SOCIAL SECURITY, MEDICARE AND MEDICAID WORK FOR VIRGINIA

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 Virginia's 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 Virginia's 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 Virginia and the nation. The numbers tell part of the story—how many people receive benefits in Virginia, 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 Virginians 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 Virginia 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 Virginia.

FIGURE 1

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

PROGRAM	BENEFICIARIES IN VIRGINIA	PERCENT OF RESIDENTS RECEIVING BENEFITS	AVERAGE BENEFIT	TOTAL ANNUAL BENEFITS[1]
Social Security	1,415,661	17 percent	$14,607	$20.7 billion
Medicare	1,203,462	14.7 percent	$8,875	$9.7 billion
Medicaid	843,000	10.2 percent	$8,649	$7.3 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

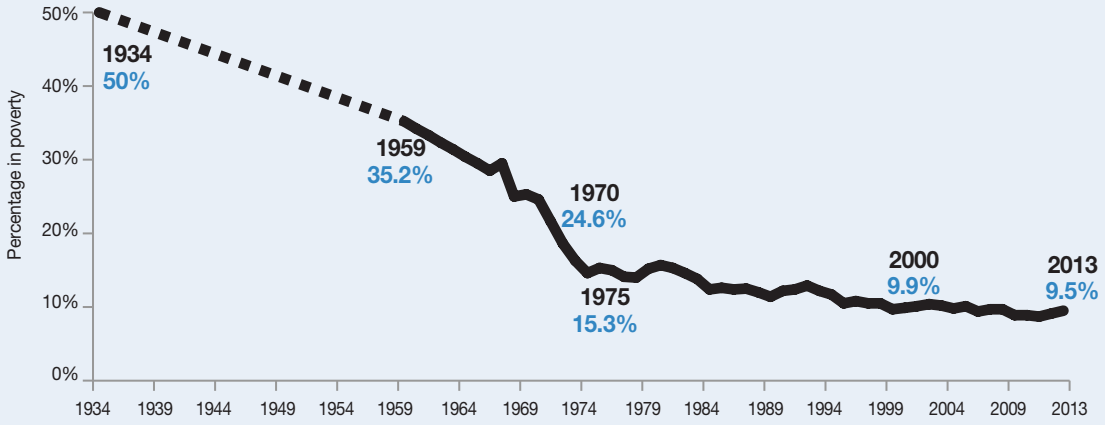
Before the creation of Social Security, poverty among older Americans was pervasive. In 1934, President Roosevelt's Committee on Economic Security estimated that "at least one-half" of all Americans aged 65 and older were poor.[1] These seniors had to rely on family, friends and private charity for support—or 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.

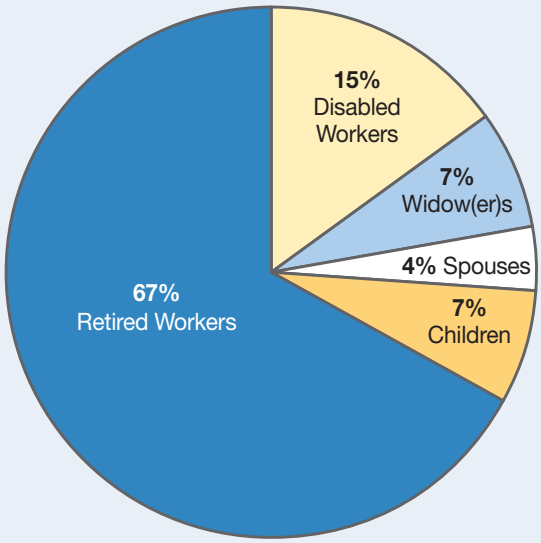
For his service in this capacity he was awarded the Silver Star, the third highest decoration for valor given by the Army. Sixteen days after he was mustered out of the Army, he returned to his home in Wisconsin—and was in a serious car crash, sustaining a high-level spinal cord injury.

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 Virginia 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

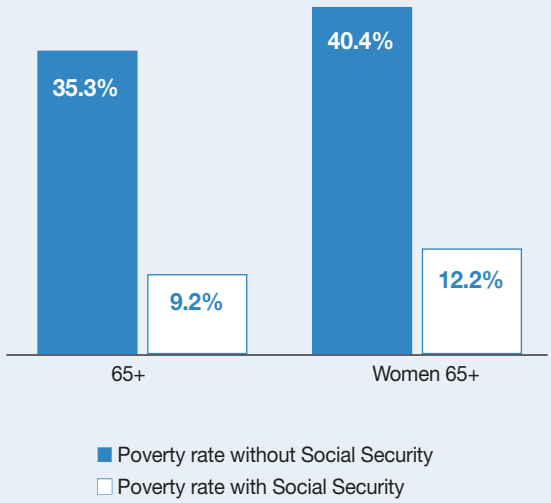
Virginia's Social Security Beneficiaries, 2014



Source: Social Security Administration, 2015

FIGURE 4

Poverty Rate for Virginia 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 Virginia's Residents and Economy [Figure 1]

- Social Security provided benefits to 1,415,661 Virginians in 2014, around 1 in 6 (17 percent) residents.[18]
- Virginians received Social Security benefits totaling $20.7 billion in 2014, an amount equivalent to 5 percent of the state's total personal income.[19]
- The average Social Security benefit in Virginia was $14,607 in 2014.[20]
- Social Security lifted 436,000 Virginians out of poverty in 2013.[21]

Social Security Works for Virginia's Seniors[22]

- Social Security provided benefits to 950,681 of Virginia's retired workers in 2014, two-thirds (67.2 percent) of beneficiaries [Figure 3].[23]
- The typical benefit received by a retired worker in Virginia was $15,959 in 2014.[24]
- Social Security lifted 284,000 Virginians 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 Virginia would have increased from 1 in 11 (9.2 percent) to one-third (35.3 percent) [Figure 4].[27]

