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Keeping Medicare Solvent

How Immigrants Subsidize Medicare's Trust Fund for All U.S. Seniors

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Background

Medicare is a publicly funded health insurance program that provides care to roughly 60 million American seniors and disabled individuals. The Hospital Insurance Trust Fund (HITF) is the core trust fund that finances hospital and nursing home care through what is known as Medicare Part A. The HITF is now predicted to become insolvent by 2024, two years earlier than previously forecast due to COVID-19's economic effects.[1] The Congressional Budget Office estimates that without Congressional action to shore up the Trust Fund, Medicare spending will have to be cut by 17 percent — about $1,000 per beneficiary — to keep the program operational for future generations.[1]

Previous research has already found that immigrants contributed billions more to the Trust Fund between 1996 and 2011 than the Trust Fund expended for their benefits—helping to keep the trust fund solvent.[2] The HITF is mostly funded by payroll taxes, also known as FICA taxes. As immigrants tend to be younger and active in the workforce, their net contribution to the Trust Fund is large relative to their use of Medicare-funded care. In this brief, we examine immigrants' contributions to Medicare's HITF from 2012 to 2018 nationally and in states with significant numbers of immigrants.

Between 2012 and 2018 immigrants contributed an average of $165.52 more per capita annually to the Medicare Trust Fund than Medicare spent on their behalf. Over the same time period, the U.S.-Born cost the Trust Fund an average of $51.46 per capita, as more was spent on their behalf than was contributed.

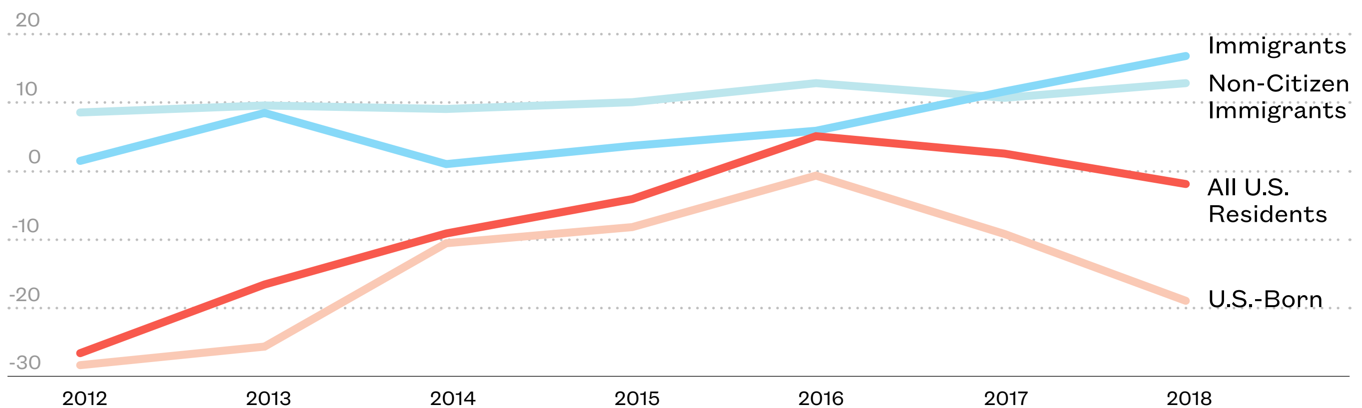
TABLE 1: IMMIGRANTS AND U.S.-BORN PER CAPITA CONTRIBUTIONS, EXPENDITURES, AND NET CONTRIBUTIONS, 2012-2018

	Immigrants			U.S.-Born		
Year	Tax Contributions	Withdrawals (Spent on their behalf)	Net Surplus (Loss)	Tax Contributions	Withdrawals (Spent on their behalf)	Net Surplus (Loss)
2012	$867	$823	**$44**	$858	$961	**($103)**
2013	$888	$670	**$219**	$862	$955	**($93)**
2014	$900	$860	**$40**	$872	$910	**($37)**
2015	$958	$865	**$92**	$909	$937	**($28)**
2016	$994	$860	**$135**	$946	$947	**($1)**
2017	$989	$733	**$256**	$949	$980	**($31)**
2018	$982	$609	**$373**	$939	$1,006	**($67)**

Results

Immigrants paid $51 billion more in taxes that pay for Medicare than they used in Medicare-paid services between 2012 and 2018. Non-citizen immigrants specifically contributed nearly $75 billion more than they used over the same period. Meanwhile, their U.S.-born counterparts used $98 billion dollars more than they contributed to the Trust Fund in taxes.

FIGURE 1: NET MEDICARE HOSPITAL INSURANCE TRUST FUND SURPLUSES OR DEFICITS ATTRIBUTABLE TO IMMIGRANTS, U.S.-BORN PERSONS, NON-CITIZEN IMMIGRANTS, AND ALL U.S. RESIDENTS, 2012-2018



The table below displays immigrants' contributions to Medicare between 2012 and 2018 in the states with large numbers of immigrants.

