SOCIAL SECURITY, MEDICARE AND MEDICAID WORK FOR ILLINOIS




www.socialsecurityworks.org

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Our *Social Security, Medicare and Medicaid Work for America* series of reports is written for public officials, members of the press, advocates and other concerned citizens. In addition to providing information about each program's history, character and vitality, as well as relating compelling, real-life stories, every report includes statistics about the number of people who receive benefits, the types of benefits they receive, and the total amount of funds flowing from these programs into a particular state, including its congressional districts and counties. Reports are available online for all 50 states, Washington D.C., Puerto Rico, American Samoa, Guam, the Northern Mariana Islands and the U.S. Virgin Islands. A national report, "Social Security Works for the United States," is also available.

Please note that a short fact sheet summarizing the data in this report can be found at the end of the report, directly following the endnotes.

For congressional district-level Social Security data, please see "Appendix 1: Social Security Works for Illinois' Congressional Districts," toward the back of the report, just before the endnotes.

For county-level Social Security, Medicare, Medicaid and demographic data, please see "Appendix 2: Social Security, Medicare, and Medicaid Data for Illinois' Counties," toward the back of the report, just before the endnotes.

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We hope the report is useful to you as you work to strengthen Social Security in its 80th anniversary year, and Medicare and Medicaid in their 50th anniversary years. Please contact our Communications Director, Lacy Crawford (lcrawford@socialsecurityworks.org), if you have questions about the report.

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The Alliance for Retired Americans is a grassroots organization representing more than 4 million retirees and seniors nationwide. Headquartered in Washington, DC, the Alliance's mission is to advance public policy that protects the health and economic security of older Americans by teaching seniors how to make a difference through activism. Learn more about The Alliance and its work at www.retiredamericans.org.

The mission of Social Security Works is to protect and improve the economic status of all Americans, especially disadvantaged and at-risk populations, and, in so doing, to promote social justice for current and future generations of children as well as young, middle-aged and older adults. www.socialsecurityworks.org.

The Strengthen Social Security Coalition is made up of more than 320 national and state organizations, representing more than 50 million Americans. The Coalition is united around core principles, which include that Social Security benefits should be expanded, and the belief that our nation's Social Security, Medicare and Medicaid systems are fundamental to the well-being of America's families and to the type of nation we are. www.strengthensocialsecurity.org.

INTRODUCTION AND SUMMARY

"We can never insure one-hundred percent of the population against one-hundred percent of the hazards and vicissitudes of life. But we have tried to frame a law which will give some measure of protection to the average citizen and to his family against the loss of a job and against poverty-ridden old age. This law, too, represents a cornerstone in a structure which is being built but is by no means complete. It is a structure intended to lessen the force of possible future depressions. It will act as a protection to future Administrations against the necessity of going deeply into debt to furnish relief to the needy. The law will flatten out the peaks and valleys of deflation and of inflation. It is, in short, a law that will take care of human needs and at the same time provide for the United States an economic structure of vastly greater soundness."

—FRANKLIN D. ROOSEVELT, August 14, 1935

In 1935, when President Franklin D. Roosevelt signed the Social Security Act into law he called it a cornerstone, the foundation, of a structure to be maintained and built upon by and for future generations. Social Security could not protect all Americans against every risk, but, as the President said, it could lessen the consequences of lost earnings in old age for workers and their families.

Since then, we have built our Social Security structure carefully and deliberately, first adding life insurance for survivors in 1939—initially for widows and dependent children, but eventually extended to widowers as well. Disability Insurance benefits were added in 1956, followed by Medicare and Medicaid in 1965. Important inflation protection—the automatic cost of living adjustment—was added in 1972, designed to maintain the purchasing power of benefits no matter how long someone lives. We built, maintained and strengthened these institutions for a reason—to enable working men and women to protect themselves and their families. We built them because we, as a nation, value hard work, personal responsibility, human dignity and caring for our parents, our children, our spouses, our neighbors and ourselves.

This report reveals the success of these institutions for Illinois and the nation. The numbers tell part of the story—how many people receive benefits in Illinois, in its congressional districts and counties; how many dollars flow into these jurisdictions in a year; the types of benefits and the types of people who receive those benefits. Perhaps more importantly, the report presents the stories of hard-working Illinois residents and their families whose lives have been made immeasurably better by the protections they have earned.

As you read through this report, we urge you to think of the people you know. Family members who live in dignity in old age because they can count on a Social Security check, each and every month—checks they or another family member have earned. Think of that older person who has Medicare, and with it the peace of mind that he or she can receive medical care without going bankrupt. Think of a family you know who is able to care for a functionally disabled child at home because Medicaid is there. Think of a grandparent, a parent, an older aunt, uncle, cousin or family friend, whose life savings may have been exhausted paying for nursing home care, but who is still able to receive that care because of Medicaid.

Think, too, of how these institutions, like the nation's highway system, are part of a rich legacy of those who came before, a legacy that keeps working in good times and bad. Throughout the difficult years of the Great Recession and its aftermath, Social Security, Medicare and Medicaid have been even more vital than before for Illinois residents, and the lifeblood of many small businesses, hospitals, nursing homes and home caregivers. Virtually all of the jobs these programs support stay in America. Figure 1 summarizes the positive impact our Social Security, Medicare and Medicaid systems are having on the people and economy of Illinois.

FIGURE 1

Impact of Social Security, Medicare and Medicaid on the Economy and Population of Illinois

PROGRAM	BENEFICIARIES IN ILLINOIS	PERCENT OF RESIDENTS RECEIVING BENEFITS	AVERAGE BENEFIT	TOTAL ANNUAL BENEFITS[1]
Social Security	2,155,290	16.7 percent	$14,933	$32.2 billion
Medicare	1,907,859	14.8 percent	$10,706	$19.2 billion
Medicaid	2,690,000	20.9 percent	$5,821	$15.7 billion

Source: Social Security Administration, 2015; U.S. Census Bureau, 2013-2015; Kaiser Family Foundation, accessed June 2015. The most recent data available for total annual benefits by state are FY 2013 for Medicaid, and FY 2009 for Medicare.

SOCIAL SECURITY WORKS

As we celebrate the 80th anniversary of the enactment of Social Security, it is time to recall the contributions our Social Security system has made to American economic security. For 80 years, even as our nation has endured wars, political crises and severe economic recessions, Social Security has never missed a payment; it has paid every dollar of earned benefits, on time and in full.

Social Security Made Dignified Retirement Possible for the Broad Middle Class

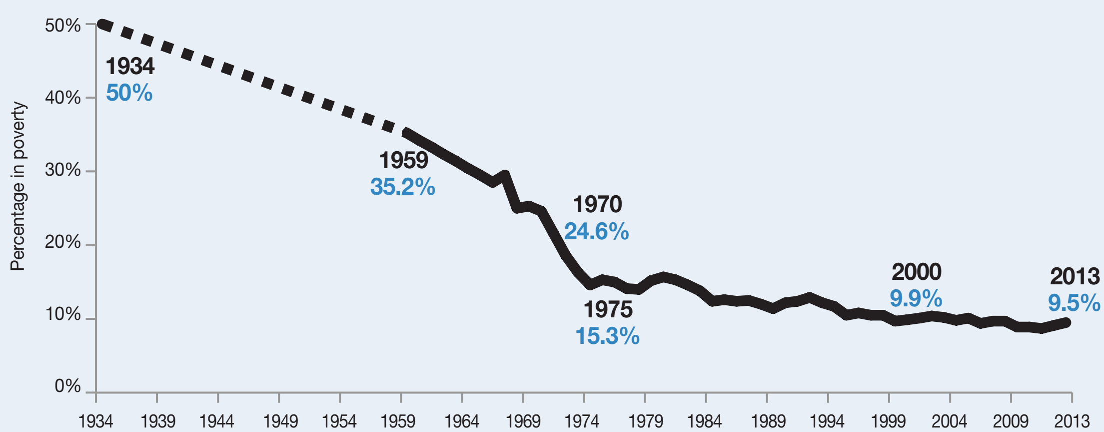
Before the creation of Social Security, poverty among older Americans was pervasive. In 1934, President Roosevelt's Committee on Economic Security estimated that "at least one-half" of all Americans aged 65 and older were poor.[1] These seniors had to rely on family, friends and private charity for support—or literally, go to the poor house. In addition to short-term measures designed to address the immediate crisis, F.D.R. introduced Social Security old-age insurance in 1935 to ensure that both current and future generations of Americans would enjoy a measure of security in their later years. By 1959, when the Census first began to officially count the poor, poverty among older Americans had declined to 35 percent [Figure 2].

And poverty among seniors continued to fall throughout the rest of the 20th century—to 25 percent by 1970 and about 10 percent in 2000, where it has hovered ever since, as measured by the official federal poverty line.[2] Research suggests that the entire decline in elderly poverty between 1967 and 2000 can be attributed to the maturation and expansion of the Social Security program.[3]

Social Security provided $848 billion in benefits in 2014 to 59 million beneficiaries—nearly 1 in 5 (18.3 percent) Americans.[4] It is important to recognize that Social Security is more than a retirement program for seniors. Nearly 17 million people under age 65 received Social Security benefits in 2014—about 2 in 7 (28.7 percent) beneficiaries.[5]

FIGURE 2

Elderly Poverty before and after Social Security, 1934–2013



Source: 1934: Committee on Economic Security, "Report of the Committee on Economic Security," January 15, 1935. 1959-2013: Economic Policy Institute, "Per Capita Social Security Expenditures and the Elderly Poverty Rate, 1959–2013," *The State of Working America, 12th Edition* (accessed May 20, 2015).

In fact, Social Security is the nation's largest and, despite its modest benefits, most generous children's program. The vast majority of America's children are protected against financial destitution in the event of the death, disability, or old age of workers on whose support they depend. As a consequence of Social Security's protections, there were an estimated 8.5 million children under age 18 receiving Social Security benefits in 2014, 11.6 percent of all children.[6] These included an estimated 3.2 million children who received Social Security benefits directly, and an additional 5.3 million children who lived in households where all or part of the income of the household came from Social Security. In addition to these children under age 18, there were 140,000 student children aged 18-19, as well as 1.0 million disabled adult children in 2014.[7]

Social Security benefits are modest: the average annual Social Security benefit for all beneficiaries was $14,375 in 2014, and $15,943 for retired workers.[8] Despite their modest size, Social Security's benefits are vital for the vast majority of beneficiaries, young and old alike. Almost two-thirds (64.6 percent) of elderly beneficiaries relied on Social Security for half or more of their income in 2012.[9] The program lifted 22.1 million Americans out of poverty in 2013, including 1.2 million children.[10]

Social Security Provides Critical Protection against Lost Wages Due to Disability

Social Security Disability Insurance (DI) provides insurance against a risk faced by all Americans: the experience of a life-changing disability that renders one unable to support oneself through work. When workers who have paid into Social Security become incapable of substantial work, as defined by the program's strict eligibility criteria, they can expect to have, as a result of their work and Social Security contributions, a portion of their wages replaced by DI. For these disabled workers and their families, Social Security is a lifeline. Social Security's DI benefits provide 75 percent of the income or more for nearly 6 in 10 non-institutionalized beneficiaries.[11] Nonetheless, 1 in 5 DI beneficiaries remains in poverty.[12]

GUS, Wisconsin

Gus was a "tunnel rat" in Vietnam—one of the volunteer Army infantrymen who specialized in entering the web of narrow tunnels created by the VietCong. The tunnel rats would kill enemy soldiers hiding there and plant explosives to destroy these underground avenues of guerilla warfare.

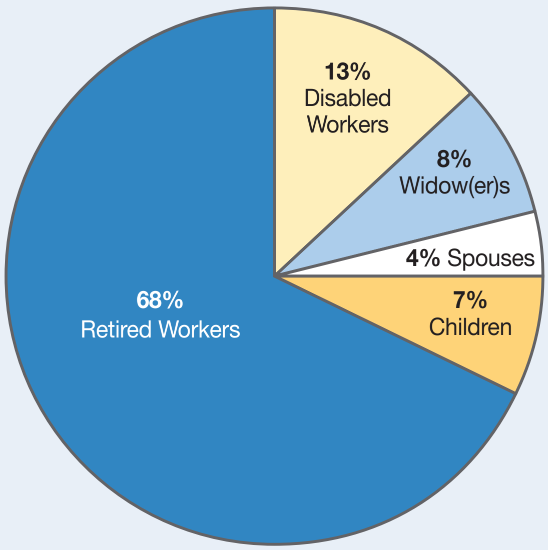
For his service in this capacity he was awarded the Silver Star, the third highest decoration for valor given by the Army. Sixteen days after he was mustered out of the Army, he returned to his home in Wisconsin—and was in a serious car crash, sustaining a high-level spinal cord injury.

Because his injury was sustained outside military service, he was not eligible for service-connected disability compensation and had to turn to Social Security Disability Insurance. "To put it quite simply," he says, "SSDI was a life saver."

Through their hard work and Social Security contributions, nearly all American workers earn Social Security's retirement, disability and survivorship protections for themselves and their families. Social Security is the primary disability and life insurance protection for most Illinois workers. A 30-year-old worker with a spouse and two young children, earning $30,000-$35,000, receives Social Security insurance protections equivalent to disability and life insurance protections worth about $631,000 and $612,000, respectively.[13] Today, 212 million working Americans have earned Social Security's protections for themselves and their families.[14]

FIGURE 3

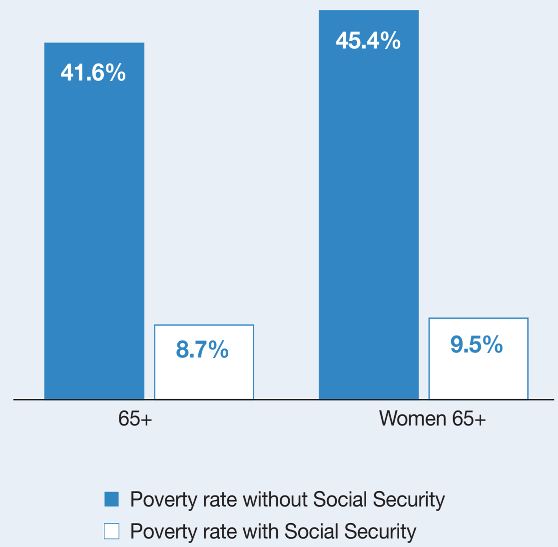
Illinois' Social Security Beneficiaries, 2014



Source: Social Security Administration, 2015

FIGURE 4

Poverty Rate for Illinois Beneficiaries 65+ with/without Social Security, 2011-2013



Source: Center on Budget & Policy Priorities, 2015

There is a significant chance that a worker will need Social Security's disability and/or survivor protections before he or she retires. Nationwide, just over 1 in 4 people who turned 20 in 2013 are projected to become severely disabled during their working years.[15] And 1 in 8 of today's 20-year olds are projected to die before reaching retirement age.[16] Taken together, this means that roughly 1 in 3 young adults entering the workforce today will die or become disabled before reaching the full retirement age.[17] Social Security provides peace of mind throughout the life span, insuring families against lost wages due to old age, disability or death.

Social Security Works for Illinois' Residents and Economy [Figure 1]

- Social Security provided benefits to 2,155,290 Illinois residents in 2014, around 1 in 6 (16.7 percent) residents.[18]
- Illinois residents received Social Security benefits totaling $32.2 billion in 2014, an amount equivalent to 5.2 percent of the state's total personal income.[19]
- The average Social Security benefit in Illinois was $14,933 in 2014.[20]
- Social Security lifted 792,000 Illinois residents out of poverty in 2013.[21]

Social Security Works for Illinois' Seniors[22]

- Social Security provided benefits to 1,463,959 of Illinois' retired workers in 2014, two-thirds (67.9 percent) of beneficiaries [Figure 3].[23]
- The typical benefit received by a retired worker in Illinois was $16,535 in 2014.[24]
- Social Security lifted 560,000 Illinois residents aged 65 or older out of poverty in 2013.[25]
- Without Social Security, the elderly poverty rate, as defined by the official poverty level,[26] in Illinois would have increased from 1 in 11 (8.7 percent) to 2 in 5 (41.6 percent) [Figure 4].[27]

Social Security Works for Illinois' Women

- Social Security provided benefits to 1,116,457 Illinois women in 2014, 1 in 6 (17 percent) Illinois women.[28]
- Social Security provided benefits to 86,210 Illinois spouses in 2014, 1 in 25 (4 percent) beneficiaries [Figure 3].[29]
- Social Security lifted 348,000 Illinois women aged 65 or older out of poverty in 2013.[30]
- Without Social Security, the poverty rate of elderly women would have increased from 1 in 10 (9.5 percent) to 4 in 9 (45.4 percent) [Figure 4].[31]

Social Security Works for Illinois' Widow(er)s

- Social Security provided survivors benefits to 160,955 Illinois widow(er)s in 2014, 1 in 13 (7.5 percent) Illinois beneficiaries [Figure 3].[32]
- The typical benefit received by a widow(er) in Illinois was $16,379 in 2014.[33]

Social Security Works for Illinois' Workers with Disabilities[34]

- Social Security provided disability benefits to 289,730 Illinois workers in 2014, 1 in 7 (13.4 percent) Illinois beneficiaries [Figure 3].[35]
- The typical benefit received by a disabled worker beneficiary in Illinois was $13,056 in 2014.[36]

Social Security Works for Illinois' Children

- Social Security is the primary life and disability insurance protection for 98 percent of Illinois' 2,988,474 children.[37]
- Social Security provided benefits to 154,436 Illinois children in 2014, 1 in 14 (7.2 percent) Illinois beneficiaries [Figure 3].[38]
- Social Security is the most important source of income for the 283,675 children living in Illinois' grandfamilies, which are households headed by a grandparent or other relative.[39]

SUSIE, North Dakota

Susie worked with her husband in their family shoe store for more than 22 years.