Social Security Works for Virginia's Women

- Social Security provided benefits to 737,494 Virginia women in 2014, 1 in 6 (17.4 percent) Virginia women.[28]
- Social Security provided benefits to 53,274 Virginia spouses in 2014, 1 in 26 (3.8 percent) beneficiaries [Figure 3].[29]
- Social Security lifted 173,000 Virginia 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 8 (12.2 percent) to 2 in 5 (40.4 percent) [Figure 4].[31]

Social Security Works for Virginia's Widow(er)s

- Social Security provided survivors benefits to 97,874 Virginia widow(er)s in 2014, 1 in 14 (6.9 percent) Virginia beneficiaries [Figure 3].[32]
- The typical benefit received by a widow(er) in Virginia was $15,287 in 2014.[33]

Social Security Works for Virginia's Workers with Disabilities[34]

- Social Security provided disability benefits to 212,945 Virginia workers in 2014, 1 in 7 (15 percent) Virginia beneficiaries [Figure 3].[35]
- The typical benefit received by a disabled worker beneficiary in Virginia was $13,115 in 2014.[36]

Social Security Works for Virginia's Children

- Social Security is the primary life and disability insurance protection for 98 percent of Virginia's 1,869,115 children.[37]
- Social Security provided benefits to 100,887 Virginia children in 2014, 1 in 14 (7.1 percent) Virginia beneficiaries [Figure 3].[38]
- Social Security is the most important source of income for the 172,343 children living in Virginia's 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 Virginia's African Americans

- In Virginia, Social Security provided benefits to one-quarter (24.8 percent) of African American households in 2013, 138,924 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 Virginia's Latinos

- In Virginia, Social Security provided benefits to 1 in 11 (9 percent) Latino households in 2013, 15,669 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 Virginia's American Indians and Alaska Natives

- In Virginia, Social Security provided benefits to one-quarter (26.3 percent) of American Indian and Alaska Native households in 2013, 2,254 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 Virginia's Asian Americans, Hawaiian Natives and Pacific Islanders

- In Virginia, Social Security provided benefits to 1 in 7 (14.3 percent) Asian American, Hawaiian Native and Pacific Islander households in 2013, 19,933 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 Virginia's Rural Communities

- Social Security is more important to Virginians living in rural or non-metropolitan counties than to Virginians living in metropolitan counties. 2 in 7 (28.1 percent) rural Virginians received Social Security in 2014, compared with 1 in 6 (15.5 percent) metropolitan Virginians.[56]
- Social Security is more important to the local economies of Virginia's rural or non-metropolitan counties than to its metropolitan counties. Total personal income in Virginia's rural counties was $36.3 billion in 2014 of which $4.1 billion, or 11.4 percent, was from Social Security. By comparison, total personal income in the state's metropolitan counties was $367.1 billion, of which $17 billion, or 4.6 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]

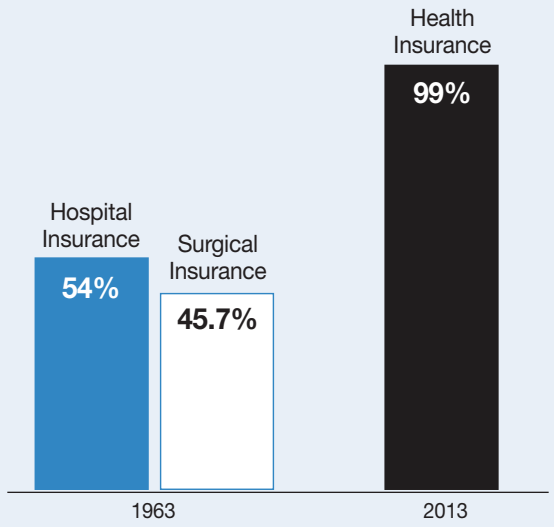
As we celebrate the 50th anniversary of Medicare, it is worth reflecting on the difference it has made in our lives. Before Medicare, roughly half of the elderly were uninsured [Figure 5]. This is because private health insurance companies, which must generate returns for their shareholders, were not 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

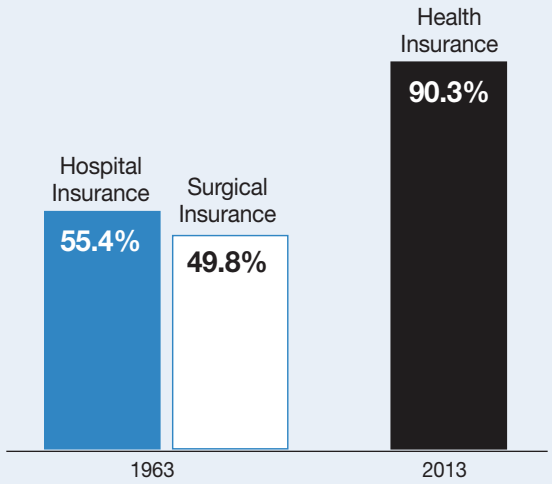
Americans 65 or Older with Health Insurance,1963 vs. 2013



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]

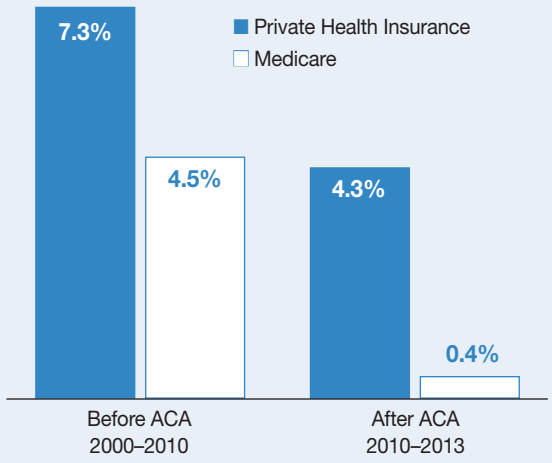
Traditional Medicare is also more efficient than Medicare Advantage plans. The Government Accountability Office (GAO) found that in 2006, Medicare Advantage plans' administrative costs averaged 16.7 percent.[109] The ACA stipulated that starting in 2014, Medicare Advantage plans could not devote more 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 Virginia's Economy.

