

## **ENSURING MEDICARE'S FINANCIAL HEALTH**

**Marilyn Moon, Ph. D.**

Center for Medicare Advocacy Visiting Scholar

---

Medicare, which represents a substantial share of the federal budget, is often a target of criticism and concern precisely because of its size and growth over time. And, the Part A Trust Fund, which often commands a lot of attention, is scheduled to be depleted in just a few years.<sup>1</sup> These facts often trigger discussion about the need to either cut the program--or less often—to raise taxes to support it. But before discussing proposals to curb its growth or to raise revenue, it is important to consider how Medicare has operated over time, how well it is doing at present, and what changes have been used to keep the program financially strong. This paper considers these matters and then focuses on ways to enhance revenue for the Medicare program.

### **Spending on Medicare**

Medicare is a large and complicated program that has grown rapidly since its inception in 1966, rising from 0.71 percent of GDP in 1970 to 3.73 percent in 2019.<sup>2</sup> Medicare's growth reflects both expansion in the number of beneficiaries, reflecting greater numbers of older Americans and the addition of the disabled to the program in 1972, and increases in the per capita costs of health care.

The number of Medicare beneficiaries has risen from 20.4 million in 1970 to 60.9 million in 2019.<sup>3</sup> This also represents growth as a share of the U.S. population: Medicare is caring for a

larger proportion of the population over time; the share has grown from 10 percent in 1970 to 18.6 percent in 2019.<sup>4</sup> Thus, Medicare should be expected to cost more over time (and result in lower spending on healthcare elsewhere).

Medical care has also changed substantially over this period with improvements in treatment and changes in how care is delivered. Life-saving treatments are now available that were not even dreamed of in 1966.<sup>5</sup> And, such care is often expensive. Costs of care have gone up faster than other expenses in the economy regardless of who is paying for that care. That is, increases in the per capita costs of care are not confined to Medicare. In fact, Medicare's per capita growth has often been at a slower rate than that for private insurance for younger populations.<sup>6</sup>

Further, in many ways, higher costs for Medicare over time signal substantial success:

Americans are living longer and receiving better medical care. Medicare has done a better job of holding down spending than other parts of the health care system. But it has also put pressure on care delivery through the many changes made over the years. Cost cutting efforts in place since the 1980s helped to control growth<sup>7</sup> and have often contributed to extending the expected date of depletion of the Part A Trust Fund. These efforts have included lower payments to providers of care, and innovations to improve care delivery, and higher contributions from beneficiaries.<sup>8</sup>

The substantial cost cutting over the last 30 years has meant that Medicare is not an overly generous program.<sup>9</sup> It has often lagged behind coverage available to many working Americans and studies have documented the unmet needs of these most vulnerable of our citizens.<sup>10</sup> Further limitations on coverage or payments to providers could leave even more beneficiaries at risk for

getting good care. Indeed, there are strong arguments to be made for increasing benefits—in terms of improvements in post hospital and long-term care and better protections for those with modest incomes as just two examples. But concerns about financing Medicare have often precluded serious considerations for improving the program.

Certainly, seeking ways to make the program function better or adopting new approaches that might provide good care at lower cost need to be part of any discussion of policy changes. And there are a number of areas that deserve further attention. For example, Medicare Advantage is often cited as in need of reform in the way that plans are paid and such changes could lower future costs substantially.<sup>11</sup> A number of changes could generate savings. Because plans are paid on the basis of health status, there is an incentive to “upcode” patients to ensure higher payments than would be called for if compared with patients in traditional Medicare where such “upcoding” does not occur (largely because there is no “reward” to physicians for doing so). Further, the historical nature of the basic Medicare Advantage payment system has been found to result in overpayments that have declined over time, but not been eliminated. Finally, MA plans receive bonus payments that might also be modified or eliminated.<sup>12</sup>

Part D drug benefits similarly have been cited as an area in which seeking discounts for the costs of drugs and other reforms make sense.<sup>13</sup> And Medicare’s innovation center is charged with finding new ways to enhance the delivery of care that may reduce unnecessary use or find more efficient approaches to treatment. But, 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.

