Center for Medicare Advocacy
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Medicare Myths vs. Truth

The truth is Medicare works. By and large it has been a resounding, cost-effective success. Nonetheless, some politicians continue to propose changing Medicare into a "voucher" system that will hurt beneficiaries and their families, ignoring options for real savings that would not harm beneficiaries or eliminate the Medicare program as we know it.[1]

Here are some of the many inaccurate things that have been said about Medicare, and the truth to counter them.. Help us set the record straight, shine light on fair, financially sound policies, and demonstrate how Medicare works for millions of Americans – including your family and neighbors. Spread the word with our handy reference chart below, and use our candidate questions!

The Myth	The Truth	Here's Why
"Medicare is going broke."	**Medicare is not in crisis. It is on solid financial footing, and, in fact, is stronger than was predicted before the enactment of the Affordable Care Act.**	Medicare Part A is mostly paid for with payroll taxes which go into a trust fund. Prior to the enactment of the ACA, the Part A trust fund was expected to be insolvent in 2017. As a result of the ACA and the recession, the trust fund is not expected to be insolvent until 2028.[2] **However**, even if Medicare Part A were to become insolvent by spending more than it is taking in, the program will still be able to pay out 87 percent of its benefits.[3] While not ideal, this is a far cry from "bankruptcy." Further, the date of projected insolvency is not set in stone, and changes regularly. The trust fund largely reflects the health of the economy. At various times since 1970, the trustees have projected Trust Fund insolvency in as few as 4 years or as many as 28 years.[4] Importantly, Medicare Part B is funded by a certain percent of general revenues and premiums, and therefore cannot "go broke."
"Costs are growing out of control."	**Medicare's spending grew 5.5 percent from 2013 to 2014, but most of this cost is due to the high prices pharmaceuticals have charged Medicare for recent, expensive breakthrough drugs.[5]**	Between 1997 and 2014, Medicare spending per enrollee grew at 3.3 percent a year on average while private insurance spending per enrollee grew 6.3 percent during this same time.[6] Medicare's spending is projected to grow 4.5 percent from 2015 to 2025 and private health insurance's growth rate is projected to be 4.8 percent.[7] While it is true that as the large Baby Boom generation retires and begins to utilize their Medicare benefits, Medicare's spending will increase, thoughtful reforms, including those included in the Affordable Care Act, can work to sustain Medicare's long-term fiscal health

		and should be given an opportunity to work. One easy way to save Medicare money is to pay private Medicare plans no more than traditional Medicare receives to provide the same coverage. Some private plans in 2016 cost the Medicare program 115 percent more than Traditional Medicare costs.[8] Another way would be to allow Medicare to obtain fairer drug prices on behalf of its beneficiaries.
Beneficiaries should pay more in order to make the Medicare benefit more sustainable.	**Many people on Medicare already live on tight budgets and face high out-of-pocket costs.**	Half of all Medicare beneficiaries had incomes below $24,150 per person in 2014.[9]
Raising the age of Medicare eligibility will save the program substantial amounts of money	**Raising the age of eligibility would increase overall health spending because it would leave individuals who would have otherwise retired on private health insurance plans that cost much more than Medicare.[10] This move would also create a likely older and sicker Medicare beneficiary population.**	Raising the age of eligibility would have only a small effect and would only have reduced Medicare payments by 3 percent by 2038. The effect is small for the following reason: people who would have been dually eligible for both Medicare and Medicaid had the age of eligibility not been raised would instead receive federal Medicaid funding for their health costs.[11] Available research also shows that raising the Medicare eligibility age would shift billions of dollars of out-of-pocket health costs to those who are between 65 and 66.[12] The raising of the age of eligibility would also shift costs to "employers who provide health coverage for their retirees, to Medicare beneficiaries, to younger people who buy insurance through the new health insurance exchanges, and to states."[13] Other research has shown that the impact of the proposal to increase the age of eligibility would be felt primarily by poor people and minority groups such as African-Americans and Latinos, who already have poorer health relative to the rest of the population.[14]
Medicare should not be able to negotiate Medicare drug prices.[15]	**The Medicare program should be allowed to negotiate drug prices with prescription drug companies just as the Veterans Administration is able to do. Another effort could be to offer drug rebates to people who are dually eligible for both Medicare and Medicaid—given that Medicare covers drug costs for dually eligible beneficiaries and that it cannot negotiate prices the way Medicaid can, such a move would be a step in the right direction.**	Members of the Medicare Payment Advisory Commission stated in March 2015 that the "use of high-cost drugs poses a big challenge" to Part D beneficiaries who have to pay 25 to 30% of the costs of these drugs in out-of-pocket costs.[16] The government is projected to have spent $2,203 per Part D beneficiary in 2015.[17] If the Medicare program could negotiate prices, it could bring down the costs of some of the newer, pricier Hepatitis C drugs, for instance, such as Sovaldi—these newer Hepatitis C treatments cost Medicare $4.5 billion in 2014.[18] As stated above, most of the growth of Medicare expenses in 2014 relate to the costs pharmaceuticals charge beneficiaries. The costs of drugs to Medicare grew 9.5 percent from