- Medicare provided $9.7 billion in benefits to Virginians in 2009—19.7 percent of all health care spending in the state.[123] The average expenditure per Medicare beneficiary was $8,875 [Figure 1].[124]

Medicare Works for Virginia's Residents.

- Medicare insured 1,203,462 Virginians in 2012—1 in 7 (14.7 percent) state residents [Figure 1].[125]

Medicare Works for Virginia's Seniors.

- 1,005,258 of Virginia's 1,203,462 Medicare beneficiaries were aged 65 or older in 2012—4 in 5 (81.6 percent) beneficiaries.[126]

Medicare Works for Virginia's People with Disabilities.

- 226,382 of Virginia's 1,203,462 Medicare beneficiaries were people with disabilities in 2012—1 in 5 (18.4 percent) beneficiaries.[127]

Medicare Works for Virginia's 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 Virginia's 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 Virginia 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

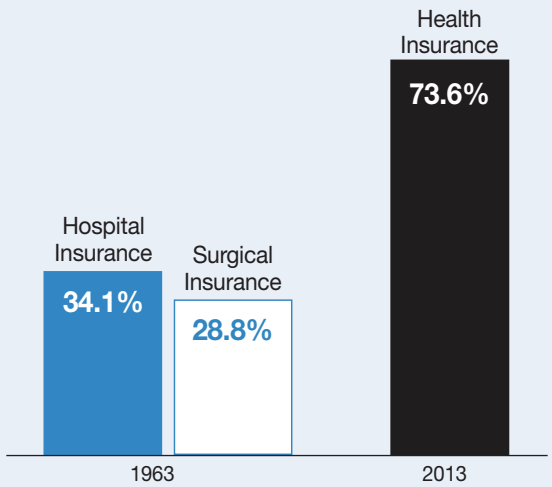
As we celebrate the 50th anniversary of Medicaid, let us recall what a difference it has made. We built our Medicaid system to provide health and long-term care coverage for low-income families, seniors and people with disabilities. In 1963, before Medicaid was created, only 34.1 percent of low-income 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]

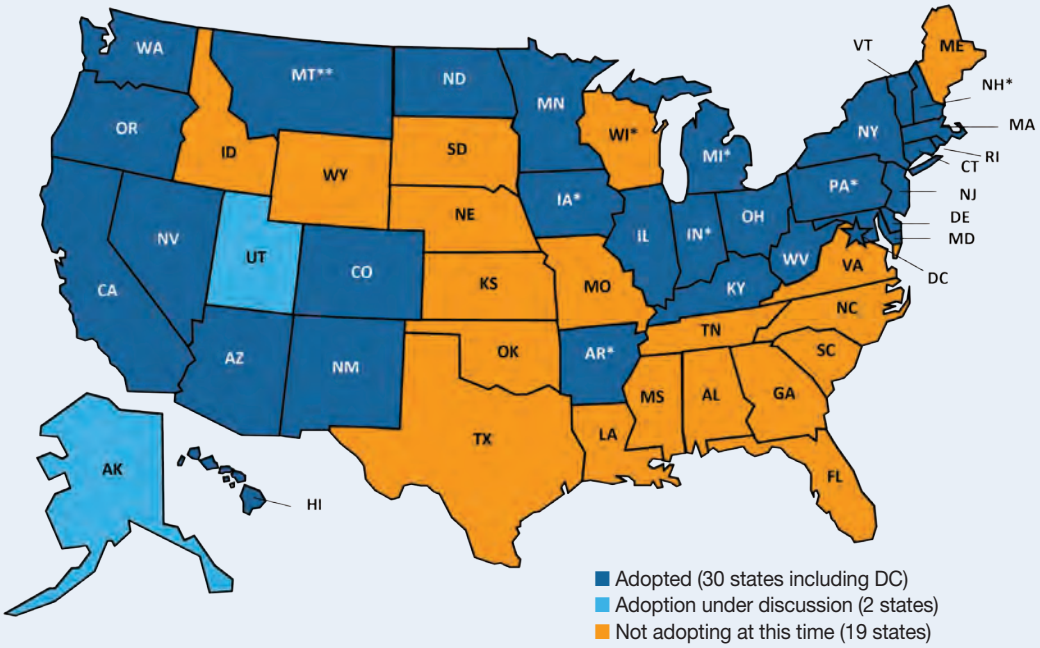
The Affordable Care Act expanded Medicaid eligibility to nearly all individuals with incomes at or below 138 percent of poverty ($16,243 for an individual in 2015), broadly expanding the program to reach low-income adults who were previously excluded from Medicaid. In June 2012, however, the Supreme 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

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.*

to shift more long-term care spending to home and 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 Virginia's Economy.

- Medicaid covered $7.3 billion in health care costs for Virginia's low-income residents in 2013—and in 2009, Medicaid spending represented 11.7 percent of all health care spending in the state.[149] The average cost per Medicaid beneficiary in 2013 was $8,649 [Figure 1].[150]

Medicaid Works for Virginia's Residents.