## **Financing of Medicare**

The sources of financing for Medicare have not changed substantially over time but the proportions coming from each source have changed, largely because of evolution in the way that care is delivered. Since its inception, Medicare has been divided into parts, with each covering different types of care. The first two parts, A and B, were an artifact of how the legislation evolved.<sup>14</sup> Part A covers inpatient hospital, skilled nursing, hospice and some home health care. It is primarily funded by payroll tax contributions from workers and employers that are earmarked and placed in the Part A trust fund. Part B, Supplementary Medical Insurance, is available to persons eligible for Medicare on a voluntary basis (although nearly everyone takes up Part B). It covers physician services, hospital outpatient services, ongoing home health care, community-based services, and some preventive services. Part B is funded by a combination of general revenues<sup>15</sup> (75 percent of the total) and beneficiary premiums (25 percent). A voluntary drug benefit, Part D, was added in 2006 and is financed in essentially the same way as Part B. Part D, provided through private plans, is growing over time as coverage of drugs by employers is declining and drug costs rise faster than other types of health care.<sup>16</sup>

Over time, the share of Medicare that comes from general revenues and premiums has increased substantially as compared to the share from payroll taxes, largely because of changes in the health care system rather than any formal policy change in financing. (Although an increasing amount of hospital care is considered outpatient and “observation status,” which is billed to Part B. The long-term trend of medical care shifting from inpatient hospital has meant that Part B now represents a much greater share of spending as compared to Part A than when the program

was first begun in 1966. Also, physician payments have grown as a share of spending. Looking at just Parts A and B (the original portions of Medicare), Part B is now 53 percent of Medicare spending as compared to 28 percent in 1970. And when Part D is taken into account, the shift away from payroll taxes is even greater. Consequently, the share that payroll taxes cover for all Medicare has fallen from 61.8 percent in 1970 to 36.4 percent in 2019.<sup>17</sup> This makes the financing of Medicare more progressive since personal income taxes—which are the main portion of general revenues—capture more than just wages.<sup>18</sup>

However, much of the attention on financing still centers on the payroll tax because of the dedicated nature of that tax and the visibility of the Part A Trust Fund that it supports. In the early years of Medicare, the payroll tax rate was increased a number of times—as had been expected from the program’s earliest days. 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>19</sup> It was well known at that time that the payroll tax would not increase at the same rate as the costs of Medicare and hence would need to be raised periodically. Indeed, in the early years of the program, both current and future scheduled rates changed several times.

But those rate increases stopped in 1986.<sup>20</sup> Other changes took some of the pressure off of relying on rate increases for funding the program. The lifting of the cap on wages subject to tax was particularly important and occurred in 1994. In recent years, the shift of spending from Part A to Part B has helped the outlook for the trust fund along with specific efforts to reduce spending through a number of cost-cutting measures. Nevertheless, it is notable that since the

last rate increase, in 1986, both Medicare's share of the population and total spending per capita have nearly doubled.

The date of projected exhaustion of the Part A Trust Fund has varied substantially over time and is again facing a shorter period of time before changes need to be made to ensure its stability.

The effects of the pandemic in reducing payroll tax contributions while increasing costs of care have further hastened the predicted exhaustion of the Part A Trust Fund.<sup>21</sup> Thus, it is reasonable to again look at the issue of raising revenues for Medicare.

### **Who Pays for Medicare?**

It is also important to consider how much of Medicare is paid by beneficiaries themselves as compared to the younger (under age 65) taxpaying population. First, note that Medicare was never set up to be a fully funded system — i.e. one where one generation pays into the system and then draws down its benefits when retired. It has always been funded on a current basis: costs in a particular year are paid out of taxes and premiums raised in that year. Nonetheless, critics of Medicare often worry about its intergenerational burdens and whether beneficiaries themselves are paying “enough” of the costs of the program. Images of seniors as “takers” of resources is a common characterization when discussions of financing of Medicare arise.<sup>22</sup>

One popular way that people highlight the issue of burden is to point to the share of taxpayers relative to beneficiaries. This ratio has been declining over time and that decline accelerated as the baby boom generation began to pass the age of 65. For example, it was 3.0 in 2018 but will be just 2.4 to 1 in 2030.<sup>23</sup> That does put a greater burden on younger taxpayers than if the

younger population were growing faster. However, Robert Ball, one of Social Security and Medicare's early leaders, pointed out that "the financing of the system was planned with the expectation that the ratio of workers to beneficiaries would drop substantially as the elderly population continued to grow." In fact, the 1937-38 Social Security Advisory Council offered more pessimistic estimates of that ratio than what has actually occurred.<sup>24</sup> Further, this indicator does not tell the full story because it does not take into account other aspects of the current and future financing contributions made by young taxpayers versus Medicare beneficiaries.

