Medicare: Protecting Seniors and Families

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JOINT ECONOMIC COMMITTEE
DEMOCRATS
U.S. Senator Martin Heinrich
Ranking Member

Medicare: Protecting Seniors and Families

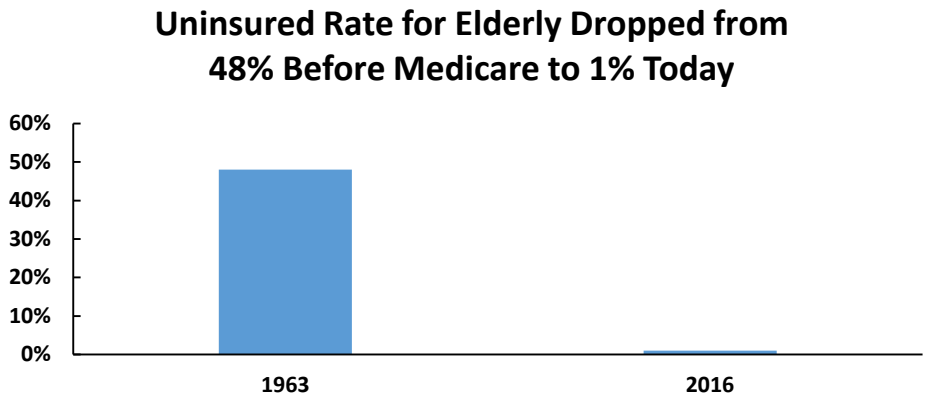
Medicare is one of the success stories of the last half century. Since its passage in 1965, Medicare has facilitated the near-universal health coverage of the elderly population in America and the dramatic decline in their poverty rate. With Medicare's help, seniors are able to access the high-quality care they need while minimizing strain on their pocketbooks. Today, more than 58 million seniors and people with disabilities are able to live longer, healthier, and more financially secure lives.[1]

Medicare is more than just a health insurance program, however. Beyond protecting beneficiaries' physical and financial wellness, it plays a critical role in supporting the millions of families across the country who help care for their elderly loved ones. Medicare provides relief to adult children who might otherwise have to choose between keeping their jobs and taking care of their parents. It provides reassurance for those who are struggling to care for both their children and elderly relatives. And it ensures family budgets are better protected from unexpected or catastrophic medical expenses as their elderly relatives age.

Republican efforts to cut Medicare not only threaten seniors' health and livelihoods, but they also endanger the financial stability of millions of middle- and low-income families and the strength of local economies. To protect seniors' health and financial security, and to support families who are juggling their caregiving and professional responsibilities, Congress must preserve this critical earned benefit and ensure seniors and families are getting the help they need.

Provides Access to High-Quality Health Care

Medicare has greatly increased access to medical care, allowing millions of seniors to live longer, healthier lives than ever before. Today, only 1 percent of America's seniors lack health insurance, down from nearly half in 1963.[2] This has led to better health outcomes and better-quality care for our elderly population. Medicare beneficiaries admitted to hospitals through the emergency room have a 20 percent lower mortality rate than older Americans without Medicare.[3] Beneficiaries are also less likely than those who are the under the age of 65 with private insurance to report having negative insurance experiences.[4]

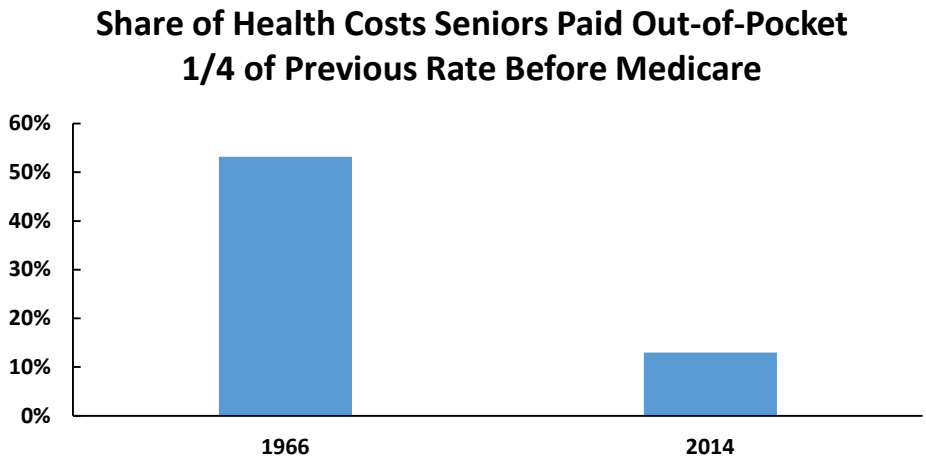


Source: JEC Democratic staff analysis of data from the Social Security Administration and 2017 CPS ASEC.
Note: Elderly refers to those ages 65+ and over. Health insurance rates may not be directly comparable due to differences in survey methodology.