TABLE 2. CONTRIBUTIONS, EXPENDITURES, AND NET CONTRIBUTIONS TO MEDICARE BY THE U.S.-BORN AND BY IMMIGRANTS IN STATES WITH LARGE IMMIGRANT POPULATIONS, 2012-2018

	Immigrants			U.S.-Born		
State	Tax Contributions	Withdrawals (Spent on their behalf)	Net Surplus (Loss)	Tax Contributions	Withdrawals (Spent on their behalf)	Net Surplus (Loss)
CA	$965	$714	**$251**	$927	$760	**$167**
TX	$822	$488	**$334**	$823	$704	**$119**
AZ	$802	$338	**$464**	$868	$777	**$92**
IL	$1,038	$461	**$577**	$960	$856	**$105**
GA	$795	$114	**$681**	$811	$909	**($97)**
VA	$1,141	$450	**$691**	$1,039	$1,265	**($227)**
WA	$1,048	$787	**$261**	$1,012	$994	**$19**
NY	$983	$1,254	**($271)**	$1,006	$808	**$198**
FL	$829	$1,323	**($494)**	$867	$1,061	**($194)**
MA	$1,121	$1,306	**($185)**	$1,098	$1,278	**($180)**
NJ	$1,092	$901	**$191**	$1,050	$590	**$461**

Conclusions

What the data show is that immigrants continue to be important contributors to Medicare's Hospital Insurance Trust Fund. Comparison with prior analyses which included years 1996-2011[2] suggest the annual amount of this immigrant subsidy has fallen slightly in more recent years. This difference likely reflects the changing age distribution in the United States overall, and among immigrants in particular. Migration rates have slowed in recent years[3] and the average age of immigrants has risen. As age is the biggest driver of average Medicare Trust Fund contributions (via payroll taxes from working adults) and withdrawals (via care delivered to those eligible for Medicare, typically those age 65 and older), results are sensitive to these age shifts.

State-level findings are similar to national results with some state-specific differences likely driven by the average age of residents (compared to the U.S. average) as well as the within-state age differences between immigrants and the U.S.-born. For example, in Florida the overall older age of both groups led to net deficits for both immigrants and U.S.-born persons. In New York, the average age of immigrants and the proportion of immigrants age 65 and older exceeded those of the U.S-born, which has led to a net deficit for immigrants and a small surplus among the U.S.-born. In some states where the average age was lower than the national average (e.g. California) both immigrants and the U.S.-born contributed a net surplus to the Trust Fund with immigrants contributing more per-capita. These state-level age differences likely reflect state-specific, historical migration patterns.

Overall, however, the data is clear. Immigrants contribute substantial subsidies to Medicare's Hospital Insurance Trust Fund helping stave off its insolvency. In light of current predictions about the impact of the COVID-19 pandemic on the solvency of the trust fund, these subsidies are likely to be even more critical in the future. Recent efforts to reduce the flow of immigrants is likely to threaten the solvency of the HITF and jeopardize healthcare for the 60 million Americans who rely on it. These findings suggest that efforts to stabilize the program's finances should include immigration reform efforts that encourage the flow of immigrant workers into the United States.

METHODOLOGY

Data Sources

Current Population Survey

To determine Medicare Health Insurance Trust Fund (HITF) contributions, we analyzed data for persons of all ages from the March supplements to the 2013-2019 Current Population Survey (CPS), reflecting events occurring in 2012-2018. The CPS is a continuous monthly survey conducted jointly by the Census Bureau and the Bureau of Labor Statistics that provides detailed, nationally representative income information for the civilian non-institutionalized U.S. population.[4] The March, 2019 CPS (the most recent reliable year of survey data reflecting 2018 events) included 180,101 respondents. Because of problems with data collection due to the COVID-19 pandemic, data from the 2020 CPS is considered less reliable and were thus not included. The information available from each year's survey includes self-reported personal income from the previous calendar year. The CPS also provides information on respondent citizenship status and birthplace.

Medical Expenditure Panel Survey

Medicare expenditures on behalf of each population group were determined using data from the 2012-2018 Medical Expenditure Panel Surveys (MEPS). MEPS is a nationally representative survey of the U.S. civilian non-institutionalized population conducted by the Agency for Healthcare Research and Quality (AHRQ). Because MEPS provides data on health care expenditures by each payment source, it allows researchers to isolate Medicare expenditures. Our final 2018 MEPS sample included 29,338 respondents for whom place of birth could be identified.

Immigrant and Citizenship Status

The CPS includes detailed information on birthplace and citizenship status. To determine citizenship and immigrant status for MEPS respondents we linked each MEPS respondent to their data from the National Health Interview Survey (from which the MEPS sample is drawn), which includes information on nativity and citizenship status. We considered all participants born outside of the U.S. to be immigrants.