- Medicaid insured 843,000 Virginians in 2013—1 in 9 (10.2 percent) state residents [Figure 1].[151]

Medicaid Works for Virginia's Children.

- Medicaid insured 594,400 Virginia children in FY2011—one-third (32 percent) of children in the state.[152]

Medicaid Works for Virginia's Seniors.

- 112,900 of Virginia's 843,000 Medicaid beneficiaries were aged 65 or older in 2011—1 in 9 (10.5 percent) beneficiaries.[153]

Medicaid Works for Virginia's People with Disabilities.

- 186,400 of Virginia's 843,000 Medicaid beneficiaries were people with disabilities in 2011—1 in 6 (17.4 percent) beneficiaries.[154]

Medicaid Works for Virginia's Long-Term Care Recipients.

- Medicaid provided $2.5 billion in long-term care benefits for Virginia residents in 2013. That includes:
  - $1.2 billion in home health care services (48.9 percent)
  - $851.6 million to nursing home facilities (33.9 percent)
  - $134.7 million to mental health facilities (5.4 percent)
  - $298.1 million to intermediate care facilities for the mentally retarded (11.9 percent).[155]

- Medicaid is the primary payer for the vast majority of Virginia residents who opt for nursing home care. 17,042 of Virginia's 28,168 nursing home residents were Medicaid beneficiaries in 2011—3 in 5 (60.5 percent) nursing home residents.[156] The average annual cost of nursing home care for a semi-private room in Virginia was $75,920 in 2012.[157] Given the high cost of nursing home care, many Virginia 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 Virginia's Congressional Districts

		STATE TOTAL	CONGRESSIONAL DISTRICTS									
			1	2	3	4	5	6	7	8	9	10	11
Total annual benefits ($ in millions)*		**$21,106M**	$1,916M	$1,751M	$1,715M	$1,976M	$2,519M	$2,397M	$2,193M	$1,176M	$2,750M	$1,475M	$1,239M
Number of residents in state/congressional district		**8,184,299**	751,432	726,166	745,074	738,953	728,231	735,731	745,462	760,961	723,948	765,146	763,195
Number of residents receiving Social Security benefits		**1,415,661**	124,974	117,726	128,402	134,315	173,964	164,185	134,546	73,370	197,606	88,987	77,586
Percent of residents receiving Social Security benefits		**17.3%**	16.6%	16.2%	17.2%	18.2%	23.9%	22.3%	18.0%	9.6%	27.3%	11.6%	10.2%
SOCIAL SECURITY BENEFICIARIES BY CATEGORY	***Women***	**737,494**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Retired workers	**950,681**	89,645	80,703	77,230	88,468	117,482	110,318	97,291	54,932	110,997	66,093	57,522
	Disabled workers	**212,945**	14,020	15,346	27,592	21,255	27,455	26,281	14,998	6,493	45,467	7,548	6,490
	Widow(er)s	**97,874**	8,452	9,149	9,177	9,513	11,382	11,024	9,007	4,519	15,803	5,429	4,419
	Spouses	**53,274**	5,012	4,652	2,764	4,138	5,490	5,252	4,878	3,647	8,471	4,612	4,358
	Children	**100,887**	7,845	7,876	11,639	10,941	12,155	11,310	8,372	3,779	16,868	5,305	4,797

Sources: U.S. Census Bureau, *ACS Demographic and Housing Estimates*, "2011-2013 American Community Survey 3-Year Estimates," 2014.
SSA, "Virginia," *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 Virginia (Page 1/4)

