A PLAIN-ENGLISH FACT CHECK

# WHO PAYS FOR YOUR CARE

*The Story of Medicare and Medicaid from 1965 to Today*



MEDICARE · MEDICAID · COSTS · CLAIMS

**How the Two Programs Work, What They Cost, and What the Records Show**

ANDREW DOMINGUEZ

TRINFINITY Enterprises

# Who Pays for Your Care

The Story of Medicare and Medicaid from 1965 to Today

Andrew Dominguez

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Who Pays for Your Care: The Story of Medicare and Medicaid from 1965 to Today

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**The information in this book stops at November 12, 2026.** Laws, premiums, enrollment figures and office holders change. Figures after that date are not included.

This book is for general information only. It explains how Medicare and Medicaid work. It is not medical, legal or insurance advice. Check your own coverage at Medicare.gov or 1-800-MEDICARE (1-800-633-4227), with your state Medicaid office, or with a State Health Insurance Assistance Program (SHIP) counselor at shiphelp.org.

Every fact in this book is footnoted to a source the reader can open. Facts I could not confirm are marked [Not verified].

First edition, 2026.

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# Chapter 1. Introduction: Why This Book, and How to Read It

*Information in this book stops at November 12, 2026.*

Almost every American family touches Medicare or Medicaid at some point. A grandparent goes into the hospital. A baby is born. A parent needs a nursing home. A neighbor loses a job and signs up for coverage until the next one comes along. Yet most of us could not explain who pays for these programs, how they started, or what the arguments about them are really about.

I wrote this book to fix that for myself and for you. My goal is simple: explain how Medicare and Medicaid work, where they came from, and where they stand today, in plain language, with every fact traced to a source you can open and check.

This book is part of a series. Each book in the series follows the same rules, uses the same kinds of sources, and gives the same kind of verdicts on popular claims. If you have read the Social Security book in this series, you will find the same layout here.

## What Medicare and Medicaid are, in one paragraph each

**Medicare** is federal health insurance for people 65 and older, for many younger people with long-term disabilities, and for people with permanent kidney failure. The federal government runs it, and it is the same in every state. It has four parts: Part A (hospital insurance), Part B (doctor and outpatient insurance), Part C (Medicare Advantage, private plans that take the place of Parts A and B), and Part D (prescription drugs). In 2025 it covered 69.3 million people and spent $1,210.1 billion.[1]

**Medicaid** is health coverage for people with low incomes, run by each state under federal rules and paid for jointly by the federal government and the states.[2] Because each state runs its own program, who qualifies and what is covered can differ a lot from one state line to the next. A related program, the Children's Health Insurance Program (CHIP), covers children in families that earn too much for Medicaid but not enough to afford private coverage. In July 2026, Medicaid and CHIP together covered 72,946,510 people, about 47.8 percent of them children.[3]

You might ask, "Why put them in one book?" Because they were born in the same law on the same day, July 30, 1965. They share a federal agency, the Centers for Medicare and Medicaid Services (CMS). Millions of people are enrolled in both. And together they pay for about two out of every five dollars spent on health care in the United States: 21 percent through Medicare and 18 percent through Medicaid in 2024.[4]

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[1] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026, Table II.B1.

[2] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[3] Centers for Medicare and Medicaid Services, "July 2026 Medicaid and CHIP Enrollment Data Highlights," updated October 30, 2026, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights, accessed November 12, 2026.

[4] Centers for Medicare and Medicaid Services, "NHE Fact Sheet" (2024 data), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet, accessed November 12, 2026.

## The date this book stops

Health policy changes every month. A new rule comes out, a court rules, a report updates its numbers. So the first thing you need to know is the date my information stops: **November 12, 2026**.

Every current number in this book comes from the newest official report I could find on that date. The main ones are:

| Report | Who publishes it | Date | What I use it for |
|---|---|---|---|
| 2026 Medicare Trustees Report | Boards of Trustees of the Medicare trust funds | Transmitted June 9, 2026 | Trust fund dates, spending, income, enrollment |
| National Health Expenditure Accounts (2024 data) | CMS | Latest data year 2024 | Total U.S. health spending and the shares paid by each program |
| Medicaid and CHIP enrollment report (July 2026 data) | CMS | Updated October 30, 2026 | Medicaid and CHIP enrollment |
| Fiscal Year 2025 Improper Payments Fact Sheet | CMS | January 15, 2026 | Payment error rates |
| March 2026 Report to the Congress | Medicare Payment Advisory Commission (MedPAC) | March 2026 | Medicare Advantage payments |

If you read this book after November 12, 2026, some numbers will have changed. Where it matters, I tell you where to look for the newest version.

## How I chose sources

The rule for this series is that every fact must trace to a source you can open. Not every source is equally strong, so I sorted them into five tiers and used the strongest one I could find.

| Tier | Type | Examples in this book |
|---|---|---|
| 1. Primary and official | Laws, government data, official reports, presidential papers | Public laws, Medicare Trustees Reports, CMS data, Medicaid.gov, HHS Office of Inspector General audits, presidential libraries |
| 2. Nonpartisan analysis | Congressional and government research offices | Congressional Research Service (CRS), Congressional Budget Office (CBO), Government Accountability Office (GAO), MedPAC, Medicaid and CHIP Payment and Access Commission (MACPAC) |
| 3. Scholarly | Peer-reviewed research and widely used reference data | Health policy journals, university research, KFF (formerly the Kaiser Family Foundation) |
| 4. Fact-checks and journalism | Reporting and fact-check sites | Associated Press, Reuters, PolitiFact, FactCheck.org, trade press |
| 5. Advocacy and | Groups that argue for a | Paragon Health Institute, Heritage Foundation, |

| Tier | Type | Examples in this book |
|---|---|---|
| think tanks | position | Center on Budget and Policy Priorities, Committee for a Responsible Federal Budget |

Two notes on this list. First, KFF is a private research group, not a government agency. I use it because it is widely used by people of all political views as a reference for health data, and I label it when I do. Second, I use Tier 5 groups only to show what one side argues, and when I quote one side, I quote the other.

I did not use social media posts, chain emails, forums, video channels or pages written by computer programs as evidence. When I mention one, it is only as an example of a claim being spread.

## Facts, interpretations and unknowns

A fact-checked book has to keep three kinds of statements apart:

- **Confirmed facts** have a source behind them, given in a footnote. Example: the Medicare hospital trust fund is projected to run out in 2033.[5]
- **Interpretations** are someone's reading of the facts. When I give one, I name whose interpretation it is and where they said it. Example: whether Medicare Advantage costs taxpayers too much is an interpretation, and two sides read the same data differently.
- **Unknowns** are things the evidence cannot settle yet. I say so plainly and say what would settle them.

At the end of most chapters you will find a short table called "Sorting the evidence" that puts the chapter's main points into these three groups. If I could not find a source for something, I mark it **[Not verified]** and say what I searched.

## How the claim verdicts work

Part Seven tests popular claims about Medicare and Medicaid. These are things people say at kitchen tables, on talk radio, in campaign ads and online. Some come from the political right, some from the left, some from everywhere. Each one gets one of four verdicts:

| Verdict | Meaning |
|---|---|
| True | Primary sources confirm it as usually stated |
| Partly true | There is a real fact underneath, but the usual version leaves out or twists something important. I say exactly which part is true |
| False (debunked) | Primary sources contradict it |
| Inconclusive | The evidence is not enough to say either way, or an investigation is still open. I say what would settle it |

I set no verdict until I had checked the sources, and I held claims from every side to the same standard.

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[5] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

## Dollars: nominal and adjusted

A dollar in 1966 bought much more than a dollar today. When I give a dollar amount, I say whether it is **nominal** (the actual dollars of that year) or **adjusted for inflation** (converted to the dollars of a stated year). If I do not say otherwise, a dollar amount is nominal, which is how government reports usually print them.

## What this book is not

This book explains how the programs work. It is not medical, legal or insurance advice. Your own coverage depends on your age, income, state, work history and the plan you choose. To check your own situation:

- For Medicare, go to Medicare.gov or call 1-800-MEDICARE (1-800-633-4227).[6]
- For Medicaid or CHIP, contact your state Medicaid office.
- For free one-on-one help, contact your State Health Insurance Assistance Program (SHIP). Every state has one, and the counselors do not sell insurance.

## How the book is laid out

| Part | Chapters | What it covers |
|---|---|---|
| One | 2 and 3 | Health care for older and poor Americans before 1965, and the national plans that failed |
| Two | 4 and 5 | The fight over the 1965 law and the deal that passed it |
| Three | 6 to 9 | How each program works today |
| Four | 10 to 12 | Every major change from 1966 to today |
| Five | 13 and 14 | Who pays, where the money goes, and the trust funds |
| Six | 15 and 16 | Fraud, waste, improper payments and Medicare Advantage |
| Seven | 17 and 18 | Popular claims and their verdicts |
| Eight | 19 | Where things stand today and what the public thinks |
| Nine | 20 | The options for the future, with no recommendation |
| Appendices | A to F | Timeline, key people, glossary, how to read a Trustees Report, where to get help, bibliography |

You can read straight through, or jump to the part you care about. Each chapter stands on its own, and each footnote tells you exactly where a fact came from.

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[6] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

# Part One: Before 1965

## Chapter 2. Sick, Old and Poor Before 1965

Picture a retired railroad worker in 1960. He is 72. He has a small Social Security check, a paid-off house and a wife with a bad heart. One night she goes into the hospital for two weeks. Who pays?

For most older Americans in 1960, the honest answer was: they did, out of savings, or their grown children did, or a charity or county hospital did, or nobody did and the bill went unpaid. There was no Medicare and no Medicaid. This chapter explains how health care was paid for before 1965, and why older and poorer Americans were the people the system served worst.

### How most people paid for care

Before the 1930s, most Americans paid doctors and hospitals directly, out of pocket. Health insurance as we know it grew up in the middle of the twentieth century. By 1950, about 60 percent of Americans had at least basic hospital coverage, but those policies "typically covered less than 20 percent" of total medical bills.[7]

Private hospital insurance plans, including the Blue Cross plans, and job-based coverage spread in the 1940s and 1950s. I was not able to read a primary source on the origins of those plans for this book, so I do not give dates for them [Not verified]. What matters for this story is the result: by the late 1950s, working people increasingly had coverage through their jobs, and retirees, who no longer had jobs, were left out.

Most private coverage came through a job. That worked well for workers and their families. It worked badly for anyone who did not have a job: the retired, people too sick or disabled to work, and many people with low incomes.

### Why older Americans were left out

Older people use more health care than younger people. A 1959 report from the Department of Health, Education, and Welfare (HEW), quoted in the Social Security Administration's history of Medicare, found that older persons "use about two-and-a-half times as much general hospital care" as those under 65.[8]

At the same time, older people had less money and less coverage. When the 1950 census was taken, only about 1 in 8 Americans 65 and older had any health insurance, and about two-thirds

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[7] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[8] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

of them had incomes under $1,000 a year (nominal 1950 dollars).[9] The number of older Americans was also growing fast, from about 12 million in 1950 to 17.5 million in 1963.[10]

By the early 1960s, private coverage for older people had grown, but it seemed to level off "at about 50 percent." Many of those policies were thin. The Social Security Administration's historian concluded that "only about 1 in 4 of the aged had adequate hospital insurance protection" by 1964.[11] CMS's own history says that when Medicare was created, seniors were the age group most likely to be living in poverty, and only about half had health insurance.[12]

You might ask, "Why didn't insurance companies just sell more policies to older people?" The short answer is cost. An insurer that covers a group of people who use two and a half times as much hospital care has to charge two and a half times as much, or more. Many retirees on fixed incomes could not pay that. Insurers also tended to avoid people who were likely to have large claims. That is the basic problem that every proposal in this book tries to solve in one way or another.

## Help for the poor before Medicaid

Poor Americans of any age had even fewer options. Help came from a patchwork:

- **Charity and county hospitals.** Many cities and counties ran public hospitals that treated people who could not pay. [Not verified]
- **Free care from doctors.** Doctors often treated some poor patients for free or at reduced fees. [Not verified]
- **Welfare medical payments.** Starting in 1950, the federal government shared the cost when states paid doctors and hospitals for people on public assistance (welfare).[13]
- **The Kerr-Mills program (1960).** This program, described in Chapter 3, paid for care for low-income older people in states that chose to take part. It is the direct ancestor of Medicaid.[14]

The common thread is that help depended on where you lived and on proving you were poor enough. The federal government shared some costs, but it did not guarantee anything.

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[9] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[10] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[11] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[12] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[13] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[14] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

## The big question that would shape everything

By the 1950s, two very different answers to the problem were on the table, and the same two answers are still argued about today:

| Approach | How it works | Who backed it before 1965 |
|---|---|---|
| Social insurance | Everyone pays in while working, through a payroll tax. Everyone who qualifies gets the same coverage, with no test of how poor you are | Labor unions, the Truman and Kennedy administrations, many Democrats[15] |
| Help for the needy | Government pays for care only for people who prove they cannot afford it, usually through the states | The American Medical Association (AMA), many Republicans and Southern Democrats[16] |

The 1965 law ended up using both approaches. Medicare took the social insurance road. Medicaid took the help-for-the-needy road. The next two chapters show how that happened.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| About 1 in 8 older Americans had health insurance in 1950 (SSA history) | Whether private insurance would have reached most older people on its own is debated. Supporters of Medicare argued it would not; opponents argued it was spreading fast[17] | Exactly how many older Americans went without needed care before 1965 is not known from national data |
| About half of older Americans had some coverage by 1964, but only about 1 in 4 had adequate hospital coverage (SSA history) | | |
| Older people used about 2.5 times as much hospital care as those under 65 (1959 HEW report) | | |

[15] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[16] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[17] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

## Chapter 3. The Plans That Failed, 1935 to 1964

Medicare did not appear out of nowhere in 1965. It was the end of a thirty-year fight. Several presidents proposed national health insurance and lost. Understanding those losses explains why Medicare was built the way it was.

### 1935: Health is left out of Social Security

In June 1934, President Franklin Roosevelt set up a cabinet-level Committee on Economic Security to design what became the Social Security Act. Its staff studied health insurance along with old-age pensions and unemployment insurance.[18]

The American Medical Association (AMA), which represented most of the nation's doctors, objected as soon as the committee was formed. In January 1935, the AMA's House of Delegates held an emergency session and declared its "unyielding opposition" to government health insurance.[19]

Roosevelt decided the fight was not worth risking the rest of his plan. In mid-March 1935 he decided that health insurance "should not be injected into the debate" while the Social Security bill was pending. According to a report in the Social Security Administration's history, the House Ways and Means Committee, after receiving an AMA telegram, "agreed by a large majority to strike out all mention of health insurance."[20] The Social Security Act was signed on August 14, 1935, with old-age pensions and unemployment insurance but no health insurance. Only grants for maternal and child health and for public health stayed in.[21]

### 1943 to 1950: The Wagner-Murray-Dingell bills and Truman's plan

On June 3, 1943, Senators Robert Wagner and James Murray and Representative John Dingell introduced a bill to add national health insurance to Social Security. It died in committee.[22]

Roosevelt died in April 1945. On November 19, 1945, President Harry Truman sent Congress a special message asking for a full health program. It had five parts: building hospitals, expanding public health and maternal and child health services, funding medical education and research,

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[18] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 2, Social Security Administration, Office of Research and Statistics, Research Report No. 29 (1969), Social Security History website, https://www.ssa.gov/history/corningchap2.html, accessed November 12, 2026.

[19] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 2, Social Security Administration, Office of Research and Statistics, Research Report No. 29 (1969), Social Security History website, https://www.ssa.gov/history/corningchap2.html, accessed November 12, 2026.

[20] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 2, Social Security Administration, Office of Research and Statistics, Research Report No. 29 (1969), Social Security History website, https://www.ssa.gov/history/corningchap2.html, accessed November 12, 2026.

[21] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 2, Social Security Administration, Office of Research and Statistics, Research Report No. 29 (1969), Social Security History website, https://www.ssa.gov/history/corningchap2.html, accessed November 12, 2026.

[22] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

prepaying medical costs through "expansion of our existing compulsory social insurance system," and paying cash benefits to workers who lost wages to sickness.[23]

Truman anticipated the main attack. "This is not socialized medicine," he wrote. He framed the goal as "health security for all, regardless of residence, station, or race--everywhere in the United States."[24]

The AMA disagreed strongly. In 1948 it charged its members a $25 assessment each and built a fund of about $4.5 million for what it called a "national education campaign" against the plan. In 1950 alone, it spent $1.1 million on advertising (nominal dollars).[25] Truman dropped the proposal from his 1952 State of the Union address, and his successor, President Dwight Eisenhower, opposed it.[26]

### Why Truman's plan failed

The Social Security history of this period gives a detailed account of the fight, and it is worth slowing down for, because the same arguments came back in 1965, 1993 and 2009.[27]

**The first bill was huge.** The 1943 Wagner-Murray-Dingell bill did far more than health insurance. It also covered disability, maternity and death benefits and changes to unemployment insurance. The history calls it "the most comprehensive social measure ever introduced in Congress" apart from the original Social Security Act.[28]

**The public was willing, at first.** The history reports a 1942 Fortune poll showing 74 percent in favor of government health insurance and a 1943 Gallup poll showing 59 percent.[29] By late 1949, after a long campaign against it, a Gallup poll put support at 51 percent.[30] I did not read the original polls, so I report them as the history describes them.

**Congress would not move it.** Supporters could not get hearings in the House Ways and Means Committee. The 1946 elections produced the first Republican Congress since 1932.

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[23] Harry S. Truman, "Special Message to the Congress Recommending a Comprehensive Health Program," November 19, 1945, Harry S. Truman Presidential Library and Museum, https://www.trumanlibrary.gov/library/public-papers/192/special-message-congress-recommending-comprehensive-health-program, accessed November 12, 2026.

[24] Harry S. Truman, "Special Message to the Congress Recommending a Comprehensive Health Program," November 19, 1945, Harry S. Truman Presidential Library and Museum, https://www.trumanlibrary.gov/library/public-papers/192/special-message-congress-recommending-comprehensive-health-program, accessed November 12, 2026.