Medicare also plays a major role in addressing inequities in access to care. Elderly black and Hispanic beneficiaries are two-thirds and half, respectively, as likely to have supplemental coverage from an employer-sponsored plan compared to white beneficiaries.[5] Fifty-five percent of Asian American seniors only have insurance through Medicare or through Medicare and Medicaid combined, compared to 40 percent of the total elderly population.[6] For American Indian and Alaska Natives (AIAN) seniors, 66 percent lack private coverage, compared to 43 percent of white non-Hispanic seniors.[7]

Relieves Pressure on Seniors' Pocketbooks

Through providing coverage, Medicare has dramatically lowered out-of-pocket medical costs for seniors. Out-of-pocket costs are especially burdensome for the elderly. While their medical expenses increase with age, seniors often live on low and fixed incomes. Medicare helps offset these costs, allowing seniors to keep more of their limited incomes. In 2014, the share of health care costs seniors paid out of pocket was 13 percent, one-fourth of the share in 1966.[8] Qualifying for Medicare also reduces the percentage of people with out-of-pocket spending that exceeds their income by over half.[9]



Source: JEC Democratic Staff analysis from the Social Security Administration and MEDPAC
Note: Seniors are those age 65+.

Protecting against medical risk and lowering out-of-pocket costs means less financial strain on seniors and their families. Medicare beneficiaries are half as likely to report problems paying bills compared with people with employer-based coverage. In fact, Medicare beneficiaries are less likely to experience burdensome medical bills than those under age 65 who have employer-sponsored or individual insurance coverage.[10]

Medicare and Nonelderly Americans with Disabilities

In 1973, Medicare began extending its coverage to people with disabilities and end-stage renal disease, regardless of age. Americans with disabilities become eligible for Medicare after a 24-month waiting period once they receive Social Security Disability Insurance (SSDI). People under age 65 with end-stage renal disease (ERSD) or with amyotrophic lateral sclerosis (ALS) are exempted from this waiting period.

Today, Medicare covers 9.1 million people with disabilities under age 65, totaling 16 percent of all beneficiaries. Many SSDI recipients have substantial health care needs: 34 percent of recipients in 2014 qualified due to mental disorders, for instance, while 28 percent qualified due to musculoskeletal system and connective tissue diseases that limit mobility.[11] These kinds of chronic conditions put added strain on people already limited in their ability to work.

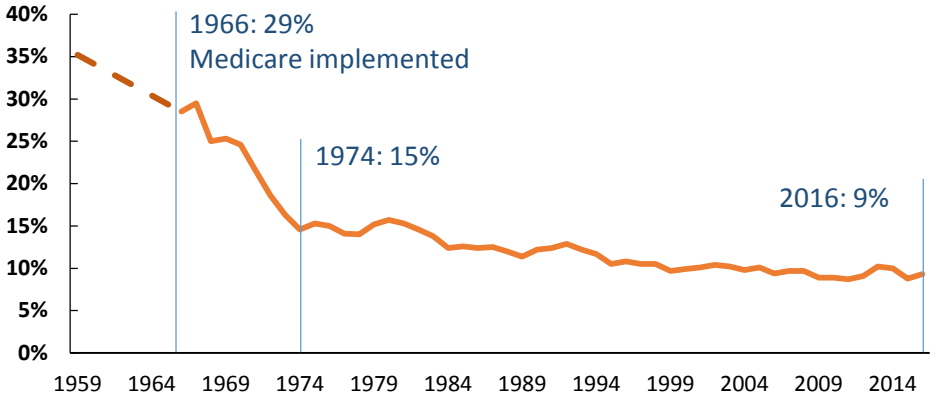
Medicare spends on average $13,098 per beneficiary under 65, approximately $3,000 more than beneficiaries over 65. This is primarily driven by higher prescription drug spending. Three-fourths of Medicare beneficiaries under 65 are enrolled in Medicare Part D prescription drug coverage, compared to two-thirds of elderly beneficiaries. [12]