		VIRGINIA 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
Virginia Total (98 Counties)	N/A	8,260,405	$61,782	11.8%	1,105,381	13.4%	$21,105,492,000	5.2%	17.1%	1,415,660	950,680	212,945	97,875	53,270	100,890	16.4%	10.6%
Accomack	Non-Metropolitan	33,148	$38,064	19.3%	6,893	20.8%	$125,652,000	10.1%	27.7%	9,175	6,385	1,360	615	250	565	25.4%	18.8%
Albemarle*	Metropolitan	147,349	$57,676	13.5%	20,654	14.0%	$386,784,000	5.0%	16.2%	23,805	17,325	2,700	1,470	1,020	1,290	15.8%	8.0%
Alleghany*	Non-Metropolitan	21,979	$39,444	14.5%	4,882	22.2%	$93,432,000	12.5%	29.7%	6,530	3,770	1,355	550	320	535	29.1%	16.8%
Amelia	Metropolitan	12,745	$52,055	12.1%	2,225	17.5%	$46,524,000	9.7%	25.0%	3,185	2,160	500	205	115	205	21.7%	15.0%
Amherst	Metropolitan	32,178	$47,268	14.2%	5,863	18.2%	$117,768,000	10.8%	25.3%	8,135	5,350	1,380	535	240	630	22.7%	12.2%
Appomattox	Metropolitan	15,255	$44,062	16.2%	2,842	18.6%	$55,392,000	10.7%	25.6%	3,910	2,560	685	235	130	300	24.1%	15.8%
Arlington	Metropolitan	224,906	$101,533	8.5%	20,430	9.1%	$305,700,000	1.6%	8.3%	18,770	14,330	1,650	1,065	885	840	10.1%	4.2%
Augusta*	Metropolitan	119,525	$45,660	11.7%	22,348	18.7%	$438,576,000	9.7%	24.9%	29,735	20,325	4,575	1,965	1,005	1,865	23.2%	11.9%
Bath	Non-Metropolitan	4,616	$42,951	11.7%	1,133	24.5%	$18,792,000	8.7%	28.8%	1,330	960	165	90	40	75	28.3%	9.9%
Bedford*	Metropolitan	75,773	$47,525	9.8%	14,268	18.8%	$290,148,000	9.0%	25.4%	19,230	13,260	2,875	1,150	645	1,300	21.9%	8.9%
Bland	Non-Metropolitan	6,735	$41,939	15.0%	1,290	19.2%	$25,632,000	11.6%	26.8%	1,805	1,085	380	130	80	130	26.2%	10.5%
Botetourt	Metropolitan	33,002	$61,005	7.4%	6,337	19.2%	$126,204,000	8.2%	24.7%	8,160	5,760	1,125	500	280	495	23.4%	5.6%
Brunswick	Non-Metropolitan	16,973	$37,800	21.7%	3,097	18.2%	$58,512,000	11.6%	26.0%	4,410	2,870	755	335	110	340	22.9%	19.6%
Buchanan	Non-Metropolitan	23,597	$31,621	24.4%	4,371	18.5%	$116,100,000	13.3%	35.0%	8,255	2,865	2,760	905	685	1,040	33.2%	21.8%
Buckingham	Metropolitan	17,136	$39,538	22.8%	2,773	16.2%	$50,676,000	11.0%	22.3%	3,820	2,395	700	290	120	315	19.6%	15.5%
Campbell*	Metropolitan	133,249	$43,950	18.7%	20,633	15.5%	$422,388,000	9.5%	22.0%	29,285	18,750	5,250	1,955	860	2,470	20.5%	15.2%
Caroline	Metropolitan	29,298	$55,760	14.5%	4,284	14.6%	$83,076,000	7.5%	20.0%	5,870	3,835	955	420	185	475	17.9%	13.2%
Carroll*	Non-Metropolitan	36,918	$34,978	17.7%	7,744	21.0%	$147,912,000	12.8%	30.0%	11,090	7,125	2,150	685	290	840	27.4%	18.5%
Charles City	Metropolitan	7,130	$48,394	12.2%	1,428	20.0%	$28,248,000	11.3%	26.9%	1,920	1,330	305	140	55	90	23.3%	11.5%
Charlotte	Non-Metropolitan	12,305	$35,715	19.7%	2,458	20.0%	$42,708,000	11.1%	26.9%	3,310	2,130	565	240	95	280	27.5%	19.5%
Chesterfield	Metropolitan	327,745	$67,454	8.0%	40,154	12.3%	$903,324,000	5.9%	17.0%	55,595	38,565	7,300	3,440	1,950	4,340	15.1%	8.5%
Clarke	Metropolitan	14,348	$74,384	7.9%	2,540	17.7%	$46,416,000	7.4%	20.8%	2,980	2,250	275	200	125	130	19.8%	5.8%
Craig	Metropolitan	5,210	$45,527	12.9%	1,056	20.3%	$19,140,000	10.7%	27.2%	1,415	845	300	85	35	150	25.3%	11.9%
Culpeper	Metropolitan	48,506	$63,876	10.1%	6,547	13.5%	$129,276,000	7.0%	18.1%	8,785	5,910	1,230	610	345	690	17.0%	11.4%
Cumberland	Non-Metropolitan	9,841	$41,799	18.2%	1,838	18.7%	$34,800,000	10.1%	25.9%	2,550	1,685	415	170	80	200	21.9%	18.2%
Dickenson	Non-Metropolitan	15,486	$33,386	21.8%	2,804	18.1%	$77,904,000	16.9%	37.0%	5,735	1,955	2,000	625	395	760	31.5%	23.4%
Dinwiddie*	Metropolitan	78,076	$44,734	19.3%	12,829	16.4%	$251,460,000	7.9%	23.0%	17,970	11,285	3,560	1,260	420	1,445	22.2%	19.2%
Essex	Non-Metropolitan	11,229	$44,427	15.5%	2,225	19.8%	$42,996,000	10.6%	26.7%	3,000	2,040	430	230	75	225	24.5%	18.5%
Fairfax*	Metropolitan	1,317,297	$100,795	6.3%	144,888	11.0%	$2,278,572,000	2.4%	10.5%	138,045	105,005	9,880	7,970	8,085	7,105	11.7%	5.6%