[25] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[26] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[27] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[28] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[29] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[30] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

Republicans offered their own alternative, the Taft-Smith-Ball bill, which would have given states about $200 million in matching grants to buy private insurance for the "medically indigent." That idea, help for the needy through the states, is the same one that later became Kerr-Mills and then Medicaid.[31]

**The doctors organized.** In December 1948, after Truman's surprise election win, the AMA's House of Delegates voted a $25 special assessment on each member to resist what it called "the enslavement of the medical profession," hired a public relations firm, and built a $4.5 million fund for a "national education campaign" (nominal dollars).[32] In its first year, the campaign distributed several million pieces of literature and won endorsements from 1,829 organizations, including the U.S. Chamber of Commerce, the American Bar Association and the American Legion. Before the 1950 election, the AMA spent $1.1 million on advertising in about 11,000 newspapers, 30 national magazines and 1,000 radio stations, and allied groups spent about $2 million more.[33] Physicians campaigned against several members of Congress who supported the plan, and some of them lost. The history says health insurance became a "pariah issue."[34]

**Labor turned to employers.** Unions had backed the plan, but after World War II they increasingly won health benefits at the bargaining table. The Social Security history describes that private coverage as "second best" from the unions' point of view, but it reduced their need for a government plan.[35] Private coverage grew fast: from about a quarter of Americans in 1946 to about 60 percent with basic hospital coverage by 1950.[36]

**What did pass.** Congress did pass pieces. The 1946 Hill-Burton Act funded hospital construction, taking one title of the original bill. And in 1950, Congress began paying part of the cost when states paid doctors and hospitals ("medical vendors") for people on public assistance, an early step toward Medicaid.[37]

The history sums up the causes of failure as a cautious Congress, massive opposition from the AMA with sympathy from many other groups, less than full support from some backers including labor, a hostile press, the rapid growth of private insurance, and a political climate

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[31] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[32] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[33] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[34] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[35] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[36] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[37] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

shaped by the Cold War and the Korean War.[38] Those are the historian's interpretations, but they rest on a detailed record.

After Truman's broad plan stalled, officials at the Social Security Administration worked out a narrower idea: instead of covering everyone, cover only people already getting Social Security retirement benefits, and only for hospital care. The idea was aired publicly in 1951, and identical bills were introduced in Congress on April 10, 1952.[39]

The logic was political as much as practical. Older people were the group private insurance served worst, and it is hard to argue that a retired person is choosing not to work. A program tied to Social Security could also use Social Security's payroll tax and records. This "retirees first" idea is the seed of Medicare.

In 1957, Representative Aime Forand of Rhode Island introduced a bill along these lines. His first version provided up to 60 days of hospital care for Social Security beneficiaries.[40] The AFL-CIO, the nation's largest federation of labor unions, made the Forand bill its top priority.[41] The House Ways and Means Committee held hearings in 1958 but rejected the bill in 1960, by a vote of 17 to 8 on the later attempt.[42]

## 1960: Kerr-Mills, the forerunner of Medicaid

Opponents of a payroll-tax program needed an answer to the real problem of older people who could not afford care. They found it in a bill written by Representative Wilbur Mills of Arkansas, the chairman of the Ways and Means Committee, and pressed in the Senate by Senator Robert Kerr of Oklahoma. It created a new category of "medically indigent" older people: people who could pay their everyday bills but not their medical bills. The federal government would share the cost when states paid for their care.[43]

The bill passed the House 381 to 23 and the Senate 91 to 2 on August 23, 1960. It was signed on September 13, 1960, as Public Law 86-778, and became known as Kerr-Mills.[44]

Kerr-Mills did less than its supporters hoped. A May 1962 report found that only a little more than half the states had programs running and "only 88,000 elderly people had been helped, mainly in four States." After more than three years, 32 of the 50 states had programs, and five

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[38] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[39] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[40] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[41] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[42] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[43] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[44] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

states received 83 percent of the federal money.[45] The Social Security history calls the 1960 plan "the forerunner of what we know today as Medicaid."[46]

## 1961 to 1964: Kennedy and the King-Anderson bill

President John F. Kennedy made hospital insurance for older Americans a major goal. In January 1961, Senator Clinton Anderson of New Mexico and Representative Cecil King of California introduced his plan.[47]

Kennedy took the case to the public. On May 20, 1962, he spoke at a rally at Madison Square Garden in New York that drew nearly 20,000 older people.[48]

The AMA ran what the Social Security history calls an "all-out effort" against the bill, with "several million pamphlets," a "70-man speakers bureau," and a letter-writing drive called "Operation Coffee Cup."[49] As part of that drive, the AMA produced a 1961 recording featuring the actor Ronald Reagan, titled "Ronald Reagan Speaks Out Against Socialized Medicine." A copy is held by the National Library of Medicine, which lists the AMA as its creator.[50] Chapter 4 tells that story in more detail.

On July 17, 1962, the Senate killed the plan by two votes, 52 to 48, on a motion to table an amendment offered by Senators Anderson and Jacob Javits of New York.[51] In the House, the bill never got out of the Ways and Means Committee, where it was about one vote short.[52]

Kennedy was assassinated in November 1963. In 1964, under President Lyndon Johnson, the Senate for the first time passed government hospital insurance, adopting the King-Anderson plan as an amendment by a vote of 49 to 44 on September 2, 1964. But House and Senate

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[45] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[46] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[47] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[48] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[49] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[50] National Library of Medicine, History of Medicine Division, "Finding Aid to the Operation Coffeecup - Ronald Reagan Speaks Out Against Socialized Medicine, 1961," HMD MS ACC 2009-038 (creator: American Medical Association), https://findingaids.nlm.nih.gov/repositories/ammp/resources/__101523449, accessed November 12, 2026.

[51] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[52] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

negotiators deadlocked in October, with House negotiators led by Mills voting 3 to 2 against any health plan, and the bill died.[53]

## What thirty years of failure taught

Looking back, a few lessons stand out, and each one shows up in the 1965 law:

1. **Start with a group that is hard to argue against.** Broad plans for everyone failed. A plan for retirees had a better chance.
2. **Tie it to Social Security.** People had come to trust Social Security, and it already had a payroll tax and a records system.
3. **Give opponents a piece.** Kerr-Mills showed that the help-for-the-needy approach could pass with big majorities. The 1965 law kept it and expanded it as Medicaid.
4. **Elections matter.** The bill was always a few votes short. The 1964 election changed that, as the next chapter shows.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| Roosevelt left health insurance out of the 1935 bill after AMA opposition (SSA history) | The SSA historian, writing in 1969, called the 1935 decision Roosevelt's own, even though the same record shows heavy AMA pressure. How much weight to give each is a matter of interpretation[54] | Whether a 1935 health plan could have passed is unknowable |
| Kerr-Mills passed in 1960 by wide margins and reached few people at first (SSA history) | Supporters of Medicare saw Kerr-Mills's slow start as proof that a needs-based program would not work; opponents saw it as a program that needed time[55] | |
| The Senate passed hospital insurance for the first time on September 2, 1964, 49 to 44 (SSA history) | | |

[53] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[54] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 2, Social Security Administration, Office of Research and Statistics, Research Report No. 29 (1969), Social Security History website, https://www.ssa.gov/history/corningchap2.html, accessed November 12, 2026.

[55] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

# Part Two: The 1965 Law

## Chapter 4. The Fight: Doctors, Unions, Hospitals, Insurers and the 1964 Election

Every big law has winners, losers and people who think they might be either. Medicare and Medicaid were no different. This chapter introduces the main players in the fight that ended in 1965, what each wanted, and why the 1964 election broke the deadlock.

### The American Medical Association

The AMA was the strongest opponent of government health insurance for three decades. Its leaders argued that a government program would put bureaucrats between doctors and patients, lead to government control of medicine, and harm the quality of care. Those concerns appear again and again in the AMA's campaigns described in the Social Security Administration's history of Medicare.[56]

The AMA's methods in the early 1960s, as that history describes them, included:

- "several million pamphlets" and a "70-man speakers bureau"[57]
- a political action committee, the American Medical Political Action Committee (AMPAC), formed in the summer of 1961[58]
- "Operation Coffee Cup," in which doctors' wives hosted coffee gatherings and urged neighbors to write to Congress[59]
- "Operation Hometown," launched in the spring of 1963[60]
- in January 1965, a counterproposal called "Eldercare," which would have helped states pay private insurance premiums for low-income older people[61]

#### The Reagan record

The best-remembered piece of the Coffee Cup campaign is a 1961 long-playing record titled "Ronald Reagan Speaks Out Against Socialized Medicine." At the time, Reagan was an actor and

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[56] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[57] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[58] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[59] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[60] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[61] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

a spokesman for General Electric, not yet a politician. The National Library of Medicine holds a copy and lists the American Medical Association as its creator.[62]

A transcript of the recording, published with audio from the Ronald Reagan Presidential Library, shows Reagan arguing against the Forand bill and its successor from "Congressman King of California," calling it "this King Bill which is really the Forand Bill." He urged listeners to write to Congress and said that if the issue were put to a vote, the American people would "unhesitatingly vote against it."[63] His larger argument was that government health insurance for the elderly would be a first step toward government control of medicine for everyone.[64]

The record is worth knowing about for two reasons. First, it shows how the AMA framed the fight: not as a debate over hospital bills for retirees, but as a step toward government control of all of medicine. Second, Reagan later became president and, as Chapter 10 shows, signed one of the biggest changes in how Medicare pays hospitals.

## The administration's strategist

Behind the presidents stood a career official named Wilbur J. Cohen. As a young man, he had worked as research assistant to the executive director of the Committee on Economic Security, "which drafted the original Social Security Act," and in 1935 he was "the first employee to join the newly established Social Security Board."[65] President-elect Kennedy put him in charge of a task force on health and Social Security, and he became Assistant Secretary for Legislation at the Department of Health, Education, and Welfare (HEW), where the Social Security history calls him "the administration's chief strategist on Medicare."[66] President Johnson later named him Under Secretary of HEW in 1965 and Secretary in 1968.[67]

On the other side, the AFL-CIO made hospital insurance for retirees its top legislative priority starting with the Forand bill in 1957.[68] Unions had a direct interest: many had won retiree health benefits at the bargaining table, and a government program would take over part of that cost. They also saw the issue as a way to build a movement of older voters.

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[62] National Library of Medicine, History of Medicine Division, "Finding Aid to the Operation Coffeecup - Ronald Reagan Speaks Out Against Socialized Medicine, 1961," HMD MS ACC 2009-038 (creator: American Medical Association), https://findingaids.nlm.nih.gov/repositories/ammp/resources/__101523449, accessed November 12, 2026.

[63] Ronald Reagan, "Radio Address on Socialized Medicine" (recorded about 1961; audio from the Ronald Reagan Presidential Library), transcript at American Rhetoric, https://americanrhetoric.com/speeches/ronaldreagansocializedmedicine.htm, accessed November 12, 2026.

[64] Ronald Reagan, "Radio Address on Socialized Medicine" (recorded about 1961; audio from the Ronald Reagan Presidential Library), transcript at American Rhetoric, https://americanrhetoric.com/speeches/ronaldreagansocializedmedicine.htm, accessed November 12, 2026.

[65] Social Security Administration, "Wilbur J. Cohen (1913-1987)," Social Security History website, https://www.ssa.gov/history/cohen.html, accessed November 12, 2026.

[66] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[67] Social Security Administration, "Wilbur J. Cohen (1913-1987)," Social Security History website, https://www.ssa.gov/history/cohen.html, accessed November 12, 2026.

[68] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

## Hospitals, insurers and others

Hospitals and insurers had more mixed views than the doctors. I was not able to read a reliable source on the positions of the hospital and insurance industries for this book, so I do not characterize them [Not verified].

## The parties

The fight did not split neatly along party lines. Many Northern Democrats backed hospital insurance. Many Republicans and conservative Southern Democrats opposed it. The key gatekeeper in the House was a Southern Democrat, Wilbur Mills of Arkansas, chairman of the Ways and Means Committee, who had opposed the payroll-tax approach up to 1963.[69] In the Senate, the 1962 defeat came by two votes, and the 1964 Senate passage was 49 to 44.[70]

## The 1964 election

In November 1964, President Lyndon Johnson won a landslide over Senator Barry Goldwater of Arizona, who had opposed Medicare. In the words of the Social Security Administration's history, Johnson "was returned to office by the largest plurality in history." Democrats gained 38 seats in the House, for a margin of 295 to 140, and two seats in the Senate.[71]

The same history is careful not to overstate the reason: "Medicare was by no means the foremost campaign issue."[72] But the new Congress had the votes, and everyone knew it. After the election, Mills said he could "support a pay-roll tax for financing health benefits."[73] The question was no longer whether something would pass, but what.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| The AMA ran Operation Coffee Cup and produced the 1961 Reagan record (NLM, SSA history) | Whether the AMA's warnings about government control were reasonable is still debated; supporters and critics of today's health system read them differently | The total amount spent on lobbying by all sides; the SSA history says only that it "exceeded several million dollars"[74] |
| Democrats won 295 | How much the 1964 landslide was | |

[69] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[70] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[71] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[72] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[73] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[74] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 5, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap5.html, accessed November 12, 2026.

| Confirmed facts | Interpretations | Unknowns |
| --- | --- | --- |
| House seats in 1964 (SSA history) | about Medicare versus other issues | |

## Chapter 5. The Deal: Wilbur Mills and the Law of July 30, 1965

The bill that Congress passed in 1965 was bigger than anything its supporters had proposed. That surprise came from one man's decision to combine three competing ideas into one law.

### Three ideas on the table

When the new Congress met in January 1965, three main proposals were in play:

| Proposal | Sponsors | What it did |
|---|---|---|
| King-Anderson (the administration's plan) | President Johnson, Democrats | Hospital insurance for retirees, paid by a payroll tax[75] |
| "Bettercare" | Representative John Byrnes of Wisconsin, the top Republican on Ways and Means | A voluntary, federally run insurance plan for doctor bills, paid partly by premiums and partly by the government[76] |
| "Eldercare" | The AMA; introduced by Representatives Herlong and Curtis | Help for states to buy private insurance for low-income older people[77] |

### Mills puts them together

In early 1965, Mills "took charge of re-drafting the bill into its final form."[78] Instead of choosing one plan, he used pieces of all three:

1. **Hospital insurance**, financed by Social Security payroll taxes, became **Part A** of Medicare. The basic program covered 90 days of hospital care.[79]
2. Byrnes's voluntary plan for doctor bills became **Part B**, with a premium of $3 a month from each enrollee and a matching amount from the government (nominal 1966 dollars).[80]
3. An expanded version of the Kerr-Mills help-for-the-needy program became **Medicaid**.[81]

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[75] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[76] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[77] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[78] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[79] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[80] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[81] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 5, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap5.html, accessed November 12, 2026.

The Social Security history sums up the result as "social security (Medicare) supplemented by an expanded Kerr-Mills program."[82]

You might ask, "Why would Mills, who had opposed Medicare for years, build an even bigger program?" The record gives two clear clues. First, the 1964 election changed the math. Johnson was "returned to office by the largest plurality in history," and House Democrats gained 38 seats for a 295 to 140 majority. After the election, Mills said: "I can support a pay-roll tax for financing health benefits just as I have supported a payroll tax for cash benefits."[83] Second, the AMA's own Eldercare plan advertised broader benefits than the administration's bill, and the Social Security history says that pushed the committee to expand Medicare rather than shrink it.[84] Adding Byrnes's voluntary plan gave Republicans' ideas a place in the bill, and expanding Kerr-Mills as Medicaid answered the argument that help should go to the needy.[85] Beyond what the record shows, Mills's private motives are a matter of interpretation.

## What the 1965 law covered

The original Medicare was smaller and simpler than today's program. According to the Social Security history:[86]

- **Part A (hospital insurance)**, financed by Social Security payroll taxes, covered up to 90 days of hospital care, 100 days of care in a nursing home after a hospital stay, 100 home nursing visits per "spell" of illness, and hospital outpatient services, all with deductibles and coinsurance.
- **Part B (supplementary medical insurance)** was voluntary. It paid 80 percent of doctors' fees above a $50 yearly deductible, plus some home nursing, diagnostic tests, therapies, ambulance service and surgical dressings. Each enrollee paid a $3 monthly premium, matched by general revenue (nominal 1966 dollars).
- **Medicaid** expanded the Kerr-Mills idea of help for "medical indigency" beyond people over 65.

There was no prescription drug coverage outside the hospital, no coverage for long-term custodial care, and no limit on what an enrollee could pay out of pocket. Some of those gaps were filled later (Chapters 10 through 12). Others are still there.

In the law itself, the two programs sit in separate titles, or sections, of the Social Security Act. The 1965 law added Title XVIII, "Health Insurance for the Aged," with Part A for hospital

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[82] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 5, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap5.html, accessed November 12, 2026.

[83] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[84] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[85] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[86] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

insurance benefits and Part B for supplementary medical insurance benefits.[87] Medicaid went into a separate title. In the words of Medicaid.gov, "Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965 alongside Medicare."[88] The split is one reason the two programs still have different rules, different ways to qualify and different sources of money.

The bill moved quickly:

**Table 5.1. The path of the 1965 law**

| Date | Step | Vote |
|---|---|---|
| March 23, 1965 | Ways and Means approves the "Mills bill" (H.R. 6675) | 17 to 8 |
| April 8, 1965 | House passes H.R. 6675 | 313 to 115 |
| June 24, 1965 | Senate Finance Committee reports the bill | 12 to 5 |
| July 9, 1965 | Senate passes the bill | 68 to 21 |
| July 27 and 28, 1965 | House and Senate approve the final version after negotiators resolve 513 differences | See Table 5.2 |
| July 30, 1965 | President Johnson signs Public Law 89-97 in Independence, Missouri | |

Source: Social Security Administration history of Medicare (Corning, 1969), Chapters 4 and 5; signing date from President Johnson's remarks.[89]

Two sources disagree on one date. The Social Security history of Medicare says the Senate Finance Committee reported the bill on June 24, 1965, by a vote of 12 to 5. A separate Social Security history page on the vote tallies says the committee reported it June 30.[90] I use June 24 in Table 5.1 because the first source gives the vote count, and I note the difference here.

**Table 5.2. Final passage of Medicare, July 1965, by party**

| Chamber | Party | Yes | No | Not voting |
|---|---|---|---|---|
| Senate | Democrats | 57 | 7 | 4 |

[87] National Archives, "Medicare and Medicaid Act (1965)," Milestone Documents, published October 5, 2021, last reviewed February 8, 2022, https://www.archives.gov/milestone-documents/medicare-and-medicaid-act, accessed November 12, 2026.

[88] Centers for Medicare and Medicaid Services, "Program History and Prior Initiatives," Medicaid.gov, https://www.medicaid.gov/about-us/program-history, accessed November 12, 2026.

[89] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026; Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 5, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap5.html, accessed November 12, 2026; Lyndon B. Johnson, "Remarks with President Truman at the Signing in Independence of the Medicare Bill," July 30, 1965, reprinted on the Social Security History website, https://www.ssa.gov/history/lbjstmts.html, accessed November 12, 2026.

