

STRENGTHEN SOCIAL SECURITY

...don't cut it.

Frequently Asked Questions about Medicare

As Congress and the incoming Administration debate changes to our nation's health care system, Americans should be especially watchful for proposals that would cut or weaken Medicare, including proposals that would privatize benefits. Medicare is a large and complex program, and discussions about Medicare policy in the media are often filled with myths and misinformation. To help advocates, journalists, and members of the public better understand the debate surrounding Medicare, this fact sheet explains essential information about our Medicare system, including the coverage it provides, the people it serves, and major myths about the program.

What is Medicare?

Medicare is a public health insurance program that was created in 1965 to address the growing healthcare costs facing American seniors, many of whom did not have access to, or could not otherwise afford, health insurance. Today, Medicare provides health insurance coverage to seniors, people with severe and work-ending disabilities, and others with qualifying conditions. Medicare consists of four parts:

- **Traditional Medicare (Parts A and B)**
 - **Hospital Insurance, (Part A)**, which covers inpatient hospital treatment, skilled nursing facility and hospice care, and some home health visits;
 - **Supplementary Medical Insurance (Part B)**, which covers physician, outpatient, and preventative services, as well as some home health care;
- **Medicare Advantage (Part C)**, which allows Medicare beneficiaries to enroll in a private plan as an alternative to traditional Medicare; and
- **Prescription drug coverage (Part D).**¹

Why is Medicare important?

Medicare provides health insurance to Americans who typically have the greatest healthcare needs, as well as fixed incomes and limited resources: seniors and people with severe and life-altering disabilities. Before the creation of Medicare in 1965, and its expansions since, these Americans typically did not have access to, or could not afford health care coverage through private insurers.

Today, the vast majority of seniors and people with severe disabilities in the United States have health insurance, largely through Medicare.² Medicare ensures that the most vulnerable Americans do not have to forgo critical healthcare services, or paying for other basic needs (such as food and heat) because of high healthcare costs.³

Who receives Medicare?

Roughly 1 in 5 Americans receives health care coverage through Medicare. In 2015, Medicare provided health insurance coverage to 55.3 million Americans, including 46.3 million Americans ages 65 and

older, and 9 million Americans under age 65 who have a severe and work-ending disability or another qualifying condition.⁴ To be eligible for Medicare, beneficiaries must have made mandatory contributions to Medicare during their working years, and:

- **be 65 or older;**
- **have a severe and work-limiting disability** that has entitled them Social Security Disability Insurance (SSDI) benefits for 24 months;
- **have Lou Gehrig’s disease** (amyotrophic lateral sclerosis, or ALS); or
- **have end-stage renal disease** (ESRD) and receive maintenance dialysis or a kidney transplant.⁵

Virtually all Medicare beneficiaries also receive Social Security retirement or disability benefits, and the majority live on fixed incomes and limited savings. Half of all Medicare beneficiaries had incomes under \$24,150 and savings under \$63,350 in 2014.⁶

How is Medicare financed?

Medicare has a variety of revenue sources. Traditional Medicare, or Part A, is financed primarily through payroll contributions on earnings, made by workers and their employers—much like Social Security. Parts B and D are financed primarily through premiums paid by beneficiaries, supplemented by general revenues. Part C (the Medicare Advantage program) also financed primarily by premiums and general revenues.⁷

Why was Medicare created?

Since the implementation of Social Security and the New Deal, policymakers concerned with healthcare costs and access have envisioned a national health insurance program for all Americans, based on the same social insurance model used by Social Security. Various attempts at such a program were raised, and failed, until the introduction of Medicare as a crucial component of President Lyndon Johnson’s War on Poverty.

Although its architects envisioned Medicare as the first incremental step of a national health insurance program with universal coverage, they decided to start with Americans over age 65, who were struggling to access affordable healthcare coverage through private insurers. In 1972, Medicare was expanded to cover people with severe and life-altering disabilities, as well as those with end-stage renal disease. Since then, however, Medicare has not been significantly expanded, despite its legacy as a critical expansion of Social Security and our nation’s social insurance system.⁸

How is Medicare different from Medicaid?

Like Medicare, Medicaid is a vital part of our nation’s public health system and was a major component of President Lyndon Johnson’s War on Poverty. However, the two programs are differently administered (Medicare is a federal program, while Medicaid is operated jointly between the federal government and the states) and serve different segments of the population. While Medicare covers seniors and Americans with disabilities regardless of income, Medicaid coverage is limited to Americans (including children and non-disabled working-age adults) living in or near-poverty.

Because Medicaid protects Americans living in or near poverty from unaffordable health care costs, low-income Medicare beneficiaries also receive health care coverage through Medicaid. Medicaid also covers several services that Medicare does not, including long-term care and devices such as hearing

aids.⁹ Because of the absence of affordable long term care, many seniors spend down in order to qualify for its long term care protection. In fact, one-fifth of Medicaid's overall budget is spent on long term care.¹⁰ As a result, Medicaid is especially important to Medicare beneficiaries in need of long term care, as well as more generally for beneficiaries with limited incomes and few resources.

How is Medicare different from private insurance?