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

		VIRGINIA 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
Fauquier	Metropolitan	67,207	$82,705	7.0%	9,684	14.4%	$182,280,000	4.8%	16.8%	11,290	8,180	1,165	760	500	685	16.0%	6.4%
Floyd	Metropolitan	15,528	$41,652	14.2%	3,086	19.9%	$56,580,000	11.7%	26.2%	4,065	2,860	570	265	145	225	23.8%	12.7%
Fluvanna	Metropolitan	25,977	$63,117	8.2%	4,565	17.6%	$89,616,000	8.4%	22.3%	5,795	4,370	630	325	175	295	20.0%	6.8%
Franklin	Metropolitan	56,335	$48,070	14.4%	11,394	20.2%	$221,244,000	11.1%	27.0%	15,205	10,100	2,690	850	510	1,055	24.1%	13.1%
Frederick*	Metropolitan	108,535	$56,055	9.5%	15,856	14.6%	$311,208,000	7.1%	19.0%	20,600	14,700	2,590	1,330	680	1,300	17.5%	10.0%
Giles	Metropolitan	16,925	$43,504	13.3%	3,312	19.6%	$69,360,000	12.8%	29.0%	4,910	2,915	1,050	380	190	375	27.0%	15.0%
Gloucester	Metropolitan	36,834	$58,824	10.6%	6,193	16.8%	$124,356,000	8.0%	23.3%	8,585	5,870	1,205	660	310	540	20.3%	9.7%
Goochland	Metropolitan	21,626	$76,843	7.5%	4,019	18.6%	$85,032,000	5.3%	23.4%	5,055	3,770	500	310	235	240	21.8%	6.0%
Grayson	Non-Metropolitan	15,161	$33,302	18.3%	3,538	23.3%	$62,136,000	15.0%	31.7%	4,805	3,285	860	280	125	255	30.7%	18.6%
Greene	Metropolitan	18,804	$59,730	11.5%	2,896	15.4%	$54,972,000	6.9%	19.5%	3,670	2,670	470	210	100	220	17.4%	10.1%
Greensville*	Non-Metropolitan	17,474	$35,356	26.2%	2,678	15.3%	$51,840,000	11.5%	22.1%	3,855	2,355	770	315	90	325	21.4%	20.0%
Halifax	Non-Metropolitan	35,401	$35,553	22.2%	7,634	21.6%	$140,880,000	12.0%	30.0%	10,630	6,790	1,915	770	255	900	26.9%	20.0%
Hanover	Metropolitan	101,330	$77,316	5.6%	15,217	15.0%	$324,456,000	6.5%	19.2%	19,505	14,615	2,010	1,235	540	1105	17.6%	5.4%
Henrico*	Metropolitan	532,725	$49,650	17.0%	66,994	12.6%	$1,353,084,000	5.4%	16.6%	88,325	59,235	14,470	5,835	2255	6530	15.8%	14.1%
Henry*	Non-Metropolitan	66,372	$33,556	20.0%	13,944	21.0%	$289,668,000	13.4%	31.4%	20,845	13,230	4,400	1,280	435	1500	29.6%	21.4%
Highland	Non-Metropolitan	2,215	$38,314	14.6%	648	29.3%	$10,368,000	11.4%	34.5%	765	595	60	55	30	25	32.4%	9.1%
Isle of Wight	Metropolitan	35,656	$62,495	10.6%	5,947	16.7%	$120,060,000	7.4%	22.2%	7,930	5,535	1,055	605	245	490	20.4%	10.2%
James City*	Metropolitan	85,722	$61,843	9.9%	18,120	21.1%	$341,784,000	7.4%	24.0%	20,545	15,990	1,430	1,240	1100	785	23.3%	6.1%
King and Queen	Non-Metropolitan	7,130	$44,697	13.4%	1,438	20.2%	$25,308,000	10.2%	24.5%	1,750	1,165	275	150	55	105	22.8%	15.4%
King George	Non-Metropolitan	24,926	$78,180	7.9%	2,822	11.3%	$48,468,000	4.7%	14.1%	3,525	2,370	520	230	105	300	13.2%	9.6%
King William	Metropolitan	16,097	$61,183	9.1%	2,230	13.9%	$51,720,000	7.9%	20.7%	3,340	2,285	450	250	85	270	18.4%	10.8%
Lancaster	Non-Metropolitan	11,148	$46,578	15.2%	3,816	34.2%	$58,500,000	10.0%	34.0%	3,795	2,915	320	270	155	135	38.1%	14.3%
Lee	Non-Metropolitan	25,185	$32,092	29.0%	4,586	18.2%	$93,852,000	13.3%	29.2%	7,355	3,230	2,215	705	365	840	25.7%	25.1%
Loudoun	Metropolitan	349,679	$117,680	3.8%	26,710	7.6%	$475,596,000	2.3%	8.2%	28,785	21,230	2,245	1,925	1475	1910	8.1%	3.6%
Louisa	Non-Metropolitan	33,945	$53,170	11.7%	5,711	16.8%	$120,384,000	7.7%	24.1%	8,165	5,515	1,330	510	250	560	19.9%	11.8%
Lunenburg	Non-Metropolitan	12,527	$37,712	21.4%	2,401	19.2%	$46,008,000	12.1%	28.1%	3,525	2,275	630	255	95	270	23.3%	18.0%
Madison	Non-Metropolitan	13,200	$51,805	12.7%	2,625	19.9%	$45,876,000	8.6%	24.0%	3,170	2,260	375	215	130	190	21.1%	10.4%
Mathews	Metropolitan	8,897	$55,128	10.5%	2,433	27.3%	$44,496,000	8.9%	33.0%	2,940	2,180	245	225	140	150	30.6%	8.8%
Mecklenburg	Non-Metropolitan	31,426	$38,439	17.1%	7,252	23.1%	$134,628,000	12.8%	31.4%	9,855	6,530	1,630	710	230	755	28.7%	16.3%
Middlesex	Non-Metropolitan	10,762	$47,399	15.5%	3,060	28.4%	$51,576,000	10.5%	30.7%	3,305	2,530	320	215	115	125	32.1%	11.8%
Montgomery*	Metropolitan	113,391	$40,330	24.6%	11,722	10.3%	$243,936,000	6.9%	14.4%	16,275	10,555	2,910	1,060	555	1,195	13.3%	8.2%