[90] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026; Social Security Administration, "Vote Tallies for Passage of Medicare in 1965," Social Security History website, https://www.ssa.gov/history/tally65.html, accessed November 12, 2026.

| Chamber | Party | Yes | No | Not voting |
|---|---|---|---|---|
| Senate | Republicans | 13 | 17 | 2 |
| House | Democrats | 237 | 48 | 8 |
| House | Republicans | 70 | 68 | 2 |

Source: Social Security Administration, "Vote Tallies for Passage of Medicare in 1965."[91] The page gives party totals only. Adding them gives 70 to 24 in the Senate and 307 to 116 in the House (my arithmetic).

The table shows something that is often forgotten. Medicare was a Democratic priority, but it was not a party-line law. Nearly half of House Republicans voted for final passage, and a large group of Democrats, many from the South, voted against it.[92]

## The signing in Independence

Johnson chose to sign the bill at the Harry S. Truman Library in Independence, Missouri, with former President Truman at his side, to honor the man who had first proposed national health insurance twenty years earlier.[93]

"No longer will older Americans be denied the healing miracle of modern medicine," Johnson said. He described what the new insurance would do: it "will help pay for care in hospitals, in skilled nursing homes, or in the home."[94]

Truman spoke briefly at the signing. "I am glad to have lived this long and to witness today the signing of the Medicare bill," he said.[95] A popular story says Truman was given the first Medicare card. The record of the signing remarks I read does not mention it, so I mark that story [Not verified].

## Medicare and the end of segregated hospitals

One of the most important effects of the 1965 law is often left out of the story. The Civil Rights Act of 1964 barred discrimination in programs receiving federal money. When Medicare began paying hospitals in July 1966, a hospital had to comply to get paid. Title VI of the 1964 law

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[91] Social Security Administration, "Vote Tallies for Passage of Medicare in 1965," Social Security History website, https://www.ssa.gov/history/tally65.html, accessed November 12, 2026.

[92] Social Security Administration, "Vote Tallies for Passage of Medicare in 1965," Social Security History website, https://www.ssa.gov/history/tally65.html, accessed November 12, 2026.

[93] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 5, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap5.html, accessed November 12, 2026; Lyndon B. Johnson, "Remarks with President Truman at the Signing in Independence of the Medicare Bill," July 30, 1965, reprinted on the Social Security History website, https://www.ssa.gov/history/lbjstmts.html, accessed November 12, 2026.

[94] Lyndon B. Johnson, "Remarks with President Truman at the Signing in Independence of the Medicare Bill," July 30, 1965, reprinted on the Social Security History website, https://www.ssa.gov/history/lbjstmts.html, accessed November 12, 2026.

[95] Lyndon B. Johnson, "Remarks with President Truman at the Signing in Independence of the Medicare Bill," July 30, 1965, reprinted on the Social Security History website, https://www.ssa.gov/history/lbjstmts.html, accessed November 12, 2026.

"prohibited the provision of federal funds" to organizations that discriminated, and "The first significant test of Title VI enforcement came with the implementation of the Medicare program in 1966." According to a Commonwealth Fund report, "More than 1,000 hospitals quietly and uneventfully integrated" their staffs and wards in less than four months.[96] Medicare money, in other words, did in months what years of court cases had not.

## Launch day: July 1, 1966

Medicare began on July 1, 1966. More than 19 million people were enrolled by that date.[97] Medicaid was optional for states, and states joined over time. I was not able to read an official source giving each state's start date for this book, so I do not list them [Not verified].

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| The House passed the Mills bill 313 to 115 on April 8, 1965, and the Senate passed its version 68 to 21 on July 9, 1965 (SSA history) | Why Mills built a larger bill than anyone proposed; historians offer different explanations | |
| Johnson signed Public Law 89-97 in Independence, Missouri, with Truman present (SSA history; Johnson's remarks) | | |
| More than 19 million people enrolled in Medicare by July 1, 1966 (CMS) | | |

[96] The Commonwealth Fund, "Eliminating Disparities in Treatment and the Struggle to End Segregation," fund report, August 2005, https://commonwealthfund.org/publications/fund-reports/2005/aug/eliminating-disparities-treatment-and-struggle-end-segregation, accessed November 12, 2026.

[97] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

# Part Three: How Each Program Works Today

## Chapter 6. Medicare Parts A and B: Who Qualifies, What It Covers, What It Costs

*Information in this chapter stops at November 12, 2026. Dollar figures are for 2026, from CMS's fact sheet released November 14, 2025, unless stated.*

Most people think of Medicare as one thing. It is really a set of parts that each work differently. This chapter covers the two original parts: Part A, hospital insurance, and Part B, medical insurance. Together they are often called "Original Medicare" or "traditional Medicare."

### Who qualifies

You can get Medicare if you are a U.S. citizen or a lawfully present resident who meets residency rules, and you are in one of these groups:[98]

- **Age 65 or older.**
- **Under 65 with a disability**, after you have received Social Security disability benefits for 24 months.
- **Any age with end-stage renal disease (ESRD)**, meaning permanent kidney failure that needs dialysis or a transplant.
- **Any age with amyotrophic lateral sclerosis (ALS)**, also called Lou Gehrig's disease, as soon as disability benefits begin.

In 2025, Medicare covered 69.3 million people: 62.2 million because of age and 7.1 million because of disability.[99]

### Part A: Hospital insurance

Part A helps pay for inpatient hospital stays, care in a skilled nursing facility after a hospital stay, hospice care, and some home health care.

**Is Part A free?** For most people, yes. If you or your spouse worked and paid Medicare taxes for at least 40 quarters (about 10 years), you pay no Part A premium. People with fewer quarters can buy Part A: in 2026 the premium is $311 a month for people with 30 to 39 quarters, and $565 a month for people with fewer than 30.[100]

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[98] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, pp. 15-17; Medicare.gov, "Parts of Medicare," https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare, accessed November 12, 2026.

[99] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026, Table II.B1.

[100] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

Part A is not free of costs when you use it, though:

**Table 6.1. What you pay under Part A, 2026 (nominal dollars, as of November 12, 2026)**

| Item | Amount |
|---|---|
| Inpatient hospital deductible (per benefit period) | $1,736 |
| Hospital days 61 to 90 | $434 per day |
| Lifetime reserve days (after day 90; 60 days per lifetime) | $868 per day |
| Skilled nursing facility days 1 to 20 | $0 |
| Skilled nursing facility days 21 to 100 | $217 per day |

Source: CMS, "2026 Medicare Parts A and B Premiums and Deductibles."[101]

A "benefit period" starts when you go into a hospital and ends when you have been out of the hospital or skilled nursing care for 60 days in a row. You can pay the deductible more than once a year if you have more than one benefit period.[102]

You might ask, "Does Medicare pay for a nursing home?" Only in a narrow way. Part A pays for skilled nursing care, like rehabilitation after a hospital stay, for up to 100 days per benefit period. It does not pay for long-term custodial care, meaning help with bathing, dressing and eating over months or years. That is the single biggest gap in Medicare, and it is why Medicaid ends up paying for so much nursing home care. Chapter 9 explains.[103]

### An example: a hospital stay and rehab

When a bill arrives, three questions sort out most of it. Which service was it: a hospital stay, a doctor visit, a drug? Which part of Medicare, or which plan, covers that service? And what does that part expect you to pay: a deductible, a copayment or a share of the cost? The examples in this chapter and the next walk through those three questions with real 2026 amounts.

Numbers in a table are easier to understand with a person attached. Here is a made-up example using the 2026 amounts above. It is my own arithmetic, for illustration only.

Margaret, 74, is in traditional Medicare with no supplemental coverage. She falls, breaks a hip, and spends 6 days in the hospital. She then spends 30 days in a skilled nursing facility for rehabilitation.

- Hospital: she pays the Part A deductible of $1,736. Days 1 through 60 have no daily charge, so her 6 days cost nothing more.[104]

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[101] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[102] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

[103] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

[104] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

- Skilled nursing: days 1 through 20 cost her nothing. Days 21 through 30 cost $217 each, so 10 days times $217 is $2,170.[105]
- Doctors' bills during the hospital stay and rehab fall under Part B, not Part A, so she also owes 20 percent of the Medicare-approved amount for those after her Part B deductible.[106]

So Margaret owes $3,906 for the hospital and nursing facility alone, before her doctors' bills. If she had stayed 100 days in rehab, days 21 through 100 would cost 80 times $217, or $17,360. On day 101, Part A would stop paying for that stay entirely. This is why so many people with traditional Medicare buy a Medigap policy or have retiree coverage, and why long stays in nursing homes usually end up on Medicaid (Chapter 9).

## Part B: Medical insurance

Part B helps pay for doctor visits, outpatient care, lab tests, preventive services like screenings and flu shots, ambulance rides, durable medical equipment such as wheelchairs, and some drugs given in a doctor's office.

Part B is voluntary, and almost everyone who takes it pays a monthly premium.

**Table 6.2. What you pay under Part B, 2026 (nominal dollars, as of November 12, 2026)**

| Item | Amount |
|---|---|
| Standard monthly premium | $202.90 (up from $185.00 in 2025) |
| Annual deductible | $283 (up from $257 in 2025) |
| Your share after the deductible | Usually 20% of the Medicare-approved amount |
| Monthly premium for higher incomes (IRMAA) | $284.10 to $689.90, depending on income |

Source: CMS, "2026 Medicare Parts A and B Premiums and Deductibles."[107]

CMS said the 2026 premium increase was "mainly due to projected price changes and assumed utilization increases that are consistent with historical experience."[108] The Part B premium is set to cover about one quarter of Part B costs for an average enrollee; general tax revenue covers

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[105] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[106] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, p. 11.

[107] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026; Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, p. 11.

[108] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

most of the rest.[109] In 2025, Part B premiums brought in $150.7 billion while Part B spending was $584.3 billion.[110]

**Income-related premiums.** Since 2007, people with higher incomes pay more for Part B.[111] In 2026, an individual with modified adjusted gross income above $109,000 (or a couple above $218,000) pays more than the standard premium, up to $689.90 a month for an individual with income of $500,000 or more.[112]

### An example: a year of doctor visits

Take James, 68, in traditional Medicare in 2026 with no other coverage. Over the year he sees his doctor several times, has lab work and an imaging scan, and the Medicare-approved amounts add up to $1,500. Here is my arithmetic, for illustration only:

- Premiums: $202.90 a month for 12 months is $2,434.80.[113]
- Deductible: the first $283 of approved costs.[114]
- Coinsurance: 20 percent of the remaining $1,217, which is $243.40.[115]

James pays $2,961.20 for the year, most of it in premiums. Many preventive services, such as some screenings, have no cost sharing, so his real total could be lower. The point of the example is that Part B is valuable but not free, and premiums are the biggest piece for a healthy person.

## How Medicare pays doctors and hospitals

You never see most of Medicare's payment rules, but they shape your care. The basic methods have been stable for years. The Congressional Research Service's Medicare Primer describes

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[109] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[110] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026, Table II.B1.

[111] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[112] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[113] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[114] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[115] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, p. 11.

them; the dollar figures in that report are from 2020 and out of date, so I use it only for how the systems work.[116]

- **Hospitals (inpatient).** Since 1983, Medicare pays a set amount per hospital stay based on the patient's diagnosis group, adjusted for local wages, with add-ons for teaching hospitals, hospitals serving many low-income patients, unusually costly cases and some new technologies. Payments can be reduced under quality programs, such as one that penalizes hospitals with high readmission rates.[117]
- **Hospital outpatient care.** Medicare pays per service, with services grouped into payment classes and related items bundled together.[118]
- **Doctors.** The physician fee schedule lists more than 7,000 services. Each has relative values for the doctor's work, practice expenses and malpractice costs, adjusted for location and converted to dollars by a national conversion factor. Doctors who "accept assignment" take Medicare's amount as payment in full, billing patients only their coinsurance and deductible. Others may bill somewhat more, within limits. Doctors who opt out must sign private contracts with their Medicare patients.[119]
- **Skilled nursing facilities.** Medicare pays a daily rate adjusted for the patient's condition. To qualify for Medicare-covered skilled nursing care, a patient generally needs a hospital stay of at least three days in a row first.[120]
- **Hospice.** For people with a terminal illness and a life expectancy of six months or less, Medicare pays daily rates for hospice care. Enrollees can still get treatment for unrelated conditions and can leave hospice at any time.[121]
- **Kidney dialysis.** Since 2011, Medicare has paid dialysis facilities a single bundled payment that covers the treatment and related drugs and tests.[122]

You might ask, "Why does any of this matter to me?" Because payment rules affect behavior. When Medicare switched to paying hospitals a set amount per stay in 1983, hospitals had a

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[116] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[117] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[118] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[119] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[120] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[121] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[122] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

reason to shorten stays. When Medicare Advantage plans are paid more for sicker enrollees, they have a reason to record every diagnosis (Chapter 16). Understanding how money moves helps explain many of the debates in the rest of this book.

## The gaps in Original Medicare

Original Medicare leaves people exposed in several ways:

1. **No yearly cap on what you pay.** Part B's 20 percent share has no upper limit. A long cancer treatment can run up large bills.
2. **No long-term custodial care.**
3. **No routine dental, vision or hearing care**, with some exceptions.[123]
4. **No outpatient drugs**, unless you add a Part D plan (Chapter 7).

People fill these gaps in different ways: a retiree plan from a former employer, Medicaid for people with low incomes (Chapter 9), a Medicare Advantage plan (Chapter 7), or a Medigap policy.

## Medigap

Medigap is private "Medicare supplement" insurance that pays some or all of the costs Original Medicare leaves, such as the 20 percent coinsurance and the hospital deductible. Since 1980, Medigap policies have been under federal oversight, and later laws standardized them into lettered plans.[124]

Timing matters with Medigap. Federal law gives you a six-month window, starting when you are 65 or older and enrolled in Part B, during which a Medigap company cannot turn you down or charge more because of your health. Outside that window, in most states, companies can.[125]

### Who has extra coverage, and who has none

Most people in traditional Medicare have something besides Medicare to help with its gaps. KFF's analysis of 2023 federal survey data found that 87 percent of traditional Medicare enrollees had some additional coverage: 43 percent had Medigap, 29 percent had coverage from a former employer or union, and 14 percent had Medicaid. But "3.5 million Medicare beneficiaries in traditional Medicare (13%) had no additional coverage."[126] KFF notes these

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[123] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, p. 12.

[124] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026; Medicare.gov, "Parts of Medicare," https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare, accessed November 12, 2026.

[125] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

[126] Nancy Ochieng, Juliette Cubanski and Tricia Neuman, "A Snapshot of Sources of Coverage Among Medicare Beneficiaries," KFF, December 19, 2025, https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/, accessed November 12, 2026.

people tend to have modest incomes, too high for Medicaid, and "Traditional Medicare does not include a cap on out-of-pocket costs."[127]

KFF puts the average Medigap premium at about $2,600 a year.[128] Plan G is "the most popular policy," and Plans C and F, which cover the Part B deductible, can no longer be sold to people who became eligible on or after January 1, 2020.[129]

The Medigap timing rule matters most when people switch from Medicare Advantage back to traditional Medicare. Under federal rules, a person who tries Medicare Advantage for the first time and leaves within a year can buy Medigap without a health check. Outside that and a few other protected situations, Medigap insurers in most states may turn down people with pre-existing conditions. KFF estimates that 74 percent of Medicare Advantage enrollees have a condition that could lead to a denial. A handful of states, including Connecticut, Massachusetts, Maine and New York, require insurers to accept applicants year-round or once a year.[130] Rules differ by state, so this is a good question for a SHIP counselor.

## Signing up, and the penalties for waiting

If you are already getting Social Security when you turn 65, you are enrolled in Parts A and B automatically. Otherwise, you sign up through the Social Security Administration during a seven-month window around your 65th birthday.[131]

If you do not sign up for Part B when first eligible, and you do not have coverage from a current job, you may pay a late enrollment penalty for as long as you have Part B. The same is true for Part D.[132] This is one of the most common and costly mistakes people make, and it is a good reason to talk with a SHIP counselor before you turn 65.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| 2026 Part B premium is | Whether Part B premiums are "affordable" | Future premiums, |

[127] Nancy Ochieng, Juliette Cubanski and Tricia Neuman, "A Snapshot of Sources of Coverage Among Medicare Beneficiaries," KFF, December 19, 2025, https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/, accessed November 12, 2026.

[128] Nancy Ochieng, Juliette Cubanski and Tricia Neuman, "A Snapshot of Sources of Coverage Among Medicare Beneficiaries," KFF, December 19, 2025, https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/, accessed November 12, 2026.

[129] Meredith Freed, Yasmina Issaka, Nancy Ochieng and Juliette Cubanski, "Medigap Guaranteed Issue Requirements: An Overview of Federal and State Rules," KFF, October 13, 2026, https://www.kff.org/medicare/medigap-guaranteed-issue-requirements-an-overview-of-federal-and-state-rules/, accessed November 12, 2026.

[130] Meredith Freed, Yasmina Issaka, Nancy Ochieng and Juliette Cubanski, "Medigap Guaranteed Issue Requirements: An Overview of Federal and State Rules," KFF, October 13, 2026, https://www.kff.org/medicare/medigap-guaranteed-issue-requirements-an-overview-of-federal-and-state-rules/, accessed November 12, 2026.

[131] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, p. 17.

[132] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

| Confirmed facts | Interpretations | Unknowns |
| --- | --- | --- |
| $202.90 and the deductible $283 (CMS) | depends on income; advocates for seniors and budget groups weigh this differently | which depend on spending growth |
| Part A deductible is $1,736 per benefit period (CMS) | | |
| Original Medicare has no out-of-pocket cap for Parts A and B | | |

# Chapter 7. Medicare Advantage and Part D: Private Plans and Prescription Drugs

*Information in this chapter stops at November 12, 2026. Dollar figures are for 2026 unless stated.*

Parts A and B were the original Medicare. Parts C and D came later, and both are run through private insurance companies under contract with Medicare. This chapter explains what they are and how a person chooses among them. Chapter 16 covers the money fight over Medicare Advantage.

## Part C: Medicare Advantage

Medicare Advantage plans are private health plans approved by Medicare. If you join one, the plan takes the place of Parts A and B for most of your care. You still have Medicare, and you still pay your Part B premium, but the plan handles your bills.[133]

Medicare Advantage has grown fast. It enrolled 37 percent of eligible beneficiaries in 2018 and 55 percent in 2025, about 34.9 million people.[134] In 2026, the average Medicare beneficiary could choose from 39 plans offered by an average of eight companies.[135]

**How Medicare Advantage differs from traditional Medicare**

| Feature | Traditional Medicare (Parts A and B) | Medicare Advantage (Part C) |
|---|---|---|
| Who pays your doctors | Medicare, directly | The private plan |
| Doctor and hospital choice | Any provider in the country that takes Medicare | Usually a plan network; going outside may cost more or not be covered |
| Yearly limit on what you pay out of pocket | None for Parts A and B, unless you buy a Medigap policy | Yes, every plan must have one[136] |
| Prescription drugs | Separate Part D plan | Usually built in |
| Prior authorization (plan approval before some care) | Rare; a pilot program started in 2026 in some states (see Chapter 19) | Common |
| Extra benefits such as dental, vision, hearing | Not covered | Often included, paid largely from rebates |

[133] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, p. 11.