The relief Medicare provides is particularly important for women. While women live longer and have more chronic conditions than men, they also tend have lower annual incomes and lower Social Security benefits on average, in part due to the gender pay gap.[13]

Keeps Seniors Out of Poverty

Medicare has helped drastically reduce the elderly poverty rate in the U.S., along with other programs such as Social Security. Following the passage of Medicare, the elderly poverty rate fell dramatically, from 29 percent in 1966 to 9.3 percent today.[14] This reflects the fact that many Medicare beneficiaries are of modest means: Half of Medicare beneficiaries have incomes below $26,200 and half have savings below $74,450.[15] If the support that Medicare and Medicaid provided to low- and middle-income Americans was taken into account, income inequality would be about 30 percent lower.[16]

Elderly Poverty Cut By Over Two-Thirds Since Medicare



Source: CPS ASEC data for years 1959 to 1979
Note: Data not available for years 1960-1965, as denoted by the dotted line.

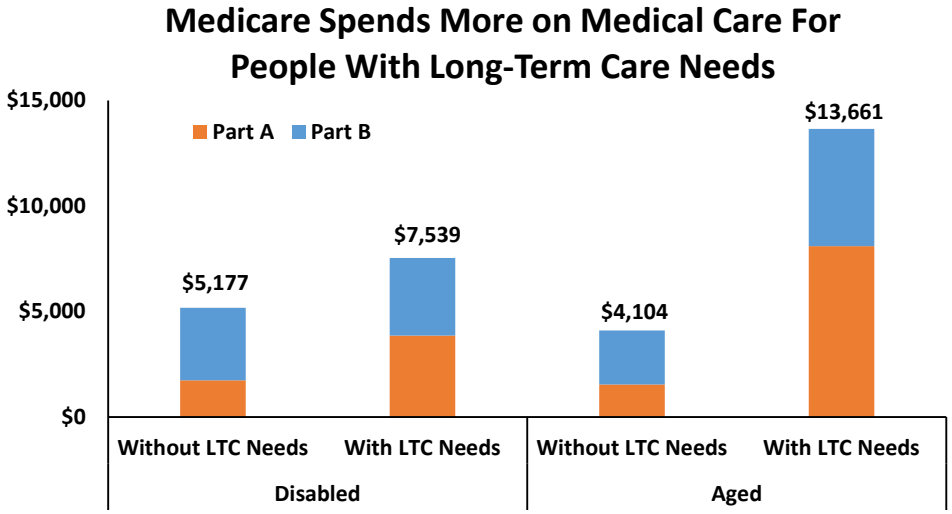
Protects the Financial Security of Millions of Families

Beyond protecting seniors' financial security, Medicare ensures families across the country can help care for their elderly relatives without straining their own finances or taking too much time away from their jobs or children. By supporting seniors' financial stability and independence, Medicare helps alleviate some of the burden that families assume when their loved ones age.

About a quarter of adults age 50 and older provide financial support to an aging parent. [17] On average, families spend nearly $7,000 a year on costs related to caregiving, with a quarter of those costs devoted to medical expenses.[18] Among middle-aged adults, more than one-in-seven provide financial support for both an aging parent and a child. These responsibilities can strain family budgets considerably. Over 40 percent of those who financially support an aging parent have less than or just enough to meet basic expenses, compared to a quarter of non-caregivers.[19]

Although Medicare does not pay for most long-term care, it spends more on beneficiaries with long-term care needs because they tend to require more medical services. Medicare spending on seniors with long-term care needs is more than three times that for seniors without long-

term care needs. Similarly, Medicare also spends significantly more on beneficiaries under 65 with long-term care needs than those without. Without Medicare, families caring for elderly relatives or family members with disabilities that require more generous care would be especially hampered.



Source: JEC Democratic Staff analysis of 2015 data from Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey. LTC is long-term care. Having LTC needs is having difficulties with 3+ activities of daily living (ADLs) for those dwelling in the community, or receiving supervision or assistance with 3+ ADLs for those in faciltities. Expenditures are gross expenditures, not net of premiums or cost-sharing.

The burden on family caregivers has significant consequences for the economy more broadly. More than one-third of caregivers leave their jobs or reduce the hours they work.[20] According to one study, this may result in more than $300,000 in lost wages, Social Security benefits, and private pensions for a single caregiver. For the nearly 10 million Americans age 50 or older that are caring for an elderly parent, this amounts to $3 trillion in lost wages and retirement savings.[21] While Medicare cannot stem these losses alone, it enables families to better juggle their caregiving responsibilities with their professional lives.