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

		VIRGINIA 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
Nelson	Metropolitan	14,789	$45,990	15.8%	3,350	22.7%	$64,536,000	9.6%	29.5%	4,360	3,125	545	300	150	240	27.6%	13.9%
New Kent	Metropolitan	19,507	$72,150	6.7%	2,814	14.4%	$64,932,000	8.4%	20.8%	4,060	2,995	490	225	115	235	18.1%	5.6%
Northampton	Non-Metropolitan	12,125	$36,211	22.4%	2,900	23.9%	$50,232,000	10.1%	30.2%	3,660	2,550	535	255	90	230	28.8%	23.0%
Northumberland	Non-Metropolitan	12,200	$49,054	16.1%	4,081	33.5%	$79,176,000	14.0%	42.1%	5,140	4,045	410	325	175	185	37.6%	12.1%
Nottoway	Non-Metropolitan	15,773	$34,805	23.5%	2,854	18.1%	$49,200,000	9.1%	24.0%	3,780	2,430	670	260	100	320	23.6%	19.4%
Orange	Non-Metropolitan	34,689	$60,829	10.4%	6,729	19.4%	$118,992,000	9.0%	23.0%	7,970	5,765	975	465	265	500	23.9%	10.3%
Page	Non-Metropolitan	23,821	$41,070	15.3%	4,615	19.4%	$86,472,000	11.2%	27.0%	6,420	4,130	1,160	445	210	475	24.5%	14.8%
Patrick	Non-Metropolitan	18,368	$34,654	19.4%	4,340	23.6%	$79,092,000	15.3%	31.8%	5,845	3,945	1,075	325	120	380	28.0%	17.5%
Pittsylvania*	Non-Metropolitan	105,333	$35,774	19.2%	20,435	19.4%	$409,404,000	11.7%	28.3%	29,825	19,155	5,515	2,040	780	2,335	25.8%	20.4%
Powhatan	Metropolitan	28,259	$74,820	7.7%	4,223	14.9%	$92,976,000	7.0%	20.0%	5,665	4,195	645	315	195	315	17.4%	5.3%
Prince Edward	Non-Metropolitan	22,802	$39,077	23.5%	3,482	15.3%	$66,168,000	11.8%	21.5%	4,905	3,095	930	330	115	435	19.4%	15.1%
Prince George*	Metropolitan	59,416	$52,533	16.5%	7,891	13.3%	$164,940,000	6.7%	19.0%	11,295	7,020	2,000	860	380	1,035	16.6%	13.1%
Prince William*	Metropolitan	496,434	$78,515	7.3%	38,961	7.8%	$721,020,000	3.2%	9.3%	46,285	31,985	5,545	2,830	2,095	3,830	8.9%	8.3%
Pulaski	Metropolitan	34,507	$43,555	15.7%	6,876	19.9%	$137,148,000	11.0%	27.6%	9,535	5,915	2,035	670	255	660	25.8%	15.8%
Rappahannock	Metropolitan	7,478	$60,945	10.3%	1,687	22.6%	$29,616,000	8.1%	25.8%	1,930	1,445	170	135	85	95	25.0%	7.9%
Richmond	Non-Metropolitan	8,953	$42,738	20.3%	1,710	19.1%	$28,140,000	10.7%	22.6%	2,020	1,430	265	150	50	125	21.2%	12.8%
Roanoke*	Metropolitan	217,288	$47,574	15.0%	36,509	16.8%	$722,076,000	7.7%	22.7%	49,275	31,855	9,095	3,420	1,455	3,450	22.5%	14.1%
Rockbridge*	Non-Metropolitan	36,157	$41,773	16.4%	7,403	20.5%	$134,220,000	10.7%	25.6%	9,260	6,285	1,385	655	370	565	24.3%	11.0%
Rockingham*	Metropolitan	129,136	$46,612	17.4%	17,645	13.7%	$329,544,000	7.5%	17.5%	22,625	15,985	3,000	1,460	785	1,395	16.1%	9.3%
Russell	Non-Metropolitan	28,264	$36,107	18.8%	5,121	18.1%	$115,596,000	13.7%	29.9%	8,455	3,565	2,625	835	535	895	28.2%	21.0%
Scott	Metropolitan	22,640	$38,336	18.4%	4,730	20.9%	$99,060,000	15.1%	32.9%	7,450	3,810	1,795	685	560	600	29.7%	18.9%
Shenandoah	Non-Metropolitan	42,684	$47,874	11.6%	8,502	19.9%	$153,600,000	9.9%	24.9%	10,635	7,695	1,305	730	290	615	23.1%	11.3%
Smyth	Non-Metropolitan	31,652	$37,475	17.3%	6,138	19.4%	$125,460,000	12.8%	30.3%	9,590	5,375	2,335	720	320	840	28.1%	19.6%
Southampton*	Non-Metropolitan	26,766	$41,437	18.4%	4,638	17.3%	$90,360,000	9.6%	23.9%	6,395	4,045	1,080	565	210	495	21.8%	18.0%
Spotsylvania*	Metropolitan	155,480	$60,632	9.5%	17,551	11.3%	$344,676,000	5.2%	14.8%	23,045	15,535	3,305	1,605	790	1,810	13.6%	9.7%
Stafford	Metropolitan	136,788	$93,014	6.4%	11,846	8.7%	$230,796,000	3.8%	11.1%	15,175	10,350	1,940	990	540	1,355	10.2%	6.5%
Surry	Non-Metropolitan	6,765	$50,554	13.6%	1,246	18.4%	$24,816,000	9.9%	25.0%	1,690	1,120	280	155	50	85	22.3%	12.7%
Sussex	Metropolitan	11,810	$38,948	24.0%	1,865	15.8%	$35,040,000	9.8%	22.1%	2,610	1,635	495	210	55	215	20.0%	13.9%
Tazewell	Non-Metropolitan	44,103	$38,336	17.5%	8,163	18.5%	$189,576,000	12.4%	30.7%	13,550	6,370	3,510	1,490	815	1,365	27.5%	17.3%
Warren	Metropolitan	38,699	$56,291	12.0%	5,469	14.1%	$107,172,000	6.9%	18.6%	7,210	4,795	1,095	555	225	540	17.7%	10.9%
Washington*	Metropolitan	72,248	$38,705	16.5%	14,101	19.5%	$290,376,000	10.9%	28.7%	20,720	12,425	4,310	1,660	855	1,470	26.6%	16.2%