The common view of Medicare's financing is often that younger taxpayers fund all but the premiums and copayments charged to beneficiaries. But in fact, beneficiaries also contribute to the taxes that fund the system—and these contributions have been growing substantially over time. Again, the shift of spending from Part A to Parts B and D means that the resulting rise in the share from general revenues fall more directly on beneficiaries (who pay a considerable share of income taxes) than in earlier years. After many years of Americans retiring early, more people are working past the age of 65 and hence are contributing more to both general revenue and payroll taxes than in earlier years.<sup>25</sup> Consequently, the shares of these two major taxes paid by persons over age 65 have increased over time while the shares paid by younger Americans have declined. That trend is likely to continue.

An analysis of who pays indicates that beneficiaries contribute much more on an annual basis than many analysts often assume. When contributions include what beneficiaries pay in premiums and cost sharing for their benefits each year *and* what they also pay in income and payroll taxes, the share is substantial and has risen over time.<sup>26</sup> In 2016, taxpayers were

responsible for 58.9 percent of the costs of Medicare services while beneficiaries, their families or former employers were responsible for 41.1 percent. A conservative estimate for 2035 indicates that the share paid by younger taxpayers under age 65 will fall further to 51 percent.<sup>27</sup> Thus, over time, younger taxpayers' *share* of the costs of Medicare has actually declined and will continue to fall as older Americans remain longer in the labor force and as income-related elements in the law that raise premiums for higher income beneficiaries continue to increase their cost-sharing obligations.

### **The Future of Financing**

It is likely that Medicare's costs will continue to rise over time as per capita costs of care and the share of the population over the age of 65 grow. Further, the heavy burden of the pandemic on these most vulnerable members of our population will mean that Medicare will also bear a disproportionate share of the costs of COVID's unexpected burden.<sup>28</sup> Older persons are more likely to be infected by Covid19 and have serious immediate illness, and the long-term effects – which are currently unknown – could create further burdens that will also fall disproportionately on Medicare. Some consideration of ways to increase funding to the program is going to be important for the future health of Medicare.<sup>29</sup>

**Short term solutions.** In the near term, funding decisions need to recognize the short-term economic problems from the pandemic and not expect to bolster the Part A trust fund through the usual approaches. General tax increases do not make sense as the economy is recovering. But there could be proposals to help pay for some of these pandemic costs (for people of all ages) through new and temporary revenue sources. Looking for ways to level the unequal burdens that



this health and financial crisis has imposed may include special surcharges on incomes — especially seeking to tax those who have profited during this period. This might not only mean taxes on higher income people in general, but also a temporary surtax on “excess” profits made by those who were fortunate enough to work in areas that thrived during this period. While many businesses and workers experienced difficulties in functioning while health concerns required stringent limitations on activities, others were in a position to benefit. Such an excess profits surcharge might compare incomes before and during the pandemic to determine whether there are feasible ways to reduce some of the inequality attributable to the enormous disruptions this disease imposed on the way that the economy functions. These revenues could help bolster Medicare’s higher costs.

Some other more minor changes in tax laws could also be considered. Key among these would be to dedicate at least a portion of the existing Net Investment Income Tax which was passed as part of the Affordable Care Act to the Part A Trust Fund. Although it was justified in the legislation as a way to help finance Medicare, *none* of that revenue was dedicated to the Part A Trust Fund. This tax on those with higher incomes is expected to bring in approximately \$350 billion to the U.S. Treasury over the next 10 years and at least some of it could be earmarked for Part A.<sup>30</sup> (Closing other tax loopholes might also be an option and are discussed below.)

**Solutions over the longer term.** To ensure stable financing for Medicare over time, it is important to look at the two largest sources of revenues that support the federal government: payroll taxes and personal income taxes. As noted above, both are important current sources of

financing for Medicare and over time, general revenues have grown and will continue to grow as a share of the total even if no policy changes are made. Each has advantages and disadvantages.