"That's how we made our living," she says. "We made about $100,000 a year during good years. It wasn't all profit, we also had expenses but we got by." And even though her husband passed away 19 years ago, she's reminded of their sacrifices and successes when she receives her earned Social Security and Medicare.

She began work as a waitress at 14 years old in tiny Reeder, North Dakota. From there she maintained a series of jobs including later on, at her own shoe store. Today, she receives about $700 a month from Social Security along with support from Medicare. Even in Dickinson, the money doesn't go far. "I'm on both Medicare and Social Security, and together they pay less than I earned when I worked," Susie says.

At 68 years old, Susie has the benefit of hindsight when she surveys her life and the lives of other seniors. When asked how she feels about some who say seniors could afford to get by on $50 less each month if Social Security were cut, she has a stark reminder for younger generations: "Yes, $50 is a big deal! That means that I will have to drastically cut my food budget. It's already being cut as we speak. I don't even do entertainment out of the house anymore, because I can't afford it. My way of living has been reduced dramatically."

Social Security Works for Illinois' African Americans

- In Illinois, Social Security provided benefits to one-quarter (25.4 percent) of African American households in 2013, 167,702 households.[40]
- Nationwide, Social Security lifted 1,231,000 African Americans aged 65 or older out of poverty in 2012.[41] Without Social Security, the poverty rate among African American seniors would have increased from 1 in 6 (18 percent) to half (51 percent).[42]
- Nationwide, Social Security provided nearly three-quarters (71.5 percent) of the income of African American elderly couples and unmarried individuals receiving benefits, on average, in 2012. Social Security made up 90 percent of the total income for nearly half (46.4 percent) of these African American elderly households.[43]
- African Americans were 12.6 percent of the population in 2011, but represented 19 percent of disabled worker beneficiaries.[44]

Social Security Works for Illinois' Latinos

- In Illinois, Social Security provided benefits to 1 in 7 (13.7 percent) Latino households in 2013, 71,290 households.[45]
- Nationwide, Social Security lifted 999,000 Latinos aged 65 or older out of poverty in 2012.[46] Without Social Security, the poverty rate among Latino seniors would have increased from 1 in 5 (21 percent) to half (52 percent).[47]
- Nationwide, Social Security provided three-quarters (74.5 percent) of the total income of Latino elderly couples and unmarried individuals receiving benefits, on average, in 2012. Social Security was 90 percent of the income for more than half (52.6 percent) of these Latino elderly households.[48]
- The Social Security Administration estimates that Latinos receive a higher rate of return on their Social Security contributions than the overall population—the highest of any group. That's because they tend to have lower lifetime income, longer life expectancy, higher incidence of disability, and larger families.[49]

Social Security Works for Illinois' American Indians and Alaska Natives

- In Illinois, Social Security provided benefits to 2 in 9 (22.8 percent) American Indian and Alaska Native households in 2013, 2,274 households.[50]
- Nationwide, Social Security provided 90 percent of the income for 1 in 8 (12 percent) elderly American Indian and Alaska Native married couples, and half (50 percent) of elderly unmarried persons in 2011.[51]
- Since Social Security has a higher income replacement rate for workers with lower earnings, Social Security replaces a larger share of pre-retirement earnings for American Indians and Alaska Natives than for the overall population. The median earnings of working-age American Indians and Alaska Natives is about $34,600, compared to $43,000 for all working-age people. Social Security

provides average benefits of about $14,546 and $12,207 annually for American Indian and Alaska Native men and women aged 65 or older, respectively.[52]

Social Security Works for Illinois' Asian Americans, Hawaiian Natives and Pacific Islanders

- In Illinois, Social Security provided benefits to 1 in 7 (15.1 percent) Asian American, Hawaiian Native and Pacific Islander households in 2013, 29,900 households.[53]
- Nationwide, Social Security provided, on average, over two-thirds (67.7 percent) of the total income for Asian American households with beneficiaries aged 65 or older in 2012. Social Security was 90 percent of the income for over 4 in 10 (44.4 percent) Asian American elderly households.[54]
- Nationwide, Asian Americans and Pacific Islanders receive a high rate of return from Social Security because of their long life expectancies. An Asian American or Pacific Islander man aged 65 in 2011, can expect to live until age 85, compared to age 82 for all men. An Asian American or Pacific Islander woman of the same age can expect to live until age 88, compared to age 85 for all women.[55]

Social Security Works for Illinois' Rural Communities

- Social Security is more important to Illinois residents living in rural or non-metropolitan counties than to Illinois residents living in metropolitan counties. 2 in 9 (23 percent) rural Illinois residents received Social Security in 2014, compared with 1 in 6 (15.9 percent) metropolitan Illinois residents.[56]
- Social Security is more important to the local economies of Illinois' rural or non-metropolitan counties than to its metropolitan counties. Total personal income in Illinois' rural counties was $60.1 billion in 2014 of which $4.9 billion, or 8.2 percent, was from Social Security. By comparison, total personal income in the state's metropolitan counties was $545.1 billion, of which $27.5 billion, or 5.1 percent, was from Social Security.[57]

Social Security Works for Immigrants

- Social Security is critical for immigrants, of whom 7 in 10 (71.5 percent) are Latino or Asian American in 2013.[58]
- New immigrants tend to have lower career earnings, so Social Security is likely to be a larger source of retirement income for them. Nationwide, the median household income of foreign-born residents was $47,753 in 2013, 10.8 percent lower than the median for native-born Americans, which was $52,910.[59]
- Social Security is a lifeline for older workers who have serious health problems, difficult jobs or major work disabilities, among whom immigrants are disproportionately represented.[60] Nearly 6 in 10 (55.7 percent) immigrant workers aged 58 or older work in physically demanding jobs or difficult conditions, compared with 4 in 10 (43.8 percent) native-born workers.[61]
- An analysis by the Office of the Chief Actuary of the Social Security Administration shows that providing a path to citizenship for the country's 11 million unauthorized immigrants would net Social Security $284 billion by 2024, and extend Social Security's full solvency by two years.[62]

Social Security Works for Same-Sex Couples and Their Families

Social Security has generally looked to state law to determine who is married. Until recently, however, the federal Defense of Marriage Act and state restrictions on the right of same-sex couples to marry prevented same-sex couples and their families from obtaining all of the Social Security protections provided to different-sex married couples and their families. With the Supreme Court's historic rulings in U.S. v. Windsor (June 26, 2013) striking down the Defense of Marriage Act, and in Obergefell v. Hodges (June 26, 2015), affirming the constitutional right of same-sex couples to marry in all states, federal marriage benefits and protections are now available to all same-sex couples, regardless of state of residence.

RUBY, Arizona

I was born when Franklin Delano Roosevelt was elected into office in 1932, and three short years later he signed Social Security into law. I am retired now, so Social Security affects my life that way, but it also affected my life, and my children's lives, through survivors' benefits because we received benefits after their father died prematurely. It was a hunting accident. A guy across the hill from him shot, and my husband was hit, so I was left with the five kids.

It was such a shock that I didn't really know what I was going to do. It was really difficult. I got to the point where for three months, I could barely do anything and I finally had to go to the doctor. I could barely put one foot in front of me to physically walk to the doctor's office. I don't know what I would have done without Social Security. When I went to work, I only earned one dollar thirty cents an hour. It was tough but it was workable. Without Social Security I don't know how it would have been.

Married same-sex couples and their families in every state will now be able to claim the same spousal, survivor, and young dependent benefits guaranteed to all other married couples and their families.[63] Social Security's crucial protections will potentially benefit thousands of Americans, including:

- the 390,000 same-sex couples who are currently married under state law;[64]
- the estimated 70,000 same-sex couples in the 13 states that did not previously recognize or allow same-sex marriage who are expected to marry in the next three years;[65]
- the estimated 210,000 children being raised by same-sex couples.[66]

Social Security is Fiscally Responsible and Affordable

A public trust, Social Security is the nation's most conservatively financed and carefully monitored institution. Social Security does not, and, by law, cannot add a penny to the federal debt.[67] While the federal budget has run a deficit in every year but five over the last half century, Social Security is not allowed to pay benefits unless it has the funds to cover every penny of the cost; it simply does not have borrowing authority.[68] This is why Social Security has nothing to do with reducing the federal budget deficit, and should not be part of any deficit reduction legislation considered by our nation's leaders.

It is only because Social Security is required to project its finances 75 years into the future—an extremely long projection period by virtually any measure—that we even know about its modest long-term shortfall.[69] The 2015 report, signed by Social Security's trustees—the secretaries of the Treasury, Health and Human Services and Labor, the Commissioner of

Social Security and two Public Trustees appointed by the President—projects that Social Security can pay all benefits in full and on time for 19 years.[70] After that, if Congress were not to act, it could still pay 79 cents of every dollar of earned benefits.[71]

Social Security's projected shortfall is incredibly modest as a share of the economy. Even with the retirement of the baby boomers, Social Security's costs are projected to go from their current level of 5.0 percent of gross domestic product (GDP) to 6.1 percent in 2037, after which they are projected to fall and then rise again gradually to 6.2 percent in 2090.[72] The cost of bringing Social Security into actuarial balance is equal to roughly 1 percent of GDP.[73] This increase in Social Security spending is smaller than the increase in spending on public education that occurred when the boomers were children.[74]

Rising Inequality Calls for Scrapping Cap, Expanding Benefits

While incomes at the top—from wages and investments—have skyrocketed in recent decades, the wages of the typical worker have stagnated: the median male worker earned roughly the same amount, adjusted for inflation, in 2010 as his predecessor in 1964.[75] As a result, whereas from 1948-79 two-thirds of income growth went to the bottom 90 percent, from 1979-2012 *all* income growth has gone to the top 10 percent.[76] In other words, since 1979, the bottom 90 percent of households have, as a whole, seen their income decline in real terms.

While the lowest 94 percent of earners make Social Security contributions on all of their wages, millionaires and billionaires contribute on only the first $118,500 of their earned income in 2015.[77] And their investment income is completely outside the Social Security system. The fact that virtually all aggregate income growth has been occurring above the Social Security tax cap has hurt Social Security's finances, and is projected to harm them even more in the coming decades.[78]

We should not only scrap the cap, i.e. remove the limit on wages subject to Social Security contributions, but also incorporate high earners' investment income into Social Security. This would ensure that high earners contribute to Social Security on all their income at the same rate as average workers. And it would eliminate all of Social Security's projected 75-year funding gap, while providing enough revenue to expand benefits.[79] In addition or alternatively, dedicating revenue from the federal estate tax, our most progressive tax, to our Social Security system would also reduce income and wealth inequality while providing sufficient revenue to expand Social Security. It is important to recognize that the idea of a system of old age and disability pensions, financed from an estate tax, was proposed by one of our nation's Founding Fathers, Thomas Paine, over two centuries ago.[80]

Social Security Must Not be Held Hostage to the Need for Fund Rebalancing by 2016

Though Social Security is a single program, its benefits are paid from two separate trust funds—the Old Age and Survivors Trust Fund (OASI) and the Disability Insurance (DI) Trust Fund. From time to time, the funds need to be rebalanced. This requires Congressional legislation. For long-anticipated, well-understood reasons, Social Security's actuaries project that a rebalancing between the two trust funds will have to be enacted before the end of 2016, to allow DI benefits to continue to be paid in full and on time.[81] Several major demographic shifts between 1980 and 2010 increased the size of the disability beneficiary population considerably. During that period, the working-age population increased by nearly half, resulting in more covered workers who might become eligible for DI. The Baby Boomers aged into their disability-prone years and this, together with lower birth rates in the generations that followed, shifted the population's age distribution, increasing the prevalence of disability. Finally, the growing number of women in the workforce since 1970 has resulted in a significant increase (from 50 to 68 percent) in the number of women insured for disability benefits.[82] The weak labor market and falling interest rates of the Great Recession compounded these strains on the system's finances, primarily by lowering the revenues coming into the system, as well as by reducing the interest earned on the DI Trust Fund's reserves. All of these trends which have hurt the disability fund's solvency are now projected to level off.[83]

There is a simple way to extend DI solvency to 2034—by rebalancing the share of payroll contributions going into the Social Security retirement and disability trust funds, as Congress has done 11 times, in both directions, in the past.[84] This would guarantee workers' full suite of Social Security protections without affecting the system's overall solvency. Moreover, by scrapping the cap and incorporating high earners' investment income into Social Security, the solvency of both the DI and OASI funds could be extended to nearly the end of the century.[85]

MIKE, Ohio

Mike was a small business owner. He had his own home construction business. While on vacation in the Bahamas, he suffered a massive stroke. He was only 60 years old. Although he did receive some initial medical attention in the Bahamas, his family, through the help of friends, was able to charter a plane to bring him back to the States for treatment.

His stroke left him paralyzed on his right side and with aphasia, which means he could understand, but not speak. While most SSDI cases take a couple of years to get approval, Mike's case was so compelling, he was approved immediately. In the seven years since his accident, Mike has managed to go through his IRA, which he used to pay for unexpected medical expenses. If he did not have SSDI and now his Social Security retirement benefit, his family does not know what he would have done.

MEDICARE WORKS

For half a century, Medicare has given seniors and people with disabilities access to efficient, affordable health care they can count on. It protects beneficiaries and their families against health-related expenditures that might otherwise overwhelm their finances. Even more importantly, it allows them to receive necessary—and often life-saving—medical care that many would otherwise not be able to afford.

For 50 Years, Medicare Has Provided Health Care in Retirement and Disability[86]

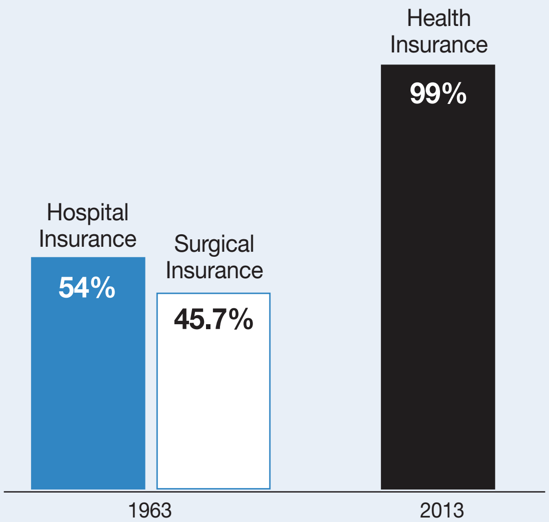
As we celebrate the 50th anniversary of Medicare, it is worth reflecting on the difference it has made in our lives. Before Medicare, roughly half of the elderly were uninsured [Figure 5]. This is because private health insurance companies, which must generate returns for their shareholders, were not able or willing to insure seniors and people with disabilities at affordable rates, given these groups' greater medical needs. Those who were insured paid nearly three times as much as younger people, even though they had, on average, only half as much income.[87]

To prevent these growing health care costs from continuing to threaten the economic security of Americans in retirement, the Social Security Act was expanded in 1965 to include a health insurance program for the elderly, known as Medicare. Today virtually all Americans aged 65 and older have health insurance, predominantly through Medicare.[88]

In 1972, Medicare was expanded to include people with disabilities under age 65 who receive Social Security Disability Insurance benefits. People with disabilities are eligible for Medicare after a two-year waiting period.[89] In 1963, before Medicare, only about

FIGURE 5

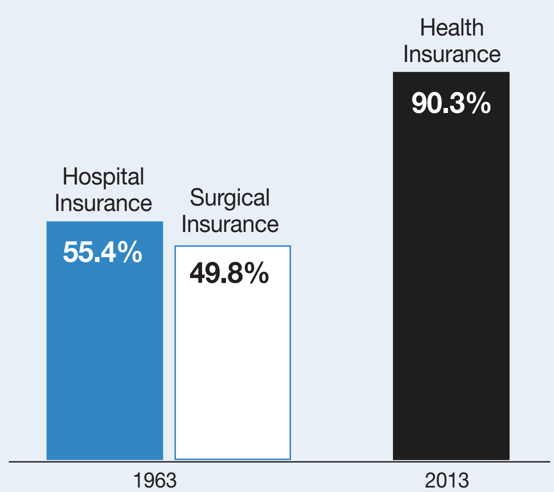
Americans 65 or Older with Health Insurance,1963 vs. 2013



Source: 1963: National Center for Health Statistics, "Health Insurance Coverage: United States—July 1962-June 1963," August 1964.
2013: U.S. Census Bureau, "Health Insurance Coverage Status by Sex by Age," 2011-2013 *American Community Survey* 3-Year Estimates, 2013.

FIGURE 6

Americans with Disabilities with Health Insurance (All Ages),1963 vs. 2013



Source: 1963: National Center for Health Statistics (NCHS), "Health Insurance Coverage: U.S.—July 1962-June 1963," August 1964. 2013: U.S. Census Bureau, "Age by Disability Status by Health Insurance Coverage Status," 2011-2013 *American Community Survey* 3-Year Estimates, 2013.