Creates Jobs and Bolsters Local Economies

As the country's biggest health care payer, Medicare accounts for a significant share of health care providers' revenues. In 2016, Medicare accounted for one-fifth of total national health spending, including one quarter of all spending on hospital, physician, and clinical services and nearly 30 percent of retail prescription drug spending.[22]

Cuts to Medicare would affect the nine in ten primary care physicians who accept Medicare. Moreover, for nearly a third of primary care physicians in the country, Medicare beneficiaries account for half of their patients.[23] In 2014, nearly half of hospital discharges were for patients covered by Medicare.[24]

Medicare is especially important to rural communities, which have older populations on average. In rural areas, Medicare accounts for 50 percent of hospital revenues, compared to 33

percent in hospitals in other areas.[25] Cuts to Medicare would endanger rural hospitals by decreasing paying clients, or by cutting provider payments, at a time when 673 rural hospitals around the country are vulnerable to closure.[26] If all of these at-risk hospitals were to close, 137,000 rural residents would lose their jobs, and the national economy would lose $277 billion over ten years.[27]

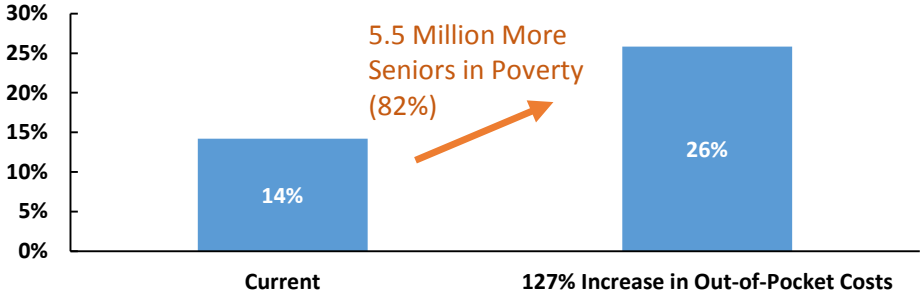
Medicare Going Forward

Republican actions to sabotage the health care markets have already threatened Medicare, as was made clear in the 2017 Trustees Report.[28] The report found that provisions in the Republican tax bill contributed to moving up the insolvency of the Medicare Hospital Insurance trust fund by three years.[29] When Republican policies hike premiums and increase the number of uninsured, they have ripple effects on Medicare beneficiaries and their families.

Further, there is a long history of Republican efforts to undermine Medicare and the benefits it provides. In 2011, now-Speaker Paul Ryan proposed a budget that would have privatized Medicare by converting it into a voucher program, ending Medicare as we know it and piling the burden of medical costs on beneficiaries. The CBO predicted that under the Ryan plan, out-of-pocket costs for beneficiaries would more than double.[30] If medical out-of-pocket costs increased by 127 percent, 5.5 million more seniors would be in poverty, or one in four seniors overall.

With Increased Out-of-Pocket Costs, 82% More Seniors Would Be in Poverty

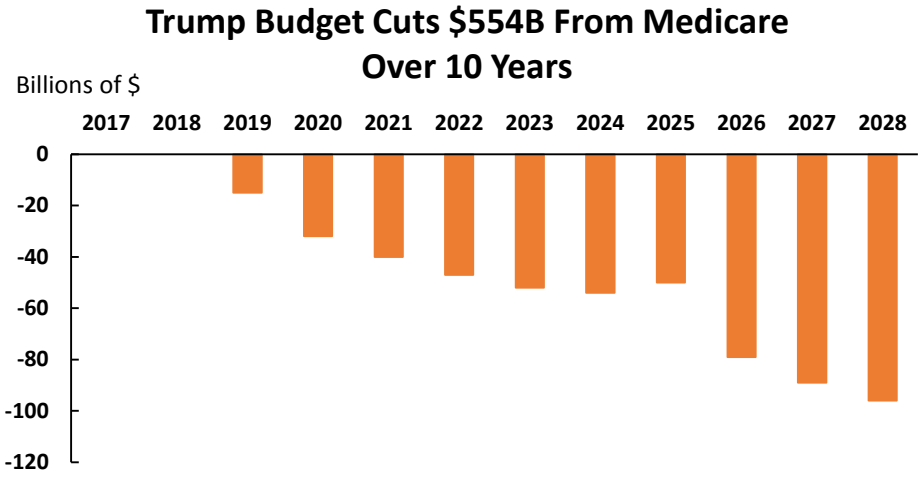
In 2011, CBO found that Ryan budget would double out-of-pocket costs