Payroll taxes have always been popular among the general public, likely because they are simple, administered by employers with no filing requirements by most workers, and because they are dedicated to Social Security and Medicare which remain popular programs. Taxpayers see a direct link between their taxes and these key sources of retirement and disability protections. Traditionally, the payroll tax has been criticized by economists, largely because of its lack of progressivity. Assessed only against wages—and for a long time with an upper limit on the wages subject to tax—the burdens of the tax fall more heavily on persons with lower incomes. On the one hand, progressivity for the Medicare 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 to the program. 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.<sup>31</sup> This worsens the progressivity of the tax to some degree.

Nonetheless, a modest increase in the payroll tax could raise substantial new revenues to Medicare's Part A Trust Fund, extending its life substantially and keeping the dedicated nature of the tax that funds most of Part A. For example, a Congressional Budget Office estimate in 2020 indicated that a one percentage point increase (0.5 percent each on employers and employees) would raise nearly \$900 billion between 2021 and 2030.<sup>32</sup> Introducing such a change through a more gradual increase in that rate over time as the economy recovered would

bring in less, but still provide substantial support for the Part A Trust Fund. 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 over time.

An alternative would be to add personal income taxes to the funding for Part A<sup>33</sup> (presumably as a dedicated amount to retain the Trust Fund nature of this part of the program).<sup>34</sup> Income taxes are applied to all types of income, including wages, capital gains, and interest and dividends. This would mean that there would be no extra burden on individuals whose incomes come mainly from wages, but that the burden would be more evenly spread across all income sources. This breaks the historical link between wages and retirement benefits, but that has changed to a considerable degree over time anyway.

Another variation of this approach would be to specifically target certain types of income to be devoted to the Part A Trust Fund. 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>35</sup> The Congressional Budget Office has offered a number of options for increasing revenue in this way, often with a particular focus on capital gains treatment in the personal income tax.<sup>36</sup> For example, a tax on capital gains could be used to explicitly supplement the existing payroll tax and hence implicitly enhance the progressivity of taxation. This would avoid raising taxes further on wages and instead tax income from capital—often associated with those with higher incomes. But it would also fall disproportionately on older taxpayers who are more likely to own stocks and bonds than younger persons with similar incomes.<sup>37</sup> That could be viewed as a positive by those who would like to

see seniors pay a greater share of the costs of Medicare, but it would further add to the shifting of the burden of costs onto this group as was noted above. Another loophole closer might be to eliminate existing exclusions from tax offered to various business structures. For example, including income from S Corporations and limited partnerships in various tax bases such as the Net Investment Income Tax has been proposed. Although it would affect only a very small number of people, such a change could raise over \$200 billion over a ten year period.<sup>38</sup>

## **Conclusion**

Creating new and dedicated tax revenues to protect Part A and recognizing that the automatic nature of increasing revenues for Parts B and D that occur as costs rise would put Medicare on firmer ground over time and reduce the imperative that often drives critics of Medicare to seek further spending reductions and coverage denials.

One of the critical lessons of the pandemic is the importance of a strong health care system with flexibility to respond to health challenges that arise unexpectedly. Medicare has responded well under these pressures but it will be important not to allow the likely future concerns about the costs of rising federal aid to be used as an argument for further cuts in this vital program.

## Endnotes

---

<sup>1</sup> The implications for depletion of the Part A Trust Fund are often confusing. Technically speaking, benefits cannot be paid if there are not sufficient funds in the Trust Fund to do so. But the Trust Fund is more an accounting phenomenon than an actual fund with dollars waiting to be spent. It is essentially a way of signaling the need for additional funds in the future so that no such shortfall occurs. It is sometimes treated as a signal to cut benefits to keep the fund solvent, but it is equally valid to discuss increasing revenues to support the fund.

<sup>2</sup> Board of Trustees, 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020, Washington, DC: U.S. Government Printing Office. <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf>

<sup>3</sup> Board of Trustees, 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020, Washington, DC: U.S. Government Printing Office. <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf>

<sup>4</sup> Board of Trustees, 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020, Washington, DC: U.S. Government Printing Office.

