COMMENTARY

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An Intergenerational Evaluation of Medicare

Congress has been grappling with an ambitious agenda this legislative session, debating plans to support working families with child care, tax credits, housing support, preschool education, and other efforts to strengthen the middle class.[1] In the end, none of these programs were included in legislation. The failure of efforts to address the needs of Millennial young families and working adults stands in stark contrast with the continued success of one of the largest public programs to address the needs of the Baby Boom population—the Medicare program. The federal government continues to support this $1 trillion program without any substantial debate (except about ways to expand the benefits of the program). Regardless of the merits of any particular program on the legislative agenda, the disparate treatment of the needs of these different generations, Millennials and Baby Boomers, requires further reflection.

Medicare finances are again in the headlines, with a new analysis that the pandemic has extended the life of the Medicare Part A Trust fund by 2 years to 2028.[2] Once again, the perception in the press is that the Medicare program remains solvent. However, a review of the entirety of the Medicare program suggests how this perception is wildly misleading. The Medicare program requires enormous taxpayer support on an annual basis, currently projected to be $440 billion in 2023, growing to $823 billion in 2030 (Figure).[2-4]

Medicare funding consists of 3 basic programs: hospital insurance (Part A), medical insurance (Part B), and a prescription drug benefit (Part D) added in 2006. This structure reflects the design of Blue Cross/Blue Shield insurance plans in 1964, the underlying model for Medicare. Importantly, while all 3 programs are considered the Medicare program, each component has different funding streams. Medicare hospital insurance is funded through Medicare payroll taxes, a 2.9% tax on wages paid equally by employers and employees (and an additional tax of 0.9% on wages above an income threshold based on filing status). Medical insurance is an option under the program, and is paid for by premium payments (set at 25% of the expected cost of the medical insurance program in the coming year). Drug insurance is also an option, but premiums account for only 15% of the cost of the drug benefit (states contribute to the drug benefit to fund their share of the cost of dual-eligible Medicaid beneficiaries). As a result, roughly 75% of the cost of medical insurance and drug insurance comes from the federal treasury (general tax revenues or borrowing).[2-4] Thus, medical insurance and drug insurance, the fastest growing parts of Medicare, require significant annual public support, even if hospital insurance remains "solvent."

Even this sobering assessment is not a full description of the economics of the Medicare program. Solvency of the hospital insurance program in newspaper headlines merely reflects whether there are more contributions to the hospital insurance program than there are expenses of the program. Given the size of the Baby Boom population, there were more people in the workforce contributing to the program than the program cost, so there was a modest fund balance that accrued. However, the Baby Boom generation began to retire in 2011. Medicare went from a program of 47.4 million people in 2011, to the current 66.9 million in 2023, and will reach 77.5 million by 2030.[2,3] As a result, payroll tax revenues are diminishing relative to the expenses of the program.

The solvency headline is just an assessment of whether any fund balance remains after expenses. Tied into this misperception is the idea that payroll taxes were being saved for future spending. In fact, 99% of the Medicare payroll taxes collected in 2023 will be used to fund the cost of the program that year. Thus, from the perspective of working families paying both income tax and payroll tax, Medicare will consume $849 billion in tax revenue in 2023, growing to $1.4 trillion in 2030. For the labor force participant 16-64 years of age, that will be $5556 per person in 2023 alone. From 2023-2030, workers and taxpayers will need to contribute $8.8 trillion to the Medicare program to keep it afloat.

How is it that modest investments in the needs of working families face so much scrutiny and extended debate, while massive transfers to the needs of the elderly escape any notice? Medicare was set up as a mandatory spending program, more commonly called an entitlement. Medicare spending is not part of the annual budget debate on Capitol Hill. In fact, as a mandatory program, Medicare will

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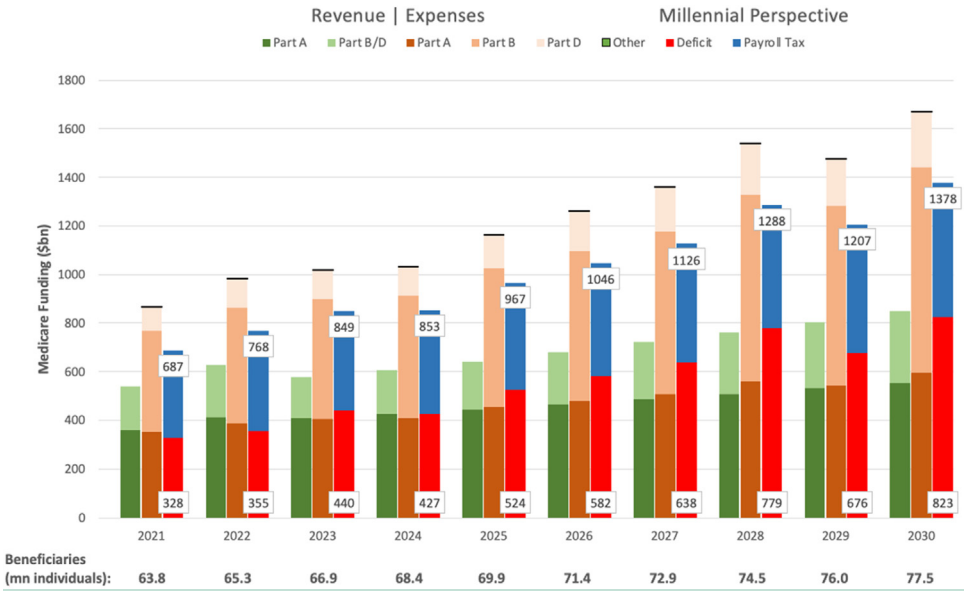

Figure Medicare revenue and expenses derived from the Congressional Budget Office.[2] Revenues represent Medicare payroll tax for Hospital Insurance (Part A), beneficiary payments for Medical Insurance (Part B), and beneficiary and state payments for the Prescription Drug Benefit (Part D). Expenses are program expenses. The deficit is the general tax revenue required to fund the program expenses above program revenue. The Millennial perspective is the general revenue and hospital insurance costs (funded through payroll taxes) to provide Medicare benefits in a given year. Beneficiaries are people enrolled in at least Medicare hospital insurance.[2-4]

continue to pay for health care services for beneficiaries whether Congress passes a budget or not. This is in stark contrast to the proposed Biden agenda, which is a set of discretionary programs that require funding through the annual appropriation process.

The purpose of this effort at accounting is not to debate the merits of one program or another, but to highlight the massive inconsistency in how the needs of the different demographic subgroups are being addressed by the federal government. For example, Medicare paid for 425,000 total joint arthroplasty procedures in 2017.[5] Examined as a line item, the cost of total joint arthroplasty might be a significant fraction of the money required for universal prekindergarten education in this country (which offers lifetime economic and health benefits), but this type of comparison in priorities is never made by the federal government nor presented to the public.

Thirty years ago, Bill Clinton became the first of the Baby Boom generation to become President, marking a generational change in leadership for the country. Over that time period, the Baby Boom generation has failed to honestly inform the public of these issues, let alone address the financial challenges of the Medicare program. It is not clear if Medicare can continue on the present trajectory of spending without an expanded national debate on the benefits and financing of the program. Such a discussion may not be popular, but it seems well past due. While there is significant commentary on the political divergence between red states and blue states, the real political battleground may emerge around the role of the federal government in setting intergenerational priorities, including the massive wealth transfer from Millennial working families to the retired Baby Boom population that is Medicare.

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