Source: JEC Democratic staff analysis of data from 2015-2017 pooled CPS ASEC
Note: In poverty refers to individuals below the Supplemental Poverty Measure (SPM). The Congressional Budget Office estimates that under the 2011 Ryan budget, for a typical 65-year-old with average health costs and a plan with similar benefits as Medicare coverage, Medicare beneficiaries would bear 68 percent of the cost of coverage instead of 30 percent in the alternative fiscal scenario, resulting in more than double out-of-pocket costs.

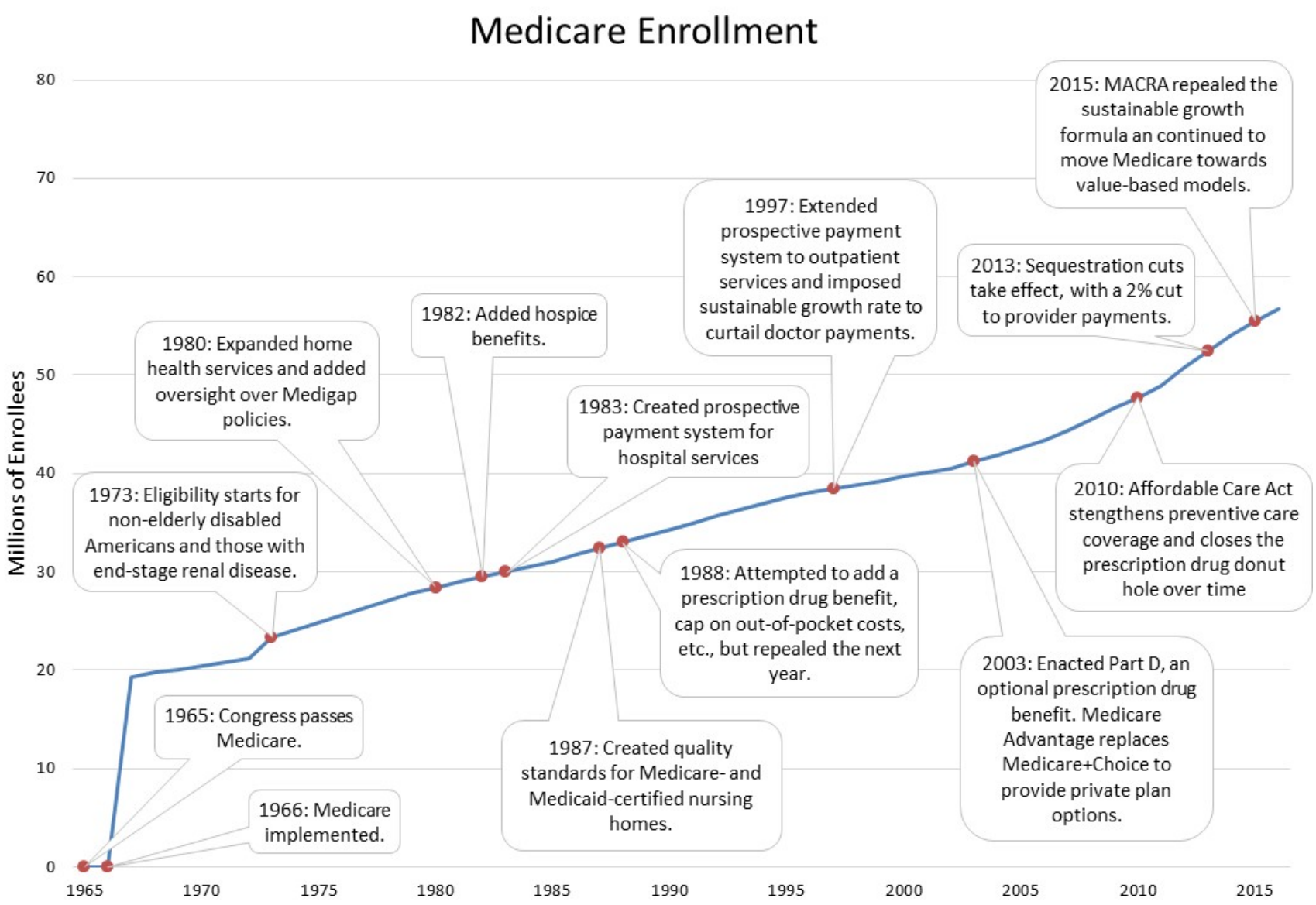
The administration's FY19 proposed budget calls for many of the same failed ideas. In total, the budget cuts $554 billion from Medicare over the next 10 years.[31] This includes $100 billion in bad debt and uncompensated care payments, threatening the balance sheets of hospitals already struggling to serve lower-income and higher-uninsured populations, including those in rural areas.[32] The budget also slashes $48 billion from graduate medical education programs