Calculating Contributions, Expenditures, Surpluses, and Deficits

Contributions to the HITF come primarily from payroll taxes, with smaller amounts coming from income taxes on the Social Security benefits received by higher-income beneficiaries. To calculate payroll contributions to the HITF by immigrants and others, we multiplied wage and salary earnings by 2.9 percent (the rate of payroll taxes that fund Medicare). We then added revenue from taxes on some Social Security income. In order to calculate the value of taxes on Social Security, we used the latest available, appropriate tax rates obtained from a Congressional Budget Office analysis of both the 2005 Current Population Survey and Statistics of Income data published in 2011.[5]

To calculate HITF expenditures for individuals covered by Medicare's fee-for-service program, we summed hospitalization expenditures paid directly by Medicare. Expenditures for those covered under Medicare's managed care plans (Medicare Advantage) were estimated by summing Medicare Advantage plans' total payments to providers and inflating them by the inverse of the average Medicare Advantage medical loss ratio (obtained from a 2009 survey of 41 major Medicare Advantage plans[6]), a standard tool used to adjust payments for administrative and other expenditures by health insurance companies. In order to tabulate home health care and Medicare Advantage expenditures, we determined the proportion of these expenditures that were financed by the Trust Fund.[7] Trust Fund contribution and expenditure dollar estimates were generated by multiplying each group's share of total contributions (or expenditures) by the Medicare Trustee's estimate of total HITF revenues and outlays for each year of analysis. Total net surplus or deficit was calculated for each group (non-immigrants, immigrants overall, and non-citizen immigrants) by subtracting that group's Trust Fund withdrawals from their Trust Fund contributions. CPS data was used for population estimates in calculating per capita figures. All values were adjusted for inflation to 2018 dollars using the Consumer Price Index,[8] and all analyses of the MEPS and the CPS used sampling weights and appropriate statistical procedures to account for each survey's the complex sampling design.

State Specific Analyses

We used publicly available information on the state of residence in the CPS and in restricted use files from the MEPS. To ensure robust estimates, we pooled data across eight years (2012-2018) for states with the largest number of immigrants in the sample.

Data Appendix

Appendix Table 1: Immigrants and U.S.-born persons' total Medicare contributions, expenditures, and net contributions, 2012-2018

	Immigrants			U.S.-Born		
Year	Contributions, $	Expenditures, $	Net Surplus (Loss), $	Contributions, $	Expenditures, $	Net Surplus (Loss), $
2012	34,783,934,640	33,020,550,514	**1,763,384,126**	232,566,555,360	260,504,399,886	**(27,937,844,526)**
2013	36,433,595,680	27,460,119,570	**8,973,476,110**	234,807,489,560	260,012,095,590	**(25,204,606,030)**
2014	37,965,561,524	36,281,445,482	**1,684,116,042**	238,948,057,256	249,189,732,438	**(10,241,675,182)**
2015	41,245,772,494	37,272,974,823	**3,972,797,671**	250,626,919,266	258,345,938,197	**(7,719,018,931)**
2016	43,594,872,688	37,693,032,868	**5,901,839,820**	261,712,794,662	261,967,059,332	**(254,264,670)**
2017	44,920,210,075	33,292,414,936	**11,627,795,139**	263,448,898,445	272,152,038,454	**(8,703,140,009)**
2018	45,010,586,377	27,917,400,884	**17,093,185,493**	261,608,965,623	280,272,455,116	**(18,663,489,493)**

Appendix Table 2: Immigrants and U.S.-born persons' total Medicare contributions, expenditures, and net contributions by state, 2012-2018

	Immigrants			U.S.-Born		
State	Contributions, $	Expenditures, $	Net Surplus (Loss), $	Contributions, $	Expenditures, $	Net Surplus (Loss), $
CA	68,095,478,074	50,404,160,680	**17,691,317,395**	186,282,274,623	152,729,485,636	**33,552,788,987**
TX	26,387,666,417	15,662,977,053	**10,724,689,364**	130,773,505,815	111,850,692,514	**18,922,813,300**
NY	29,780,722,664	37,982,234,972	**(8,201,512,308)**	107,164,696,759	86,102,090,593	**21,062,606,166**
FL	24,276,613,513	38,751,275,823	**(14,474,662,309)**	96,837,216,164	118,530,377,888	**(21,693,161,724)**
AZ	6,018,180,006	2,534,843,141	**3,483,336,865**	35,032,608,705	31,334,653,574	**3,697,955,130**
MA	8,774,404,499	10,224,989,113	**(1,450,584,614)**	43,108,675,212	50,175,437,060	**(7,066,761,848)**
NJ	15,186,844,463	12,524,256,018	**2,662,588,445**	50,642,533,277	28,432,105,404	**22,210,427,873**
IL	13,057,202,262	5,794,977,211	**7,262,225,051**	73,261,638,011	65,279,777,193	**7,981,860,818**
GA	5,924,802,382	847,588,032	**5,077,214,350**	51,170,647,052	57,317,783,144	**(6,147,136,092)**
VA	8,692,570,233	3,425,297,686	**5,267,272,547**	51,812,779,303	63,122,094,685	**(11,309,315,382)**
WA	7,539,282,291	5,661,989,825	**1,877,292,465**	43,642,982,570	42,840,346,460	**802,636,111**

ENDNOTES

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