Note: The NCHS and U.S. Census Bureau both define disability as a chronic condition that impedes normal life and work activities. This definition is broader than the stricter definition used by Social Security and Medicare: inability to engage in "substantial gainful activity" as the result of a medical condition expected to last at least 1 year or end in death.

> *"[T]he later years of life should not be years of despondency and drift….Since World War II, there has been increasing awareness of the fact that the full value of Social Security would not be realized unless provision were made to deal with the problem of costs of illnesses among our older citizens."*
>
> — LYNDON BAINES JOHNSON, January 7, 1965

half of Americans with disabilities (of all ages) had health insurance [Figure 6]. Today, 90 percent do.

If Medicare did not exist, many seniors and people with disabilities today would not be able to afford basic medical services. Medicare beneficiaries are mostly people of modest means. Half had annual incomes below $23,500 in 2013.[90] Even with Medicare, more than one-third of the average Social Security check of retirees and their surviving spouses is consumed by out-of-pocket health care costs.[91]

Medicare: One System with Four Parts

Medicare works—for seniors, people with disabilities, people with end-stage renal disease and people with ALS (Lou Gehrig's disease). For all of these populations, the program covers needed hospital, physician, medical testing, pharmaceutical and rehabilitation services, as well as other necessary medical services and equipment.[92] Medicare provided health care coverage to 53.8 million Americans in 2014, of whom 84 percent (45.1 million) were aged 65 or older; and the remaining 16 percent (8.7 million) were severely disabled workers.[93] The average expenditure per Medicare beneficiary in 2014 was $10,641.[94]

Medicare consists of four parts, each of which provides different medical benefits or service delivery options. Medicare Part A, the Hospital Insurance (HI) program, covers hospital stays as well as select kinds of skilled nursing facility services and home health and hospice care. Hospital Insurance is earned during one's working years, and paid for by insurance contributions of 2.9 percent of wages, divided equally (1.45 percent each) between employers and employees.[95] Since 2013, households with income above the unindexed threshold of $200,000 ($250,000 for couples) pay an additional 0.9 percent Hospital Insurance contribution on their earned income (without an employer match). Medicare Part A's funding is further supplemented by a portion of the federal income taxes that Social Security beneficiaries with incomes above certain unindexed thresholds pay on their benefits.[96]

Medicare Part B, the Supplemental Medical Insurance (SMI) program, helps pay for physician care and related medical services including preventive care, lab tests, and durable medical equipment. One quarter of its costs are funded from premiums (generally deducted from beneficiaries' Social Security checks), and three-quarters from general federal revenues.[97] The 5.5 percent of beneficiaries with incomes above $85,000 ($170,000 for couples) pay significantly higher premiums.[98] For low-income Medicare beneficiaries who are also enrolled in Medicaid, Medicaid can cover Medicare's Part B premium and out-of-pocket costs. Low-income beneficiaries ineligible for full Medicaid benefits may qualify for one of several Medicare

Savings Programs, to help cover the cost of Medicare Part B premiums and cost sharing.[99]

Medicare Part C, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private insurance plan that covers Medicare Part A and B benefits (and usually Part D as well, described below). About 15.7 million Medicare beneficiaries were enrolled in Medicare Advantage in 2014—three in ten (30 percent) beneficiaries.[100] These private plans receive payments from Medicare to cover physician and hospital services (and in most cases, prescription drug benefits). Historically, Medicare Advantage plans have cost more for the same services as provided under traditional Medicare (Parts A and B).[101] Prior to passage of the Patient Protection and Affordable Care Act of 2010 (ACA), Medicare was paying Medicare Advantage insurance companies over $1,000 per person more on average annually than traditional Medicare.[102] These extra costs resulted in not only higher government outlays but also higher Part B premiums for those enrolled in traditional Medicare. The ACA included provisions designed to bring the costs of Medicare Advantage closer to those of traditional Medicare.[103]

Medicare Part D, the prescription drug benefit, covers most outpatient prescription drugs. Part D benefits are provided by private plans that contract with Medicare. Part D benefits are purchased by beneficiaries either as stand-alone plans, or as part of a Medicare Advantage plan. In 2014, 37.6 million beneficiaries were enrolled in a Part D plan—7 in 10 (69.9 percent) beneficiaries.[104] The ACA ensures that seniors and people with disabilities in Part D who reach the prescription drug coverage gap, known commonly as the "donut hole," receive discounts on brand-name and generic prescription drugs. This year, beneficiaries reach the coverage gap after spending $2,960 on covered drugs, and the donut hole closes at the catastrophic coverage limit of $4,700.[105] On drugs purchased within the coverage gap, beneficiaries in 2015 only pay 45 percent of the price for brand-name covered drugs, and 65 percent for generic drugs. As a result of the ACA, these discounts will increase steadily until the donut hole is completely closed in 2020.

For most beneficiaries, roughly one-quarter of Part D costs are funded by premiums (generally deducted from beneficiaries' Social Security checks), and three-quarters from general revenue. States are required to pay premiums for low-income beneficiaries who are enrolled in Part D programs. Assistance paying for Medicare Part D premiums and cost sharing is also available for eligible low-income beneficiaries through the Low-Income Subsidy of Medicare Part D (commonly known as Extra Help), a program administered by the federal government through the Social Security Administration. A small proportion—about 5 percent—of Part D beneficiaries with incomes above $85,000 ($170,000 for couples) pay higher premiums. Higher-income beneficiaries pay between 35 and 80 percent of Part B and D program costs, with the share rising with income.[106]

Medicare Has Lower Administrative Costs than Private Health Insurance

Even though the traditional Medicare program (Parts A and B) covers people who, on average, have more health care claims and more expensive medical conditions than those covered by private insurance, its administrative costs are lower than those of private insurers. Traditional Medicare's administrative costs were 1.6 percent of total expenditures in 2014.[107] Private health insurance's administrative costs are generally much higher, for they include additional non-medical expenses such as marketing, advertising and retained profit to insurers. The Congressional Budget Office (CBO) estimated that in 2007 these administrative costs varied from about 7 percent for large employer plans with 1,000 or more covered employees to as much as 30 percent for insurance sponsored by very small firms or purchased by individuals.[108]

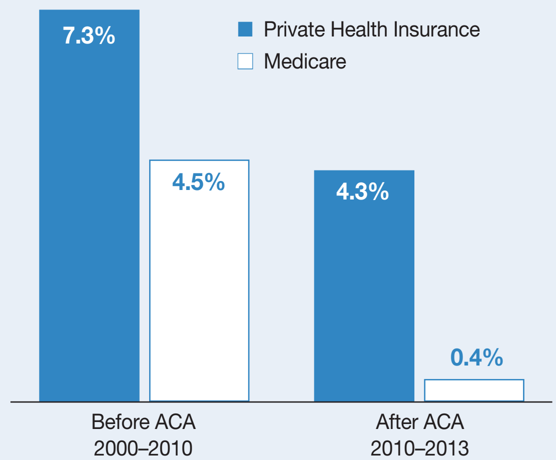
Traditional Medicare is also more efficient than Medicare Advantage plans. The Government Accountability Office (GAO) found that in 2006, Medicare Advantage plans' administrative costs averaged 16.7 percent.[109] The ACA stipulated that starting in 2014, Medicare Advantage plans could not devote more than 15 percent of their Medicare payments to administration, profits and other non-healthcare related items. In response, these plans are now becoming more efficient. A recent GAO study found that in 2011, Medicare Advantage plans' administrative costs had dropped to 13.6 percent—still far above those of traditional Medicare.[110]

Medicare Controls Health Costs Better than Private Insurance As Well, Especially since ACA

In the United States, we pay far more for doctors, hospitals and pharmaceutical products than other countries. In 2011, we spent 17.7 percent of gross domestic product (GDP) on health care, compared to an average of 9.4 percent across all advanced economies.[111] Within our overpriced health care system, Medicare historically performs better than private insurance at controlling costs. For common benefits provided in Medicare and private insurance, from 1969 to 2013, per-person costs increased by 9.1 percent per year in private insurance, compared to about 7.5 percent in Medicare.[112] In the decade immediately prior to passage of the ACA in 2010, the costs of commonly provided benefits grew by 7.3 percent per enrollee per year in private health insurance, vs. 4.5 percent in Medicare. Figure 7 shows that since the passage of the ACA, which added many new cost-control provisions to our health care system, and particularly to Medicare, Medicare outperforms private health insurance even more starkly.

FIGURE 7

Average Growth Rate in Costs of Private Health Insurance vs. Medicare for Common Benefits per Enrollee, before and after ACA



Source: Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, "NHE Tables" (accessed June 30, 2015).

Indeed, since passage of the ACA, Medicare's costs for commonly provided benefits per enrollee have risen at less than one-tenth the rate of private insurance. Part of this slowdown in cost growth is no doubt attributable to the Great Recession; but the recession began in December 2007 and officially ended in June 2009, while the stark decline in cost growth did not begin until 2010 and has persisted through the latest data available (2013). Hence much of the slowdown in cost growth cannot be explained by the recession; the ACA's numerous payment and delivery reforms have surely played a role in containing costs as well.[113]

Tools in the ACA Must be Leveraged to Ensure Medicare's Long-Term Affordability

The Affordable Care Act is showing promising initial signs of bending the cost curve throughout our health care system, particularly in Medicare.[114] While the ACA has been implemented only gradually since 2010, the structural reforms contained in the law sent immediate signals to the health care industry that value, not quantity, would be rewarded in the post-

ACA world, particularly in the Medicare program.[115] Physicians and hospitals, on the one hand, and Medicare Advantage plans, on the other, quickly began changing how they do business in anticipation of the new value-based system. (Insurers in the individual and group health insurance markets had to become more efficient as well.)

The ACA's cost-control provisions include measures to encourage provision of coordinated care for groups of patients (so-called Accountable Care Organizations, or ACOs); reimbursement of providers on the basis of expected costs for clinically-defined episodes of care ("bundled payments") rather than simply paying for each service billed ("fee-for-service"); reduction of excessive payments to private insurers who operate in Medicare Advantage; reduction of payments to hospitals with high rates of preventable readmissions; increased monitoring and punishment of waste, fraud and abuse; comparative effectiveness research to get a better sense of what works and what doesn't; and a new innovation center (the Center for Medicare & Medicaid Innovation), tasked with testing innovative payment and service-delivery models to reduce program expenditures while preserving or enhancing the quality of care.[116] Each of these measures is likely to result in higher-quality care at lower costs over the long term. At a minimum, these innovations will inform ongoing initiatives to control costs and enhance health care quality.

In part as a result of the ACA, the Medicare Hospital Insurance (Part A) Trust Fund's solvency has been extended by 13 years, from 2017 to 2030, after which time it will be able to pay 86 percent of payments from current payroll contributions and other revenue in 2030, and 79 percent in 2039 and thereafter.[117] To express Medicare's finances another way, the total long-term shortfall in hospital insurance funding over the next 75 years is now less than one fifth as large as it was before the passage of the Affordable Care Act.[118]

Still, Congress must pursue policies that sustain affordable access to Medicare benefits over the long term. In so doing, however, it must resist efforts to simply shift costs from the federal government to beneficiaries. The most egregious of such proposals would replace Medicare with a voucher, as proposed in this year's House Republican Budget.[119] Without a strong public Medicare system, the cost of health care for seniors and people with disabilities would likely rise much faster than at present, and higher out-of-pocket costs could keep millions of lower and even many middle-income beneficiaries from getting the care they need.[120]

Cutting Medicare benefits would simply shift costs to the sickest and oldest among us, forcing some seniors and people with disabilities to forego treatment, likely leading to more costly health care needs like emergency room visits, ambulance rides and hospitalizations, and worse health outcomes over the long-term. Promising proposals are available, however, to control Medicare's costs without shifting the burden to older adults and people with disabilities. For starters, Congress could allow Medicare to use its considerable market power to negotiate better prices for beneficiaries on prescription drugs. Currently, under the law that created the Part D program, Congress is forbidden from doing so.[121] Medicare's administrators are also *prohibited* by Congress from conducting cost-effectiveness research, the kind of research more efficient health-care systems around the world use to determine whether their money is being spent on care that actually works and improves upon existing treatments.[122]

The bottom line is that substantial cost-savings are possible within our health care system without sacrificing quality or coverage. To this end, policymakers should continue to leverage the cost-control tools contained in the Affordable Care Act, and resist any efforts to shift Medicare costs to seniors and people with disabilities.

Medicare Works for Illinois' Economy.

- Medicare provided $19.2 billion in benefits to Illinois residents in 2009—22 percent of all health care spending in the state.[123] The average expenditure per Medicare beneficiary was $10,706 [Figure 1].[124]

Medicare Works for Illinois' Residents.

- Medicare insured 1,907,859 Illinois residents in 2012—1 in 7 (14.8 percent) state residents [Figure 1].[125]

Medicare Works for Illinois' Seniors.

- 1,625,331 of Illinois' 1,907,859 Medicare beneficiaries were aged 65 or older in 2012—5 in 6 (83.5 percent) beneficiaries.[126]

Medicare Works for Illinois' People with Disabilities.

- 322,173 of Illinois' 1,907,859 Medicare beneficiaries were people with disabilities in 2012—1 in 6 (16.5 percent) beneficiaries.[127]

Medicare Works for Illinois' Residents with End-Stage-Renal Disease (ESRD).

End-stage-renal disease (ESRD) occurs when a person's kidneys stop functioning at a level needed for everyday life. People suffering from ESRD generally must undergo dialysis treatment or receive a kidney transplant, which are both prohibitively expensive.[128]

Medicare Works for Illinois' Residents with Amyotrophic Lateral Sclerosis (ALS).

Amyotrophic Lateral Sclerosis, more commonly known as ALS, or Lou Gehrig's disease, is a nervous system disease that gradually shuts down all muscles in a person's body, eventually resulting in death from respiratory failure.[129] Many Illinois residents with ALS would impoverish themselves or their families without the help of Medicare.

Seniors and people with disabilities cannot be economically secure if they are one illness away from bankruptcy. Medicare should be strengthened, not cut. As private-sector health insurance continues to rise in cost, preserving a strong public Medicare program is more important than ever.

MEDICAID WORKS

The period from the beginning of the 20th century through the end of the 1950s witnessed significant medical advancements.[130] Yet by the 1960s, these achievements had still failed to reach many: an estimated 40 to 50 million Americans were poor and lacked adequate medical care.[131] Children from low-income families were only able to visit doctors half as frequently as their middle-class peers. And public assistance for low-income Americans was fragmented, with inadequate benefits and, in some states, no medical benefits at all.[132] Consequently, health care for the nation's poor was an essential component of President Johnson's War on Poverty, declared in 1964.[133] Medicaid, the joint federal-state program that helps with medical and long-term care costs for people with low income and resources, was one of the major steps taken in the fight to end poverty.

Before Medicaid, 2 out of 3 Low-Income Americans Lacked Health Insurance

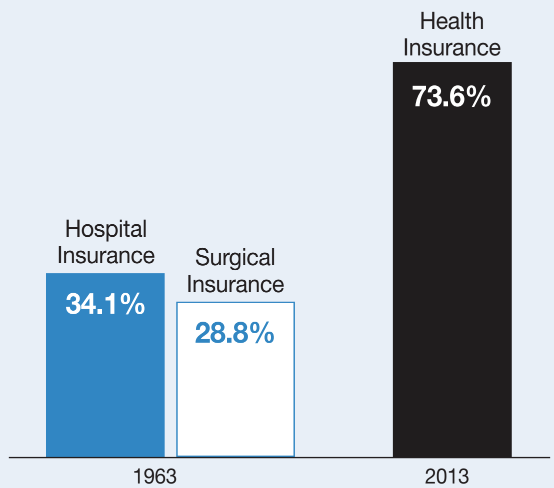
As we celebrate the 50th anniversary of Medicaid, let us recall what a difference it has made. We built our Medicaid system to provide health and long-term care coverage for low-income families, seniors and people with disabilities. In 1963, before Medicaid was created, only 34.1 percent of low-income Americans had hospital insurance, and only 28.8 percent had surgical insurance—the two most common forms of health insurance at that time.[134] Today, thanks to Medicaid and its expansion through the Affordable Care Act of 2010, nearly three-quarters of Americans (73.6 percent) living in or near poverty have some form of health insurance [Figure 8].[135]

For half a century, Medicaid has provided crucial health and long-term care coverage for low-income Americans. While Medicaid originally insured only Americans receiving cash welfare assistance, Congress expanded Medicaid over the years to help insure those without affordable access to private insurance as well as the increasing number of people left behind by erosions of coverage in the private system.[136] In 2013, Medicaid insured 55.4 million Americans—a broad range of Americans including pregnant women, children and some parents in both working and jobless families, and children and adults with physical and mental disabilities. Medicaid also helps some poor elderly and disabled Medicare beneficiaries with premiums, co-pays and other health care needs.[137] Medicaid is a lifeline for low-income Americans who, without the program, would likely be uninsured.

Before the Affordable Care Act, the federal government required states to provide Medicaid to children and pregnant women up to a minimum income threshold (which states had the option to raise), and to provide Medicaid to parents and children in families with income up to the threshold in effect for welfare in the state on July 16, 1996. These thresholds were and remain extremely low in many states: 33 states

FIGURE 8

Low-Income Americans with Health Insurance, 1963 and 2013



Source: Data from 1963: National Center for Health Statistics, "Health Insurance Coverage: United States - July 1962-June 1963," August 1964. Data for 2013: U.S. Census Bureau, "Health Insurance Coverage Status by Ratio of Income to Poverty Level in the Past 12 Months by Age," 2011-2013 *American Community Survey* 3-Year Estimates, 2013.