<https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf>. Bureau of the Census, “Older People Working Longer, Earning More,” by Erika McEntarfer, April 24, 2018. <https://www.census.gov/library/stories/2018/04/aging-workforce.html>.

<sup>5</sup> Health Affairs, “Contributions of Public Health, Pharmaceuticals, and Other Medical Care to US Life Expectancy Changes, 1990-2015,” by Jason Buxbaum, Michael Chernew, A. Mark Fendrick and David Cutler, September 2020, Vol. 39, No. 9. Doi.org/10.1377/hlthaff.2020.00284. Christine Cassel, Medicare Matters: What Geriatric Medicine Can Teach American Health Care, Milbank Memorial Fund and University of California Press, 2005.

<sup>6</sup> Health Affairs, “Comparing Medicare and Private Insurance: Growth Rates in Spending over Three Decades, by Cristina Boccuti and Marilyn Moon, 2003, Volume 22, pp. 230-237; Medicare Payment Advisory Commission (MedPAC), A Data Book: Health Care Spending and the Medicare Program,” 2013, Washington, D.C.; Kaiser Family Foundation 2019

<sup>7</sup> Health Affairs, “Did 1980s Legislation Slow Medicare Spending?” by Sandra Christiansen, 1991, Vol 10, No. 2, pp.135-42.

<sup>8</sup> Beneficiaries have particularly been asked to pay more in premiums for those with high incomes and in higher deductible for Part B (which is important because of shifts in services from Part A to Part B).

<sup>9</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>10</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>11</sup> Options for changing Medicare Advantage payments can be found in many places, including MedPac; Commonwealth Fund, “Regaining Equilibrium in Medicare Financing,” by Melinda Buntin, January 28, 2021 and “Addressing Medicare Solvency Will Require Both Revenue and Spending Changes,” by Mark Miller and Erica Socker, January 28, 2021. Congressional Budget Office, “Options for Reducing the Deficit: 2019 to 2028, 2018. [www.cbo.gov/budget-options/2018/54804](http://www.cbo.gov/budget-options/2018/54804).

<sup>12</sup> Greater detail about the payment structure and options for change can be found in Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2021. [http://medpac.gov/docs/default-source/reports/mar21\\_medpac\\_report\\_to\\_the\\_congress\\_sec.pdf](http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf)

<sup>13</sup> Part D proposals are also widespread. See Congressional Budget Office, “Options for Reducing the Deficit: 2019 to 2028, 2018. [www.cbo.gov/budget-options/2018/54804](http://www.cbo.gov/budget-options/2018/54804). Commonwealth Fund, “Addressing Medicare Solvency Will Require Both Revenue and Spending Changes,” by Mark Miller and Erica Socker, January 28, 2021.

<sup>14</sup> What became Part A was the original proposal for insurance since hospital and other institutional care dominated health care spending at the time. Part B was added as part of the final negotiations over the legislation.

<sup>15</sup> General revenues refer to a broad range of federal taxes, but are dominated by the individual personal income tax.

<sup>16</sup> Board of Trustees, 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020, Washington, DC: U.S. Government Printing Office.

<https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf>

---

<sup>17</sup> In 1970, there was still a contribution from general revenues into Part A as part of the transition for making all people over the age of 65 eligible for the program. Contributions from payroll taxes reached 68 percent in 1980 and have been declining thereafter. Board of Trustees, 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020, Washington, DC: U.S. Government Printing Office. <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf>

<sup>18</sup> Progressivity captures the degree to which higher income Americans pay more in taxes than those with lower incomes. Since higher income persons rely less on wages than those with lower incomes, payroll taxes tend to be less progressive than income taxes.

<sup>19</sup> Robert Myers, Medicare, Irwin Press, 1970.

<sup>20</sup> Social Security Administration, “Annual Statistical Supplement to the Social Security Bulletin, 2007,” [www.socialsecurity.gov/policy](http://www.socialsecurity.gov/policy).

<sup>21</sup> Congressional Budget Office, “The Outlook for Major Federal Trust funds: 2020 to 2030,” September 2020.

<sup>22</sup> For example, see Robert Moffitt, “Most Senior Citizens Haven’t Paid for their Medicare and Social Security Benefits,” Daily Signal, Heritage Foundation, December 22, 2015.

