17 Medicare Facts


- **Medicare patients cannot pay cash for care.** A 1997 law (Balanced Budget Act, section 4507) forbids private contracts between patients and doctors. With few exceptions, Medicare recipients cannot pay cash for a Medicare-covered service that Medicare denies until the doctor has opted out of Medicare. Most physicians cannot afford to opt out, so the law essentially prohibits private contracting between elderly patients and their doctors. Obamacare cut $500 billion from Medicare and enacted two administrative panels that are expected to advance rationing: the Independent Payment Advisory Board (IPAB) and the Patient-Centered Outcomes Research Institute (PCORI).

- **Initial refusal to enroll in Medicare Part B leads to costly penalties.** Seniors are automatically enrolled in Medicare Part B. Those who refuse and later change their minds will pay a premium for the rest of their lives that is 10 percent higher for EACH year they were not enrolled.

- **Citizens do not have a right to their Medicare contributions (payroll taxes).** There is no binding contract between the government and citizens for future payment of Medicare benefits. Congress can alter or eliminate Medicare benefits at their discretion.

- **Medicare comes in four parts.** Medicare Part A (hospitalization insurance) is funded through payroll taxes. Obamacare increased the payroll tax for individuals earning more than $200,000 and couples earning more than $250,000. In 2006, Medicare Part B (supplemental medical insurance for physician services, diagnostic tests, and other services) was funded approximately 76 percent by federal income taxes and 21 percent by Medicare recipients. Under Medicare Part C, the Medicare Advantage HMO managed care plan, insurers receive approximately $800 per month per Medicare enrollee. Medicare Part D allows senior citizens to receive subsidized drug coverage.

- **Medicare dependency is growing.** In 2003, there were 40 million Medicare recipients. In 2010, there were 47.5 million recipients. In 2011, the first of 77 million baby boomers began entering Medicare.

- **Medicare faces insufficient funding.** In 1955, 8.6 workers/taxpayers supported each Medicare recipient. In 2003, around 4 workers supported each recipient. In 2010, there were less than three workers per retiree. In 2030, only 2.3 workers/taxpayer are estimated per Medicare recipient. Medicare is expected to grow from 3.6% to 6.2% of GDP.

- **Medicare is heading toward bankruptcy.** According to the Medicare Trustees 2011 report, Medicare will be insolvent by 2024—five years earlier than estimated in 2010. Each new Medicare beneficiary is expected to cost $7,700 per year and “the total cost of the program to expand to $929
billion in 2010—an 80% increase over 10 years.” (American Health Line blog, 12/30/2010)

- **Medicare is not health insurance.** Medicare does not pay for hospitalization longer than 150 days, and there is no cap on out-of-pocket expenses. “Medigap” insurance is often purchased to protect against huge medical bills not covered by Medicare.

- **Medicare does not cover the cost of long-term care and nursing home care** - unless it is related to a hospitalization or other urgent medical care.

- **Medicare pays only about half of all health care costs of seniors.** In 1997, 39,840 seniors paid an average of $22,124, either in out of pocket costs or through supplemental insurance.

- **Medicare frequently denies payment.** In 2001, 3.7 million appeals were filed for denial of payment by Medicare Part B. Despite a 2000 law requiring swift processing of appeals, a 2003 report by the General Accounting Office found significant delays in appeals processing.

- **Medicare has not significantly decreased out of pocket payments for seniors.** In 2000, a study by the American Association of Retired Persons (AARP) found seniors paying an average of $2,510 per year—about 19 percent of their income—on out-of-pocket costs. This does not include home care or nursing home care. In 1964, a year before Medicare passed, seniors were paying 20 percent of their income on health care.

- **Medicare wastes taxpayer money.** Almost $107 billion in improper payments were paid between 1997 and 2003. In 2002, $13.3 billion was lost to improper payment. In 2010, $47.9 billion was improperly paid (HealthLeaders, 7/29/11). CCHF calculates the 2010 loss at $131 million per day.

- **Doctors, hospitals and others who accept Medicare patients are at enormous risk.** There are over 130,000 pages of Medicare regulations that must be meticulously followed. In 1996, Congress made health care fraud a federal crime—a felony. Even minor billing errors can be considered fraud and extrapolated across the practice. Obamacare increased fines per violation from $10,000 to $50,000.

- **Medicare threatens patient privacy.** The federal government requires home health agencies to regularly send private data on Medicare recipients. This is called the Outcomes Assessment Information System (OASIS). Obamacare requires extensive reporting by doctors and hospital on patient treatments and outcomes. And, doctors and hospitals that make inadvertent errors in billing can be forced to hand over the patient’s entire medical record for investigation of fraud.

- **Medicare dollars used beyond patient care.** Medicare dollars fund medical education, and a research institute (PCORI) created under Obamacare, leaving fewer dollars for treating the tsunami of Medicare recipients. In 2008, Medicare paid $9.0 billion to train doctors.

Information taken liberally from *Medicare’s Midlife Crisis*, (Sue Blevins, Institute for Health Freedom, published by Cato Institute); GAO REPORT: “Medicare Appeals: Disparity between Requirements and Responsible Agencies’ Capabilities” (September 2003); Kaiser Family Foundation documents; testimony to Congress (House Budget Committee) from the Office of Inspector General (July 9, 2003); Americans for Tax Reform; the 2010 Affordable Care Act; and other sources.

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