Rethinking Medicare’s Payroll Tax After Health Care Reform

By Richard L. Kaplan

Richard L. Kaplan explains how Medicare is financed and analyzes the tax changes enacted in the 2010 health care reform legislation that affect upper-income taxpayers, and then considers whether the dedicated taxes that finance Medicare should be abolished in favor of funding Medicare through general tax revenues.

Among the most significant tax changes enacted in the 2010 health care reform legislation are some serious new impositions to fund the Medicare program that affect upper-income taxpayers. These changes go into effect in 2013 and apply generally to anyone, retired or not, whose adjusted gross income exceeds $200,000, or $250,000 for a married couple filing jointly. This article examines those changes and what they mean for affected taxpayers and for the Medicare program itself. The article begins by explaining how Medicare is financed. It then analyzes the new changes, noting some of the administrative complexity that will be involved, and then considers whether the dedicated taxes that finance Medicare should be abolished in favor of funding this program through general tax revenues.

How Medicare Is Financed

Medicare is the federal government’s health care program for Americans who are at least age 65 years old or are disabled.1 Although Medicare is frequently discussed as a single program, it actually consists of four distinct components, or Parts, each with its own coverage, limitations and means of financing. The most comprehensive component is Medicare Part A, which covers most hospital stays, some skilled care in a nursing facility, some home health care and hospice care. It is financed exclusively by a 1.45-percent tax on the wages and salaries of an individual,2 with a matching 1.45-percent tax paid by that individual’s employer.3 Self-employed individuals pay both portions of this payroll tax, meaning that they pay 2.9 percent of their net income from self-employment.4 It is this component of the Medicare system that is the principal focus of this article.

Nevertheless, it is important to understand that Medicare has other components as well. Medicare Part B covers most doctors’ fees, ambulance services and certain durable medical equipment. It is financed through a combination of general tax revenues and monthly premiums paid by the individual who enrolls in the program. The monthly premium in 2011 is generally $115.40,5 but certain higher-income enrollees—typically those with annual income in excess of $85,000—pay an additional amount depending on their level of income (see Chart 1 below).6

Chart 1. Medicare Part B Premiums

<table>
<thead>
<tr>
<th>Income (if Single)</th>
<th>Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$115.40</td>
</tr>
<tr>
<td>$85,001–$107,000</td>
<td>$161.50</td>
</tr>
<tr>
<td>$107,001–$160,000</td>
<td>$230.70</td>
</tr>
<tr>
<td>$160,001–$214,000</td>
<td>$299.90</td>
</tr>
<tr>
<td>Over $214,000</td>
<td>$369.10</td>
</tr>
</tbody>
</table>

Richard L. Kaplan is the Peer and Sarah Pedersen Professor of Law at the University of Illinois where he teaches federal income taxation and elder law. He is the co-author of Elder Law In a Nutshell and the faculty advisor to The Elder Law Journal.

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This so-called means-testing of Medicare Part B is a relatively new development that began in 2006 and was not part of Medicare’s original conception. My article in the JOURNAL OF RETIREMENT PLANNING explains that provision in greater detail.7

In addition, Medicare Part D covers prescription medications and is financed similarly to Medicare Part B; i.e., general tax revenues of the federal government plus monthly premiums paid by persons who enroll in the program. There is, however, no one Medicare Part D plan, and private insurers devise new arrangements each year that offer various tiers of covered pharmaceuticals, with restricted formularies, limits on dosage amounts and dosing frequency, and varying monthly premiums as well. In 2011, for example, someone enrolled in Medicare Part D has a choice of 28 to 38 different plans depending upon where that person lives.8 As one might expect, more comprehensive plans cost more and enrollee premiums reflect that reality.

Moreover, upper-income enrollees in Medicare Part D pay an additional premium that is based on the same income parameters that apply to Medicare Part B, as described previously. This premium surcharge was added by the Patient Protection and Affordable Care Act9 and took effect in 2011. That same legislation also froze the applicable income levels for both Medicare Part B and Part D through calendar year 2019.10

Finally, Medicare Part C, or “Medicare Advantage” as it is commonly denominated, provides most of the benefits of Medicare Parts A, B and D through various managed care arrangements in exchange for a single premium that is subsidized by the federal government. These managed care arrangements also generally cover many of the deductibles and co-payment obligations that enrollees in so-called traditional Medicare typically face. As a result, most Medicare Part C enrollees do not need to purchase a private “medigap” insurance policy to pay for such expenditures. These plans greatly simplify the record-keeping hassles involved in Medicare but usually have explicit restrictions in terms of hospitals, physicians, pharmacies and other health care providers. Medicare Part C presently covers approximately one in four Medicare beneficiaries.