Note: In 1963,"low-income" = annual family income <$2,000 ($15,226 in 2013 dollars); in 2013, low-income = <138% of the poverty threshold ($15,856 for an individual).

limited coverage to families with incomes below the federal poverty line, which is $11,770 for an individual and $24,250 for a family of four in 2015;[138] and in 17 states, Medicaid eligibility was restricted to families living on *less than half* the poverty line.[139] Adults without dependent children (unless pregnant or disabled) were excluded from Medicaid eligibility by federal law unless a state used state-only funds or obtained a waiver from the federal government (CMS).[140]

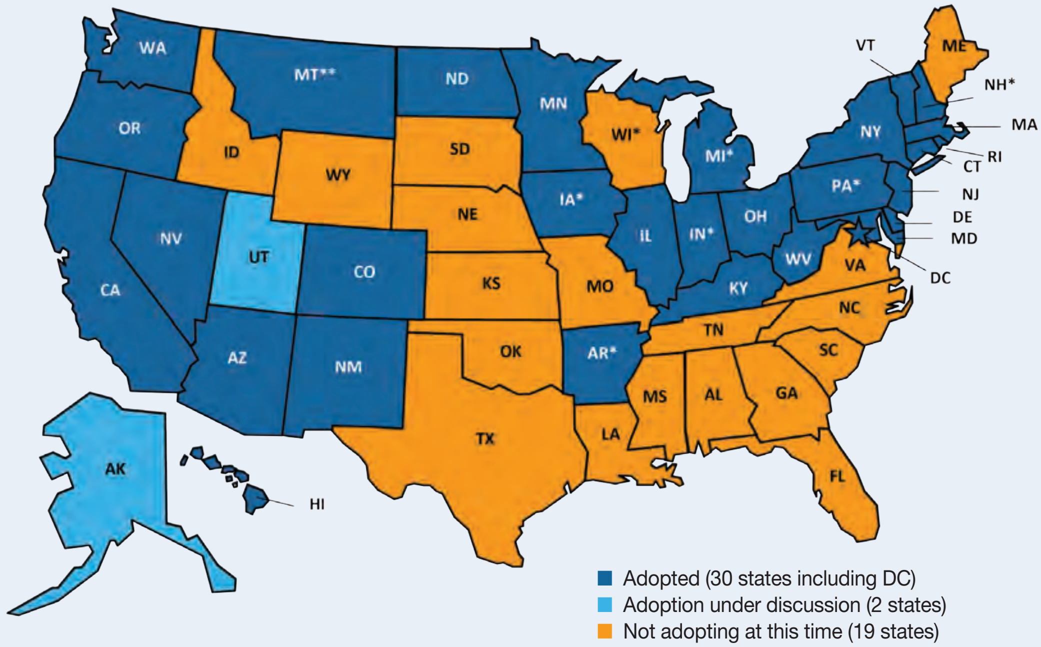
The Affordable Care Act expanded Medicaid eligibility to nearly all individuals with incomes at or below 138 percent of poverty ($16,243 for an individual in 2015), broadly expanding the program to reach low-income adults who were previously excluded from Medicaid. In June 2012, however, the Supreme Court ruled, in effect, that states could opt out of the Medicaid expansion. To date, 29 states and the District of Columbia have expanded Medicaid coverage under the Affordable Care Act, 19 have not, and in 2 states it is under discussion [Figure 9].

In the states that have expanded Medicaid, uninsured rates for all working-age adults have fallen by more than half, from 14.6 percent to 7.5 percent. The 21 states that have not expanded Medicaid also saw a decline in uninsured rates—due to the ACA's individual mandate, health insurance exchanges, premium subsidies, greater awareness of coverage, and enrollment simplification—but the decline has been much smaller, namely just under one third (from 21.4 percent to 17.1 percent).[141]

Medicaid remains especially crucial to seniors and people with disabilities in need of long-term care services. Medicare does not cover most long-term care costs, and private insurance plans that cover long-term care are often prohibitively expensive. As a result, many individuals exhaust their assets under the weight of steep long-term care costs and become eligible for Medicaid, which pays nearly half of long-term costs nationwide.[142] The ACA established enhanced opportunities for state Medicaid programs to shift more long-term care spending to home and

FIGURE 9

A Majority of States Have Adopted ACA Medicaid Expansion



Source: Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated June 22, 2015.

*Note: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers.*

community-based long-term services and supports, rather than institutional care.[143]

Nearly two-thirds (63 percent) of all Medicaid spending is for seniors and people with disabilities.[144] About one out of every four—16.5 million—seniors and people with disabilities depended on Medicaid in 2011. That included 6.4 million seniors and 10.1 million people with disabilities.[145] All told, 21 percent of Medicare beneficiaries were also enrolled in Medicaid (as so-called "dual eligibles") in 2011.[146]

Medicaid is also crucially important to children, who are about half of its beneficiaries nationwide.[147] More than one in every three of the nation's children now receive their health insurance through Medicaid or the smaller Children's Health Insurance Program (CHIP).[148]

Medicaid Works for Illinois' Economy.

- Medicaid covered $15.7 billion in health care costs for Illinois' low-income residents in 2013—and in 2009, Medicaid spending represented 15.1 percent of all health care spending in the state.[149] The average cost per Medicaid beneficiary in 2013 was $5,821 [Figure 1].[150]

Medicaid Works for Illinois' Residents.

- Medicaid insured 2,690,000 Illinois residents in 2013—1 in 5 (20.9 percent) state residents [Figure 1].[151]

Medicaid Works for Illinois' Children.

- Medicaid insured 1,572,100 Illinois children in FY2011—half (50.9 percent) of the children in the state.[152]

Medicaid Works for Illinois' Seniors.

- 225,200 of Illinois' 2,690,000 Medicaid beneficiaries were aged 65 or older in 2011—1 in 13 (7.7 percent) beneficiaries.[153]

Medicaid Works for Illinois' People with Disabilities.

- 333,000 of Illinois' 2,690,000 Medicaid beneficiaries were people with disabilities in 2011—1 in 9 (11.4 percent) beneficiaries.[154]

Medicaid Works for Illinois' Long-Term Care Recipients.

- Medicaid provided $4.6 billion in long-term care benefits for Illinois residents in 2013. That includes:
  - o $1.7 billion in home health care services (36.6 percent)
  - o $1.8 billion to nursing home facilities (39.1 percent)
  - o $151.1 million to mental health facilities (3.3 percent)
  - o $956 million to intermediate care facilities for the mentally retarded (20.9 percent).[155]

- Medicaid is the primary payer for the vast majority of Illinois residents who opt for nursing home care. 46,677 of Illinois' 74,564 nursing home residents were Medicaid beneficiaries in 2011—5 in 8 (62.6 percent) nursing home residents.[156] The average annual cost of nursing home care for a semi-private room in Illinois was $63,875 in 2012.[157] Given the high cost of nursing home care, many Illinois residents would not be able to afford it without Medicaid.

As health care costs increase system-wide, Medicaid's costs rise as well. But Medicaid spending has grown more slowly than private insurance—at a rate of 1.1 percent since 2007, vs. 4.4 percent for private insurance.[158] Medicaid budgets are strained, largely due to rising social inequality, which leaves an ever larger share of the population below 138 percent of the poverty line and without employer health coverage. Medicaid is part of the solution to these problems, not a problem in need of a solution.

Cutting Medicaid access by converting its federal long-term care funding to a block grant to states, and by capping per-person spending on low-income children and parents, as the current Congressional budget agreement proposes to do, would simply shift costs to states who, in turn, would likely shift them further onto those who can least afford it, leading many to forgo necessary care. Instead of taking more politically courageous measures to reduce health-care cost growth, such an approach would reduce access to health and long-term care among particularly vulnerable populations.[159]

The passage of Medicare and Medicaid in 1965 was intended by many policymakers to be the first step toward achieving health insurance coverage for all Americans.[160] The ACA's coverage expansions have brought us closer to this goal. If Medicaid were expanded in the remaining 21 states, so as to cover all Americans at or below 138 percent of the poverty line, an additional 4 million people would have health insurance coverage,[161] preventing between 7,000 and 17,000 deaths annually, according to a Harvard study.[162] For the sake of these very low-income adults, it is time for all states to expand Medicaid.

CONCLUSION

We built our Social Security and Medicare systems because they are the most efficient, secure, universal and fair ways for Americans to achieve income security in retirement, and health security in retirement and disability. We built our Medicaid system so that Americans of modest means can have access to the fundamental human right of health care.

As important as these protections are today, the need for them will only increase in the coming years. Income growth is, at best, slow for most of today's workers, and income inequality is higher than it has been in nearly a century. Jobs are less secure, and many workers have sustained substantial losses of home equity and other savings. Furthermore, most employers who historically offered supplements to Social Security have terminated traditional pension plans, replacing them with far more risky and inadequate 401(k)-style savings accounts.

Our nation faces an impending retirement security crisis. Workers today are saving no more at various ages than their counterparts did in 1983, even though they need much more, given that pensions are disappearing, out-of-pocket health-care costs are higher, and many are living longer.[163] The typical household nearing retirement has only $14,500 in retirement savings.[164] More than half (52 percent) of today's working Americans are not expected to have sufficient resources to maintain their standard of living in old age. The outlook is even more dismal when anticipated health and long-term care costs are counted; then, roughly two-thirds of working-age households are not expected to be able to maintain their living standard in retirement.[165]

Were it not for Social Security, Medicare and Medicaid, the retirement security crisis awaiting today's workforce would be much worse. These programs are fortresses of security and reliability, and they work extremely well. In this uncertain world, where no one is invulnerable to premature death, permanent disability or poor health, Social Security, Medicare and Medicaid are there to cushion the blow. Their protections should be expanded, not cut.

These programs, like our highways, are fundamental to our family and community life. In an increasingly uncertain economic environment, they will be even more important to future generations of retirees—today's middle-aged and younger workers.

We are much wealthier as a nation than we were in 1935, 1939, 1956, 1965 or 1972, when these structures were built and improved. Now it is our turn to maintain and improve them, as previous generations have done, for ourselves and for those who follow. To build our own legacy for our nation's children and grandchildren so when they become workers, they will have the economic security that Social Security, Medicare and Medicaid provide.

Maintaining our Social Security, Medicare and Medicaid systems must not be reduced to a matter of simple arithmetic. Any changes we make to these vital programs must help advance their mission of providing economic security and dignity to the American people. Reducing expenditures in these programs is not an end in itself; doing so in ways that expose beneficiaries to economic insecurity or health risks would solve the arithmetic problem while compromising these programs' fundamental promise.

The solution is clear—it is time to double down on what works. We must expand Social Security and Medicare, in order to buttress retirement security in an era of wage stagnation and inequality. And Medicaid should be expanded to cover all American households living under 138 percent of poverty in all 50 states.

At base, this is about what kind of nation we want to live in and leave for those who follow. Today's workers have a stake in preserving these foundational systems—for themselves, their families, and their children and grandchildren. And politicians have the opportunity to maintain, improve and pass on these paramount achievements for future generations, just as previous Congresses and presidents have done for us.

Appendix 1: Social Security Works for Illinois' Congressional Districts

		STATE TOTAL	CONGRESSIONAL DISTRICTS																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
	Total annual benefits ($ in millions)*	**$32,485M**	$1,781M	$1,869M	$1,737M	$956M	$1,470M	$1,911M	$1,368M	$1,622M	$1,984M	$1,751M	$1,501M	$2,015M	$1,935M	$1,796M	$2,156M	$2,211M	$2,222M	$2,200M
	Number of residents in state/ congressional district	**12,868,770**	712,618	708,298	716,709	718,208	724,545	721,408	719,753	720,402	715,178	712,624	716,438	708,957	715,252	721,517	708,115	706,371	708,861	713,516
	Number of residents receiving Social Security benefits	**2,155,290**	123,902	130,029	114,430	74,904	96,337	109,553	98,495	101,010	122,168	105,994	94,897	144,069	135,003	107,508	154,265	143,645	154,042	145,039
	Percent of residents receiving Social Security benefits	**16.7%**	17.4%	18.4%	16.0%	10.4%	13.3%	15.2%	13.7%	14.0%	17.1%	14.9%	13.2%	20.3%	18.9%	14.9%	21.8%	20.3%	21.7%	20.3%
SOCIAL SECURITY BENEFICIARIES BY CATEGORY	***Women***	**1,116,457**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Retired workers	**1,463,959**	80,107	80,127	79,351	45,198	70,075	82,665	59,771	71,920	89,608	75,988	64,646	89,094	88,051	79,239	101,202	99,170	103,596	104,151
	Disabled workers	**289,730**	19,406	22,209	13,666	13,252	10,525	9,144	18,601	12,187	12,620	11,078	12,590	24,861	20,391	10,907	22,240	18,688	22,145	15,220
	Widow(er)s	**160,955**	9,735	10,135	9,080	5,379	6,663	7,258	7,219	6,737	8,133	7,228	6,501	12,279	10,535	6,752	13,420	10,700	11,993	11,208
	Spouses	**86,210**	3,539	4,095	5,105	4,385	4,083	5,046	2,902	4,222	5,576	5,383	3,747	5,522	5,059	3,889	6,494	5,331	5,830	6,002
	Children	**154,436**	11,115	13,463	7,228	6,690	4,991	5,440	10,002	5,944	6,231	6,317	7,413	12,313	10,967	6,721	10,909	9,756	10,478	8,458

Sources: U.S. Census Bureau, *ACS Demographic and Housing Estimates*, "2011-2013 American Community Survey 3-Year Estimates," 2014.
SSA, "Illinois," *Congressional Statistics, December 2014*, 2015.
SSA, *Annual Statistical Supplement, 2015*, "Table 5.J5.1: Number by state or other area and sex, December 2014," 2015.
*The annual benefits for the Congressional districts were calculated by taking the monthly benefits and multiplying by 12. The state annual benefits number is the sum of the congressional district numbers.

Appendix 2: Social Security, Medicare and Medicaid Data by County in Illinois (Page 1/4)

