is much more in balance than is often claimed.² As Figure 1 shows, the present value of expected benefits is less than the estimated contributions for those turning age 65 in 2015 in the top two wage categories. And since Medicare was intended to be a progressive program, offering greater protections to those with average or lower incomes, this finding is actually what one would expect from a well-functioning Medicare program. Indeed, a misplaced focus on average workers and the sufficiency of their contributions distorts how not only the Medicare program is supposed to work but also how our entire tax system is designed. Average taxpayers do not fully pay for any government benefits. Public programs of all types in the US ask higher income taxpayers to pay more—assuring that the “average” taxpayer pays less than “average” benefits are worth.

Figure 1. Net Lifetime Medicare Benefits for Single Male, by Wage Level, 2030



Further, an overarching problem with this measure is essentially that it takes a lifetime perspective when the program was actually established as a pay-as-you-go system with current taxpayers paying for current beneficiaries. It is not a “funded” system

² See, for example, Robert Moffit, 2015, “Most Senior Citizens Haven’t Paid for their Medicare and Social Security Benefits,” Daily Signal, Heritage Foundation, December 22.

that might best be analyzed with a lifetime balance approach. The need to take account of this distinction is why a different measure may be more appropriate.

The Burden of Future Medicare Costs on Taxpayers

The second measure that can help inform the discussion over Medicare’s future is whether the burdens of future Medicare benefits are too much to ask of taxpayers. We tackle this question on a current accounts basis focusing on the full program—that is, all parts of Medicare. We question whether burdens will become untenable on future taxpayers.

Commonly, analysts address the issue of burden by pointing to statistics about the share of taxpayers relative to beneficiaries into the future that are presented each year in the annual Medicare trustees report. But this measure is inadequate, failing to take into account whether we can actually afford the benefits or whether taxpayers are willing to pay for them. In contrast, the indicator we have developed takes into consideration a broader range of factors to look at this question. It is based on earlier work,³ but updated to reflect numerous changes in Medicare over the past decade. In particular, Part D was added, increasing program costs, though beneficiaries are paying more through income related premiums, higher copays, taxation of Social Security benefits, and a new added tax on high wage income.

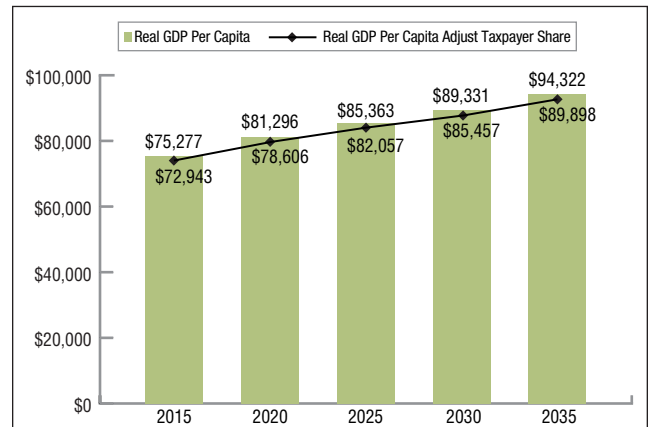
Over time, taxpayers’ share of Medicare’s costs has actually declined and will decline further as older Americans remain longer in the labor force and as income-related elements in the law that raise premiums over time for higher income beneficiaries become even more important. Going forward, taxpayers will see their Medicare costs increase over time as overall program costs rise while the number of young taxpayers to shoulder them declines. But rises in the wages and general incomes (both taxed to finance Medicare) of the working age population will also occur and need to be examined in

³ Marilyn Moon and Matthew Storeygard, 2002, “Solvency or Affordability? Ways to Measure Medicare’s Financial Health,” Henry J. Kaiser Family Foundation.

assessing burden. While the costs of Medicare are expected to grow faster than GDP, GDP is much larger so growth in the share that taxpayers will pay won't be enough to substantially dampen growth in real incomes over time.

Instead of looking only at demographics, our measure looks at how much the taxpayer burden will grow relative to per capita GDP. Between 2015 and 2035, GDP per capita is expected to rise by 25 percent in real (inflation-adjusted) terms. That means a substantial increase in the potential standard of living for young taxpayers. If the burden of Medicare on taxpayers' resources is subtracted from this measure, the rate of growth in real GDP falls, but only by two percentage points—to 23 percent. As Figure 2 shows, the burden from Medicare rises, but not enough to substantially dampen the outlook for increasing economic well-being over time for younger taxpayers. Again, a careful look at the numbers suggests that critics of Medicare often overstate the financing challenges that will face this program in the future.

Figure 2. Per Capita GDP for Young Taxpayer With and Without Medicare Burden



Conclusion

Just as we have criticized others for overstating the financing challenges facing Medicare, we cannot objectively argue that there is no problem or that no changes should be made to the program to try to reduce its costs over time. Indeed, it is in the interest of all Americans, young and old, to find ways to reduce health care costs. And a legitimate argument can be made that without those changes, burdens on future taxpayers will rise. What we do question here is the magnitude of those burdens on the young and the impression that beneficiaries themselves are not paying much toward the costs of their own care.

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