		2012-2013 and then 17 percent from 2013-2014.[19] If Medicare were given this ability to negotiate drug prices once the law is changed to allow this, some researchers estimate that the Medicare program could save anywhere between $15.2 to $16 billion per year. Other researchers estimate savings of $541 billion over 10 years under certain circumstances.[20]
Private Medicare Part-D has been such a low-cost success, so privatizing the rest of the Medicare program would also work well	**Since 2006, Part D cost sharing for brand-name drugs has increased and the use of lower cost generics has grown over time. A beneficiary's greater out-of-pocket costs and use of generics may make Part D's finances more solvent, but the reasons for Part D's lower costs should not serve as evidence that supports a privatization of Medicare.**	Cost sharing from 2006 to 2015 increased by 36 percent for beneficiaries in stand-alone Prescription Drug Plans and by 70 percent for those in MA drug plans.[21] Other factors outside of market forces such as lower-than-expected enrollment has driven down Part D spending. It remains unproven whether market forces are any better than the government at keeping costs down,[22] And, in fact, the private Medicare Advantage program costs taxpayers MORE than traditional Medicare.
Medicare needs to be "restructured" or "redesigned."	**While there are certainly ways to expand Medicare benefits, reduce beneficiaries' cost-sharing burdens, and make the program less confusing, proposals to "restructure" or "redesign" Medicare are almost always offered within a budget context with the purpose of achieving savings. More often than not, this means asking middle-and upper-income beneficiaries to pay more for Medicare, and receive less.**	Policymakers periodically float a number of "restructuring" proposals, such as: 1) combining the Part A and B deductibles; 2) implementing a single coinsurance rate for services, and 3) turning all or part of Medicare into a premium support or voucher program. Each of these proposals would shift additional costs onto Medicare beneficiaries.[23] (Also see "Raising the Age of Medicare Eligibility..." above)

[1] Gretchen Jacobson, Christina Swoope, Tricia Neuman, and Karen Smith. “Income and Assets of Medicare Beneficiaries, 2014 – 2030.” Kaiser Family Foundation.10 September 2015. http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030/ (site visited November 16, 2015).

[2] [2] Board of Trustees, Federal Hospital Insurance and Federal Supplementary Health Insurance Trust Funds. “2016 Annual Report.” 22 June 2016. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2016.pdf (site visited November 15, 2016). P.5.

[3] Ibid.

[4] Phil Galewitz and Marilyn Werber Sarafini. "Trustees Issue Warnings on Medicare But Make No Changes to Solvency Projections." Kansas Health Institute. 24 April 2012. http://www.khi.org/news/article/trustees-issue-warnings-medicare-make-no-changes-s (site visited November 16, 2016).

[5] Anne B. Martin, Micah Hartman, Joseph Benson, and Aaron Catlin. “National Health Spending In 2014: Faster Growth Driven By Coverage Expansion and Prescription Drug Spending.” *Health Affairs.* December 2015. 34: 12.

[6] CMS. “National Health Expenditures 2013 Highlights.” 9 December 2014. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf (site visited November, 2016).

[7] Juliette Cubanski and Tricia Neuman. “The Facts on Medicare Spending and Financing.” Kaiser Family Foundation. 20 July 2016. http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ (site visited November 15, 2016).

[8] Kaiser Family Foundation. “Medicare Advantage.” 11 May 2016. http://kff.org/medicare/fact-sheet/medicare-advantage/ (site visited November 15, 2016).

[9] Gretchen Jacobson, Christina Swoope, Tricia Neuman, and Karen Smith. “Income and Assets of Medicare Beneficiaries, 2014 – 2030.” Kaiser Family Foundation.10 September 2015. http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030/ (site visited November 16, 2015).

[10] Shannon Muchmore and Harris Meyer. Raising Medicare Eligibility Age Would Spike Overall Health Spending.” Modern Healthcare. 02 May 2016. http://www.modernhealthcare.com/article/20160502/NEWS/160509997 (site visited November 17, 2016).

[11] CBO. “Raising the Age of Eligibility for Medicare to 67: An Updated Estimate of the Budgetary Effects.” October 2013. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44661-EligibilityAgeforMedicare.pdf (site visited November 17, 2016). P. 2-3.