[134] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[135] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[136] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026, p. 11.

Sources: MedPAC March 2026 report; other rows as noted.[137]

You might ask, "If Medicare Advantage plans offer more benefits and lower costs, why doesn't everyone join?" The trade-offs are real. Plans limit networks and use prior authorization, and switching back to traditional Medicare later can make it hard to buy a Medigap policy in many states (Chapter 6).[138] People who travel, who want any doctor, or who have complex conditions often weigh this differently from people who are healthy and want lower costs. Your SHIP counselor can walk you through the choice for free.

### Who is in Medicare Advantage in 2026

KFF's annual count, using CMS enrollment data from March 2026, gives a detailed picture.[139]

- **Size.** "More than half (55%) of eligible Medicare beneficiaries are enrolled in Medicare Advantage in 2026," about 35.2 million of the 64.2 million people with both Parts A and B. That share was 19 percent in 2007.[140]
- **Growth is slowing.** Enrollment grew about 1.1 million, or 3 percent, from 2025 to 2026, compared with 4 percent the year before. KFF reports that CBO projects the Medicare Advantage share of all beneficiaries will reach 63 percent by 2034.[141]
- **Types of plans.** About 61 percent of enrollees are in individual plans open to anyone. About 23 percent, 8.2 million people, are in special needs plans, which serve people with both Medicare and Medicaid, people with certain chronic conditions, or people who need nursing-home-level care. Special needs plans made up 85 percent of the net growth in 2026. Another 16 percent are in employer or union group plans for retirees, the lowest share since 2010.[142]

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[137] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[138] Meredith Freed, Yasmina Issaka, Nancy Ochieng and Juliette Cubanski, "Medigap Guaranteed Issue Requirements: An Overview of Federal and State Rules," KFF, October 13, 2026, https://www.kff.org/medicare/medigap-guaranteed-issue-requirements-an-overview-of-federal-and-state-rules/, accessed November 12, 2026.

[139] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

[140] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

[141] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

[142] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

- **A few big companies.** "UnitedHealth Group and Humana account for nearly half of all Medicare Advantage enrollees nationwide in 2026": UnitedHealth about 26 percent and Humana about 20 percent. CVS Health has about 12 percent, Kaiser about 6 percent and Elevance about 5 percent. In 28 percent of counties, UnitedHealth and Humana together hold at least three-quarters of enrollment.[143]
- **Choice.** The average beneficiary can choose plans from 8 parent companies, and 29 percent can choose from 10 or more.[144]

Employer plans deserve a note, because they connect to the claim in Chapter 18 that seniors are being "pushed" into Medicare Advantage. In seven states, employer and union group plans make up a quarter or more of Medicare Advantage enrollment, including all of it in Alaska and 60 percent in Vermont.[145] When a former employer moves its retirees into a group Medicare Advantage plan, the retirees may not have made that choice themselves.

## Part D: Prescription drug coverage

Part D began in 2006, created by the Medicare Modernization Act of 2003. It is delivered entirely through private plans, either stand-alone drug plans that go with traditional Medicare or drug coverage built into a Medicare Advantage plan.[146]

For its first two decades, Part D had a well-known gap in coverage, nicknamed the "doughnut hole," and no cap on what a person could pay in a year. The Inflation Reduction Act of 2022 changed that. Starting in 2025, it capped what an enrollee pays out of pocket for covered drugs at $2,000 a year. The cap rises with drug costs each year, and for 2026 it is $2,100.[147] The highest deductible a Part D plan can charge in 2026 is $615.[148]

Here is what the cap means in practice. Suppose Rosa, 70, takes an expensive cancer drug in 2026 whose full cost runs thousands of dollars a month. Before 2025, she could have owed a

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[143] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

[144] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

[145] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

[146] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[147] Centers for Medicare and Medicaid Services, "Final CY 2026 Part D Redesign Program Instructions," fact sheet, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions, accessed November 12, 2026.

[148] Centers for Medicare and Medicaid Services, "Final CY 2026 Part D Redesign Program Instructions," fact sheet, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions, accessed November 12, 2026.

share of the cost all year with no ceiling. In 2026, once her own out-of-pocket spending on covered drugs reaches $2,100, she owes nothing more for covered drugs for the rest of the year.[149] She still pays her monthly plan premium. For someone who takes only a few cheap generic drugs, the cap makes no difference; for someone with very high drug costs, it can save thousands of dollars a year. (This example is mine, for illustration.)

The base beneficiary premium, a figure used to calculate Part D premiums, is $38.99 a month in 2026.[150] Actual premiums vary a lot by plan.

People with higher incomes pay extra for both Part B and Part D. This is called the Income-Related Monthly Adjustment Amount (IRMAA). In 2026 it starts for individuals with modified adjusted gross income above $109,000 and couples above $218,000. For Part D, the extra amount ranges from $14.50 to $91.00 a month.[151]

### Part D in numbers

KFF's snapshot of Part D gives the shape of the program.[152]

- In 2025, 54.8 million of 68.8 million people with Medicare had Part D coverage, 58 percent through Medicare Advantage drug plans and 42 percent through stand-alone plans.[153]
- For 2026, there are 360 stand-alone drug plans from 17 companies nationwide, down 22 percent from 2025. Each state has 8 to 12 stand-alone plans.[154]
- The standard 2026 benefit has a $615 deductible, then 25 percent coinsurance until the enrollee has spent $2,100 out of pocket, then nothing more for covered drugs.[155]

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[149] Centers for Medicare and Medicaid Services, "Final CY 2026 Part D Redesign Program Instructions," fact sheet, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions, accessed November 12, 2026.

[150] Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

[151] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[152] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026.

[153] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026.

[154] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026.

[155] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026; Centers for Medicare and Medicaid Services, "Final CY 2026 Part D Redesign Program Instructions," fact sheet, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions, accessed November 12, 2026.

- People with low incomes and limited savings can get "Extra Help," also called the Low-Income Subsidy, which lowers premiums and copays. People with both Medicare and Medicaid qualify automatically. About 13.9 million enrollees got this help as of May 2025.[156]
- The Inflation Reduction Act limits insulin costs to no more than $35 a month in all Part D plans, and makes recommended adult vaccines covered by Part D free.[157]
- If you go without Part D or other "creditable" drug coverage after you first become eligible, you may pay a late enrollment penalty of 1 percent of the national average premium for each month you waited, for as long as you have Part D.[158]
- Medicare's actuaries estimate net Part D spending of about $141 billion in 2026. The federal government pays about 75 percent of Part D's cost, beneficiary premiums about 13 percent and states about 12 percent.[159]

## Drug price negotiation

The Inflation Reduction Act also allowed Medicare, for the first time, to negotiate prices directly with drug makers for some high-cost drugs that have been on the market for years without generic or biosimilar competition.

- **First round:** negotiated prices for 10 Part D drugs took effect January 1, 2026.[160]
- **Second round:** CMS announced in November 2025 negotiated prices for 15 more drugs, including the diabetes and weight-loss drugs Ozempic and Wegovy, effective January 1, 2027. CMS said the prices produce net savings of 44 percent, or $12 billion, compared with the prior year's spending on those drugs. About 5.3 million Part D enrollees used these drugs in 2024.[161]

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[156] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026.

[157] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026.

[158] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026.

[159] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 7, 2025, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/, accessed November 12, 2026.

[160] Centers for Medicare and Medicaid Services, "CMS Delivers Savings for Seniors on 15 Major Drugs for Cancer and Chronic Disease," press release, November 25, 2025, https://www.cms.gov/newsroom/press-releases/cms-delivers-savings-seniors-15-major-drugs-cancer-chronic-disease, accessed November 12, 2026.

[161] Centers for Medicare and Medicaid Services, "CMS Delivers Savings for Seniors on 15 Major Drugs for Cancer and Chronic Disease," press release, November 25, 2025, https://www.cms.gov/newsroom/press-releases/cms-delivers-savings-seniors-15-major-drugs-cancer-chronic-disease, accessed November 12, 2026; Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF (nonpartisan health research group), March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/, accessed November 12, 2026.

- **Third round:** in January 2026, CMS selected 15 more drugs, including Part B drugs given in doctors' offices for the first time. Their prices take effect January 1, 2028. From then on, up to 20 drugs can be added each year.[162]

The 2025 budget law changed the program by widening an exclusion for "orphan" drugs, which treat rare diseases. CBO estimated that change would cost $8.8 billion over a decade.[163] Chapter 17 tests the claim that negotiation will stop new medicines from being made.

## Choosing a plan

Every fall, during open enrollment from October 15 to December 7, people with Medicare can switch between traditional Medicare and Medicare Advantage, or change Part D plans, for the next year.[164] Plan costs, networks and covered drugs change every year, so it pays to check, even if you liked your plan last year. The Medicare Plan Finder on Medicare.gov compares plans by your own list of drugs.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| Part D out-of-pocket cap is $2,100 in 2026 (CMS) | Whether Medicare Advantage or traditional Medicare is "better" depends on the person; studies and advocates differ | How negotiated prices will affect future drug development (see Chapter 17) |
| 25 drugs will have negotiated prices by 2027 (CMS) | | |
| 55% of eligible beneficiaries were in Medicare Advantage in 2025 (MedPAC) | | |

[162] Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF (nonpartisan health research group), March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/, accessed November 12, 2026.

[163] Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF (nonpartisan health research group), March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/, accessed November 12, 2026.

[164] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

# Chapter 8. Medicaid and CHIP: One Program, Fifty-One Versions

*Information in this chapter stops at November 12, 2026.*

If you move from one state to another, your Medicare stays the same. Your Medicaid does not. Medicaid is a partnership: the federal government sets the basic rules and pays most of the bill, and each state designs and runs its own program within those rules. So there are really 51 Medicaid programs (the 50 states plus the District of Columbia), along with programs in the U.S. territories.

## Who Medicaid covers

In July 2026, Medicaid covered 65,742,057 people and CHIP covered 7,204,453, for a total of 72,946,510. Children made up 47.8 percent of the total.[165]

Medicaid was first built around categories of people, not just income. Federal law requires every state to cover certain groups, called **mandatory groups**, and lets states choose to cover others, called **optional groups**.[166]

| Group | Mandatory or optional | Notes |
|---|---|---|
| Low-income children | Mandatory up to set income levels | Many states go higher, often through CHIP |
| Pregnant women with low incomes | Mandatory up to set income levels | Medicaid pays for a large share of U.S. births (41 percent in 2023)[167] |
| Older and disabled people getting Supplemental Security Income (SSI) | Mandatory in most states | Since 1972, Medicaid for these groups is linked to SSI[168] |
| Low-income parents | Mandatory at very low income levels | Levels vary widely by state |
| Adults under 65 up to 138% of the poverty level | Optional (the "expansion group") | Created by the Affordable Care Act; see below |
| People who need nursing home care | Mandatory and optional pathways | See Chapter 9 |

[165] Centers for Medicare and Medicaid Services, "July 2026 Medicaid and CHIP Enrollment Data Highlights," updated October 30, 2026, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights, accessed November 12, 2026.

[166] Congressional Research Service, "Medicaid: An Overview," Report R43357, updated April 30, 2025, https://www.everycrsreport.com/reports/R43357.html, accessed November 12, 2026.

[167] Usha Ranji and others, "5 Key Facts About Medicaid and Pregnancy," KFF, May 29, 2025, https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-pregnancy/, accessed November 12, 2026.

[168] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

### How far Medicaid reaches

KFF estimates that Medicaid covers about 4 in 10 children in the country, about 8 in 10 children in poverty, about 1 in 6 adults under 65, and 41 percent of births (2023).[169] It also helps about 13 million people who have Medicare, nearly 1 in 5, by paying their Medicare premiums and covering services Medicare does not, such as most long-term care.[170]

### Income limits differ by state

Federal law sets minimum income limits, and states can go higher. For children and pregnant women, the federal floor is 133 percent of the poverty level, which works out to 138 percent with a standard 5-point income disregard, or $36,777 a year for a family of three in 2025. As of January 2025, the median state covered children up to 255 percent of the poverty level and pregnant women up to 213 percent.[171]

For people whose eligibility is based on ordinary income rules, which includes children, pregnant women, parents and expansion adults, "No asset test applies." States may still count savings and property for older people and people with disabilities.[172]

Immigration status matters too. Full Medicaid requires citizenship or a "qualified" immigration status, and most qualified immigrants face a five-year waiting period. Others can get only limited emergency coverage.[173] The 2025 budget law narrowed the qualified groups starting October 1, 2026 (Chapter 12).[174]

### How Medicaid got here

All states had joined Medicaid by the 1980s. Arizona, the last, is often named as joining in 1982, but I did not confirm the year in the sources I read [Not verified]. Medicaid was first tied closely to cash welfare. From 1984 to 1990, Congress made pregnant women and children eligible based on income compared with the poverty level instead of welfare rules, and the 1996 welfare reform law cut the remaining link between cash assistance and Medicaid for families.[175]

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[169] Robin Rudowitz and others, "Medicaid 101," KFF Health Policy 101, October 8, 2025, https://www.kff.org/medicaid/health-policy-101-medicaid/, accessed November 12, 2026.

[170] Robin Rudowitz and others, "Medicaid 101," KFF Health Policy 101, October 8, 2025, https://www.kff.org/medicaid/health-policy-101-medicaid/, accessed November 12, 2026.

[171] Robin Rudowitz and others, "Medicaid 101," KFF Health Policy 101, October 8, 2025, https://www.kff.org/medicaid/health-policy-101-medicaid/, accessed November 12, 2026.

[172] Medicaid and CHIP Payment and Access Commission, "Eligibility," Medicaid 101, https://www.macpac.gov/medicaid-101/eligibility/, accessed November 12, 2026.

[173] Medicaid and CHIP Payment and Access Commission, "Eligibility," Medicaid 101, https://www.macpac.gov/medicaid-101/eligibility/, accessed November 12, 2026.

[174] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[175] Medicaid and CHIP Payment and Access Commission, "Eligibility," Medicaid 101, https://www.macpac.gov/medicaid-101/eligibility/, accessed November 12, 2026; Robin Rudowitz and others, "Medicaid 101," KFF Health Policy 101, October 8, 2025, https://www.kff.org/medicaid/health-policy-101-medicaid/, accessed November 12, 2026.

The Affordable Care Act (ACA) of 2010 extended Medicaid to nearly all adults with incomes up to 138 percent of the federal poverty level, which was $21,597 a year for one person in 2025.[176] The ACA meant this to apply in every state. The Supreme Court made it optional in 2012 (Chapter 12 tells that story).

As of November 2026, 41 states, counting the District of Columbia, have adopted the expansion and 10 have not, according to KFF's tracking.[177] The federal government pays 90 percent of the cost of covering the expansion group.[178]

What happens to a low-income adult in a state that did not expand? In many of those states, a working-age adult with no children cannot get Medicaid at any income, and a parent qualifies only at very low incomes. Some of these adults earn too little to get help buying private coverage on the ACA marketplace, which starts at the poverty line. This group is often called the "coverage gap." KFF reports that in January 2025 the median income limit for parents was 138 percent of the poverty level in expansion states but only 33 percent in states that had not expanded.[179] I was not able to read a current count of people in the coverage gap, so I give no number.

Nevada, where I live, adopted the expansion. Its expansion took effect January 1, 2014.[180]

## What Medicaid covers

Federal law requires every state to cover certain services, such as hospital and doctor care, lab and X-ray services, nursing facility care for adults, and home health care. States can add optional services, such as prescription drugs, dental care for adults, and physical therapy. Every state covers prescription drugs, even though drugs are technically optional.[181]

Children get an especially broad benefit called Early and Periodic Screening, Diagnostic and Treatment (EPSDT), established in 1967.[182] It requires states to cover any medically necessary service for a child, even if the state does not cover that service for adults.[183]

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[176] KFF, "Status of State Medicaid Expansion Decisions," November 6, 2026, https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/, accessed November 12, 2026.

[177] KFF, "Status of State Medicaid Expansion Decisions," November 6, 2026, https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/, accessed November 12, 2026.

[178] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[179] Robin Rudowitz and others, "Medicaid 101," KFF Health Policy 101, October 8, 2025, https://www.kff.org/medicaid/health-policy-101-medicaid/, accessed November 12, 2026.

[180] KFF, "Status of State Action on the Medicaid Expansion Decision," State Health Facts (data as of November 2026), https://www.kff.org/affordable-care-act/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/, accessed November 12, 2026.

[181] Congressional Research Service, "Medicaid: An Overview," Report R43357, updated April 30, 2025, https://www.everycrsreport.com/reports/R43357.html, accessed November 12, 2026.

[182] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

Medicaid generally charges little or nothing. Federal law limits premiums and copayments, especially for people with the lowest incomes.[184] The 2025 budget law adds new cost sharing for some expansion adults above the poverty line, starting in later years (Chapter 12).

### Rules on benefits and costs

Federal law sets some ground rules that apply in every state. Benefits generally "must be equivalent in amount, duration, and scope for all enrollees in the state," the same across the whole state, and enrollees must be able to choose among participating providers or plans.[185] Within those rules, "States can choose how to limit benefits, or whether to limit benefits at all," for example by capping hospital days for adults.[186]

Children are the big exception. Under EPSDT, states must cover any necessary service named in federal law, "including optional services not otherwise covered by the state," and "without caps or other limits that are unrelated to medical necessity."[187]

Cost sharing is tightly limited. Children in mandatory groups, people in hospice and nursing homes, and services such as emergency care, pregnancy care and family planning are exempt. Adults at or below the poverty line can be charged only nominal amounts and no premiums. And total cost sharing above nominal amounts cannot exceed 5 percent of a family's monthly or quarterly income.[188]

Medicaid also covers some things private insurance rarely does, such as long-term care, interpreters and rides to medical appointments.[189]

## Managed care

Most people on Medicaid today do not deal with the state directly for their care. Instead, the state pays a private managed care company a set amount per person per month, and the company arranges the care, much like Medicare Advantage. KFF reports that three-quarters of all Medicaid enrollees get care through comprehensive managed care organizations. MACPAC,

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[183] Medicaid.gov, "Early and Periodic Screening, Diagnostic, and Treatment," https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html, accessed November 12, 2026.