that help train our health workforce, at a time when there are drastic shortages in health care professionals.



Source: Office of Management and Budget, FY 2019 President's Budget

These Republican proposals would make it harder for Medicare beneficiaries to access the care they need. In addition to this, Republican proposals would also financially strain families and the elderly. As it looks to protect the growing elderly population and middle-class families across the country, Congress must preserve and strengthen Medicare to serve beneficiaries and their families better.


Medicare Enrollment
Millions of Enrollees
80
70
60
50
40
30
20
10
0
1965
1970
1975
1980
1985
1990
1995
2000
2005
2010
2015
1965: Congress passes Medicare.
1966: Medicare implemented.
1973: Eligibility starts for non-elderly disabled Americans and those with end-stage renal disease.
1980: Expanded home health services and added oversight over Medigap policies.
1982: Added hospice benefits.
1983: Created prospective payment system for hospital services
1987: Created quality standards for Medicare- and Medicaid-certified nursing homes.
1988: Attempted to add a prescription drug benefit, cap on out-of-pocket costs, etc., but repealed the next year.
1997: Extended prospective payment system to outpatient services and imposed sustainable growth rate to curtail doctor payments.
2003: Enacted Part D, an optional prescription drug benefit. Medicare Advantage replaces Medicare+Choice to provide private plan options.
2010: Affordable Care Act stengthens preventive care coverage and closes the prescription drug donut hole over time
2013: Sequestration cuts take effect, with a 2% cut to provider payments.
2015: MACRA repealed the sustainable growth formula an continued to move Medicare towards value-based models.

Medicare State-by-State Facts

	Medicare Enrollees (in thousands)			Medicare Spending		Impact of Increasing Out-of-Pocket Costs by 127%	
State	Total	Aged	Disabled	Billions of $	% of State Budget (if states paid)	Average Increase in Out-of-Pocket Costs	% Increase in Seniors in Poverty
US	57,148	48,261	8,887	581	N/A	N/A	82%
AL	991	763	228	10	39%	$12,654	104%
AK	88	76	13	1	6%	$15,722	76%
AZ	1,181	1,026	155	11	28%	$14,950	64%
AR	607	471	136	6	23%	$11,960	119%
CA	5,826	5,111	715	65	26%	$14,066	50%
CO	818	714	104	7	20%	$15,374	74%
CT	643	561	83	7	25%	$16,010	75%
DE	187	160	27	2	21%	$13,201	83%
DC	91	75	15	1	9%	$14,478	26%
FL	4,166	3,616	550	48	67%	$13,792	71%
GA	1,575	1,291	285	15	34%	$12,354	97%
HI	252	229	24	2	16%	$13,888	56%
ID	295	251	43	2	34%	$18,250	113%
IL	2,114	1,820	294	23	35%	$16,450	93%
IN	1,181	976	205	12	41%	$15,047	75%
IA	586	509	77	5	24%	$14,115	117%
KS	500	427	73	5	32%	$14,198	98%
KY	882	679	203	9	28%	$12,882	91%
LA	816	651	165	9	33%	$11,278	78%
ME	315	256	59	3	36%	$14,253	156%
MD	961	831	130	11	27%	$16,522	69%
MA	1,251	1,043	208	14	24%	$14,299	94%
MI	1,943	1,593	351	21	39%	$14,808	124%
MN	941	816	125	9	25%	$15,800	107%
MS	572	442	130	6	31%	$11,341	96%
MO	1,162	948	215	12	48%	$13,580	103%
MT	209	181	28	2	25%	$14,686	126%
NE	322	280	42	3	28%	$14,119	126%
NV	473	409	64	5	40%	$12,725	63%
NH	275	228	48	2	45%	$16,193	115%
NJ	1,527	1,328	198	18	32%	$14,803	79%
NM	386	321	65	3	18%	$12,060	58%
NY	3,421	2,903	518	40	28%	$12,200	67%
NC	1,827	1,503	324	18	40%	$13,320	94%
ND	122	107	15	1	14%	$15,260	81%
OH	2,207	1,848	359	23	36%	$13,955	105%
OK	694	568	125	7	31%	$13,058	119%
OR	784	676	108	7	17%	$15,642	99%
PA	2,588	2,181	407	28	38%	$15,069	130%
RI	208	171	37	2	26%	$14,634	121%
SC	976	802	174	9	41%	$13,353	113%
SD	161	142	19	1	35%	$14,868	115%
TN	1,269	1,020	249	13	41%	$13,227	94%
TX	3,765	3,189	576	42	37%	$13,846	70%
UT	359	310	49	3	24%	$16,638	112%
VT	136	113	22	1	22%	$12,876	194%
VA	1,392	1,184	207	13	27%	$16,862	61%
WA	1,237	1,061	176	10	26%	$16,414	100%
WV	424	332	91	4	26%	$12,368	118%
WI	1,082	922	161	10	21%	$15,739	142%
WY	99	86	13	1	16%	$15,825	130%