In any case, once a person reaches age 65 and is eligible to receive Social Security retirement benefits, that person is “entitled” to Medicare Part A coverage without any additional premium being charged.11 That person’s spouse12 (and former spouse if the marriage lasted at least 10 years)13 is also entitled to so-called premium-free Medicare. In actuality, of course, Medicare Part A is not premium-free; the premiums were simply “prepaid,” one might say, during the future beneficiary’s working life.

The requirement that the person be eligible for Social Security retirement benefits usually means that the individual earned at least 40 “quarters of coverage” during his or her working life.14 A “quarter of coverage” requires a certain minimum amount of wages, salaries or self-employment income and varies by year. In 2011, the required amount is $1,120.15 No specific amount of time need actually be worked, however. So, if Sally earns $1,200 working two weeks before Christmas, she has earned a “quarter of coverage” despite the short duration of her employment. At the same time, no more than four “quarters of coverage” can be earned in any one calendar year. As a result, the requirement of 40 “quarters of coverage” typically translates into working to some extent during at least 10 years.

### Additional High-Earnings Tax

Beginning in 2013, the employee portion of the Medicare payroll tax is increased by 0.9 percent from 1.45 percent to 2.35 percent.16 The employer’s portion of this tax is not affected. The additional tax applies to wages, salaries and net income from self-employment received in excess of $200,000 per year, or $250,000 for married couples filing jointly ($125,000 for married taxpayers filing separately).17 The fact that the employee’s tax and the employer’s tax will not be the same for employees earning more than $200,000 is simply one more peculiar complication in this convoluted regime.18 In any case, the pertinent dollar parameters are not indexed for inflation,19 so this additional Medicare tax will become more significant over time.

Furthermore, this change has particular consequences for married couples with more than one earner, because the 0.9-percent additional tax applies to a couple’s combined earnings—the first time in history that marital status has mattered to the collection of Medicare’s payroll tax.

**Example 1.** Jack and Jill each earn $150,000 in wages. Although neither earns more than $200,000, their combined income of $300,000 makes them liable for 0.9 percent of their earnings in excess of $250,000, or $450 (0.9% × $50,000).

Moreover, combining a couple’s income to determine its tax liability raises issues of enforcement, because
Medicare’s payroll tax has largely been collected via employer withholding from gross wage income. The new law provides that an employer is responsible for withholding this additional Medicare tax only on the wages of the specific employee in excess of $200,000 and may disregard any earnings of the employee’s spouse. Thus, in Example 1, neither Jack’s employer nor Jill’s employer need withhold this additional Medicare tax, because neither Jack nor Jill earned more than $200,000.

In this circumstance, the affected couple will need to include the additional Medicare tax when calculating their estimated tax liabilities. Some high-earning couples may need to file estimated taxes for the first time if their nonwage income and other activities did not otherwise necessitate such filings.

New Investment Income Tax

Historically, Medicare’s taxes have been imposed exclusively on income from employment and self-employment and not on income from investment activities. Beginning in 2013, however, that limitation is removed for taxpayers with investment income in excess of the same thresholds that apply to earnings—namely, $200,000 for individuals and $250,000 for married couples filing jointly. In this case, the tax rate is 3.8 percent, which combines the employee and employer shares of the regular Medicare payroll tax (2.9 percent) and the newly added additional 0.9-percent tax on high earnings. This 3.8-percent tax applies to the lesser of the taxpayer’s (1) “net investment income” or (2) the excess of adjusted gross income (AGI) over the applicable threshold.

Example 2. Barry earns $400,000 as an employee while his wife, Michelle, receives interest income and dividends of $25,000. Their combined AGI, therefore, is $425,000, so the excess over their applicable threshold of $250,000 is $175,000. Their “net investment income,” however, is only $25,000, which is less than their excess AGI. Accordingly, the new investment income tax applies only to this $25,000. Of course, Barry’s wages in excess of the threshold (here, $150,000) were already subject to the 0.9-percent additional earnings tax.

The most critical component of this new tax regime is the definition of “net investment income.” This phrase includes what might be considered the usual suspects—namely, interest income, dividends, net capital gains (after the customary residential sale exclusion) and royalties. It also includes rents unless those rents derive from the conduct of a trade or business, unless that business is a “passive activity” as that term is otherwise understood.

“Net investment income” also includes income from annuities, but it does not include annuities from qualified retirement funds or other distributions from such plans. Such distributions are included in AGI, of course, unless they came from Roth versions of those retirement plans. As a result, such distributions might indirectly trigger Medicare’s new investment income tax despite their explicit exclusion.

Example 3. Retired couple receives interest income, dividends and net capital gains of $220,000, all of which constitutes “net investment income.” Due to their age, they must take a “required minimum distribution” (RMD) of $70,000, which will increase their AGI this year to $290,000. At this level, their AGI exceeds the applicable threshold of $250,000 by $40,000, and that amount is subject to the 3.8-percent investment income tax.