[184] Congressional Research Service, "Medicaid: An Overview," Report R43357, updated April 30, 2025, https://www.everycrsreport.com/reports/R43357.html, accessed November 12, 2026.

[185] Medicaid and CHIP Payment and Access Commission, "Benefits," Medicaid 101, https://www.macpac.gov/medicaid-101/benefits/, accessed November 12, 2026.

[186] Medicaid and CHIP Payment and Access Commission, "Benefits," Medicaid 101, https://www.macpac.gov/medicaid-101/benefits/, accessed November 12, 2026.

[187] Medicaid and CHIP Payment and Access Commission, "Benefits," Medicaid 101, https://www.macpac.gov/medicaid-101/benefits/, accessed November 12, 2026.

[188] Medicaid and CHIP Payment and Access Commission, "Benefits," Medicaid 101, https://www.macpac.gov/medicaid-101/benefits/, accessed November 12, 2026.

[189] Medicaid and CHIP Payment and Access Commission, "Benefits," Medicaid 101, https://www.macpac.gov/medicaid-101/benefits/, accessed November 12, 2026.

counting all forms of managed care, put the share at 83 percent in 2019.[190] KFF also reports that payments to those companies were 52 percent of Medicaid spending in fiscal year 2023.[191] The gap between those two shares, most people but only about half the money, exists because the costliest groups, such as people needing long-term care, are less often in managed care.[192]

### How Medicaid pays doctors

In traditional fee-for-service Medicaid, the state pays providers directly for each service, at rates the state sets. Federal law requires those rates to be "consistent with efficiency, economy, and quality of care." In practice, MACPAC reports: "On average, Medicaid FFS physician payment rates are two-thirds of the rates Medicare pays." Research MACPAC cites links low payment rates to fewer doctors taking Medicaid patients.[193] For hospitals the picture is different: once extra "supplemental" payments and provider contributions are counted, MACPAC finds Medicaid inpatient hospital payment is "comparable or higher than Medicare."[194]

## Waivers: how states experiment

Section 1115 of the Social Security Act lets the Secretary of Health and Human Services waive some Medicaid rules for state "demonstration projects." States use these waivers to try new approaches, from covering more people to adding work requirements. Section 1915 waivers, created in 1981, let states pay for home and community-based care instead of nursing homes.[195] Section 1115 projects "must also be 'budget neutral' to the Federal government," meaning they cannot cost Washington more than the state's program would have cost without the waiver. They are generally approved for five years and can be extended.[196]

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[190] Medicaid and CHIP Payment and Access Commission, "Provider Payment and Delivery Systems," Medicaid 101, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/, accessed November 12, 2026.

[191] Alice Burns, Elizabeth Hinton, Robin Rudowitz and Maiss Mohamed, "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/10-things-to-know-about-medicaid/, accessed November 12, 2026.

[192] Medicaid and CHIP Payment and Access Commission, "Provider Payment and Delivery Systems," Medicaid 101, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/, accessed November 12, 2026.

[193] Medicaid and CHIP Payment and Access Commission, "Provider Payment and Delivery Systems," Medicaid 101, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/, accessed November 12, 2026.

[194] Medicaid and CHIP Payment and Access Commission, "Provider Payment and Delivery Systems," Medicaid 101, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/, accessed November 12, 2026.

[195] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026; Medicaid.gov, "About Section 1115 Demonstrations," https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html, accessed November 12, 2026.

[196] Medicaid.gov, "About Section 1115 Demonstrations," https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html, accessed November 12, 2026.

## CHIP: the Children's Health Insurance Program

Congress created CHIP in the Balanced Budget Act of 1997.[197] CMS says it was designed "to give health insurance and preventive care to nearly 11 million, or 1 in 7, uninsured American children."[198] In Medicaid.gov's words, "Children eligible for CHIP are in families with incomes too high to qualify for Medicaid."[199] It covers children in families with incomes too high for Medicaid but too low to easily afford private coverage. States can run CHIP as part of Medicaid, as a separate program, or a mix. The federal government pays a higher share of CHIP costs than of regular Medicaid: the law reduces the state's share by 30 percent.[200]

## How much states spend per person

Because states set their own benefits, payment rates and eligibility, spending per enrollee varies a great deal. In 2023, full-benefit Medicaid spending per enrollee ranged from $4,780 in Alabama to $12,295 in the District of Columbia (nominal dollars).[201] The federal matching rate varies too. For federal fiscal year 2027, which began October 1, 2026, the federal share is 50 percent in ten states and highest in Mississippi, at 77 percent.[202]

| | Medicare | Medicaid |
|---|---|---|
| Who runs it | Federal government | Each state, under federal rules |
| Who it serves | Mainly people 65+ and people with disabilities, regardless of income | Mainly people with low incomes |
| How it is paid for | Payroll taxes, premiums, federal general revenue | Federal and state general funds |
| Premiums | Most people pay a Part B premium | Usually none or very small |
| Long-term nursing home care | Not covered beyond short skilled stays | Covered for those who qualify |
| Same in every state? | Yes | No |

[197] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[198] Centers for Medicare and Medicaid Services, "History," page last modified February 12, 2026, https://www.cms.gov/about-cms/who-we-are/history, accessed November 12, 2026.

[199] Medicaid.gov, "Children's Health Insurance Program (CHIP)," https://www.medicaid.gov/chip/index.html, accessed November 12, 2026.

[200] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[201] Elizabeth Williams, Alice Burns, Anna Mudumala and Robin Rudowitz, "Medicaid Financing: The Basics," KFF, March 4, 2026, https://www.kff.org/medicaid/medicaid-financing-the-basics/, accessed November 12, 2026.

[202] Elizabeth Williams, Alice Burns, Anna Mudumala and Robin Rudowitz, "Medicaid Financing: The Basics," KFF, March 4, 2026, https://www.kff.org/medicaid/medicaid-financing-the-basics/, accessed November 12, 2026.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| 72.9 million people were in Medicaid or CHIP in July 2026 (CMS) | Whether expansion is good policy is debated (see Chapters 12 and 18) | How enrollment will change once the 2025 law's work requirements start in 2027 |
| 41 states including DC have expanded Medicaid; 10 have not (KFF, Nov. 2026) | | |
| The federal government pays 90% of expansion costs (MACPAC) | | |

# Chapter 9. Long-Term Care and People on Both Programs

*Information in this chapter stops at November 12, 2026.*

Ask people who pays for nursing homes in America, and many will say Medicare. The real answer, for long stays, is mostly Medicaid. This chapter explains why, what "spending down" means, and how people who qualify for both programs get their care.

## What long-term care is

Long-term care means help over months or years with everyday activities like bathing, dressing, eating, using the toilet and moving around, for people who cannot manage those tasks alone because of age, illness or disability. It can happen in a nursing home, an assisted living facility or a person's own home. Policy reports often call it "long-term services and supports" (LTSS).

As Chapter 6 explained, Medicare pays only for short stays of skilled nursing care after a hospital stay, up to 100 days per benefit period, with a daily charge after day 20.[203] It does not pay for long-term custodial care.[204]

## Medicaid as the main payer

Medicaid is the largest payer of long-term care in the United States.[205] KFF reports Medicaid covers 61 percent of total long-term care spending and about 5 in 8 nursing home residents.[206] Nursing facility care is a mandatory Medicaid benefit for adults who qualify.[207]

## Spending down

Medicaid is for people with low incomes and few assets. So how do middle-class people end up on Medicaid in a nursing home? Through what is called **spending down**. A person pays for care out of their own savings until their assets fall below their state's limit, and then Medicaid begins to pay. Most of their income, such as Social Security, then goes toward the cost of care, with a small personal needs allowance.[Not verified]

To prevent people from simply giving away their money to qualify, Medicaid looks back at transfers made in the five years before applying and can impose a waiting period for assets given away for less than they were worth.[Not verified]

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[203] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[204] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

[205] Alice Burns, Elizabeth Hinton, Robin Rudowitz and Maiss Mohamed, "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/10-things-to-know-about-medicaid/, accessed November 12, 2026.

[206] Alice Burns, Elizabeth Hinton, Robin Rudowitz and Maiss Mohamed, "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/10-things-to-know-about-medicaid/, accessed November 12, 2026.

[207] Congressional Research Service, "Medicaid: An Overview," Report R43357, updated April 30, 2025, https://www.everycrsreport.com/reports/R43357.html, accessed November 12, 2026.

**Protecting the spouse at home.** Before 1988, a married couple could be impoverished when one spouse entered a nursing home. The Medicare Catastrophic Coverage Act of 1988 created special rules, called spousal impoverishment protections, that let the spouse who stays at home keep a set amount of income and assets. [208] Those rules survived the 1989 repeal of the rest of that law [Not verified].

**Estate recovery.** Federal law requires states to try to recover the cost of long-term care from the estates of certain Medicaid enrollees after they die, with protections for surviving spouses and some others.[Not verified]

## Care at home instead of a nursing home

Most people would rather get help at home than move into a nursing home. Since 1981, Medicaid waivers have let states pay for home and community-based services.[209] In 1999, the Supreme Court ruled in *Olmstead v. L.C.* that unjustified isolation of people with disabilities in institutions can be discrimination under the Americans with Disabilities Act, which pushed states further toward community care.[210] KFF reports that Medicaid spending on home and community-based services first passed spending on institutions in 2013 and reached 57 percent of Medicaid long-term care spending by 2016. Joint federal and state spending on these services was $92 billion in fiscal year 2018 (nominal dollars). Nursing home care is a required Medicaid benefit, but nearly all home and community-based care is optional for states, much of it offered through waivers that can cap enrollment.[211] Those figures are several years old; I did not find a newer national total in the sources I read.

## Dual eligibles: people on both programs

Millions of people qualify for both Medicare and Medicaid. They are called **dual eligibles**, or "duals." Most are older people or people with disabilities who have low incomes. In calendar year 2022, 13.6 million people were dually eligible for at least one month. They were 20 percent of people on Medicare but 36 percent of Medicare spending, and 13 percent of Medicaid enrollees but 27 percent of Medicaid spending. Combined spending on them was $548.8 billion.[212] About 73 percent of duals qualified for full Medicaid benefits in 2021.[213]

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[208] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[209] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[210] Olmstead v. L.C., 527 U.S. 581 (1999), decided June 22, 1999, Legal Information Institute, Cornell Law School, https://www.law.cornell.edu/supremecourt/text/527/581, accessed November 12, 2026.

[211] Molly O'Malley Watts, MaryBeth Musumeci and Priya Chidambaram, "Medicaid Home and Community-Based Services Enrollment and Spending," KFF, February 4, 2020, https://www.kff.org/medicaid/medicaid-home-and-community-based-services-enrollment-and-spending/, accessed November 12, 2026.

[212] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," December 2025, https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/, accessed November 12, 2026.

For a full dual eligible, Medicare pays first for services it covers, and Medicaid pays most of what is left, such as Medicare premiums and cost sharing, plus services Medicare does not cover, like long-term care.[214]

Others get partial help through the **Medicare Savings Programs**. These programs, run by state Medicaid offices, pay Medicare premiums and sometimes cost sharing for people with limited income and resources. They began with the Qualified Medicare Beneficiary program in 1988 and the Specified Low-Income Medicare Beneficiary program in 1990.[215]

If you or a parent might qualify, the place to ask is your state Medicaid office or your SHIP counselor. Rules and income limits for these programs vary by state, so it is worth asking even if you think you earn too much.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| Medicare covers only up to 100 days of skilled nursing care per benefit period (CMS) | Whether Medicaid should keep paying for middle-class nursing home care, or whether people should be pushed toward private long-term care insurance, is a long-running debate | How families will pay for long-term care as the number of Americans over 85 grows |
| Spousal impoverishment protections and the QMB program date from 1988 (CMS) | | |

[213] Congressional Research Service, "Medicaid: An Overview," Report R43357, updated April 30, 2025, https://www.everycrsreport.com/reports/R43357.html, accessed November 12, 2026.

[214] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," December 2025, https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/, accessed November 12, 2026.

[215] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

# Part Four: Growth and Change, 1966 to Today

## Chapter 10. From 1966 to 1989: Growth, Cost Control and a Law Congress Took Back

Medicare and Medicaid were barely running before Congress began changing them. This chapter covers the first quarter century: new groups added, costs that grew faster than anyone expected, a new way of paying hospitals, and the only major Medicare expansion ever repealed.

### 1967 to 1972: New benefits and new groups

In 1967, Congress required every state Medicaid program to offer children a broad screening and treatment benefit called EPSDT (Chapter 8).[216]

The Social Security Amendments of 1972, signed by President Richard Nixon and enacted as Public Law 92-603 on October 30, 1972, made two big changes to Medicare:[217]

- **Disability.** People under 65 who had received Social Security disability benefits for a set period became eligible for Medicare.
- **Kidney failure.** People of any age with end-stage renal disease (ESRD), meaning permanent kidney failure that requires dialysis or a transplant, became eligible. This made ESRD the only disease that by itself qualifies a person for Medicare. [218]

The same law linked Medicaid for older, blind and disabled people to the new federal Supplemental Security Income (SSI) program.[219]

### Rising costs

Medicare and Medicaid cost much more than first projected. I was not able to read a reliable source comparing the 1965 cost projections with actual spending for this book, so I do not give figures. Popular claims about how far off the estimates were are [Not verified].

Congress and presidents of both parties tried to slow the growth. In 1977, President Jimmy Carter's administration created the Health Care Financing Administration (HCFA) to run

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[216] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[217] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026; Robert M. Ball, "Social Security Amendments of 1972: Summary and Legislative History," Social Security Bulletin, March 1973, Social Security History website, https://www.ssa.gov/history/1972amend.html, accessed November 12, 2026.

[218] Robert M. Ball, "Social Security Amendments of 1972: Summary and Legislative History," Social Security Bulletin, March 1973, Social Security History website, https://www.ssa.gov/history/1972amend.html, accessed November 12, 2026.

[219] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

Medicare and Medicaid together.[220] In 2001, HHS Secretary Tommy Thompson renamed it the Centers for Medicare and Medicaid Services (CMS).[221]

## The 1970s and early 1980s: managed care, a new agency and the first waivers

Several smaller changes in these years set up much of what came later. CMS's own history lists them:[222]

- **1973:** The Health Maintenance Organization (HMO) Act offered start-up grants and loans for HMOs, health plans that provide care through their own networks for a set fee. Medicare was allowed to contract with them, the first step toward today's Medicare Advantage.
- **1977:** The Health Care Financing Administration (HCFA) was created to run Medicare and Medicaid together. It was renamed the Centers for Medicare and Medicaid Services (CMS) in 2001.
- **1980:** Medicare home health coverage was broadened, and Medigap policies were brought under federal oversight.
- **1981:** Medicaid "freedom of choice" waivers and home and community-based services waivers were created, and states were required to make extra payments to hospitals serving many low-income patients, called disproportionate share hospitals (DSH).
- **1982:** A budget law made it easier for HMOs to take full financial risk for Medicare enrollees and created peer review organizations to check the quality of care.

At first, Medicare paid hospitals based on their costs. The more a hospital spent, the more Medicare paid. That gave hospitals little reason to hold costs down.

In 1983, Congress replaced that system for most hospital stays with a **prospective payment system**: Medicare would pay a set amount per stay, decided in advance, based on the patient's diagnosis.[223] The diagnosis categories are called diagnosis-related groups (DRGs). If a hospital treats a patient for less than the set amount, it keeps the difference. If it spends more, it absorbs the loss. The change was part of the Social Security Amendments of 1983, signed by President Ronald Reagan, the same man who had warned against Medicare on the 1961 AMA record.[224]

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[220] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[221] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[222] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[223] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[224] Social Security Administration, Office of Legislation and Congressional Affairs, "Summary of P.L. 98-21 (H.R. 1900), Social Security Amendments of 1983," November 26, 1984, https://www.ssa.gov/history/1983amend.html, accessed November 12, 2026.

The same year, Medicare added a hospice benefit for people who are terminally ill.[225]

## 1986: Emergency care for everyone

In 1986, Congress passed the Emergency Medical Treatment and Labor Act (EMTALA). It requires hospitals that take Medicare and offer emergency services to provide an appropriate medical screening and stabilizing treatment to anyone who comes to the emergency room, regardless of ability to pay.[226] Because nearly every hospital takes Medicare, EMTALA covers nearly every emergency room in the country. It is one reason emergency care is available to people who are uninsured, including immigrants without legal status (Chapter 18).

Also in 1986, Congress began a series of laws letting and then requiring states to cover more pregnant women and young children through Medicaid, cutting the program's tie to welfare.[227]

## 1988 and 1989: The catastrophic coverage law and its repeal

In 1988, Congress passed and President Reagan signed the Medicare Catastrophic Coverage Act. CMS's own history calls it the most significant change to Medicare since the program began. It improved hospital and skilled nursing benefits, covered mammograms, added an outpatient prescription drug benefit and capped how much a beneficiary would have to pay.[228]

The catch was how it was paid for. Congress decided the new benefits should be paid for by Medicare beneficiaries themselves, mainly through a new premium tied to income that fell most heavily on higher-income seniors. Congress "raised Medicare premiums and enacted a surtax on the incomes of the wealthiest Americans aged 65 and older."[229] The House passed it 328 to 72 and the Senate 86 to 11 in June 1988.[230]

Many higher-income seniors, some of whom already had drug and catastrophic coverage through former employers, objected to paying for benefits they did not need. In 1989, Congress repealed the drug benefit and most of the other improvements "after higher-income seniors

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[225] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[226] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[227] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[228] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[229] Dan Diamond, "When Health Repeal Was Catastrophic," California Healthline, February 2, 2011, https://californiahealthline.org/news/when-health-repeal-was-catastrophic/, accessed November 12, 2026.

[230] Dan Diamond, "When Health Repeal Was Catastrophic," California Healthline, February 2, 2011, https://californiahealthline.org/news/when-health-repeal-was-catastrophic/, accessed November 12, 2026.

protested new premiums," in the words of CMS's history.[231] The anger was visible. In 1989, House Ways and Means Chairman Dan Rostenkowski was "booed and jeered following a raucous town hall" in Chicago, and a senior citizen "ultimately jumped on the hood of Rostenkowski's car."[232] Congress repealed most of the law in November 1989.[233]

The repeal was a lesson every later Congress remembered: seniors notice who pays. When Congress added drug coverage again in 2003, it did not ask seniors to pay for it through a surtax.