		ILLINOIS COUNTY DEMOGRAPHICS, 2013					SOCIAL SECURITY BENEFITS, 2013-2014		SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014*							MEDICARE & MEDICAID, 2011-2012	
County	Metropolitan/ Non-Metropolitan	2013 Population	Median Household Income, 2013	% in Poverty, 2013	Population over Age 65, 2013	% of Population over Age 65, 2013	Annual Total Benefits, 2014	% of Total Personal Income, 2013	% of Population Receiving Benefits, 2014	Total Beneficiaries	Retired Workers	Disabled Workers	Widow(er)s	Spouses	Children	% Receiving Medicare, 2012	% Receiving Medicaid, 2011
Illinois Total (102 Counties)	N/A	12,882,135	$56,212	14.6%	1,743,641	13.5%	$32,485,428,000	5.4%	16.7%	2,155,290	1,463,960	289,730	160,955	86,210	154,435	16.3%	19.9%
Adams	Non-Metropolitan	67,130	$43,604	15.9%	12,272	18.3%	$217,176,000	7.5%	22.8%	15,305	10,645	1,965	1,140	590	965	21.9%	29.3%
Alexander	Metropolitan	7,629	$30,141	33.0%	1,366	17.9%	$23,892,000	10.4%	25.2%	1,925	1,095	420	165	65	180	24.7%	38.1%
Bond	Metropolitan	17,470	$48,464	16.0%	2,830	16.2%	$52,872,000	8.0%	21.7%	3,790	2,465	590	345	150	240	19.8%	18.8%
Boone	Metropolitan	53,957	$59,537	10.2%	7,277	13.5%	$153,468,000	7.5%	18.1%	9,765	6,775	1,285	635	385	685	16.5%	16.9%
Brown	Non-Metropolitan	6,860	$46,522	16.0%	879	12.8%	$15,072,000	6.4%	16.0%	1,100	710	170	105	50	65	15.6%	12.9%
Bureau	Non-Metropolitan	34,056	$49,062	12.0%	6,654	19.5%	$120,024,000	7.9%	23.7%	8,055	5,785	895	620	300	455	22.3%	18.1%
Calhoun	Metropolitan	5,059	$48,504	12.0%	1,121	22.2%	$18,036,000	9.6%	24.8%	1,255	835	155	120	80	65	25.7%	17.2%
Carroll	Non-Metropolitan	14,910	$43,643	14.0%	3,416	22.9%	$58,968,000	9.3%	28.0%	4,170	2,950	515	330	145	230	28.1%	19.3%
Cass	Non-Metropolitan	13,324	$45,257	12.9%	2,139	16.1%	$36,516,000	7.2%	19.5%	2,595	1,730	315	250	95	205	19.6%	20.3%
Champaign	Metropolitan	204,897	$46,917	21.6%	22,171	10.8%	$357,612,000	4.4%	12.9%	26,460	17,760	3,670	1,960	950	2,120	12.8%	15.1%
Christian	Non-Metropolitan	34,298	$49,391	13.1%	6,251	18.2%	$122,076,000	8.5%	24.5%	8,400	5,510	1,160	800	370	560	22.7%	23.4%
Clark	Non-Metropolitan	16,182	$46,287	13.7%	2,976	18.4%	$53,892,000	8.1%	23.9%	3,860	2,530	550	375	170	235	22.8%	22.3%
Clay	Non-Metropolitan	13,566	$42,369	14.2%	2,520	18.6%	$46,452,000	8.8%	25.9%	3,510	2,245	570	315	155	225	24.5%	24.9%
Clinton	Metropolitan	37,907	$61,843	9.5%	5,931	15.6%	$101,208,000	6.3%	18.7%	7,105	4,800	815	625	245	620	18.7%	10.1%
Coles	Non-Metropolitan	53,697	$39,353	19.8%	7,868	14.7%	$135,252,000	6.7%	18.5%	9,940	6,690	1,470	775	330	675	17.6%	19.1%
Cook	Metropolitan	5,240,700	$53,795	17.8%	664,394	12.7%	$11,645,868,000	4.5%	15.0%	786,215	527,925	110,495	57,560	31,555	58,680	15.1%	23.6%
Crawford	Non-Metropolitan	19,505	$47,517	14.0%	3,508	18.0%	$65,832,000	8.1%	23.3%	4,535	3,135	575	370	205	250	22.0%	18.5%
Cumberland	Non-Metropolitan	10,939	$47,382	12.1%	1,913	17.5%	$34,584,000	7.3%	23.2%	2,535	1,680	355	205	130	165	21.5%	19.1%
DeKalb	Metropolitan	104,741	$54,204	18.7%	11,340	10.8%	$220,488,000	6.0%	13.9%	14,510	10,125	1,825	1,025	455	1,080	13.2%	15.2%
De Witt	Metropolitan	16,420	$53,303	13.8%	2,896	17.6%	$54,012,000	7.4%	22.1%	3,635	2,500	515	280	135	205	21.2%	18.6%
Douglas	Non-Metropolitan	19,887	$49,179	10.7%	3,223	16.2%	$53,748,000	6.2%	18.7%	3,725	2,560	435	355	170	205	20.1%	18.5%
DuPage	Metropolitan	932,126	$76,269	7.0%	121,034	13.0%	$2,350,284,000	4.3%	14.9%	138,455	102,810	13,070	9,285	6,155	7,135	14.9%	11.5%
Edgar	Non-Metropolitan	17,960	$44,433	18.5%	3,590	20.0%	$63,036,000	8.3%	25.1%	4,510	2,900	690	400	195	325	24.1%	23.2%
Edwards	Non-Metropolitan	6,672	$45,675	12.7%	1,236	18.5%	$22,860,000	9.3%	24.7%	1,645	1,100	210	155	80	100	23.5%	15.6%
Effingham	Non-Metropolitan	34,307	$50,900	11.1%	5,562	16.2%	$107,832,000	7.3%	22.2%	7,610	5,075	1,030	675	350	480	19.8%	19.8%
Fayette	Non-Metropolitan	22,060	$43,014	16.9%	3,717	16.8%	$56,904,000	8.3%	19.4%	4,280	2,725	655	360	190	350	21.4%	23.3%
Ford	Metropolitan	13,832	$52,375	11.4%	2,701	19.5%	$43,116,000	5.9%	21.9%	3,025	2,065	375	275	105	205	21.8%	19.8%
Franklin	Non-Metropolitan	39,202	$35,681	20.0%	7,518	19.2%	$144,600,000	11.2%	26.7%	10,450	6,285	1,820	980	560	805	25.0%	29.0%
Fulton	Non-Metropolitan	36,346	$46,342	14.8%	6,894	19.0%	$123,348,000	9.2%	23.6%	8,580	5,775	990	875	445	495	22.7%	20.8%

Appendix 2: Social Security, Medicare and Medicaid Data by County in Illinois (Page 2/4)

		ILLINOIS COUNTY DEMOGRAPHICS, 2013					SOCIAL SECURITY BENEFITS, 2013-2014		SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014*							MEDICARE & MEDICAID, 2011-2012	
County	Metropolitan/ Non-Metropolitan	2013 Population	Median Household Income, 2013	% in Poverty, 2013	Population over Age 65, 2013	% of Population over Age 65, 2013	Annual Total Benefits, 2014	% of Total Personal Income, 2013	% of Population Receiving Benefits, 2014	Total Beneficiaries	Retired Workers	Disabled Workers	Widow(er)s	Spouses	Children	% Receiving Medicare, 2012	% Receiving Medicaid, 2011
Gallatin	Non-Metropolitan	5,415	$40,349	17.1%	1,194	22.0%	$21,348,000	8.7%	28.4%	1,540	960	225	160	105	90	28.5%	28.3%
Greene	Non-Metropolitan	13,629	$41,588	18.3%	2,430	17.8%	$42,240,000	8.3%	22.7%	3,100	1,920	515	285	160	220	23.2%	23.6%
Grundy	Metropolitan	50,228	$68,474	8.0%	6,203	12.3%	$134,952,000	6.9%	17.0%	8,545	5,670	1,180	725	370	600	15.3%	14.6%
Hamilton	Non-Metropolitan	8,368	$42,330	14.9%	1,672	20.0%	$25,380,000	7.3%	22.7%	1,900	1,210	270	185	95	140	24.5%	23.0%
Hancock	Non-Metropolitan	18,618	$47,965	12.2%	3,983	21.4%	$68,484,000	8.9%	25.8%	4,805	3,365	545	415	220	260	24.3%	19.9%
Hardin	Non-Metropolitan	4,181	$36,567	20.3%	949	22.7%	$16,596,000	11.8%	29.5%	1,235	715	225	120	55	120	29.1%	27.3%
Henderson	Non-Metropolitan	6,990	$45,022	12.8%	1,594	22.8%	$24,576,000	7.5%	24.5%	1,710	1,230	200	135	55	90	25.0%	17.2%
Henry	Metropolitan	49,860	$52,117	11.2%	9,099	18.2%	$165,408,000	7.6%	22.6%	11,245	8,110	1,085	1,015	520	515	21.9%	16.7%
Iroquois	Non-Metropolitan	28,982	$46,977	14.0%	5,788	20.0%	$103,656,000	7.7%	24.7%	7,160	4,775	980	615	275	515	24.3%	21.7%
Jackson	Metropolitan	59,814	$34,243	29.5%	7,497	12.5%	$117,588,000	5.4%	15.3%	9,140	5,840	1,465	725	320	790	15.4%	21.1%
Jasper	Non-Metropolitan	9,592	$52,187	10.5%	1,728	18.0%	$30,024,000	7.1%	22.8%	2,185	1,495	255	210	120	105	22.9%	17.5%
Jefferson	Non-Metropolitan	38,644	$40,663	18.4%	6,655	17.2%	$120,264,000	8.5%	22.4%	8,650	5,645	1,315	725	345	620	21.3%	25.3%
Jersey	Metropolitan	22,641	$54,331	10.5%	3,875	17.1%	$78,720,000	8.4%	23.6%	5,335	3,365	900	475	260	335	21.6%	15.1%
Jo Daviess	Non-Metropolitan	22,407	$49,573	10.2%	5,267	23.5%	$92,016,000	8.6%	27.4%	6,145	4,845	480	410	220	190	26.3%	12.0%
Johnson	Non-Metropolitan	12,677	$39,965	17.9%	2,376	18.7%	$43,716,000	11.8%	25.5%	3,235	2,135	455	240	155	250	23.8%	19.8%
Kane	Metropolitan	523,643	$71,444	10.9%	58,856	11.2%	$1,155,696,000	5.5%	13.6%	71,410	51,205	8,420	4,470	2,740	4,575	12.5%	17.1%
Kankakee	Metropolitan	112,120	$49,584	16.7%	16,265	14.5%	$328,704,000	7.9%	19.8%	22,205	13,895	3,585	1,675	765	2,285	18.7%	22.4%
Kendall	Metropolitan	119,348	$79,648	5.8%	10,335	8.7%	$229,944,000	4.8%	11.8%	14,140	9,940	1,685	910	460	1,145	10.8%	11.3%
Knox	Non-Metropolitan	52,078	$39,494	19.6%	10,066	19.3%	$172,608,000	8.7%	23.2%	12,075	8,335	1,535	885	410	910	23.8%	22.4%
Lake	Metropolitan	703,019	$75,106	9.5%	82,950	11.8%	$1,670,856,000	3.9%	14.3%	100,285	71,335	10,865	6,685	4,845	6,555	13.8%	13.5%
LaSalle	Non-Metropolitan	112,183	$49,487	13.8%	19,342	17.2%	$377,280,000	8.3%	22.2%	24,940	17,005	3,335	2,040	890	1,670	20.8%	19.2%
Lawrence	Non-Metropolitan	16,558	$39,670	18.2%	2,707	16.3%	$48,480,000	8.7%	21.0%	3,480	2,245	525	380	120	210	20.6%	19.1%
Lee	Non-Metropolitan	34,858	$53,126	12.4%	5,957	17.1%	$115,680,000	8.0%	22.5%	7,835	5,135	1,145	595	280	680	21.8%	17.4%
Livingston	Non-Metropolitan	38,186	$52,819	12.5%	6,306	16.5%	$122,352,000	6.4%	21.3%	8,140	5,390	1,060	675	320	695	19.7%	17.0%
Logan	Non-Metropolitan	29,964	$50,991	13.6%	5,023	16.8%	$92,136,000	7.8%	20.7%	6,200	4,335	805	500	185	375	19.9%	18.7%
McDonough	Non-Metropolitan	32,464	$41,661	21.1%	4,841	14.9%	$73,056,000	6.1%	17.2%	5,600	3,870	670	470	220	370	18.4%	15.2%
McHenry	Metropolitan	307,409	$75,713	7.1%	35,745	11.6%	$794,616,000	5.9%	15.6%	47,885	34,470	5,650	3,020	1,675	3,070	14.2%	11.0%
McLean	Metropolitan	174,647	$62,261	13.8%	19,103	10.9%	$376,800,000	4.8%	14.2%	24,805	17,455	3,130	1,675	870	1,675	13.4%	13.3%
Macon	Metropolitan	109,278	$46,179	18.1%	19,094	17.5%	$371,448,000	7.9%	22.7%	24,855	16,440	3,805	1,885	980	1,745	21.8%	23.9%
Macoupin	Metropolitan	46,880	$50,089	13.9%	8,583	18.3%	$165,084,000	8.7%	24.4%	11,440	7,365	1,765	1,010	535	765	22.6%	20.5%
Madison	Metropolitan	267,225	$53,864	13.7%	40,934	15.3%	$816,588,000	7.5%	20.6%	54,975	34,765	8,920	4,730	2,200	4,360	19.5%	19.3%

Appendix 2: Social Security, Medicare and Medicaid Data by County in Illinois (Page 3/4)

		ILLINOIS COUNTY DEMOGRAPHICS, 2013					SOCIAL SECURITY BENEFITS, 2013-2014		SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014*							MEDICARE & MEDICAID, 2011-2012	
County	Metropolitan/ Non-Metropolitan	2013 Population	Median Household Income, 2013	% in Poverty, 2013	Population over Age 65, 2013	% of Population over Age 65, 2013	Annual Total Benefits, 2014	% of Total Personal Income, 2013	% of Population Receiving Benefits, 2014	Total Beneficiaries	Retired Workers	Disabled Workers	Widow(er)s	Spouses	Children	% Receiving Medicare, 2012	% Receiving Medicaid, 2011
Marion	Non-Metropolitan	38,622	$40,969	19.2%	6,987	18.1%	$129,276,000	9.0%	24.7%	9,550	6,010	1,585	740	340	875	24.2%	33.4%
Marshall	Metropolitan	12,153	$50,899	10.2%	2,549	21.0%	$46,260,000	7.7%	24.7%	3,005	2,130	315	285	135	140	24.4%	21.7%
Mason	Non-Metropolitan	14,248	$45,563	14.0%	2,932	20.6%	$51,252,000	8.2%	24.8%	3,530	2,345	425	340	190	230	27.0%	25.4%
Massac	Non-Metropolitan	15,073	$41,373	17.5%	2,973	19.7%	$55,128,000	10.8%	26.5%	3,995	2,470	730	345	170	280	25.1%	26.4%
Menard	Metropolitan	12,607	$60,151	10.8%	2,196	17.4%	$40,920,000	7.5%	21.8%	2,750	1,970	305	195	85	195	20.3%	15.4%
Mercer	Metropolitan	16,178	$53,626	9.7%	3,218	19.9%	$58,440,000	7.5%	24.7%	4,000	2,890	365	365	190	190	24.5%	16.1%
Monroe	Metropolitan	33,493	$71,604	4.9%	5,119	15.3%	$98,544,000	6.0%	18.8%	6,300	4,525	670	480	245	380	17.5%	7.1%
Montgomery	Non-Metropolitan	29,654	$42,614	16.1%	5,320	17.9%	$98,664,000	9.1%	23.7%	7,015	4,580	1,000	665	295	475	22.3%	22.4%
Morgan	Non-Metropolitan	35,067	$48,223	16.0%	6,215	17.7%	$113,544,000	8.4%	22.6%	7,940	5,275	1,135	590	275	665	22.6%	20.8%
Moultrie	Non-Metropolitan	14,876	$47,645	12.4%	2,759	18.5%	$41,544,000	6.7%	18.9%	2,815	1,970	335	210	110	190	20.6%	15.8%
Ogle	Non-Metropolitan	52,385	$51,334	13.0%	8,801	16.8%	$165,816,000	7.6%	20.9%	10,945	7,690	1,370	825	370	690	19.9%	16.5%
Peoria	Metropolitan	188,429	$49,827	17.0%	27,613	14.7%	$552,708,000	6.1%	19.4%	36,555	24,915	4,830	2,805	1,500	2,505	18.5%	22.9%
Perry	Non-Metropolitan	21,887	$41,931	17.6%	3,678	16.8%	$69,204,000	10.4%	22.0%	4,820	3,045	700	460	285	330	20.7%	20.1%
Piatt	Metropolitan	16,433	$66,279	7.2%	2,902	17.7%	$56,232,000	6.0%	23.0%	3,775	2,705	385	335	160	190	21.0%	11.0%
Pike	Non-Metropolitan	16,150	$39,430	17.3%	3,193	19.8%	$51,444,000	7.9%	23.9%	3,855	2,650	485	325	175	220	23.0%	22.7%
Pope	Non-Metropolitan	4,312	$38,676	19.9%	899	20.8%	$12,852,000	9.4%	21.9%	945	610	145	75	35	80	24.6%	16.9%
Pulaski	Non-Metropolitan	5,908	$34,828	21.5%	1,149	19.4%	$19,752,000	8.9%	26.6%	1,570	930	305	145	55	135	25.9%	33.3%
Putnam	Non-Metropolitan	5,801	$58,438	9.0%	1,131	19.5%	$22,632,000	8.7%	24.8%	1,440	1,080	135	110	40	75	23.1%	15.6%
Randolph	Non-Metropolitan	32,890	$44,991	14.1%	5,572	16.9%	$103,548,000	9.7%	21.5%	7,060	4,655	975	620	310	500	20.3%	18.0%
Richland	Non-Metropolitan	16,182	$41,985	16.4%	3,217	19.9%	$53,004,000	9.1%	24.4%	3,950	2,670	535	345	155	245	23.9%	23.8%
Rock Island	Metropolitan	147,258	$48,160	15.8%	25,357	17.2%	$460,428,000	7.6%	21.1%	31,050	22,200	3,630	2,405	1,190	1,625	20.5%	21.1%
St. Clair	Metropolitan	266,955	$48,343	18.3%	36,136	13.5%	$681,252,000	6.5%	18.1%	48,300	29,720	8,535	3,885	1,600	4,560	17.1%	22.3%
Saline	Non-Metropolitan	24,939	$39,281	18.6%	4,728	19.0%	$90,084,000	9.7%	26.5%	6,620	3,970	1,055	725	345	525	25.3%	30.6%
Sangamon	Metropolitan	199,145	$55,255	15.2%	29,917	15.0%	$590,760,000	6.9%	20.5%	40,820	27,490	5,680	2,690	1,025	3,935	18.8%	20.4%
Schuyler	Non-Metropolitan	7,444	$49,808	13.2%	1,388	18.6%	$23,160,000	7.3%	22.4%	1,670	1,140	220	150	70	90	22.3%	16.1%
Scott	Non-Metropolitan	5,222	$46,004	13.3%	959	18.4%	$16,524,000	7.6%	22.3%	1,165	800	135	100	55	75	20.2%	15.8%
Shelby	Non-Metropolitan	22,119	$50,569	12.6%	4,476	20.2%	$70,740,000	8.0%	22.6%	4,990	3,345	640	440	245	320	23.1%	17.2%
Stark	Metropolitan	5,907	$52,428	11.0%	1,378	23.3%	$21,264,000	7.4%	24.1%	1,425	970	145	125	105	80	23.2%	18.6%
Stephenson	Non-Metropolitan	46,740	$42,897	18.6%	9,371	20.0%	$172,056,000	9.0%	25.1%	11,735	8,430	1,515	730	350	710	23.8%	21.2%
Tazewell	Metropolitan	136,352	$57,544	8.9%	22,470	16.5%	$444,984,000	7.8%	21.1%	28,785	20,115	3,125	2,445	1,410	1,690	19.5%	17.2%
Union	Non-Metropolitan	17,583	$42,799	16.7%	3,382	19.2%	$59,148,000	9.7%	26.2%	4,605	2,880	725	380	145	475	25.8%	27.4%