[12] “Raising the Ages of Eligibility for Medicare and Social Security.” Congressional Budget Office Issue Brief. January 2012. https://www.cbo.gov/publication/42683 (site visited November 16, 2016).

[13] Paul N. Van de Water. “Raising Medicare’s Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employees.” Center on Budget and Policy Priorities. 23 August 2011. http://www.cbpp.org/files/8-23-11health.pdf (site visited October 9, 2015).

[14] Research on this topic stretches back many years, see: Amy J. Davidoff and Richard W. Johnson. “Raising the Medicare Eligibility Age: Effects on the Young Elderly.” *Health Affairs*. 22:4. 2003. p. 198, 204. Two health equity studies conducted by Rhode Island and Minnesota from 2015 and 2014, respectively, highlight the larger number of uninsured minorities relative to Caucasians in Rhode Island and the relatively larger number of deaths relative to the state’s Caucasian population in Minnesota. See: Rhode Island Department of Health. “Minority Health Facts 2015: Major Health Indicators in the Minority Health Populations of Rhode Island.” http://www.health.ri.gov/publications/factsheets/minorityhealthfacts/Summary.pdf (site visited November 10, 2015). Page 7. Minnesota Department of Health. “Advancing Health Equity in Minnesota: Report to the Legislature.” February 2014. http://www.astho.org/Programs/Health-Equity/Minnesota-Health-Equity-Report/ (site visited November 10, 2015). Another example of racial health disparities is here: Justin Dimick, Joel Ruhter, Mary Vaughan Sarrazin, and John Birkmeyer. “Black Patients More Likely Than Whites To Undergo Surgery At Low-Quality Hospitals In Segregated Regions.” *Health Affairs.* June 2013. 32:6.

[15] “Use Medicare’s Muscle to Lower Drug Prices.” *The New York Times*. 21 September 2015. http://www.nytimes.com/2015/09/21/opinion/use-medicares-muscle-to-lower-drug-prices.html?_r=0 (site visited November 16, 2016).

[16] Robert Pear. “Obama Proposes That Medicare Be Given the Right to Negotiate the Cost of Drugs.” *The New York Times*. 27 April 2015. http://www.nytimes.com/2015/04/28/us/obama-proposes-that-medicare-be-given-the-right-to-negotiate-the-cost-of-drugs.html (site visited November 16, 2015).

[17] Kaiser Family Foundation. “The Medicare Part D Prescription Drug Benefit.” 26 September 2016. http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/ (site visited November 16, 2016).

[18] “The Cost of a Cure: Medicare Spent $4.5 Billion on New Hepatitis C Drugs Last Year.” ProPublica. 29 March 2015. https://www.propublica.org/article/cost-of-a-cure-medicare-spent-4.5-billion-on-hepatitis-c-drugs-last-year (November 16, 2016).

[19] Anne B. Martin, Micah Hartman, Joseph Benson, and Aaron Catlin. “National Health Spending In 2014: Faster Growth Driven By Coverage Expansion and Prescription Drug Spending.” *Health Affairs*. January 2016. 35:1. P. 150-160.

[20] Chuck Shih, Jordan Schwartz, and Allan Coukell. “How Would Government Negotiation of Medicare Part D Drug Prices Work?” *Health Affairs*. 01 February 2016. http://healthaffairs.org/blog/2016/02/01/how-would-government-negotiation-of-medicare-part-d-drug-prices-work/ (site visited November 16, 2016).

[21]John F. Hoadley, Juliette Cubanski, and Patricia Neuman. Medicare Part D at Ten Years: The 2015 Marketplace and Key Trends, 2006-2015. Kaiser Family Foundation. 05 October 2015. http://kff.org/medicare/report/medicare-part-d-at-ten-years-the-2015-marketplace-and-key-trends-2006-2015/ (site visited November 16, 2016).

[22]It is impossible to know whether drug discounts achieved through private Part D plans are greater than discounts that the government could have achieved with its greater bargaining power. Over all Part D spending has been moderated by the use of generic drugs. It is unclear whether generic substitution is a result of market forces or a result of such things as prior authorization and tier copayments. See: Jack Hoadley. “Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition.” Kaiser Family Foundation. May 2012. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8308.pdf (site visited November 16, 2016).

[23] “Issue Brief – Medicare “Redesign” Proposals Could Harm Many Beneficiaries.” Leadership Council of Aging Organizations. March 2016. http://www.lcao.org/files/2016/03/lcao-medicare-redesign-32016.pdf (site visited November 16, 2016).