A few parts of the 1988 law survived, including Medicaid protections for the spouse of a nursing home resident and the Qualified Medicare Beneficiary program, which pays Medicare costs for low-income people.[234]

## 1989: A new way to pay doctors

Also in 1989, Congress replaced Medicare's charge-based payments to doctors with a national fee schedule, based on the time, skill and expense involved in each service. It is called the resource-based relative value scale.[235] That fee schedule is still how traditional Medicare pays doctors today.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| Congress added disability and kidney failure coverage in 1972 (CMS) | Whether the 1983 hospital payment change lowered costs without harming care has been studied for decades, with mixed findings | |
| Medicare moved to diagnosis-based prospective hospital payment in 1983 (CMS) | Why the 1988 law failed: a design flaw in who paid, or a misunderstanding by seniors of what they got. Different analysts emphasize different reasons | |
| Most of the 1988 catastrophic law was repealed in 1989 after protests over new premiums (CMS) | | |

[231] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[232] Dan Diamond, "When Health Repeal Was Catastrophic," California Healthline, February 2, 2011, https://californiahealthline.org/news/when-health-repeal-was-catastrophic/, accessed November 12, 2026.

[233] Dan Diamond, "When Health Repeal Was Catastrophic," California Healthline, February 2, 2011, https://californiahealthline.org/news/when-health-repeal-was-catastrophic/, accessed November 12, 2026.

[234] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[235] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

# Chapter 11. From 1990 to 2009: A Failed Overhaul, a Budget Deal and a Drug Benefit

The 1990s and 2000s brought three big moments: a sweeping plan that never reached a vote, a budget law that created a new children's program and new private plan choices, and the largest expansion of Medicare since 1965.

## 1993 and 1994: The Clinton health plan

In 1993, President Bill Clinton proposed the Health Security Act, a plan to guarantee health coverage to all Americans, mainly through regulated private insurance bought through regional purchasing groups. The bill was introduced in the House on November 20, 1993 and in the Senate on November 22, 1993.[236] The plan drew opposition from insurers, many employers and Republicans. After committee debate through the summer of 1994, Senate Majority Leader George Mitchell, the Senate sponsor, declared the bill dead on September 26, 1994.[237] Medicare and Medicaid stayed largely as they were.

## 1996: Medicaid separated from welfare

In 1996, the welfare reform law replaced the old cash welfare entitlement, Aid to Families with Dependent Children, with block grants to states. It cut the automatic link between getting welfare and getting Medicaid, and created a new Medicaid group for low-income families not tied to welfare.[238] The same year, the Health Insurance Portability and Accountability Act (HIPAA) created the Medicare Integrity Program to fight fraud and set national standards for electronic health records transactions.[239]

## The early 1990s: drug rebates and limits on state financing

Two quieter changes from these years still matter. In 1990, Congress created the Medicaid drug rebate program, which requires drug makers to give rebates to states in exchange for coverage of their drugs, added the Specified Low-Income Medicare Beneficiary group to help with Medicare premiums, and set federal standards for Medigap policies. In 1991, Congress put controls on Medicaid disproportionate share hospital spending and capped the provider taxes and

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[236] William J. Clinton Presidential Library, "Health Care Reform" topic guide, https://www.clintonlibrary.gov/research/health-care-reform-topic-guide, accessed November 12, 2026.

[237] William J. Clinton Presidential Library, "Health Care Reform" topic guide, https://www.clintonlibrary.gov/research/health-care-reform-topic-guide, accessed November 12, 2026.

[238] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[239] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

donations states could use for their share, the first round of a fight that returned in the 2025 budget law.[240]

The Balanced Budget Act of 1997, a deal between President Clinton and the Republican Congress, made large changes to both programs:[241]

- **CHIP.** It created the Children's Health Insurance Program. [242]
- **Private plan choices in Medicare.** It created new Medicare managed care and other private plan options, which were given the name Medicare+Choice. This was the forerunner of today's Medicare Advantage.[243]
- **Spending cuts.** It required five new prospective payment systems for skilled nursing, home health, outpatient hospital and rehabilitation care, slowed Medicare spending growth, and, according to CMS's history, extended the life of the Medicare trust fund by 10 years.[244]
- **A formula for doctors' pay.** It set up a formula, later called the Sustainable Growth Rate (SGR), to hold down Medicare payments to doctors. CRS confirms: "Created by BBA97, the SGR formula was the statutory method for determining the annual updates" to doctors' pay.[245]

Some of the cuts proved deeper than expected. Congress gave back some money to providers in 1999 and 2000.[246]

## 1998 to 2001: Medicare reaches out to its members

Some changes were about information rather than benefits. CMS launched Medicare.gov in 1998, mailed the first annual "Medicare and You" handbook in 1999, and set up the toll-free 1-800-MEDICARE line. A 1999 law expanded coverage for people with disabilities who return to

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[240] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[241] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[242] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[243] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[244] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[245] Congressional Research Service, "The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)," Report R43962, November 10, 2015, https://www.everycrsreport.com/reports/R43962.html, accessed November 12, 2026.

[246] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

work. A 2000 law raised some Medicare payments, cut some copayments and expanded preventive coverage. In 2001, HHS Secretary Tommy Thompson renamed HCFA the Centers for Medicare and Medicaid Services.[247]

In 2003, Congress passed and President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). CMS's history calls it the most significant change to Medicare since the program began. It created an optional outpatient prescription drug benefit, Part D, starting in 2006 and delivered through private plans; added new preventive benefits; offered a temporary drug discount card until 2006; gave extra help with drug costs to people with incomes below 150 percent of the poverty level; and required higher-income beneficiaries to pay more for Part B beginning in 2007.[248] Under the law, Medicare's private plans "became known as Medicare Advantage Plans," and CMS calls the MMA "the biggest changes to the Medicare in the program in 38 years."[249]

The bill passed the House by a narrow margin after a vote that was held open for hours in the early morning of November 22, 2003, while leaders sought enough votes. The final tally was 220 to 215, on roll call 669, recorded at 5:53 a.m.[250] Democratic leaders later said the vote had been held open "for nearly three hours."[251]

The cost of the new benefit became its own controversy. When Congress passed the law, CBO estimated it would raise federal spending by $394.3 billion over fiscal years 2004 to 2013.[252] Afterward, it came out that Medicare's chief actuary, Richard Foster, had produced a higher estimate, and that his boss had kept him from sharing it with Congress. The HHS Inspector General found "that Mr. Scully ordered Mr. Foster not to provide information to members and staff," referring to then-CMS Administrator Thomas Scully. GAO, the congressional watchdog, ruled in 2004 that HHS's funds were not available to pay the salary of an official who blocked such communications.[253] The actuary's own figure is widely reported as about $534 billion, but I did not find it in the sources I read, so that number is [Not verified].

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[247] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[248] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[249] Centers for Medicare and Medicaid Services, "History," page last modified February 12, 2026, https://www.cms.gov/about-cms/who-we-are/history, accessed November 12, 2026.

[250] Office of the Clerk, U.S. House of Representatives, "Roll Call 669, H.R. 1, 108th Congress, 1st Session" (conference report on the Medicare Prescription Drug, Improvement, and Modernization Act), November 22, 2003, https://clerk.house.gov/Votes/2003669, accessed November 12, 2026.

[251] Congressional Record, House, December 8, 2003, vol. 149, page H12850, https://www.govinfo.gov/link/crec/149/H/12850, accessed November 12, 2026.

[252] Congressional Research Service, "Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted," Report RL32005, updated January 16, 2004, https://www.everycrsreport.com/reports/RL32005.html, accessed November 12, 2026.

[253] U.S. Government Accountability Office, "Department of Health and Human Services - Chief Actuary's Communications with Congress," decision B-302911, September 7, 2004, https://www.gao.gov/products/b-302911, accessed November 12, 2026.

Supporters pointed out that the new benefit was paid for mostly from general revenue rather than a surtax on seniors, a lesson from the 1988 repeal. Critics on the left objected that the law barred Medicare from negotiating drug prices directly with drug makers. Critics on the right objected that it added a large new benefit without new revenue. [Not verified]

## 2006: Part D begins

Medicare drug coverage began on January 1, 2006, after an enrollment period in late 2005.[254]

## 2009: CHIP reauthorized

On February 4, 2009, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act, which gave states significant new funding and options for covering children through Medicaid and CHIP.[255]

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| The 1997 Balanced Budget Act created CHIP and new private plan choices in Medicare (CMS) | Whether private plans in Medicare save money or cost more has been argued since 1997 (see Chapter 16) | |
| The 2003 MMA created Part D, starting in 2006 (CMS) | Whether the 2003 ban on direct drug price negotiation helped or hurt beneficiaries | |

[254] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[255] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

# Chapter 12. From 2010 to Today: The ACA, the Supreme Court, Drug Prices and the 2025 Law

*Information in this chapter stops at November 12, 2026.*

The last sixteen years brought the biggest changes to Medicaid since 1965, a landmark Supreme Court ruling, a pandemic, the first Medicare drug price negotiations, and in 2025 a budget law that will reshape Medicaid in the years ahead.

## 2010: The Affordable Care Act

President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) on March 23, 2010.[256] For Medicare and Medicaid, its main pieces were:

- **Medicaid expansion.** The law extended Medicaid to nearly all adults under 65 with incomes up to 138 percent of the poverty level, with the federal government paying most of the cost.[257]
- **Medicare benefits.** It added free preventive services and began closing the Part D coverage gap.[258]
- **Medicare savings.** It slowed the growth of Medicare payments to hospitals and other providers and reduced payments to Medicare Advantage plans over time. CBO later estimated these provisions reduced projected Medicare spending by $716 billion over 2013 to 2022 (Chapter 17, Claim 6).[259]
- **New taxes for Medicare.** It added a Hospital Insurance payroll tax on wages above $200,000 for single filers or $250,000 for joint filers.[260]
- **New ways to pay.** It created a center at CMS to test new payment and delivery models, a voluntary national pilot to "bundle payments for physician, hospital, and post-acute care services," and the Independent Payment Advisory Board.[261]

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[256] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[257] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026; KFF, "Status of State Medicaid Expansion Decisions," November 6, 2026, https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/, accessed November 12, 2026.

[258] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[259] Congressional Budget Office, letter to Speaker John Boehner on H.R. 6079, the Repeal of Obamacare Act, July 24, 2012, https://www.cbo.gov/publication/43471, accessed November 12, 2026.

[260] Congressional Research Service, "Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline," Report R41196, January 24, 2011, https://www.everycrsreport.com/reports/R41196.html, accessed November 12, 2026.

[261] Congressional Research Service, "Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline," Report R41196, January 24, 2011, https://www.everycrsreport.com/reports/R41196.html, accessed November 12, 2026.

- **Insurance marketplaces.** It created marketplaces where people could buy subsidized private coverage, opening October 1, 2013.[262]

### What the Medicare savings were made of

CBO's estimate at the time, as summarized by CRS, put the law's net reduction in Medicare spending at "close to $400 billion from FY2010 to FY2019." Gross reductions of about $465 billion were partly offset by about $65 billion in Medicare payment increases. The biggest pieces were smaller yearly payment updates for hospitals and other fee-for-service providers, $196.3 billion, and tying Medicare Advantage payments "closer to spending in fee-for-service Medicare," $135 billion.[263] Starting in 2011, Part D enrollees in the coverage gap got a "50% discount off the price of brand-name drugs," and the gap was phased out by 2020. The law also eliminated cost sharing "for certain preventive care services."[264]

The $716 billion figure that became famous in 2012 is the same set of policies measured over a later ten-year window, 2013 to 2022 (Chapter 17).[265]

Twenty-six states and the National Federation of Independent Business (NFIB) challenged the ACA. In *National Federation of Independent Business v. Sebelius*, decided June 28, 2012, the Supreme Court upheld most of the law but ruled that Congress could not force states to accept the Medicaid expansion by threatening to take away all of their existing Medicaid funding. [266] Chief Justice John Roberts wrote that the threat amounted to "economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion."[267] The remedy was narrow: the Court barred the federal government from taking away states' existing Medicaid funds for refusing the expansion and left the rest of the law in place.[268] Seven justices agreed the expansion could not be forced on states in that way, though they split on the remedy.[269]

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[262] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[263] Congressional Research Service, "Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline," Report R41196, January 24, 2011, https://www.everycrsreport.com/reports/R41196.html, accessed November 12, 2026.

[264] Congressional Research Service, "Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline," Report R41196, January 24, 2011, https://www.everycrsreport.com/reports/R41196.html, accessed November 12, 2026.

[265] Congressional Budget Office, letter to Speaker John Boehner on H.R. 6079, the Repeal of Obamacare Act, July 24, 2012, https://www.cbo.gov/publication/43471, accessed November 12, 2026.

[266] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), decided June 28, 2012, Justia, https://supreme.justia.com/cases/federal/us/567/519/, accessed November 12, 2026.

[267] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), decided June 28, 2012, Justia, https://supreme.justia.com/cases/federal/us/567/519/, accessed November 12, 2026.

[268] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), decided June 28, 2012, Justia, https://supreme.justia.com/cases/federal/us/567/519/, accessed November 12, 2026.

[269] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), decided June 28, 2012, Justia, https://supreme.justia.com/cases/federal/us/567/519/, accessed November 12, 2026.

The result: the expansion became, in practice, optional for each state. That is why the map of Medicaid today is split, with 41 states including DC in and 10 out as of November 2026.[270]

## 2014: Expansion begins

The expansion took effect in 2014 in the states that adopted it. Among the 49 states that reported data, Medicaid and CHIP enrollment grew by more than 12.8 million people between the fall of 2013 and May 2015.[271]

## 2015: MACRA ends the doctor-pay formula

The 1997 doctor-payment formula (the SGR) called for deep cuts to doctor pay almost every year, and Congress overrode it again and again with short-term "doc fixes." In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) replaced the formula with a new system and extended CHIP.[272] MACRA was signed April 16, 2015, after the House passed it March 26 and the Senate April 14.[273]

## 2017: Repeal attempts

In 2017, the Republican Congress tried to repeal and replace the ACA. The House passed the American Health Care Act on May 4, 2017, by 217 to 213, with no Democrats in favor and 20 Republicans against.[274] In the Senate, a pared-down repeal amendment failed 49 to 51 in the early morning of July 28, 2017.[275] Medicaid's expansion stayed in place.

## 2020 to 2024: The pandemic and the "unwinding"

When the COVID-19 pandemic began, Congress gave states extra federal Medicaid money on the condition that they not remove people from Medicaid during the public health emergency. The Families First Coronavirus Response Act, enacted March 18, 2020, added a 6.2 percentage point increase in the federal matching rate for states that kept people continuously enrolled.[276]

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[270] KFF, "Status of State Medicaid Expansion Decisions," November 6, 2026, https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/, accessed November 12, 2026.

[271] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[272] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[273] Congressional Research Service, "The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)," Report R43962, November 10, 2015, https://www.everycrsreport.com/reports/R43962.html, accessed November 12, 2026.

[274] Office of the Clerk, U.S. House of Representatives, "Roll Call 256, H.R. 1628, 115th Congress, 1st Session" (American Health Care Act), May 4, 2017, https://clerk.house.gov/Votes/2017256, accessed November 12, 2026.

[275] U.S. Senate, "Roll Call Vote 115th Congress - 1st Session, Vote Number 179" (McConnell Amendment No. 667 to H.R. 1628), July 28, 2017, https://www.senate.gov/legislative/LIS/roll_call_votes/vote1151/vote_115_1_00179.htm, accessed November 12, 2026.

[276] Congressional Research Service, "Medicaid Recession-Related FMAP Increases," Report R46346, May 7, 2020, https://www.everycrsreport.com/reports/R46346.html, accessed November 12, 2026.

Enrollment grew sharply. A 2022 law ended the continuous enrollment rule on March 31, 2023, and states then had to recheck everyone's eligibility, a process called the "unwinding."[277]

KFF counted more than 25 million people disenrolled and more than 56 million renewed. Even after the unwinding, enrollment was about 10 million higher than before the pandemic.[278]

## 2022: The Inflation Reduction Act

The Inflation Reduction Act of 2022, signed by President Joe Biden, made the biggest changes to Medicare drug coverage since Part D began. It capped insulin costs, capped yearly out-of-pocket drug spending in Part D starting in 2025 ($2,000 in 2025, $2,100 in 2026), and let Medicare negotiate prices for some drugs, with the first negotiated prices taking effect January 1, 2026 (Chapter 7).[279] The law was signed August 16, 2022.[280]

## 2025: The budget law and Medicaid

On July 4, 2025, President Donald Trump signed a large budget law, Public Law 119-21. It was introduced as H.R. 1 and is often called the One Big Beautiful Bill Act.[281] I call it the 2025 budget law. Its health provisions are the largest changes to Medicaid since the ACA.

**Table 12.1. Main Medicaid changes in the 2025 budget law (Public Law 119-21), as of November 12, 2026**

| Change | What it does | When |
|---|---|---|
| Work and | Requires many adults in the | January 1, 2027, for most states[282] |

[277] KFF, "As Medicaid Unwinding Concludes in Most States, KFF Finds 25 Million Lost Medicaid Coverage, but Enrollment Is 10 Million Higher Than Pre-Pandemic Levels," September 18, 2024, https://www.kff.org/medicaid/as-medicaid-unwinding-concludes-in-most-states-kff-finds-25-million-lost-medicaid-coverage-but-enrollment-is-10-million-higher-than-pre-pandemic-levels/, accessed November 12, 2026.

[278] KFF, "As Medicaid Unwinding Concludes in Most States, KFF Finds 25 Million Lost Medicaid Coverage, but Enrollment Is 10 Million Higher Than Pre-Pandemic Levels," September 18, 2024, https://www.kff.org/medicaid/as-medicaid-unwinding-concludes-in-most-states-kff-finds-25-million-lost-medicaid-coverage-but-enrollment-is-10-million-higher-than-pre-pandemic-levels/, accessed November 12, 2026.

[279] Centers for Medicare and Medicaid Services, "Final CY 2026 Part D Redesign Program Instructions," fact sheet, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions, accessed November 12, 2026; Centers for Medicare and Medicaid Services, "CMS Delivers Savings for Seniors on 15 Major Drugs for Cancer and Chronic Disease," press release, November 25, 2025, https://www.cms.gov/newsroom/press-releases/cms-delivers-savings-seniors-15-major-drugs-cancer-chronic-disease, accessed November 12, 2026; Centers for Medicare and Medicaid Services, "Statements from CMS Leadership on President Biden Signing the Inflation Reduction Act into Law," press release, August 16, 2022, https://cms.gov/newsroom/press-releases/statements-cms-leadership-president-biden-signing-inflation-reduction-act-law, accessed November 12, 2026 (date confirmed from the release listing).

[280] Centers for Medicare and Medicaid Services, "Statements from CMS Leadership on President Biden Signing the Inflation Reduction Act into Law," press release, August 16, 2022, https://cms.gov/newsroom/press-releases/statements-cms-leadership-president-biden-signing-inflation-reduction-act-law, accessed November 12, 2026 (date confirmed from the release listing).