Appendix 2: Social Security, Medicare and Medicaid Data by County in Illinois (Page 4/4)

		ILLINOIS COUNTY DEMOGRAPHICS, 2013					SOCIAL SECURITY BENEFITS, 2013-2014		SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014*							MEDICARE & MEDICAID, 2011-2012	
County	Metropolitan/ Non-Metropolitan	2013 Population	Median Household Income, 2013	% in Poverty, 2013	Population over Age 65, 2013	% of Population over Age 65, 2013	Annual Total Benefits, 2014	% of Total Personal Income, 2013	% of Population Receiving Benefits, 2014	Total Beneficiaries	Retired Workers	Disabled Workers	Widow(er)s	Spouses	Children	% Receiving Medicare, 2012	% Receiving Medicaid, 2011
Vermilion	Metropolitan	80,329	$44,085	19.6%	13,695	17.0%	$260,316,000	9.0%	23.3%	18,700	11,715	3,250	1,450	680	1,605	22.4%	27.7%
Wabash	Non-Metropolitan	11,665	$47,351	14.6%	2,144	18.4%	$39,408,000	8.3%	23.5%	2,740	1,805	405	240	130	160	23.0%	20.1%
Warren	Non-Metropolitan	17,726	$45,770	15.1%	3,096	17.5%	$54,516,000	7.2%	21.8%	3,860	2,655	460	335	175	235	19.3%	18.9%
Washington	Non-Metropolitan	14,448	$53,967	9.9%	2,631	18.2%	$45,024,000	6.6%	21.5%	3,110	2,095	385	295	155	180	21.3%	13.9%
Wayne	Non-Metropolitan	16,612	$42,896	17.4%	3,280	19.7%	$53,736,000	8.2%	23.7%	3,930	2,655	495	365	180	235	24.1%	21.2%
White	Non-Metropolitan	14,549	$42,621	15.5%	3,134	21.5%	$55,164,000	8.4%	27.1%	3,940	2,560	550	415	190	225	26.8%	25.7%
Whiteside	Non-Metropolitan	57,557	$50,489	12.1%	10,585	18.4%	$207,408,000	8.6%	24.7%	14,235	9,465	2,005	1,075	660	1,030	23.3%	20.2%
Will	Metropolitan	682,829	$74,669	8.5%	73,306	10.7%	$1,559,328,000	5.0%	14.3%	97,685	66,210	12,465	7,120	3,865	8,025	13.0%	14.0%
Williamson	Metropolitan	66,924	$44,041	16.2%	11,631	17.4%	$211,092,000	8.5%	22.8%	15,285	9,860	2,370	1,335	640	1,080	21.9%	22.9%
Winnebago	Metropolitan	290,666	$47,214	16.3%	44,267	15.2%	$912,708,000	8.4%	20.7%	60,030	39,560	9,935	3,960	1,960	4,615	19.2%	24.3%
Woodford	Metropolitan	39,273	$67,036	7.0%	6,273	16.0%	$120,240,000	6.4%	19.5%	7,650	5,555	695	625	335	440	18.2%	

*State totals in this appendix may not equal state figures cited elsewhere in the report, because individual county figures provided by SSA are rounded.

2013 Population: US Census Bureau, *2014 Population Estimates,* "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014," 2015. http://factfinder2.census.gov/. The total state population given in Appendix 2 may not match the state population in Appendix 1 because it is the sum of the individual county population estimates, which have a higher margin of error than congressional district population estimates.

Metropolitan/Non-Metropolitan: Unpublished calculations of US Census data performed by Dr. Roberto Gallardo, Mississippi State University Extension Service, on behalf of the Center for Rural Strategies, and shared with Social Security Works. For the purposes of this analysis, "metropolitan" refers to counties with at least one urbanized area of 50,000 people or more, and adjacent counties in which 25 percent of the workforce or more commutes to county with 50,000 people or more. "Non-metropolitan" refers to counties designated by the Office of Management and Budget (OMB) as non-metropolitan, including micropolitan areas, or "small cities," with urban clusters of 10,000-49,999 people, and non-core areas lacking a centralized population of any kind. Dr. Gallardo's initial calculations distinguished between "small cities" and "rural" counties. For Social Security Works, he created a weighted average of "small cities" and "rural" counties that allowed us to classify both as "non-metropolitan" figures. US Department of Agriculture, Economic Research Service (ERS), What is Rural?, March 16, 2015. http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural.aspx#.UeSGcGTTWGN

Total Personal Income, 2013: Bureau of Economic Analysis, "CA1 Personal Income Summary: Personal Income, Population, Per Capita Personal Income," November 20, 2014. http://bea.gov/regional/

Median Househould Income, 2013: US Census Bureau, Small Area Estimates Branch, *Small Area Income and Poverty Estimates, 2013,* "Table 1: 2013 Poverty and Median Income Estimates—Counties," 2014. http://www.census.gov/did/www/saipe/data/statecounty/data/2013.html

Percentage in Poverty, 2013: US Census Bureau, Small Area Estimates Branch, *Small Area Income and Poverty Estimates, 2013,* "Table 1: 2013 Poverty and Median Income Estimates—Counties," 2014. http://www.census.gov/did/www/saipe/data/statecounty/data/2013.html

Population over 65, 2013: US Census Bureau, *2014 Population Estimates,* "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014," 2015. http://factfinder2.census.gov/

Percent of Population Receiving Benefits, 2013: SSA, *OASDI Benefits by State and County, 2014,* "Table 4. Number of beneficiaries in current-payment status, by county, type of benefit, and sex of beneficiaries aged 65 or older, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/oasdi_sc/

Annual Total Benefits, 2014: SSA, *OASDI Benefits by State and County, 2014,* "Table 5. Amount of benefits in current-payment status, by county, type of benefit, and sex of beneficiaries aged 65 or older, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/oasdi_sc/

Social Security Beneficiaries by Characteristic, 2014: SSA, Ibid, Table 4.

Percentage of Population Receiving Medicare, 2012: Calculation based on Medicare enrollment data for 2012 and 2012 population data. Medicare enrollment data: Centers for Medicare and Medicaid Services, "Medicare Aged and Disabled By State and County, As of July 1, 2012," accessed June 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2012.pdf. 2012 Population data: US Census Bureau, *2014 Population Estimates,* "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014," 2015. http://factfinder2.census.gov/.

Percentage of Population Receiving Medicaid, 2011: Calculation based on Medicaid enrollment data for 2011 and 2011 population data. Medicaid Enrollment Data: Unpublished data provided to Social Security works by Centers for Medicare and Medicaid Services, "FY2011 Average Monthly Enrollment by State and County," June 2015. Population data: US Census Bureau, *2014 Population Estimates,* "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014," 2015. http://factfinder2.census.gov/. Due to limitations in availability of data, the percentage of residents receiving Medicaid in some counties could not be provided.

Endnotes

1 The committee described this figure as “a conservative estimate.” Committee on Economic Security, “Report of the Committee on Economic Security,” January 15, 1935. http://www.ssa.gov/history/reports/ces5.html
2 Virginia P. Reno and Benjamin Veghte, “Economic Status of the Elderly in the United States,” National Academy of Social Insurance, September 2010. http://www.nasi.org/sites/default/files/research/Economic%20Status%20of%20the%20Elderly%20in%20the%20United%20States.pdf. Poverty figures in this report are based on the official poverty measure. Since 2010 the Census has also been tracking an updated poverty measure, the Supplemental Poverty Measure (SPM), based on a recommendation from the National Academy of Sciences. The SPM measures poverty in terms of thresholds based on the actual cost of living, which varies by household size and expenses. In large part because of seniors’ high out-of-pocket health care costs, it reports substantially higher poverty levels for seniors than does the official poverty measure. U.S. Census Bureau (Kathleen Short), *The Research Supplemental Poverty Measure: 2011*, November 2012. https://www.census.gov/hhes/povmeas/methodology/supplemental/research/Short_ResearchSPM2011.pdf
3 Gary V. Engelhardt and Jonathan Gruber, “Social Security and the Evolution of Elderly Poverty,” National Bureau of Economic Research Working Paper No. 10466, May 2004. http://www.nber.org/papers/w10466
4 Total annual benefits in 2014: $812,045,000. Social Security Administration (SSA), *Annual Statistical Supplement, 2015*, “Table 5.J1—Estimated total annual benefits paid, by state or other area and program, 2014,” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html. Total beneficiaries as of December 2014: 57,978,610. SSA, ibid., “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014.” Total U.S. population 2014: 318,857,056. U.S. Census Bureau, “Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014,” *2014 Population Estimates*, 2015. http://factfinder2.census.gov/
5 Calculated by subtracting number of beneficiaries 65 and older (42,084,088) from total beneficiaries (59,007,158). SSA, ibid*.,* “Table 5.J3—Number and total monthly benefits for beneficiaries aged 65 or older, by state or other area and sex, December 2014.”
6 Congressional Research Service (CRS) (Thomas Gabe), “Social Security’s Effect on Child Poverty,” January 23, 2015. http://www.pennyhill.com/jmsfileseller/docs/RL33289.pdf
7 SSA, ibid*., 2015*, “Table 5.F4—Number of children and total monthly benefits, by type of benefit, December 1940–2014, selected years,” accessed June 25, 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5f.html#table5.f4 Disabled children may receive benefits indefinitely as long as the disability was incurred before reaching age 22.
8 Average benefit found by dividing total spending by total beneficiaries. Total annual benefits from SSA, ibid., “Table 5.J1—Estimated total annual benefits paid, by state or other area and program, 2015 (in millions of dollars),” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html. Total beneficiaries from SSA, ibid*.,* “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014.” Average retired worker benefit found by multiplying average monthly retired worker benefit by 12. SSA, ibid*.*, “Table 5.J6—Percentage distribution of monthly benefit for retired workers, by state or other area and monthly benefit, December 2014.”
9 SSA, *Income of the Population 55 or Older*, *2012*, Table 9.A1, April 2014. http://www.ssa.gov/policy/docs/statcomps/income_pop55/2012/sect09.html
10 Unpublished tabulations by the Center on Budget and Policy Priorities (CBPP) for Social Security Works of data from the U.S. Census Bureau, Current Population Survey, March 2014.
11 SSA (Michelle Stegman Bailey and Jeffrey Hemmeter), “Characteristics of Noninstitutionalized DI and SSI Program Participants, 2010 Update,” Research and Statistics Note Nr. 2014-02, February 2014, Table 2. http://www.ssa.gov/policy/docs/rsnotes/rsn2014-02.html
12 Stegman and Hemmeter, ibid., Table 5.
13 The $631,000 value of disability benefits includes $443,000 of Disability Insurance benefits, and $189,000 of Old-Age and Survivors Insurance benefits once the disabled worker reaches the full retirement age. SSA, “The Present Value of Expected Lifetime Benefits for a Hypothetical Worker Dying or Becoming Disabled at Age 30,” Unpublished Memorandum from Michael Clingman, Kyle Burkhalter, and Chris Chaplain, Actuaries, to Alice H. Wade, Deputy Chief Actuary, November 5, 2014.
14 SSA, “Estimated Number of Fully Insured Workers, by Age Group and Sex, on December 31, 1970-2014.” http://www.ssa.gov/OACT/STATS/table4c2FI.html (accessed June 21, 2015).
15 SSA, “Fact Sheet,” April 2, 2014. http://www.ssa.gov/pressoffice/factsheets/basicfact-alt.pdf
16 SSA, ibid.
17 SSA Office of the Chief Actuary (Robert Baldwin and Sharon Chu), “A Death and Disability Life Table for Insured Workers Born in 1985,” Actuarial Note 2005.6, February 2006. http://www.ssa.gov/oact/NOTES/ran6/an2005-6.pdf
18 Total beneficiaries from SSA, *Annual Statistical Supplement, 2014*, “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014,” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j2. State population data from U.S. Census Bureau, “Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014,” *2014 Population Estimates*, 2015. http://factfinder2.census.gov/
19 Total annual benefits from SSA, *Annual Statistical Supplement, 2015*, “Table 5.J1—Estimated total annual benefits paid, by state or other area and program, 2014 (in millions of dollars),” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j1. Benefits’ equivalent percentage of total personal income calculated using state figures from Bureau of Economic Analysis, *Regional Economic Accounts*, “SA1-3 Personal Income Summary (thousands of dollars),” March 25, 2015. http://www.bea.gov/regional/index.htm
20 Average benefit found by dividing total spending by total beneficiaries. Total annual benefits from Social Security Administration (SSA), *Annual Statistical Supplement, 2015*, “Table 5.J1—Estimated total annual benefits paid, by state or other area and program, 2014 (in millions of dollars),” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j1. Total beneficiaries from SSA, ibid., “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2013,” July 2014. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j2
21 Unpublished tabulations by the Center on Budget and Policy Priorities (CBPP) for Social Security Works of data from the U.S. Census Bureau, Current Population Survey, March 2014.State estimates are based on a three-year average (for 2010-2012) to improve their reliability; the national data are for 2012.
22 For the purposes of this report, “seniors” describes individuals aged 65 or older.
23 SSA, ibid., “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014,” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j2
24 For the purposes of this analysis, “typical” is used to describe the “median” benefit. Monthly median benefit multiplied by 12 to calculate annual figure. SSA, ibid., “Table 5.J6—Percentage distribution of monthly benefit for retired workers, by state or other area and monthly benefit, December 2014,” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j6
25 Unpublished tabulations by the Center on Budget and Policy Priorities (CBPP) for Social Security Works of data from the U.S. Census Bureau, Current Population Survey, March 2014.
26 See Endnote 3 for more on how poverty is measured.

27 Unpublished tabulations by the Center on Budget and Policy Priorities (CBPP) for Social Security Works of data from the U.S. Census Bureau, Current Population Survey, March 2014.
28 SSA, ibid., "Table 5.J5.1—Number, by state or other area, and sex, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j1. Percentage of women receiving benefits calculated using total female population from U.S. Census Bureau, "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014,"
2014 Population Estimates, 2015. http://factfinder2.census.gov/
29 Total spouses receiving benefits calculated by adding number of spouses of retired workers to number of spouses of disabled workers. SSA, ibid., "Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j2
30 Unpublished tabulations by the Center on Budget and Policy Priorities (CBPP) for Social Security Works of data from the U.S. Census Bureau, Current Population Survey, March 2014.
31 CBPP, unpublished, ibid.
32 SSA, ibid., "Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j2
33 Monthly median benefit multiplied by 12 to calculate annual figure. SSA, ibid., "Table 5.J9—Percentage distribution of nondisabled widow(er)s, by state or other area and monthly benefit, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j9
34 The data here are for disabled workers receiving disability benefits. It does not include those disabled workers and "disabled adult children" who receive old-age (retirement) or survivors benefits. In this report, any use of the term "disabled worker" will refer only to those disabled workers receiving disability benefits.
35 SSA, ibid., "Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j2
36 Monthly median benefit multiplied by 12 to calculate annual figure. SSA, ibid., "Table 5.J8—Percentage distribution of disabled workers, by state or other area and monthly benefit, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j8
37 In this case, "children" refers to individuals under age 18, and includes neither disabled adult children, nor individuals aged 18-19. When discussing Social Security's insurance protections for children, children under age 18 was considered the most appropriate group to reference in this analysis, since even students aged 18-19 receiving benefits as dependents of a disabled or deceased parent must have qualified for benefits before age 18. While disabled adult children may receive benefits for a severe disability sustained at age 18 or later, it must occur before age 22, meaning that a large proportion of beneficiaries will likely have begun receiving benefits before age 18 as well. Population under age 18: U.S. Census Bureau, "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014," *2014 Population Estimates*, 2015. http://factfinder2.census.gov/. Data on percentage of children insured from SSA, *Survivors Benefits*, July 2013, p. 4. http://www.ssa.gov/pubs/EN-05-10084.pdf
38 SSA, *Annual Statistical Supplement, 2015*, "Table 5.J10—Number of children, by state or other area and type of benefit, December 2014," July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j10
39 U.S. Census Bureau*, 2011-2013 American Community Survey 3-Year Estimates*, "Relationship to Householder for Children under 18 Years in Households," 2014. http://factfinder2.census.gov
40 The term "households" as it is used here refers to households reporting income in the past 12 months. Households receiving Social Security benefits are those households listed as receiving "Social Security income." U.S. Census Bureau, *2011-2013 American Community Survey 3-Year Estimates*, "Selected Population Profile in the United States," 2013. http://factfinder2.census.gov/
41 CBPP, unpublished, ibid.
42 CBPP, unpublished, Ibid.
43 SSA, *Income of the Population 55 or Older*, *2012*, Table 9.A3, April 2014. http://www.ssa.gov/policy/docs/statcomps/income_pop55/2012/sect09.html#table9.a3
44 SSA, *Social Security is Important for African Americans*, April 2014. http://www.ssa.gov/news/press/factsheets/africanamer.htm
45 The term "households" as it is used here refers to households reporting income in the past 12 months. Households receiving Social Security benefits are those households listed as receiving "Social Security income." U.S. Census Bureau, *2011-2013 American Community Survey 3-Year Estimates*, "Selected Population Profile in the United States," 2014. http://factfinder2.census.gov/
46 CBPP, unpublished, ibid.
47 CBPP, unpublished, ibid.
48 SSA, *Income of the Population 55 or Older*, *2012*, Table 9.A3, April 2014. http://www.ssa.gov/policy/docs/statcomps/income_pop55/2012/sect09.html#table9.a3
49 SSA, *Social Security is Important to Hispanics*, June 2015. http://www.ssa.gov/news/press/factsheets/hispanics-alt.pdf. This is the most recent statistically valid data available. Fernando Torres-Gil et al., "Hispanics' Large Stake in the Social Security Debate," June 28, 2005. http://www.cbpp.org/files/6-28-05socsec.pdf
50 The term "households" as it is used here refers to households reporting income in the past 12 months. Households receiving Social Security benefits are those households listed as receiving "Social Security income." U.S. Census Bureau, *2011-2013 American Community Survey 3-Year Estimates*, "Selected Population Profile in the United States," 2014. http://factfinder2.census.gov/
51 SSA, *Social Security Is Important to American Indians and Alaska Natives*, June 2015. http://www.ssa.gov/news/press/factsheets/amerindian-alt.pdf This is the most recent statistically valid data available.
52 SSA, *Social Security Is Important to American Indians and Alaska Natives*, ibid.
53 The term "households" as it is used here refers to households reporting income in the past 12 months. Households receiving Social Security benefits are those households listed as receiving "Social Security income." For states in which there are large numbers of Asian American residents as well as Native Hawaiian and Pacific Islander residents, the numbers of beneficiaries and residents were added to calculate percentage of total Asian American, Native Hawaiian and Pacific Islander residents receiving benefits. U.S. Census Bureau, *2011-2013 American Community Survey 3-Year Estimates*, "Selected Population Profile in the United States," 2014. http://factfinder2.census.gov/
54 SSA, *Income of the Population 55 or Older*, *2012*, Table 9.A3, April 2014. http://www.ssa.gov/policy/docs/statcomps/income_pop55/2012/sect09.html#table9.a3
55 SSA, *Social Security is Important to Asian Americans and Pacific Islanders*, April 2014. http://www.ssa.gov/news/press/factsheets/asian.htm.
56 SSA, *OASDI Beneficiaries by State and County, 2014*, July 2015. http://www.ssa.gov/policy/docs/statcomps/oasdi_sc/