Medicare was introduced in 1965 to provide healthcare coverage for seniors, whom private health insurers were unwilling or unable to affordably cover. Unlike private insurance, which seeks to minimize risk and maximize profit, Medicare is accountable to the public, and required to cover all eligible seniors and Americans with severe disabilities, regardless of their healthcare needs.¹¹

Because Medicare has such a broad risk pool, with no adverse selection, it is much more efficiently managed than private insurance, despite insuring individuals with more expensive healthcare needs. In 2015, administrative expenses accounted for just 1.4 percent of all Medicare expenditures.¹² In contrast, private health insurers have combined administrative expenses and profits that average around 12 to 14 percent.¹³

Isn't Medicare welfare?

No. Medicare, like Social Security, is an earned benefit. Consistent with that, unlike welfare, Medicare coverage is not need-based or means-tested—those who have made sufficient contributions to be insured for traditional Medicare and meet the eligibility criteria may receive benefits, regardless of their incomes. Medicare beneficiaries have paid for—and deserve—the healthcare coverage they receive from Medicare in the event of old age or a severe and life-altering disability.

Isn't Medicare unsustainable?

No. Even as total health care costs in the United States—private, as well as public—have grown rapidly in recent years, Medicare remains one of the most cost-effective healthcare providers, despite insuring Americans with the greatest—and most expensive—health care needs.

Medicare is extremely well-managed—in 2015, administrative expenses accounted for just 1.4 percent of all Medicare expenditures.¹⁴ And its costs have grown less rapidly than those of private insurers: Over the last three decades, Medicare's per-enrollee spending has grown at an average of 5.7 percent per year, compared to 7 percent for private health insurance.¹⁵

Can't Medicare beneficiaries find a better health insurance plan on their own?

No. Although proposals to replace traditional Medicare with vouchers for private insurers are popular with those seeking to cut the program, Medicare beneficiaries already have the option to receive their benefits through a private insurer under Medicare Advantage. These private plans are less preferred—only one-third (31 percent) of Medicare beneficiaries are covered by a Medicare Advantage plan, while the vast majority opt for coverage through traditional Medicare.¹⁶

While Medicare Advantage offers beneficiaries more customization of their health care, these plans limit out-of-pocket costs and do not allow them to enroll in a supplementary insurance (Medigap) plan to help cover costs, leaving enrollees vulnerable to high costs if they have an unexpected injury or illness. And Medicare Advantage is less cost-effective than traditional Medicare—in 2009, Medicare paid 14

percent more per beneficiary for Medicare Advantage enrollees than for those enrolled in traditional Medicare.¹⁷ Given these disadvantages of existing Medicare Advantage plans, seniors and people with disabilities are unlikely to find a better—or more affordable—health care plan through private insurers. Simply providing seniors and people with disabilities with vouchers, rather than Medicare, will improve the federal government’s balance sheet, but it does so by shifting costs to individuals who are not in any way prepared to absorb them and could wind up with no insurance whatsoever.

Didn’t the Affordable Care Act already cut Medicare?

No. The Affordable Care Act (ACA) does contain several provisions to slow the growth of costs within Medicare and in the United States health system as a whole, and to increase Medicare revenues. However, these provisions target inefficiencies in health care delivery and incentives to prioritize quantity of care over quality, and do not reduce the coverage provided to beneficiaries. Cuts in Medicare spending enacted by the ACA are almost entirely focused on payments to providers, private insurers, and hospitals, rather than on the care provided to beneficiaries. Finally, the ACA ensures better coverage for Medicare beneficiaries by eliminating cost-sharing for preventative care, phasing out the coverage gap (known as the “donut hole”) in Medicare’s Part D prescription drug plan, and creating incentives for health care providers to prioritize quality of care over quantity.¹⁸

What changes should be made to Medicare?

Medicare should be expanded, both in terms of the services it covers and the populations it serves. As vital as Medicare is to seniors and people with severe disabilities, it still does not cover several services that are especially important to these groups. Medicare coverage should be extended to vital and widely-used services such as eyeglasses, hearing aids, and dental services. Given the high costs of prescription drugs, Medicare should also be allowed to negotiate drug prices, as Medicaid already does.¹⁹ And Medicare’s long-term care coverage should be expanded as well, to ensure that beneficiaries with chronic conditions who require assistance with daily living do not exhaust their resources paying for services such as nursing facilities, home health aides, personal care, and family caregiving.

Finally, in keeping with Medicare’s legacy as a critical expansion of our nation’s social insurance system, Medicare should be expanded to cover all Americans. This proposal, often called Medicare-for-All, has long been supported by the policymakers who created and expanded Medicare over the years. Unlike healthcare proposals such as the ACA, covering all Americans under Medicare would reduce overall healthcare costs, streamline the fragmented and complex public-private healthcare system that Americans are forced to navigate today, and ensure that limited incomes and pre-existing conditions do not prevent individuals from obtaining vital and medically necessary care.²⁰ It could be done in incremental steps, by lowering the initial age of Medicare eligibility, introducing a counterpart program for children, and gradually meeting in the middle.

¹ Juliette Cubanski, et al. “A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers,” The Henry J. Kaiser Family Foundation, March 20, 2015. <http://kff.org/medicare/report/a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/>

² Social Security Works, *Social Security, Medicare and Medicaid Work for the United States: 2015*, August 14, 2015. <http://www.socialsecurityworks.org/wp-content/uploads/2015/08/US20151.pdf>

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