[281] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

| Change | What it does | When |
|---|---|---|
| community engagement requirement | expansion group to work, volunteer, go to school or take part in job training for a set number of hours a month, with exemptions | |
| More frequent eligibility checks | Expansion adults rechecked more often | Every 6 months instead of 12, starting January 1, 2027[283] |
| Cost sharing | New copayments for some expansion adults above the poverty line | Up to $35 per service for expansion adults above the poverty line, with exceptions for primary care and some other services, starting October 1, 2028[284] |
| Provider taxes | Bans most new or increased provider taxes; lowers limits in expansion states | Ban in effect; reductions begin fiscal year 2028 (October 1, 2027)[285] |
| State directed payments | Lowers extra payments states direct to hospitals through managed care | Reductions begin January 1, 2028[286] |
| Immigrant eligibility | Narrows which lawfully present immigrants can get federal Medicaid | October 1, 2026[287] |
| Rural Health Transformation | New fund for rural health care | $50 billion in total; year 1 awards announced December 29, 2025[288] |

[282] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[283] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[284] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[285] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026; Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[286] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[287] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

| Change | What it does | When |
|---|---|---|
| Program | | |

CMS issued an interim final rule to carry out the work requirement in June 2026. On October 29, 2026, a federal court, in a case brought by Massachusetts and other states (*Commonwealth of Massachusetts v. Oz*), threw out one part of the rule's definition of who is "medically frail" and therefore exempt, while leaving other parts in place.[289]

**What CBO estimated.** CBO estimated that the law's Medicaid provisions would reduce federal Medicaid spending by $989.7 billion over fiscal years 2025 to 2034 and leave 7.5 million more people uninsured in 2034. All of the law's health provisions together would leave 10.0 million more uninsured.[290] The work requirement was the largest single piece, at $325.6 billion.[291] KFF, after accounting for interactions among provisions, puts the net federal Medicaid reduction at $911 billion.[292]

**What each side says.** The White House said "there will be no cuts to Medicaid" and that the law "protects Medicaid for the truly vulnerable."[293] Opponents such as the Center on Budget and Policy Priorities said the House version was "taking away Medicaid and affordable marketplace coverage from people who are eligible."[294] Chapter 17 tests both claims.

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[288] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[289] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[290] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[291] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[292] Rhiannon Euhus, Elizabeth Williams, Alice Burns and Robin Rudowitz, "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package," KFF, July 23, 2025, https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/, accessed November 12, 2026.

[293] The White House, "Myth v Fact: The One Big Beautiful Bill" (PDF, file dated 6.28, posted July 2025), https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf, accessed November 12, 2026.

[294] Sharon Parrott, Center on Budget and Policy Priorities (policy group; generally supports safety-net programs), "House Republican Bill Fails the Country; Senate Should Reject Any Bill That Takes Away Health Coverage, Food Assistance," statement (2025), https://www.cbpp.org/press/statements/house-republican-bill-fails-the-country-senate-should-reject-any-bill-that-takes, accessed November 12, 2026.

## The 2025 law, piece by piece

Because this law will shape Medicaid for years, it is worth walking through its main pieces in more detail. The details below come from the Congressional Research Service's August 2025 summary of the law's health provisions unless noted.[295]

**The work requirement.** Adults aged 19 to 64 in the expansion group, and adults covered through similar waivers, must show 80 hours a month of work, community service, a work program, or at least half-time school, or a mix of these. States must start by December 31, 2026, and may start sooner. The law lists people who must be exempted, including people on Medicare, people who are medically frail, pregnant or postpartum women, parents and caretakers of a child under 14 or of a person with a disability, American Indians and Alaska Natives, former foster youth up to age 26, people in substance use treatment, and people recently released from jail or prison. HHS may grant states temporary "good faith" extensions, but these cannot run past December 31, 2028.[296]

Notice the gap between this and the White House's earlier description, which said the requirement applied "only to able-bodied adults without young children" and spoke of a "20-hour weekly work requirement."[297] The enacted law uses 80 hours a month, about 18.5 hours a week, and exempts parents of children under 14.[298] Political summaries written while a bill is moving often do not match the final text. Always check the law as passed.

**More frequent eligibility checks.** Starting January 1, 2027, states must recheck the eligibility of expansion adults every six months instead of every twelve.[299] More checks catch more people whose incomes have risen. They also create more chances for eligible people to lose coverage over paperwork, the same pattern seen during the pandemic unwinding (earlier in this chapter).[300]

**Shorter retroactive coverage.** Medicaid has long paid for care received in the months just before a person applied, which matters to people who apply after a hospital stay. The law shortens that window starting January 1, 2027. The sources I read describe the new limits

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[295] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[296] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[297] The White House, "Myth v Fact: The One Big Beautiful Bill" (PDF, file dated 6.28, posted July 2025), https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf, accessed November 12, 2026.

[298] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[299] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[300] KFF, "As Medicaid Unwinding Concludes in Most States, KFF Finds 25 Million Lost Medicaid Coverage, but Enrollment Is 10 Million Higher Than Pre-Pandemic Levels," September 18, 2024, https://www.kff.org/medicaid/as-medicaid-unwinding-concludes-in-most-states-kff-finds-25-million-lost-medicaid-coverage-but-enrollment-is-10-million-higher-than-pre-pandemic-levels/, accessed November 12, 2026.

differently (one month for expansion adults and two months for others in one reading; one month for all in another), so I state only that the window was shortened.[301]

**Cost sharing.** Starting October 1, 2028, states must charge expansion adults with incomes above the poverty line some cost sharing, up to $35 per service, with exceptions for primary care, mental health and substance use services, and services at community health centers and rural health clinics.[302]

**Provider taxes.** States use taxes on hospitals, nursing homes and other providers to raise their share of Medicaid, which then draws federal matching money (Chapter 13). The law freezes new or higher provider taxes, and in expansion states it lowers the allowed level step by step, from 6 percent toward 3.5 percent, starting in fiscal year 2028, with nursing home and similar facility taxes treated separately.[303] CBO counted this as the second largest savings item, $191.1 billion over ten years.[304]

**State directed payments.** States can direct their Medicaid managed care plans to pay hospitals and other providers extra. The law caps these payments at 100 percent of Medicare rates in expansion states and 110 percent in other states, with existing payments phased down by 10 percentage points a year starting January 1, 2028. CBO estimated $149.4 billion in savings.[305]

**Immigrants.** Starting October 1, 2026, federal Medicaid and CHIP funding is limited to citizens and nationals, green card holders, Cuban and Haitian entrants, and people from certain Pacific island nations under Compacts of Free Association. Refugees and asylees who do not have green cards lose eligibility. Emergency Medicaid continues, but the federal match for emergency care given to adults who would otherwise be in the expansion group drops to the state's regular rate.[306]

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[301] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[302] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[303] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[304] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[305] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[306] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Akash Pillai, Alisha Rao and Samantha Artiga, "Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider," KFF, September 22, 2026, https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/, accessed November 12, 2026.

**Medicare pieces.** The law also limits Medicare eligibility to the same groups of immigrants, with current beneficiaries who do not fit losing coverage by January 2027; raises Medicare doctor payments by 2.5 percent for 2026 only; and widens the exclusion of drugs for rare diseases from price negotiation.[307] CBO estimated the Medicare provisions together slightly increase Medicare spending, by $1.7 billion.[308]

**Rural Health Transformation Program.** The law created a $50 billion fund for states to strengthen rural health care. CRS's summary describes it as running from fiscal years 2026 through 2030 in one place and through 2032 in another, so I give only the total.[309] Year one awards were announced December 29, 2025.[310]

**Private insurance.** Outside Medicaid, CBO estimated the law's changes to the ACA marketplaces would reduce federal spending by $213.0 billion and add 2.1 million uninsured.[311]

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| The ACA was signed March 23, 2010 (CMS) | Whether the ACA's Medicare savings were "cuts" (see Chapter 17) | How many people will lose Medicaid under the work requirement once it starts in 2027 |
| 41 states including DC have adopted expansion (KFF) | Whether the 2025 law's Medicaid changes are "cuts" or "reforms" | How courts will finally rule on the work requirement rule |
| Most states must begin the work requirement January 1, 2027 | | |

[307] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF (nonpartisan health research group), March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/, accessed November 12, 2026.

[308] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[309] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[310] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[311] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

# Part Five: Follow the Money

## Chapter 13. Who Pays: Taxes, Premiums, States and the Trust Funds

*Information in this chapter stops at November 12, 2026. Figures come from the 2026 Medicare Trustees Report, transmitted June 9, 2026, unless another source is named.*

If you have ever looked closely at a pay stub, you have seen a line for Medicare. You might ask, "If I pay Medicare tax my whole working life, why do I still pay premiums when I retire? And where does the rest of the money come from?" This chapter answers those questions for Medicare and then for Medicaid.

### Medicare's money, in one table

In 2025, Medicare took in $1,226.2 billion and spent $1,210.1 billion.[312] Here is where the income came from:

**Table 13.1. Medicare income by source, calendar year 2025 (billions of nominal dollars, from the 2026 Trustees Report, as of November 12, 2026)**

| Source | Amount | What it is |
|---|---|---|
| Government contributions (general revenue) | $572.9 | Money from the federal government's general fund, mostly income taxes and borrowing |
| Payroll taxes | $403.2 | The Medicare tax on wages and self-employment income |
| Beneficiary premiums | $171.5 | Part A $6.0, Part B $150.7, Part D $14.9 |
| Taxation of Social Security benefits | $41.1 | Part of the income tax some retirees pay on their Social Security |
| Payments from states | $19.1 | States' payments for people on both Medicare and Medicaid (Part D) |
| Interest | $13.0 | Interest on the trust funds' Treasury bonds |
| Other | $5.4 | Fines, fees and other items |
| **Total** | **$1,226.2** | |

Source: 2026 Medicare Trustees Report, Table II.B1.[313]

Notice the biggest line. Almost half of Medicare's money comes from the general fund of the Treasury, not from the Medicare payroll tax. That surprises many people. It is the key to understanding everything else in this chapter.

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[312] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026, Table II.B1.

[313] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026, Table II.B1.

## Two trust funds, two different designs

Medicare money flows through two trust funds, which are accounts inside the U.S. Treasury.

**The Hospital Insurance (HI) trust fund** pays for Part A: hospital stays, skilled nursing after a hospital stay, hospice and some home health care. In 2025 it took in $462.4 billion. About 87 percent came from payroll taxes, about 9 percent from taxes on Social Security benefits, about 2 percent from interest and about 1 percent from premiums.[314]

**The Supplementary Medical Insurance (SMI) trust fund** pays for Part B (doctors and outpatient care) and Part D (prescription drugs). Government contributions from general revenue paid about 75 percent of SMI's income, premiums paid about 22 percent, and payments from states paid about 2 percent.[315]

You might ask, "Why does it matter which fund the money is in?" Because the two funds are built differently, and only one of them can run out of money.

## Why HI can run out and SMI cannot

The HI trust fund depends mostly on a fixed payroll tax. When spending grows faster than payroll tax income, the fund draws down its savings. When the savings reach zero, the fund can only pay out what comes in that year.

The SMI trust fund works differently. The law sets Part B and Part D premiums and the general revenue contribution each year to cover the coming year's costs. In the Trustees' words, SMI "is expected to be adequately financed over the next 10 years and beyond because income from premiums and Federal Government contributions for Parts B and D are reset each year."[316]

So SMI cannot run out under current law. But that does not mean it is free. As SMI costs rise, premiums rise, and so does the share of federal income taxes needed to cover the general revenue part. The Congressional Research Service (CRS) estimates that about 17.6 percent of all federal personal and corporate income taxes collected in 2025 went to pay the general revenue share of SMI. Under the Trustees' projections, that share rises to 28.6 percent in 2040 and 38.3 percent in 2100.[317]

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[314] Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

[315] Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

[316] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[317] Congressional Research Service, "Medicare's Financial Status," Report R43122, updated July 27, 2026, https://www.everycrsreport.com/files/2026-07-27_R43122_c62bed3a53adb4ca573ed677d0f189256fc884bb.html, accessed November 12, 2026.

## The HI trust fund date: 2033

The 2026 Trustees Report projects that the HI trust fund will run out of reserves in the second quarter of 2033, one quarter earlier than the 2025 report projected.[318]

That does **not** mean Medicare stops paying hospitals in 2033. Payroll taxes and other income keep coming in. The Trustees project that after 2033 that income will cover 89 percent of Part A costs, falling to 85 percent by 2050 and then rising to 93 percent by 2100.[319]

What would actually happen if the fund ran dry? Nobody knows for certain, because the law does not say. CRS puts it this way: "There are no provisions in the Social Security Act that govern what would happen if insolvency were to occur."[320] CRS describes two possible paths for CMS: pay full bills late, or pay bills on time but at reduced amounts. Both approaches are, in CRS's words, "legally untested."[321] And under current law, the program has no authority to use general revenue to fill an HI shortfall.[322]

Why did the date move? The Trustees pointed to higher assumed use of some provider services, higher assumed spending per person in Medicare Advantage, and lower income. Part of the lower income comes from the 2025 budget law (Public Law 119-21), which cut income taxes on Social Security benefits, so less of that tax flows to HI. Lower-than-expected spending in 2025 offset some of these changes.[323]

## A long history of "running out" dates

The HI fund has had a projected run-out date for most of its history, and Congress has always acted before the date arrived. The 1970 Trustees Report projected the fund would be exhausted

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[318] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[319] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026; Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

[320] Congressional Research Service, "Medicare: Insolvency Projections," Report RS20946, updated August 10, 2026, https://www.everycrsreport.com/files/2026-08-10_RS20946_37cf7cc037fcc1104a447bf924e208701216ff16.html, accessed November 12, 2026.

[321] Congressional Research Service, "Medicare: Insolvency Projections," Report RS20946, updated August 10, 2026, https://www.everycrsreport.com/files/2026-08-10_RS20946_37cf7cc037fcc1104a447bf924e208701216ff16.html, accessed November 12, 2026.

[322] Congressional Research Service, "Medicare's Financial Status," Report R43122, updated July 27, 2026, https://www.everycrsreport.com/files/2026-07-27_R43122_c62bed3a53adb4ca573ed677d0f189256fc884bb.html, accessed November 12, 2026.

[323] Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

in 1972. The latest date ever projected was 2036, in the 2024 report.[324] Across the history of these reports, projected run-out dates have ranged from 2 to 28 years after the report year.[325]

**Table 13.2. Selected HI trust fund depletion projections (as of November 12, 2026)**

| Trustees Report year | Projected depletion year |
|---|---|
| 1970 | 1972 |
| 2024 | 2036 |
| 2025 | 2033 |
| 2026 | 2033 (second quarter) |

Source: CRS Report RS20946 and the 2026 Trustees Report.[326]

The fund has never actually run out. That history is one reason some people dismiss the warnings, and another reason others say the warnings are wearing thin. Chapter 17 tests the claim that "Medicare is going bankrupt."

## The size of the long-term gap

The Trustees measure HI's long-term shortfall over 75 years as a share of taxable payroll. In the 2026 report, the HI 75-year actuarial deficit is 0.56 percent of taxable payroll, up from 0.42 percent in the 2025 report.[327] In plain terms, the payroll tax would have to rise by a little more than half a percentage point, starting now, to close the 75-year gap on its own. Chapter 20 lays out other ways to close it.

Overall Medicare spending is also growing faster than the economy. The Trustees project total Medicare costs rising from 3.9 percent of gross domestic product (GDP) in 2025 to 6.5 percent in 2050, and to about 7.5 percent by the end of the 75-year period.[328] Over 2026 to 2030, they project Part B spending growing about 8.5 percent a year and Part D about 9.4 percent a year, against economic growth of about 4.0 percent.[329]

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[324] Congressional Research Service, "Medicare: Insolvency Projections," Report RS20946, updated August 10, 2026, https://www.everycrsreport.com/files/2026-08-10_RS20946_37cf7cc037fcc1104a447bf924e208701216ff16.html, accessed November 12, 2026.

[325] Congressional Research Service, "Medicare's Financial Status," Report R43122, updated July 27, 2026, https://www.everycrsreport.com/files/2026-07-27_R43122_c62bed3a53adb4ca573ed677d0f189256fc884bb.html, accessed November 12, 2026.

[326] Congressional Research Service, "Medicare: Insolvency Projections," Report RS20946, updated August 10, 2026, https://www.everycrsreport.com/files/2026-08-10_RS20946_37cf7cc037fcc1104a447bf924e208701216ff16.html, accessed November 12, 2026; Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[327] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[328] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[329] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

## The "Medicare funding warning"

A 2003 law requires the Trustees to issue a "Medicare funding warning" when general revenue is projected to pay more than 45 percent of Medicare's costs within seven years. The 2026 report found that this threshold would be crossed in fiscal year 2026. It was the tenth year in a row the Trustees found excess general revenue funding, and the ninth year in a row a funding warning was issued.[330] When a warning is issued, the law asks the President to send Congress a plan to respond, but Congress is not required to act on it. [331]

## Paying in versus taking out

Back to the question at the top of this chapter. Here is how the money you pay maps onto what you get:

| What you pay | Which part it supports |
|---|---|
| Medicare payroll tax while working | Part A (HI trust fund) |
| Income tax on part of your Social Security, if your income is high enough | Part A (HI trust fund) |
| Part B premium in retirement ($202.90 a month standard in 2026) | Part B (SMI trust fund)[332] |
| Part D plan premium | Part D (SMI trust fund) |
| Your federal income taxes all your life | The general revenue share of Parts B and D |

So the payroll tax you paid while working mainly prepaid your hospital coverage. Doctor visits and drugs are paid mostly by premiums and general taxes. Chapter 17 looks at the claim that "Medicare is free because you paid for it."

## How Medicaid is paid for

Medicaid has no trust fund and no payroll tax. The federal government and each state share the cost of every Medicaid dollar.