57 Unpublished calculations of Social Security Administration and Bureau of Economic Analysis data performed by Dr. Roberto Gallardo, Mississippi State University Extension Service, on behalf of the Center for Rural Strategies, and shared with Social Security Works. For the purposes of this analysis, "rural" refers to counties designated by the Office of Management and Budget (OMB) as non-metropolitan, including micropolitan areas, or "small cities," with urban clusters of 10,000-49,999 people, and non-core areas lacking a centralized population of any kind. "Metropolitan" refers to counties with at least one urbanized area of 50,000 people or more, and adjacent counties in which 25 percent of the workforce or more commutes to county with 50,000 people or more. Dr. Gallardo's initial calculations distinguished between "small cities" and "rural" counties. For Social Security Works, he created a weighted average of "small cities" and "rural" counties that allowed us to contrast metropolitan and non-metropolitan figures. U.S. Department of Agriculture, Economic Research Service (ERS), *What is Rural?*, March 16, 2015. http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural.aspx#.UeSGcGTTWGN

58 Latino and Asian American status are defined here by self-identification, not nativity, and "immigrants" refers to foreign-born residents of the United Statess refer to foreign-born Americans. ere by ethnicity, not nativity. e redistributive shifts in income from the bottom . U.S. Census Bureau, *American Community Survey 2011-2013 3-Year Estimates*, "Selected Characteristics of the Native and Foreign-Born Populations," 2014. http://factfinder2.census.gov/. Social Security provided all or nearly all of the income for over half (52.6 percent) of Latino senior households, and more than 4 in 10 (44.4 percent) Asian senior households in 2012, compared with one-third (34.6 percent) of white senior households. SSA, *Income of the Population 55 or Older*, *2012*, Table 9.A3, April 2014. http://www.ssa.gov/policy/docs/statcomps/income_pop55/2012/sect09.html#table9.a3

59 U.S. Census Bureau, *American Community Survey 2011-2013,3-Year Estimates*, "Selected Characteristics of the Native and Foreign-Born Populations," 2014. http://factfinder2.census.gov/

60 Six in ten (60 percent) workers who retired earlier than expected in 2014 cited a health problem or disability as the cause. Employee Benefit Research Institute (EBRI), "2015 Retirement Confidence Survey Fact Sheet #2: Changing Expectations about Retirement," April 21, 2015, p. 2. http://ebri.org/pdf/surveys/rcs/2015/RCS15.FS-2.Expects.pdf

61 Center for Economic and Policy Research (CEPR) (Hye Jin Rho), *Hard Work? Patterns in Physically Demanding Labor Among Older Workers*, Table 8, August 2010, p. 14. http://www.cepr.net/documents/publications/older-workers-2010-08.pdf

62 SSA, Office of the Chief Actuary, *Estimated Long-Range Financial Effects on Social Security of the "Border Security, Economic Opportunity, and Immigration Modernization Act," legislation introduced as S. 744 (113th Congress) by Senator Marco Rubio and passed by the Senate on June 27, 2013*, February 2014. http://ssa.gov/oact/solvency/MRubio_20130627.pdf.

63 Prior to the Supreme Court's June 26, 2015 ruling, same-sex couples who were legally married, but living in a state that did not legally recognize gay marriage, could not receive Social Security spousal and dependent child benefits. Following the ruling, on July 9, 2015, the Department of Justice announced that married same-sex couples in every state could begin receiving these and other federal marriage benefits. Department of Justice, "Attorney General Lynch Announces Federal Marriage Benefits Available to Same-Sex Couples Nationwide," July 9, 2015. http://www.justice.gov/opa/pr/attorney-general-lynch-announces-federal-marriage-benefits-available-same-sex-couples

64 Lauren Jow, "UCLA's Williams Institute research played role in historic same-sex marriage decision," UCLA Newsroom, June 26, 2015. http://newsroom.ucla.edu/stories/ucla-s-williams-institute-research-played-role-in-historic-same-sex-marriage-decision .

65 Lauren Jow, ibid.

66 Lauren Jow, ibid.

67 Social Security does not contribute to the deficit, because benefits can only be paid from revenue collected by the Social Security trust funds—the Old-Age and Survivors Insurance (OASI) trust fund and Disability Insurance (DI) trust fund—which are completely separate from the general budget. Social Security Trustees, *2015 Social Security Trustees Report*, July 2015, Table II.B1. http://www.ssa.gov/oact/tr/2015/tr2015.pdf. The trust funds do not have borrowing authority, and therefore cannot deficit-spend. In the event that trust fund revenues fall short of what is needed to pay 100 percent of benefits, then, by law, benefits could not be paid in full and on time. That is why, if Congress does nothing to shore up the program's finances by 2034, Social Security will only have sufficient revenue to pay about three-quarters of scheduled benefits through 2090. This modest funding shortfall is often cited as evidence that the program is financially unsustainable, or "in deficit." In fact, it is just the opposite: it attests to Social Security's self-sustaining funding structure that bars it from deficit-spending or borrowing from the general budget in any way.

68 White House, Office of Management and Budget, *Table 1.1 Summary of Receipts, Outlays and Surpluses or Deficits: 1789-2018*, 2013. http://www.whitehouse.gov/omb/budget/Historicals

69 Social Security Works, "Ensuring Social Security Is in Long-Term Actuarial Balance," July 2015. http://www.socialsecurityworks.org/ensuring-social-security-is-in-long-term-actuarial-balance/

70 Social Security Trustees, *2015 Social Security Trustees Report*, July 2015. http://www.ssa.gov/oact/tr/2015/tr2015.pdf

71 Social Security Trustees, ibid.

72 Social Security Trustees, ibid, "Table II.D5.—OASDI and HI Annual and Summarized Income, Cost, and Balance as a Percentage of GDP, Calendar Years 2015-90."

73 Social Security Trustees, ibid.

74 National Academy of Social Insurance (NASI) (Janice M. Gregory, Thomas N. Bethell, Virginia P. Reno and Benjamin W. Veghte), "Strengthening Social Security for the Long Run," November 2010, p. 7. http://www.nasi.org/sites/default/files/research/SS_Brief_035.pdf

75 Michael Greenstone and Adam Looney, "The Uncomfortable Truth About American Wages," *The New York Times*, October 22, 2012. http://economix.blogs.nytimes.com/2012/10/22/the-uncomfortable-truth-about-american-wages/?_php=true&_type=blogs&_r=0

76 Thomas Piketty and Emmanuel Saez, "Income Inequality in the United States,1913-1998," Table A3, last modified August 2013. http://elsa.berkeley.edu/~saez/TabFig2012prel.xls

77 SSA, *Annual Statistical Supplement, 2013*, "Table 4.B4—Percentage of workers with earnings below annual maximum taxable, by sex, selected years 1937–2012," April 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2014/4b.html#table4.b4; SSA, "Benefits Planner: Maximum Taxable Earnings (1937-2015)." http://www.ssa.gov/planners/maxtax.htm (accessed June 24, 2015)

78 Congressional Budget Office, "The 2015 Long-Term Budget Outlook," June 16, 2015, p. 122. http://www.cbo.gov/publication/50250

79 Social Security Works, "High Earners Should Contribute Fair Share to Social Security: Policy Options," April 6, 2015. http://www.socialsecurityworks.org/wp-content/uploads/2015/04/High-Earners-Should-Contribute-Fair-Share-to-Social-Security_Policy-Options_FINAL.pdf

80 Thomas Paine, *Agrarian Justice: With a new Foreword by Nancy J. Altman, "Social Security, Thomas Paine, and the Spirit of America"*, 2015. http://amzn.to/1IAjuhT

81 Social Security Trustees, *2015 Social Security Trustees Report*, July 2015. http://www.ssa.gov/oact/tr/2015/tr2015.pdf

82 Stephen C. Goss, "The Financing Challenges Facing the Social Security Disability Insurance Program," March 14, 2013. http://www.ssa.gov/oact/testimony/HouseWM_20130314.pdf

83 Goss, ibid., p. 10.

84 Social Security Works, "Social Security Awaits Routine Technical Correction," May 27, 2014. http://www.socialsecurityworks.org/wp-content/uploads/2014/05/Social-Security-Awaits-Routine-Technical-Correction_FINAL-3.pdf. The joint effect of the last two rebalancings in 1983 and 1994 was to shift funds away from the disability to the retirement fund. Kathy Ruffing and Paul N. Van de Water, "Boosting Disability Insurance Share of Social Security Payroll Tax Would Not Harm Retirees," Center on Budget and Policy Priorities, December 2, 2014. http://www.cbpp.org/cms/?fa=view&id=4241

85 Social Security Works, "High Earners Should Contribute Fair Share to Social Security: Policy Options," April 6, 2015. http://www.socialsecurityworks.org/wp-content/uploads/2015/04/High-Earners-Should-Contribute-Fair-Share-to-Social-Security_Policy-Options_FINAL.pdf

86 As discussed in more detail below, Medicare began covering people with disabilities in 1972, 43 years ago.

87 National Academy of Social Insurance (NASI), "Medicare Finances: Findings of the 2012 Trustees Report," April 2012. http://www.nasi.org/sites/default/files/research/Medicare_Finances_Findings_of_the_2012_Trustees_Report.pdf

88 U.S. Census Bureau, "Health Insurance Coverage Status by Sex by Age," 2011-2013 *American Community Survey* 3-Year Estimates, 2014. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml. Of Americans aged 65 and older who received Medicare in 2012, 92.5 percent were enrolled in both Part A and Part B, while 7.5 percent were enrolled in Part A alone. Centers for Medicare and Medicaid Services (CMS), Medicare Enrollment - Aged Beneficiaries: as of July 1, 2012." Accessed June 3, 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/12Aged.pdf

89 People with ALS (Lou Gehrig's disease) are not subject to the waiting period—they can go on Medicare as soon as they receive SSDI. People with end-stage renal disease do not have to be collecting SSDI in order to enroll in Medicare (but to be eligible must have some work history—either their own or through a family member); they also do not have a waiting period.

90 Kaiser Family Foundation (KFF), "Income and Assets of Medicare Beneficiaries, 2013—2030," January 2014. https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8540-income-and-assets-of-medicare-beneficiaries-2013-e28093-20301.pdf

91 Social Security Works, "Shifting More Medicare Costs to Seniors Is an Indirect Social Security Cut," January 2014. http://www.socialsecurityworks.org/wp-content/uploads/2014/01/Shifting-More-Medicare-Costs-to-Seniors-Is-an-Indirect-Social-Security-Cut_Final-Jan-27.pdf

92 People with severe disabilities become eligible for Medicare coverage only after receiving Social Security Disability Insurance (DI) benefits for 24 months. People with End-Stage-Renal Disease (ESRD) and Lou Gehrig's disease become eligible for Medicare as soon as they qualify for Medicare. KFF, *A Primer on Medicare: Key Facts about the Medicare Program and the People It Covers*, March 20, 2015. http://kff.org/medicare/report/a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/

93 Center for Medicare & Medicaid Services (CMS), "CMS Fast Facts," April 21, 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html. Not all Medicare beneficiaries were workers; a small share are people with disabilities who are eligible for Medicare on the work history and social insurance contributions of a parent or other family member, i.e. as a Childhood Disability Beneficiary (CDB) or as a disabled spouse of a deceased spouse. SSA, "Medicare," July 2015. http://ssa.gov/pubs/EN-05-10043.pdf

94 Average expenditure per beneficiary is total Medicare benefit payments divided by the total number of beneficiaries. KFF, ibid.

95 KFF, ibid.

96 Up to 50 percent of Social Security benefits for couples with more than $32,000 and singles with more than $25,000 are subject to income taxes, the revenues of which flow into the Social Security trust fund. Up to 85 percent of Social Security benefits for couples with more than $44,000 and singles with more than $34,000 are subject to income taxes, and these additional revenues go to Medicare's hospital insurance fund. Virginia Reno, "What's Next for Social Security," October 2013. https://www.nasi.org/sites/default/files/research/Whats_Next_for_Social_Security_Oct2013.pdf. The ACA also introduced the Medicare Net Investment Income Tax of 3.8 percent of the lesser of a household's net investment income, or the amount by which its modified adjusted gross income exceeds $200,000 ($250,000 for joint filers). The revenues from this tax do not flow to the Medicare trust funds, however. Medicare Trustees, *2015 Medicare Trustees Report*, July, 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf

97 KFF, "Medicare's Income-Related Premiums: A Data Note," March 20, 2015. http://kff.org/medicare/issue-brief/medicares-income-related-premiums-a-data-note/

98 KFF, "Medicare's Income-Related Premiums: A Data Note," June 3, 2015. http://kff.org/medicare/issue-brief/medicares-income-related-premiums-a-data-note/

99 Medicare Rights Center, "Medicare Interactive.org." http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=390 (accessed July 14, 2015)

100 KFF, *A Primer on Medicare: Key Facts about the Medicare Program and the People It Covers*, March 20, 2015. http://kff.org/medicare/report/a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/

101 Medicare Payment Advisory Board (Medpac), *Report to the Congress: Medicare Payment Policy, Chapter 4*, March 2010. http://www.medpac.gov/documents/reports/mar10_ch04.pdf?sfvrsn=0

102 White House, Office of the Press Secretary, "The Affordable Care Act: Strengthening Medicare, Combating Misinformation and Protecting America's Seniors," June 8, 2010. http://www.whitehouse.gov/the-press-office/affordable-care-act-strengthening-medicare-combating-misinformation-and-protecting-

103 White House, Office of the Press Secretary, Ibid.

104 Center for Medicare & Medicaid Services (CMS), "CMS Fast Facts," November 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html

105 KFF, ibid.

106 KFF, "Medicare's Income-Related Premiums: A Data Note," June 3, 2015. http://kff.org/medicare/issue-brief/medicares-income-related-premiums-a-data-note/

107 In 2014, total Medicare expenditures (on Parts A, B and D) were $613.3 billion, of which $8.8 billion, or 1.4 percent, was spent on administrative expenses. Looking just at Parts A and B, spending amounted to $535.2 billion, with administrative expenses of $8.5 billion, or 1.6 percent. Administrative expense data for Medicare Part C (Medicare Advantage) plans in 2013 is not available. Medicare Trustees, "Table II.B1—Medicare Data for Calendar Year 2014," *2015 Medicare Trustees Report*, July 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf

108 Congressional Budget Office (CBO), "Key Issues in Analyzing Major Health Insurance Proposals," December 2008, p. 70. http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

109 Government Accountability Office, "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006," December 8, 2008. http://www.gao.gov/products/GAO-09-132R

110 General Accounting Office, "Medicare Advantage 2011. Profits Similar to Projections for Most Plans, but Higher for Plans with Specific Eligibility Requirements," December 2013, p. 10. http://www.gao.gov/assets/660/659836.pdf

111 Organization for Economic Cooperation and Development, *OECD Factbook 2014: Economic, Environmental and Social Statistics* (Paris: OECD Publishing, 2014). http://www.oecd-ilibrary.org/economics/oecd-factbook-2014_factbook-2014-en