But for the $70,000 RMD, none of the “net investment income” of the couple in Example 3 would be subject to Medicare’s investment income tax, because the couple’s investment income is less than the applicable threshold. Thus, although pension plan distributions are explicitly excluded from “net investment income,” such distributions can cause the new investment income tax to apply when it would not otherwise.

How Should Medicare Be Financed?

Apart from the compliance and planning difficulties highlighted above, these new Medicare taxes raise a more fundamental issue going forward about how the program—specifically, Medicare Part A—should be financed. A payroll tax was always a peculiar choice, other than its appeal for administrative convenience and perhaps its image as a dedicated tax paid by program participants. After all, there is virtually no correlation between the health care benefits received by Medicare beneficiaries and their wage and salary income—unlike the benefits received by Social Security recipients and their earnings. Once a person satisfies the rather minimal standard of 40 “quarters of coverage,” a person becomes entitled to as much health care as he or she requires—a determination that
is made by that person’s attending physicians but is not linked to how much that person paid in Medicare taxes during his or her working life.

When Medicare was first enacted, the wage base on which its payroll tax was imposed was the same that applied to the Social Security program, but there was no inevitable reason for that connection. This connection began to unravel in 1990 when Medicare’s wage base was disengaged from the Social Security wage cap and new and higher limits were enacted. In 1993, Medicare’s wage cap was removed and its tax was imposed on all of a person’s wages, salaries and self-employment income. The most recent enactment now applies Medicare’s tax rate to investment income, at least for upper-income individuals.

The point remains, however, that there is no isomorphic relationship between the Medicare taxes one pays and the value of medical benefits one receives from that program. In fact, upper-income individuals tend to be healthier and consume correspondingly fewer medical resources than do lower-income individuals. Be that as it may, the other major components of the Medicare program, particularly Medicare Part B and Part D, are financed by a combination of general tax revenues and individual enrollee premiums, and one is hard-pressed to see why Medicare Part A should be any different.

The use of general tax revenues, moreover, would make clear that financing the health care needs of the Medicare population is a societal undertaking, much like the Medicaid program, which targets low-income individuals of any age. At a minimum, eliminating the separate taxes for Medicare would simplify the lives of employees and employers alike and would additionally reduce the cost to employers of adding new employees. Perhaps changing the financing of the Medicare program along the lines just suggested might also make its beneficiaries less inclined to protest every proposed programmatic restriction and to understand that their benefits are indeed coming from a communal funding source. The resulting change in budgetary debates can only be salutary for the republic as a whole.

**Conclusion**

The 2010 health care reform legislation increased the taxes owed by upper-income taxpayers to fund the Medicare program, beginning in 2013. Beyond raising the applicable tax rate, the new law expands the taxable base to include investment income. As a result, the concept of a separate tax to fund Medicare is even less defensible than it was originally. A simpler approach would repeal the taxes that are “dedicated” to this program and fund it instead through some combination of general tax revenues and enrollee premiums.
ENDNOTES

1 See generally Lawrence A. Frolik and Richard L. Kaplan, ELDER LAW IN A NUTSHELL (5th ed. 2010), at 56–109.
2 Code Sec. 3101(b)(6).
3 Code Sec. 3111(b)(6).
4 Code Sec. 1401(b).
5 http://questions.medicare.gov/app/answers/detail/a_id/2305.
6 Code Sec. 3101(b)(6).
9 42 USC §1395w-113(a)(7)(A), (B), added by the Patient Protection and Affordable Care Act (P.L. 111-148), 124 Statutes at Large 119 (2010), §3308(a)(1).
11 42 USC §1395c(1).
12 Id., at §402(a)(1), (c)(1).
13 Id., at §416(d)(1), (4).
15 http://questions.medicare.gov/app/answers/detail/a_id/2306/session/L2F2LzEvc2lkL0s0-bUhRTHVx.
16 The income parameters are doubled for joint return filers. 42 USC §1395r(i)(3)(C)(ii).
18 Id., at §402(b)(1), (c)(1).
20 Code Sec. 3102(f)(1).
21 Code Sec. 3102(f)(2).
22 Code Sec. 1402(a)(1), (b), added by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), 124 Statutes at Large 1029 (2010), §1402(a)(1).
23 The tax pertains to “modified adjusted gross income,” but the only modification relates to foreign earned income excluded by Code Sec. 911.
24 Code Sec. 1401(a)(1).
25 Code Sec. 1411(c)(1)(A)(i), (ii), added by P.L. 111-152, 124 Statutes at Large 1029 (2010), §1402(a)(1).
26 Code Sec. 1411(c)(1)(A)(i).
27 Code Sec. 1411(c)(1)(A)(i), (2)(A).
28 Code Sec. 1411(c)(1)(A)(i).
29 Code Sec. 1411(c)(5).
30 See, e.g., Code Sec. 408A(d)(1).
32 See note 1, supra, at 295–99.
34 Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), 104 Statutes at Large 1388 (1990), §13207(a)(2).
36 See note 1, supra, at 110–38.