Sources: JEC Democratic Staff analysis based on data from the Center on Medicare and Medicaid Services, Kaiser Family Foundation, National Association of State Budget Officers, CPS ASEC 2015-2017, and Congressional Budget Office

For out-of-pocket cost calculation, in poverty refers to individuals below the Supplemental Poverty Measure (SPM). The Congressional Budget Office estimates that under the 2011 Ryan budget, for a typical 65-year-old with average health costs and a plan with similar benefits as Medicare coverage, Medicare beneficiaries would bear 68 percent of the cost of coverage instead of 30 percent in the alternative fiscal scenario, resulting in more than double out-of-pocket costs.

[1] https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[2] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/apr/1812_davis_medicare_50_years_coverage_care.pdf; https://www.ssa.gov/policy/docs/ssb/v27n7/v27n7p3.pdf
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777733/
[4] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/apr/1812_davis_medicare_50_years_coverage_care.pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194690
[6] https://napca.org/wp-content/uploads/2017/10/economic-indicators-FINAL.pdf
[7] https://www.aisc.ucla.edu/research/Memo-4.pdf
[8] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/apr/1812_davis_medicare_50_years_coverage_care.pdf; JEC Democratic Staff calculations based on data from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Age-and-Gender.html. 2012 estimate refers to out-of-pocket spending as a share of total personal health expenditures.
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5137378/
[10] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/apr/1812_davis_medicare_50_years_coverage_care.pdf
[11] https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/
[12] https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/
[13] https://nwlc.org/resources/importance-medicare-women/; https://www.wiserwomen.org/images/imagefiles/pay-gap-connected-to-the-retirement-gap-2017.pdf
[14] U.S. Bureau of the Census, Current Population Survey, Annual Social and Economic Supplements
[15] https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/
[16] If the value of Medicaid and Medicare were counted in income, the gap between incomes between the top 10 percent of Americans and the bottom 10 percent would have been 30 percent lower in 2012. https://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.30.2.53
[17] http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf
[18] https://www.aarp.org/caregiving/financial-legal/info-2017/out-of-pocket-cost-report.html
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[21] http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf
[22] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html Tables 3, 7, 8, and 16.
[23] https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/
[24] JEC Democratic Staff analysis of data from the Health Care and Utilization Project.
[25] https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/chss/Rural-Health-Conference/Chartis-Rural-ODH-Rural-Health-Conference-Aug2017.pdf?la=en
[26] https://www.beckershospitalreview.com/finance/673-rural-hospitals-vulnerable-to-closure-5-things-to-know.html
[27] iVantage Health Analytics. "Rural Relevance- Vulnerability to Value." 2016. https://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf ; Rural is defined using the Federal Office of Rural Health Policy's definition, which uses an expanded version of OMB's metropolitan areas.
[28] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html

[29] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

[30] https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/04-05-ryan_letter.pdf For a typical 65-year-old with average health spending enrolled in a plan with benefits similar to those currently provided by Medicare.

[31] https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf

[32] Bad debt refers to payments that hospitals expected to receive, but were unable to collect. Uncompensated care also encompasses payments for the hospital did not expect to be paid, including charity care and care for those unable to pay.