<sup>23</sup> Board of Trustees, 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020, Washington, DC: U.S. Government Printing Office. <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf>

<sup>24</sup> Robert Ball, Insuring the Essentials, A Century Foundation Book, 2000.

<sup>25</sup> United States Senate, “America’s Aging Workforce: Opportunities and Challenges,” Special Committee on Aging, December 2017. Social Security Bulletin, “The Increasing Labor Force Participation of Older Workers and Its Effect on the Income of the Aged,” by Michael Leonesio, Benjamin Bridges, Robert Gesumaria and Linda Del Bene, 2012, Vol, 72, No 1, pp. 59- 77. Monthly Labor Review, “Labor Force Projections to 2020: A More Slowly Growing Workforce,” by Mitra Toossi, January 2012.

<sup>26</sup> Kaiser Family Foundation, “Solvency or Affordability? Ways to Measure Medicare’s Financial Health,” by Marilyn Moon and Mathew Storeygard, 2002. American Institutes for Research, “Can We Afford Medicare?” by Marilyn Moon, Jing Guo and Yan Wang, 2016.

<sup>27</sup> Marilyn Moon unpublished calculations based on methodology described in Moon, Guo and Wang cited above.

<sup>28</sup> Congressional Budget Office, “The Outlook for Major Federal Trust funds: 2020 to 2030,” September 2020.

<sup>29</sup> As mentioned above, careful attention to spending on Medicare is warranted and savings should be pursued if the changes would improve efficiency or delivery of care. The limited nature of the benefit and the higher contributions from beneficiaries that have occurred over time argue against changes that simply shift further costs onto beneficiaries.

<sup>30</sup> Center on Budget and Policy Priorities, “Strengthening Medicare Financing: General Revenues Should be Part of the Solution,” by Paul Van der Water, December 14, 2020. <https://www.cbpp.org/research/health/strengthening-medicare-financing>

<sup>31</sup> McKinsey Global Institute, “A New Look at the Declining Labor Share of Income in the United States,” by James Manyika et al., May 2019. <https://www.mckinsey.com/featured-insights/employment-and-growth/a-new-look-at-the-declining-labor-share-of-income-in-the-united-states#>

<sup>32</sup> Congressional Budget Office, “Options for Reducing the Deficit: 2021 to 2030, 2020. [www.cbo.gov/budget-options/2020](http://www.cbo.gov/budget-options/2020)

<sup>33</sup> Bruce Vladeck has proposed making the payroll tax apply to all income and not just wages as one approach. See Commonwealth Fund, “Keeping Medicare’s Hospital Insurance Trust Fund Solvent,” by Bruce C. Vladeck, January 28, 2021. <https://www.commonwealthfund.org/blog/2021/keeping-medicare-hospital-insurance-trust-fund-solvent>. Another approach might take a share of income tax revenues and earmark them for the Trust Fund. This would mean that progressive tax rates would be used and not just a flat percentage as found in the FICA tax approach.

<sup>34</sup> A debate about the need to retain the trust fund is beyond the scope of this paper but can be found elsewhere.

<sup>35</sup> See, for example, Larrysummers.com, “A broader Tax Base that Closes Loopholes Would Raise More Money than Plans by Ocasio-Cortez and Warren,” by Natasha Sarin and Lawrence Summers, March 28, 2019. <https://www.bostonglobe.com/opinion/2019/03/28/broader-tax-base-that-closes-loopholes-would-raise-more-money-than-plans-ocasio-cortez-and-warren/BvI6zhTAKuEx08SiNrjx9J/story.html>

<sup>36</sup> Congressional Budget Office, “Options for Reducing the Deficit: 2021 to 2030, 2020. [www.cbo.gov/budget-options/2020](http://www.cbo.gov/budget-options/2020)

<sup>37</sup> See, for example, FINRA Investor Education Foundation, “A Snapshot of Investor Households in America,” September 2015. <https://www.finrafoundation.org/files/snapshot-investor-households-america#>.

<sup>38</sup> Congressional Budget Office, “Options for Reducing the Deficit: 2021 to 2030,” December 2020. <https://www.cbo.gov/publication/56783>.