112 CMS Office of the Actuary, “National Health Expenditure Data—Historical: Table 21—Medicare and Private Health Insurance; Per Enrollee Expenditures and Annual Percent Change, Calendar Years 1969-2013,” http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (accessed June 28, 2015). Common benefits refers to benefits commonly covered by Medicare and Private Health Insurance. These benefits are hospital services, physician and clinical services, other professional services and durable medical products.
113 Michael Chernew, “Examining the Present and Future of the Health Spending Growth Slowdown,” Health Affairs Blog, September 3, 2014. http://healthaffairs.org/blog/2014/09/03/examining-the-present-and-future-of-the-health-spending-growth-slowdown/
114 If we look at total program expenditures per enrollee (not just those on commonly provided benefits), we find that Medicare’s spending growth has declined from 6.5 percent per annum from 2000-10 to 0.7 percent per annum from 2010-13. CMS Office of the Actuary, “National Health Expenditure Data—Historical: Table 21—Medicare and Private Health Insurance; Per Enrollee Expenditures and Annual Percent Change, Calendar Years 1969-2013,” 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (accessed June 28, 2015).
115 Robert Wood Johnson Foundation, “How Does the ACA Control Health Care Costs?” July 2011. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71451
116 Judy Feder, Paul N. Van de Water and Henry Aaron, “The Case against Premium Support,” Center for Budget and Policy Priorities, December 21, 2011. http://www.cbpp.org/research/the-case-against-premium-support; CMS, “About the CMS Innovation Center,” http://innovation.cms.gov/about/index.html (accessed June 25, 2015)
117 Medicare Trustees, *2015 Medicare Trustees Report*, July 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf
118 The present value of the Hospital Insurance Trust Fund deficit over the next 75 years was 3.9 percent of taxable payroll in 2009, and is 0.68 percent of taxable payroll today. American Academy of Actuaries, “Medicare’s Financial Condition: Beyond Actuarial Balance,” May 2009. http://www.actuary.org/files/trustees_09.4.pdf/trustees_09.4.pdf; Medicare Trustees, *2015 Medicare Trustees Report*, July 2015. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf;
119 On the proposal, see: National Committee to Preserve Social Security and Medicare, “The Fiscal Year 2016 House and Senate Republican Budget Resolutions and Their Effect on Seniors,” March 2015. http://www.ncpssm.org/PublicPolicy/Medicare/Documents/ArticleID/1400/The-Fiscal-Year-2016-House-and-Senate-Republican-Budget-Resolutions-and-Their-Effect-on-Seniors.
120 For a cogent analysis of voucherization of Medicare, also known as “premium support,” see: Judy Feder, Paul N. Van de Water and Henry Aaron, “The Case against Premium Support,” Center for Budget and Policy Priorities, December 21, 2011. http://www.cbpp.org/research/the-case-against-premium-support
121 KFF, “The Medicare Prescription Drug Benefit Fact Sheet,” September 19, 2014. http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/
122 Alan M. Garber and Harold C. Sox, “The Role of Comparative Effectiveness Research,” *Health Affairs*, Vol. 29, no. 10 (October 2010), 1805-11. http://content.healthaffairs.org/content/29/10/1805.full
123 KFF, **“**Medicare Spending Estimates by State of Residence (in millions), 2009**,**” December 2011. http://www.statehealthfacts.org/comparemaptable.jsp?ind=620&cat=6. Total health care spending from: KFF, “Health Care Expenditures by State of Residence (in millions), 2009,” December 2011. http://www.statehealthfacts.org/comparemaptable.jsp?ind=592&cat=5
124 Average benefit found by dividing total spending by total beneficiaries. KFF, **“**Medicare Spending Estimates by State of Residence (in millions), 2009**,**” December 2011. http://www.statehealthfacts.org/comparemaptable.jsp?ind=620&cat=6 KFF, “Distribution of Medicare Beneficiaries by Eligibility Category, 2009,” 2010. http://www.statehealthfacts.org/comparetable.jsp?ind=293&cat=6
125 KFF, ”Total Number of Medicare Beneficiaries, 2012.” http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/ (accessed June 2015). Data for 2012 Medicare enrollment are the most recent available. State population data from U.S. Census Bureau, “Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014,” *2014 Population Estimates*, 2015. http://factfinder2.census.gov/
126 KFF, “Distribution of Medicare Beneficiaries by Eligibility Category, 2012.” http://kff.org/medicare/state-indicator/distribution-of-medicare-beneficiaries-by-eligibility-category-2/ (accessed June 2015). Data for 2012 distribution of Medicare beneficiaries are the most recent available.
127 KFF, ibid.
128 National Institutes of Health, U.S. National Library of Medicine (NLM), “End-stage Kidney Disease,” 2011. http://www.nlm.nih.gov/medlineplus/ency/article/000500.htm
129 NLM, “Amyotrophic Lateral Sclerosis,” 2011. http://www.nlm.nih.gov/medlineplus/amyotrophiclateralsclerosis.html
130 Rosemary A. Stevens, “Health Care in the Early 1960s,” *Health Care Financing Review* 18, no. 2, Winter 1996. http://www.ssa.gov/history/pdf/HealthCareEarly1960s.pdf
131 Rosemary A. Stevens, ibid.
132 Lyndon Baines Johnson, “Special Message to the Congress: Advancing the Nation’s Health,” January 7, 1965. http://www.presidency.ucsb.edu/ws/?pid=27240
133 Lyndon Baines Johnson, “Annual Message to the Congress on the State of the Union,” January 8, 1964. http://www.presidency.ucsb.edu/ws/?pid=26787
134 National Center for Health Statistics, “Health Insurance Coverage: United States—July 1962-June 1963,” August 1964. http://www.cdc.gov/nchs/data/series/sr_10/sr10_011acc.pdf
135 U.S. Census Bureau, Current Population Survey, “Annual Social and Economic (ASEC) Supplement,” Tables HI03 and HI04, 2014. http://www.census.gov/hhes/www/cpstables/032014/health/toc.htm
136 The Affordable Care Act’s expansion of Medicaid and Children’s Health Insurance Program (CHIP) eligibility alone is projected to result in the enrollment of an additional 25 million Americans in Medicaid and CHIP by 2025. Congressional Budget Office, “Insurance Coverage Provisions of the Affordable Care Act—CBO’s March 2015 Baseline,” Table 2. Effects of the Affordable Care Act on Health Insurance Coverage, March 2015.
137 KFF, “Monthly Medicaid Enrollment December 2013.” http://kff.org/medicaid/state-indicator/monthly-medicaid-enrollment-in-thousands/ (accessed July 1, 2015)
138 U.S. Department of Health and Human Services, “2015 Poverty Guidelines.” http://aspe.hhs.gov/poverty/15poverty.cfm#thresholds (accessed July 2, 2015)
139 Adam Peck and Tara Culp-Ressler, “Without Obamacare, Families Making Under $5,000 Aren’t Poor Enough For Medicaid In Some States,” ThinkProgress, August 15, 2012. http://thinkprogress.org/health/2012/08/15/690761/without-obamacare-families-making-under-5000-arent-poor-enough-for-medicaid-in-some-states/
140 These waivers are termed Section 1115 demonstration waivers.

141 These declines were between early 2013 and early 2015. Medicaid expansion took effect in most states in January 2014. Sharon K. Long et al., "Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015," Urban Institute Health Reform Monitoring Survey, April 16, 2015. http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html

142 Alan B. Cohen et al., ed., *Medicare and Medicaid at 50* (New York: Oxford University Press, 2015), p. 348.

143 KFF, "Medicaid Moving Forward," March 9, 2015. http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

144 KFF, "Medicaid Spending by Enrollment Group, FY 2011." http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/ (accessed July 13, 2015)

145 KFF, "Distribution of Medicaid Enrollees by Enrollment Group, FY2011," accessed June 2015. http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/

146 KFF, "Dual Eligibles as a Percent of Total Medicare Beneficiaries, FY 2011." http://kff.org/medicaid/state-indicator/duals-as-a-of-medicare-beneficiaries/ (accessed July 14, 2015)

147 KFF, "Medicaid Moving Forward," March 9, 2015, p. 2. http://files.kff.org/attachment/issue-brief-medicaid-moving-forward

148 KFF, "Medicaid: a Primer," March 2013, p. 7. https://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf

149 Due to limitations in data availability, total Medicaid expenditures are for FY2013; however, the most recent state-level total health expenditure data available are for FY2009. Consequently, while FY2013 Medicaid expenditure data are available, FY2009 Medicaid expenditure data were used to calculate the Medicaid percentage of total health care spending in each state. Data for 2013 Medicaid expenditures are from KFF, "Total Medicaid Spending, FY2013," accessed June 2015. http://kff.org/medicaid/state-indicator/total-medicaid-spending/. Data for 2009 Medicaid expenditures are from KFF, "Total Medicaid Spending, FY2009," 2012, Unpublished; Data provided to Social Security Works by Lindsay Donaldson, Research Associate at the Kaiser Family Foundation. Medicaid's percent of total health care found by dividing total Medicaid spending by total health care expenditures. KFF, "Health Care Expenditures by State of Residence (in millions), 2009", 2010. http://www.statehealthfacts.org/comparemaptable.jsp?ind=592&cat=5. Medicaid spending figure includes portion of funding that comes from state and local governments.

150 Average found by dividing total spending by total beneficiaries. KFF, "Total Medicaid Spending, FY2013," accessed June 2015. http://kff.org/medicaid/state-indicator/total-medicaid-spending/ KFF, "Monthly Medicaid Enrollment (in thousands), Dec 2013." http://kff.org/medicaid/state-indicator/monthly-medicaid-enrollment-in-thousands/ (accessed June 2015)

151 KFF, "Monthly Medicaid Enrollment (in thousands), Dec 2013." http://kff.org/medicaid/state-indicator/monthly-medicaid-enrollment-in-thousands/ (accessed June 2015). State population data from U.S. Census Bureau, "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014," *2014 Population Estimates*, 2015. http://factfinder2.census.gov/

152 KFF, "Distribution of Medicaid Enrollees by Enrollment Group, FY2011." http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/ (accessed June 2015). 2011 Children's population data from U.S. Census Bureau, "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014," *2014 Population Estimates*, 2015. http://factfinder2.census.gov/

153 KFF, "Distribution of Medicaid Enrollees by Enrollment Group, FY2011." http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/ (accessed June 2015).

154 KFF, ibid.

155 KFF, "Distribution of Medicaid Spending on Long Term Care, FY2013." http://kff.org/medicaid/state-indicator/spending-on-long-term-care/ (accessed June 2015)

156 KFF, "Overview of Nursing Facility Capacity, Financing, and Ownership in the United States in 2011," Tables 4 and 6, June 2013. https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8456-overview-of-nursing-facility-capacity.pdf

157 MetLife Mature Market Institute, "Market Survey of Long-Term Care Costs: The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," November 2012. https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf

158 Matt Broaddus, "Medicaid Works: State Fact Sheets," Center on Budget and Policy Priorities, July 10, 2015. http://www.cbpp.org/research/health/medicaid-works-state-fact-sheets

159 Leadership Council of Aging Organizations, "Medicaid Per Capita Caps," December 2014. http://www.lcao.org/files/2014/12/LCAO-Medicaid-PCC-Issue-Brief-Final1.pdf; House of Representatives, "Concurrent Resolution on the Budget for Fiscal Year 2016," April 2015. http://budget.house.gov/uploadedfiles/confrpt_on_s.con.res._11.pdf

160 Jonathan Oberlander and Theodore R. Marmor, "The Road Not Taken: What Happened to Medicare for All," in *Medicare and Medicaid at 50*, ed. by Alan B. Cohen et al. (New York: Oxford University Press, 2015), 55-76.

161 For a full analysis of the coverage gap, see KFF, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid—An Update," April 17, 2015. http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

162 Sam Dickman et al., "Opting Out Of Medicaid Expansion: The Health And Financial Impacts," Health Affairs Blog, January 30, 2014. http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicaid-expansion-the-health-and-financial-impacts/

163 Alicia H. Munnell, Wenliang Hou, and Anthony Webb, "NRRI Update Shows Half Still Falling Short," *Center for Retirement Research at Boston College*, December 2014. http://crr.bc.edu/briefs/nrri-update-shows-half-still-falling-short/

164 Nari Rhee and Illana Boivie, "The Continuing Retirement Savings Crisis," National Institute on Retirement Security, March 2015. http://www.nirsonline.org/storage/nirs/documents/RSC%202015/final_rsc_2015.pdf

165 This is a conservative estimate. The Center for Retirement Research at Boston College estimated that in 2006, just before the Great Recession, 44 percent of working-age households would be at risk of downward social mobility in retirement, but this percentage rose to 61 percent when health care costs were included, and to 64 percent when long term care costs were counted—an additional 21 percent. In its 2010 estimate, which projected that 53 percent of households were at-risk of not being able to maintain their living standards in retirement, the Center did not include an estimate of the additional share of households that would be at risk if health and long-term care costs were taken into account. If this additional share were equivalent to the 21 percent it amounted to in 2006, then more than 7 in 10 households would be at risk after taking into account health and long-term care costs. Alicia Munnell et al., "Health Care Costs Drive Up the National Retirement Risk Index," no. 8-3, Center for Retirement Research at Boston College, (February 2008). http://crr.bc.edu/wp-content/uploads/2008/02/ib_8-3.pdf; Munnell et al., "The National Retirement Risk Index: An Update," no. 12-20, Center for Retirement Research at Boston College, October 2012. http://crr.bc.edu/wp-content/uploads/2012/11/IB_12-20-508.pdf

KEY FACTS ABOUT SOCIAL SECURITY, MEDICARE AND MEDICAID IN ILLINOIS

Social Security Works for Illinois' Residents and Economy

- Social Security provided benefits to 2,155,290 Illinois residents in 2014, 1 in 6 (16.7 percent) residents.
- Illinois residents received Social Security benefits totaling $32.2 billion in 2014, an amount equivalent to 5.2 percent of the state's total personal income [Figure 1 in full report].
- The average Social Security benefit in Illinois was $14,933 in 2013.
- Social Security lifted 792,000 Illinois residents out of poverty in 2013.

Social Security Works for Illinois' Seniors

- Social Security provided benefits to 1,463,959 Illinois retired workers in 2014, two-thirds (67.9 percent) of beneficiaries [Figure 3 in full report].
- Social Security lifted 560,000 Illinois residents aged 65 and older out of poverty in 2013. Without Social Security, the elderly poverty rate in Illinois would have increased from 1 in 11 (8.7 percent) to 2 in 5 (41.6 percent) [Figure 4 in full report].

Social Security Works for Illinois' Workers with Disabilities

- Social Security provided disability benefits to 289,730 workers in 2014, 1 in 7 (13.4 percent) Illinois beneficiaries [Figure 3 in full report].

Social Security Works for Illinois' Women

- Social Security provided benefits to 1,116,457 Illinois women in 2014, 1 in 6 (17 percent) Illinois women.
- Social Security lifted 348,000 Illinois women aged 65 and older out of poverty in 2013. Without Social Security, the poverty rate of elderly women would have increased from 1 in 10 (9.5 percent) to 4 in 9 (45.4 percent) [Figure 4 in full report].

Social Security Works for Illinois' Children

- Social Security provided benefits to 154,436 Illinois children in 2014, 1 in 14 (7.2 percent) Illinois beneficiaries [Figure 3 in full report].

Social Security Works for Illinois' People of Color

- Social Security provided benefits to one-quarter (25.4 percent) of African American households in Illinois in 2013, 167,702 households.
- Social Security provided benefits to 1 in 7 (13.7 percent) Latino households in Illinois in 2013, 71,290 households.
- Social Security provided benefits to 2 in 9 (22.8 percent) American Indian and Alaska Native households in Illinois in 2013, 2,274 households.
- Social Security provided benefits to 1 in 7 (15.1 percent) Asian American, Hawaiian Native, and Pacific Islander households in Illinois in 2013, 29,900 households.

Social Security Works for Illinois' Rural Communities

- 2 in 9 (23 percent) rural or non-metropolitan Illinois residents received Social Security in 2014, compared with 1 in 6 (15.9 percent) metropolitan Illinois residents.

Medicare Works for Illinois’ Residents and Economy

- 1,907,859 Illinois residents received Medicare benefits in 2012—1 in 7 state residents.
- Medicare provided $19.2 billion in benefits to Illinois residents in 2009—22 percent of all health care spending in the state. The average expenditure per Medicare beneficiary was $10,706 [Figure 1 in full report].

Medicare Works for Illinois’ Seniors and People with Disabilities

- 1,625,331 of Illinois’ 1,907,859 Medicare beneficiaries were aged 65 or older in 2012—5 in 6 beneficiaries.
- 322,173 of Illinois’ 1,907,859 Medicare beneficiaries were people with disabilities in 2012—1 in 6 beneficiaries.

Medicaid Works for Illinois’ Residents and Economy

- 2,690,000 Illinois residents received Medicaid benefits in 2013—1 in 5 state residents.
- A total of $15.7 billion in Medicaid benefits were paid to Illinois residents in 2013. In 2009, Medicaid spending was 15.1 percent of all health care spending in the state. The average expenditure per Medicaid beneficiary in 2013 was $5,821 [Figure 1 in full report].

Medicaid Works for Illinois’ Seniors, People with Disabilities and Long-Term Care Recipients

- 225,200 of Illinois’ 2,690,000 Medicaid beneficiaries were aged 65 or older in 2011—1 in 13 beneficiaries.
- 333,000 of Illinois’ 2,690,000 Medicaid beneficiaries were people with disabilities in 2011—1 in 9 beneficiaries.
- Medicaid provided $4.6 billion in long-term care benefits for Illinois residents in 2013. In 2011 Medicaid provided nursing home care for 46,677 nursing home residents, 5 in 8 state residents enrolled in nursing homes.