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

		VIRGINIA 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
Westmoreland	Non-Metropolitan	17,612	$45,927	15.3%	4,030	22.9%	$67,560,000	9.4%	27.5%	4,840	3,540	595	325	145	235	26.2%	15.7%
Wise*	Non-Metropolitan	44,606	$34,897	19.5%	6,757	15.1%	$183,888,000	13.3%	30.0%	13,390	5,425	4,140	1,310	845	1,670	26.7%	22.6%
Wythe	Non-Metropolitan	29,344	$41,168	15.1%	5,622	19.2%	$112,584,000	12.4%	28.4%	8,320	5,040	1,815	565	245	655	25.6%	15.7%
York*	Metropolitan	397,092	$63,464	14.6%	50,392	12.7%	$964,464,000	5.7%	17.0%	67,570	44,180	10,515	5,305	2,465	5,105	16.0%	13.3%
Chesapeake, Norfolk, and Portsmouth cities	Metropolitan	572,915	$50,835	17.4%	63,422	11.1%	$1,201,872,000	5.1%	15.3%	87,825	55,570	15,470	6,900	2,630	7,255	14.5%	14.2%
Suffolk city	Metropolitan	85,728	$59,468	11.5%	10,786	12.6%	$218,244,000	6.1%	18.3%	15,695	9,900	2,780	1,070	470	1,475	16.7%	13.3%
Virginia Beach city	Metropolitan	448,479	$62,509	9.0%	53,132	11.8%	$1,029,084,000	4.5%	15.1%	67,670	46,740	8,225	5,240	2,840	4,625	13.9%	7.1%

* Calculations based on sum of County and Independent City Data within county limits.

**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

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66 Lauren Jow, ibid.

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KEY FACTS ABOUT SOCIAL SECURITY, MEDICARE AND MEDICAID IN VIRGINIA

Social Security Works for Virginia's Residents and Economy

- Social Security provided benefits to 1,415,661 Virginians in 2014, 1 in 6 (17 percent) residents.
- Virginians received Social Security benefits totaling $20.7 billion in 2014, an amount equivalent to 5 percent of the state's total personal income [Figure 1 in full report].
- The average Social Security benefit in Virginia was $14,607 in 2013.
- Social Security lifted 436,000 Virginians out of poverty in 2013.

Social Security Works for Virginia's Seniors

- Social Security provided benefits to 950,681 Virginia retired workers in 2014, two-thirds (67.2 percent) of beneficiaries [Figure 3 in full report].
- Social Security lifted 284,000 Virginia residents aged 65 and older out of poverty in 2013. Without Social Security, the elderly poverty rate in Virginia would have increased from 1 in 11 (9.2 percent) to one-third (35.3 percent) [Figure 4 in full report].

Social Security Works for Virginia's Workers with Disabilities

- Social Security provided disability benefits to 212,945 workers in 2014, 1 in 7 (15 percent) Virginia beneficiaries [Figure 3 in full report].

Social Security Works for Virginia's Women

- Social Security provided benefits to 737,494 Virginia women in 2014, 1 in 6 (17.4 percent) Virginia women.
- Social Security lifted 173,000 Virginia 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 8 (12.2 percent) to 2 in 5 (40.4 percent) [Figure 4 in full report].

Social Security Works for Virginia's Children

- Social Security provided benefits to 100,887 Virginia children in 2014, 1 in 14 (7.1 percent) Virginia beneficiaries [Figure 3 in full report].

Social Security Works for Virginia's People of Color

- Social Security provided benefits to one-quarter (24.8 percent) of African American households in Virginia in 2013, 138,924 households.
- Social Security provided benefits to 1 in 11 (9 percent) Latino households in Virginia in 2013, 15,669 households.
- Social Security provided benefits to one-quarter (26.3 percent) of American Indian and Alaska Native households in Virginia in 2013, 2,254 households.
- Social Security provided benefits to 1 in 7 (14.3 percent) Asian American, Hawaiian Native, and Pacific Islander households in Virginia in 2013, 19,933 households.

Social Security Works for Virginia's Rural Communities

- 2 in 7 (28.1 percent) rural or non-metropolitan Virginians received Social Security in 2014, compared with 1 in 6 (15.5 percent) metropolitan Virginians.

Medicare Works for Virginia's Residents and Economy

- 1,203,462 Virginians received Medicare benefits in 2012—1 in 7 state residents.
- Medicare provided $9.7 billion in benefits to Virginians in 2009—19.7 percent of all health care spending in the state. The average expenditure per Medicare beneficiary was $8,875 [Figure 1 in full report].

Medicare Works for Virginia's Seniors and People with Disabilities

- 1,005,258 of Virginia's 1,203,462 Medicare beneficiaries were aged 65 or older in 2012—4 in 5 beneficiaries.
- 226,382 of Virginia's 1,203,462 Medicare beneficiaries were people with disabilities in 2012—1 in 5 beneficiaries.

Medicaid Works for Virginia's Residents and Economy

- 843,000 Virginians received Medicaid benefits in 2013—1 in 9 state residents.
- A total of $7.3 billion in Medicaid benefits were paid to Virginians in 2013. In 2009, Medicaid spending was 11.7 percent of all health care spending in the state. The average expenditure per Medicaid beneficiary in 2013 was $8,649 [Figure 1 in full report].

Medicaid Works for Virginia's Seniors, People with Disabilities and Long-Term Care Recipients

- 112,900 of Virginia's 843,000 Medicaid beneficiaries were aged 65 or older in 2011—1 in 9 beneficiaries.
- 186,400 of Virginia's 843,000 Medicaid beneficiaries were people with disabilities in 2011—1 in 6 beneficiaries.
- Medicaid provided $2.5 billion in long-term care benefits for Virginia residents in 2013. In 2011 Medicaid provided nursing home care for 17,042 nursing home residents, 3 in 5 state residents enrolled in nursing homes.