The federal share for most services is called the Federal Medical Assistance Percentage (FMAP). It is set by a formula based on each state's income per person: states with lower incomes get a higher federal share. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent.[333]

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[330] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[331] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[332] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[333] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

**Table 13.3. Examples of federal Medicaid match rates (FMAP), fiscal year 2026 (as of November 12, 2026)**

| State | Federal share of most Medicaid spending |
|---|---|
| Mississippi (highest of the 50 states and DC) | 76.90% |
| Nevada | 59.80% |
| California, Colorado, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Washington, Wyoming (the minimum) | 50.00% |

Source: MACPAC, MACStats Exhibit 6, February 2026.[334]

Some groups and services get a higher federal share. For adults covered through the Affordable Care Act's Medicaid expansion, the federal government pays 90 percent. For CHIP, the federal share is higher than the regular rate, because the law cuts the state's share by 30 percent.[335] Most administrative costs are matched at 50 percent.[336]

Nationally, the federal government paid about 64.5 percent of Medicaid spending in fiscal year 2024, according to a preliminary estimate from the Medicaid and CHIP Payment and Access Commission (MACPAC).[337]

Medicaid is a big part of state budgets. KFF, citing state budget officers, reports that in state fiscal year 2024 Medicaid made up 30 percent of total state spending counting federal funds, and 16 percent of spending from states' own funds, second only to K-12 education.[338] In federal fiscal year 2024, total Medicaid spending was $919 billion: about $594 billion federal (65 percent) and $325 billion from states (35 percent).[339] KFF puts it simply: "Medicaid represents nearly $1 out of every $5 spent on health care in the U.S."[340]

States raise their part in several ways. For state fiscal year 2018, about 68 percent of the non-federal share came from state general funds, 12 percent from local governments, 17 percent from

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[334] Medicaid and CHIP Payment and Access Commission, "Exhibit 6. Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages by State, FYs 2023-2026," MACStats, February 2026, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-and-Enhanced-Federal-Medical-Assistance-Percentages-by-State-FYs-2023%E2%80%932026.pdf, accessed November 12, 2026.

[335] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[336] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[337] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[338] Elizabeth Williams, Alice Burns, Anna Mudumala and Robin Rudowitz, "Medicaid Financing: The Basics," KFF, March 4, 2026, https://www.kff.org/medicaid/medicaid-financing-the-basics/, accessed November 12, 2026.

[339] Elizabeth Williams, Alice Burns, Anna Mudumala and Robin Rudowitz, "Medicaid Financing: The Basics," KFF, March 4, 2026, https://www.kff.org/medicaid/medicaid-financing-the-basics/, accessed November 12, 2026.

[340] Elizabeth Williams, Alice Burns, Anna Mudumala and Robin Rudowitz, "Medicaid Financing: The Basics," KFF, March 4, 2026, https://www.kff.org/medicaid/medicaid-financing-the-basics/, accessed November 12, 2026.

taxes on health care providers, and 4 percent from other sources, according to figures from the Government Accountability Office (GAO) reported by MACPAC.[341]

Provider taxes deserve a word, because they are part of the 2025 fight. A state taxes its hospitals or nursing homes, uses the money as its share to draw down federal matching funds, and often pays much of it back to those providers through higher Medicaid rates. Federal rules allow this within limits. Before the 2025 law, a tax was generally allowed if it was no more than 6 percent of a provider's net patient revenue.[342] The 2025 budget law tightened these limits. MACPAC notes that after October 1, 2026, the threshold is 0 percent for new provider taxes, and expansion states face a lower ceiling starting in fiscal year 2028.[343] Supporters of the change call provider taxes a way for states to shift costs to federal taxpayers; states and hospitals call them a legitimate funding tool. Chapter 12 covers the 2025 law in full.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| HI trust fund projected to run out in Q2 2033, paying 89% of costs after that (2026 Trustees Report) | Whether the projected date is a crisis or a routine warning is a matter of debate (see Chapter 17) | What CMS would legally do if HI ran out; CRS calls the options "legally untested" |
| General revenue paid $572.9 billion of Medicare's $1,226.2 billion income in 2025 | Whether rising general revenue needs are a problem depends on views about taxes and federal spending | How the 2025 law's provider-tax limits will affect state budgets over time |
| FMAP ranges from 50% to 76.90% among the states and DC in FY2026 (MACPAC) | | |

[341] Medicaid and CHIP Payment and Access Commission, "Financing," Medicaid 101, https://www.macpac.gov/medicaid-101/financing/, accessed November 12, 2026.

[342] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

[343] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing," issue brief, August 2025, https://www.macpac.gov/wp-content/uploads/2025/08/Medicaid-Financing.pdf, accessed November 12, 2026.

# Chapter 14. Where the Money Goes

*Information in this chapter stops at November 12, 2026. The newest complete national data are for 2024.*

Chapter 13 followed the money in. This chapter follows it out: to hospitals, doctors, drug makers, nursing homes, private plans and the cost of running the programs.

## The big picture

In 2024, the United States spent $5.3 trillion on health care, or $15,474 per person. That was 18.0 percent of the nation's gross domestic product. Medicare spent $1,118.0 billion, 21 percent of the total, and Medicaid spent $931.7 billion, 18 percent.[344]

You might notice that Chapter 13 gave a larger Medicare figure, $1,210.1 billion. The two numbers measure different things in different years. The Trustees' figure is total Medicare spending in calendar year 2025, including all benefits and administration. The National Health Expenditure (NHE) figure is for 2024 and is built to fit CMS's national health accounts. I did not read CMS's technical notes on exactly how the two measures differ, so I simply keep them apart and label each one. When you compare numbers across sources, always check the year and what is counted.

## Medicare spending by part

**Table 14.1. Medicare spending by part, 2025 (billions of nominal dollars, as of November 12, 2026)**

| Part | What it pays for | Spending |
|---|---|---|
| Part A (HI) | Hospital stays, skilled nursing, hospice, some home health | $444.2 |
| Part B | Doctors, outpatient care, some drugs given in offices | $584.3 |
| Part D | Prescription drugs | $181.5 |
| **Total** | | **$1,210.1** |

Source: 2026 Medicare Trustees Report, Table II.B1.[345]

Medicare Advantage plans are paid from both Part A and Part B. MedPAC projects payments to Medicare Advantage plans at $615 billion in 2026.[346]

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[344] Centers for Medicare and Medicaid Services, "NHE Fact Sheet" (2024 data), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet, accessed November 12, 2026.

[345] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026, Table II.B1.

[346] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

## Spending by type of service

Across the whole health system, not just Medicare and Medicaid, the biggest categories in 2024 were hospital care, $1,634.7 billion (up 8.9 percent); physician and clinical services, $1,109.7 billion (up 8.1 percent); and retail prescription drugs, $467.0 billion (up 7.9 percent).[347] Medicare and Medicaid are major payers in each of these. The CMS summary I read did not give each program's share by service, so I do not estimate it.

**Table 14.2. Selected national health spending categories, 2024 (billions of nominal dollars, as of November 12, 2026)**

| Category | 2024 spending | Growth from 2023 |
|---|---|---|
| Hospital care | $1,634.7 | 8.9% |
| Physician and clinical services | $1,109.7 | 8.1% |
| Retail prescription drugs | $467.0 | 7.9% |
| Private health insurance (payer, for comparison) | $1,644.6 | not shown |

Source: CMS, NHE Fact Sheet, page last modified June 24, 2026.[348]

Medicaid's spending is shaped by who it covers. CRS reports that in 2020, children and non-disabled adults made up 78 percent of Medicaid enrollment but only 46 percent of benefit spending. People who were aged or had disabilities were 22 percent of enrollment but 54 percent of spending.[349] Long-term care is the reason: Medicaid covers 61 percent of all long-term care spending in the country.[350] People who qualify for both programs are expensive for both: in 2022 they were 20 percent of Medicare enrollees but 36 percent of Medicare spending, and 13 percent of Medicaid enrollees but 27 percent of Medicaid spending.[351]

Most Medicaid money now flows through private managed care companies. Payments to those companies were 52 percent of Medicaid spending in fiscal year 2023.[352]

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[347] Centers for Medicare and Medicaid Services, "NHE Fact Sheet" (2024 data), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet, accessed November 12, 2026.

[348] Centers for Medicare and Medicaid Services, "NHE Fact Sheet" (2024 data), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet, accessed November 12, 2026.

[349] Congressional Research Service, "Medicaid: An Overview," Report R43357, updated April 30, 2025, https://www.everycrsreport.com/reports/R43357.html, accessed November 12, 2026.

[350] Alice Burns, Elizabeth Hinton, Robin Rudowitz and Maiss Mohamed, "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/10-things-to-know-about-medicaid/, accessed November 12, 2026.

[351] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," December 2025, https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/, accessed November 12, 2026.

[352] Alice Burns, Elizabeth Hinton, Robin Rudowitz and Maiss Mohamed, "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/10-things-to-know-about-medicaid/, accessed November 12, 2026.

## Spending over time

Both programs have grown far faster than anyone expected in 1965, both because more people enrolled and because health care itself became more expensive and more capable. CMS publishes year-by-year figures back to 1960 in downloadable data tables. I was not able to open those tables for this book, so I do not print a historical series here; any year-by-year numbers you see elsewhere should be checked against CMS's National Health Expenditure historical data.

What I can give is the direction ahead. CMS projects national health spending to grow an average of 5.4 percent a year from 2025 to 2034, faster than the economy's 4.1 percent, raising health care's share of the economy from 18.0 percent in 2024 to 20.6 percent in 2034. Medicare spending is projected to grow 7.7 percent a year, the fastest of the major payers, as the baby boom generation ages into the program. Medicaid is projected to grow 5.0 percent a year.[353] These are nominal figures, not adjusted for inflation.

The Trustees put the same trend in terms of the economy: Medicare cost 3.9 percent of gross domestic product in 2025 and is projected to reach 6.5 percent by 2050.[354]

## How much goes to administration?

People often ask how much of each program's spending goes to overhead rather than care. The answer depends on what you count.

Supporters of traditional Medicare often say its overhead is very low compared with private insurance. Supporters of Medicare Advantage answer that this comparison leaves out costs the government pays elsewhere, and that private plans do things, such as care management, that count as overhead but may improve care. KFF, using 2021 figures, put the cost of administering traditional Medicare plus CMS's oversight of Medicare Advantage and Part D at $10.8 billion, about 1.3 percent of Medicare spending. That figure does not include the private plans' own administration and profit; KFF reports those were about 8 percent of net Part D plan benefit payments.[355] These are older figures, and I did not find a newer official breakdown. KFF also reports that state administrative costs are about 4 percent of total Medicaid spending.[356]

What I can show is the scale of the money that flows through private plans in both programs. MedPAC projects $615 billion in payments to Medicare Advantage plans in 2026.[357] In Medicaid, payments to managed care companies were 52 percent of spending in fiscal year

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[353] Centers for Medicare and Medicaid Services, "NHE Fact Sheet" (2024 data), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet, accessed November 12, 2026.

[354] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[355] Juliette Cubanski and Tricia Neuman, "What to Know about Medicare Spending and Financing," KFF, January 19, 2023 (updated May 2026), https://www.kff.org/medicare/what-to-know-about-medicare-spending-and-financing/, accessed November 12, 2026.

[356] Elizabeth Williams, Alice Burns, Anna Mudumala and Robin Rudowitz, "Medicaid Financing: The Basics," KFF, March 4, 2026, https://www.kff.org/medicaid/medicaid-financing-the-basics/, accessed November 12, 2026.

[357] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

2023.[358] Some part of that money goes to the companies' administration and profit, which do not show up as government overhead.

Paragon Health Institute, a market-oriented group, argues that government administrative costs for Parts A and B, about $12.6 billion in 2025 by its count, are left out of some comparisons with private plans.[359]

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| Medicare spent $1,118.0 billion and Medicaid $931.7 billion in 2024 (CMS NHE) | Whether low administrative costs in traditional Medicare reflect efficiency or too little oversight is debated | |
| Medicare Part B was the largest part of Medicare spending in 2025 (Trustees) | Whether private plans' overhead buys better care | The administrative share of each program (not verified here) |
| Aged and disabled people were 22 percent of Medicaid enrollment and 54 percent of its spending (2020) | | Year-by-year history from CMS's data tables (not read for this book) |
| CMS projects health spending at 20.6 percent of GDP by 2034, with Medicare growing 7.7 percent a year | Whether projections will hold | |

[358] Alice Burns, Elizabeth Hinton, Robin Rudowitz and Maiss Mohamed, "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/10-things-to-know-about-medicaid/, accessed November 12, 2026.

[359] Demetrios L. Kouzoukas and Jackson Hammond, "Taking a Closer Look at MA and Fee-For-Service Cost Comparisons," Paragon Health Institute (advocacy group; market-oriented), March 26, 2026, https://paragoninstitute.org/paragon-prognosis/taking-a-closer-look-ma-and-fee-for-service-cost-comparisons/, accessed November 12, 2026.

# Part Six: Fraud, Waste and Medicare Advantage

## Chapter 15. Fraud, Waste and Improper Payments: What the Audits Show

*Information in this chapter stops at November 12, 2026.*

Few topics in health policy produce bigger numbers, or more confusion, than fraud. You will hear that Medicare fraud costs "hundreds of billions." You will also hear that fraud is rare and the whole topic is overblown. Both camps tend to grab whatever number helps them. This chapter sorts out the words, explains how the government measures the problem, and walks through what the official auditors actually found.

### Three words that are not the same

People use "fraud, waste and abuse" as one phrase, almost one word. They are different things, and mixing them up is the source of most bad claims on this topic.

- **Fraud** is knowingly lying to get paid: billing for services never given, paying kickbacks for referrals, or faking diagnoses. It is a crime, and proving it takes evidence of intent.
- **Waste** is spending on care that does not help, or paying more than needed, without any intent to cheat. A test ordered twice because two offices do not share records is waste. Nobody goes to prison for it.
- **Improper payments** are a specific government measurement. The Government Accountability Office (GAO) defines them as payments "that should not have been made or were made in incorrect amounts."[360]

That third word is the one with the big published numbers, so it matters most to understand. Federal agencies count a payment as improper when they cannot prove it was right. GAO explains that executive branch estimates "treat as improper any payments whose propriety cannot be determined due to lacking or insufficient documentation."[361] In plain words: if the paperwork is missing or incomplete, the payment goes in the improper column, even if the patient really needed and got the care.

You might ask, "If a payment is improper, wasn't the money stolen?" Not usually. Some improper payments are fraud. Many are a missing signature, a doctor's note that did not spell out why a test was needed, or a claim billed under the wrong code. The improper payment figures are a useful measure of how well the programs police their own bills. They cannot be read as fraud figures.

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[360] U.S. Government Accountability Office, "Payment Integrity: Agencies' Estimated Improper Payments Increased to $186 Billion in Fiscal Year 2025," GAO-26-108694, April 27, 2026, https://www.gao.gov/assets/890/888176.pdf, accessed November 12, 2026.

[361] U.S. Government Accountability Office, "Payment Integrity: Agencies' Estimated Improper Payments Increased to $186 Billion in Fiscal Year 2025," GAO-26-108694, April 27, 2026, https://www.gao.gov/assets/890/888176.pdf, accessed November 12, 2026.

## How improper payments are measured

Each year, CMS estimates improper payments for each program by sampling claims and checking them against the rules. For traditional Medicare, the method is called Comprehensive Error Rate Testing (CERT). In CMS's words, "Each year, the CERT program reviews a statistically valid stratified random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules."[362]

The fiscal year 2025 figures come from claims paid between July 1, 2023 and June 30, 2024. That lag is normal: auditors need time to request and review medical records.[363] Medicaid and Medicare Advantage use their own sampling methods, but the idea is the same.

**Table 15.1. Estimated improper payments, fiscal year 2025, compared with 2024 (nominal dollars, as reported November 12, 2026)**

| Program | FY2025 rate | FY2025 amount | FY2024 rate | FY2024 amount |
|---|---|---|---|---|
| Medicare fee-for-service (traditional) | 6.55% | $28.83 billion | 7.66% | $31.70 billion |
| Medicare Advantage (Part C) | 6.09% | $23.67 billion | 5.61% | $19.07 billion |
| Medicare Part D | 4.00% | $4.23 billion | 3.70% | $3.58 billion |
| Medicaid | 6.12% | $37.39 billion | 5.09% | $31.10 billion |
| CHIP | 7.05% | $1.37 billion | 6.11% | $1.07 billion |

Source: CMS, "Fiscal Year 2025 Improper Payments Fact Sheet," January 15, 2026.[364]

Add the rows up and you get about $95.5 billion in estimated improper payments across these programs in fiscal year 2025 (my arithmetic from the table). That is a real and large number. KFF, summarizing the Medicaid estimate, reports that 77 percent of Medicaid improper payments in fiscal year 2025 were due to insufficient information, not to payments that were shown to be wrong.[365] For comparison, GAO reported about $186 billion in improper payments across the whole federal government that year, up about $24 billion from the year before. Medicare, counting its three parts, accounted for about $57 billion, and Medicaid about $37 billion.[366] So these two programs are a large share of the government's improper payment problem, mostly because they are so big.

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[362] Centers for Medicare and Medicaid Services, "Comprehensive Error Rate Testing (CERT)," page last modified August 25, 2026, https://www.cms.gov/cert, accessed November 12, 2026.

[363] Centers for Medicare and Medicaid Services, "Comprehensive Error Rate Testing (CERT)," page last modified August 25, 2026, https://www.cms.gov/cert, accessed November 12, 2026.

[364] Centers for Medicare and Medicaid Services, "Fiscal Year 2025 Improper Payments Fact Sheet," January 15, 2026, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet, accessed November 12, 2026.

[365] Elizabeth Williams, Alice Burns, Anna Mudumala and Robin Rudowitz, "Medicaid Financing: The Basics," KFF, March 4, 2026, https://www.kff.org/medicaid/medicaid-financing-the-basics/, accessed November 12, 2026.

[366] U.S. Government Accountability Office, "Payment Integrity: Agencies' Estimated Improper Payments Increased to $186 Billion in Fiscal Year 2025," GAO-26-108694, April 27, 2026, https://www.gao.gov/assets/890/888176.pdf, accessed November 12, 2026.

The error rates differ a lot inside traditional Medicare. In fiscal year 2025 the overall rate was 6.55 percent, Part B services ran 8.44 percent, and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ran 24.12 percent.[367] That last number does not prove that a quarter of wheelchair and oxygen claims are fraud. It does show where the paperwork, and the risk, is worst.

The trend moved in two directions. Traditional Medicare's rate dropped from 7.66 percent to 6.55 percent. Medicare Advantage, Part D, Medicaid and CHIP rates all rose.[368]

## How big is fraud, really?

Nobody knows the exact amount of health care fraud, because successful fraud is, by definition, hidden. MACPAC puts it plainly: "Because fraud is particularly difficult to detect, its precise magnitude is unknown." It also notes research finding that "the great majority of Medicaid providers do not engage in such actions."[369] I looked for an official federal estimate of fraud in Medicare alone and did not find one. The CMS fact sheet, the GAO payment integrity report and the CERT page I read all report improper payments, not fraud.[370]

A figure you may see is a GAO estimate that fraud across the entire federal government runs between $233 billion and $521 billion a year. I was not able to confirm that figure in the sources I could read for this book, so I mark it [Not verified], and even in its usual telling it covers all federal programs, not Medicare alone. You may also see a private industry estimate that fraud takes "3 to 10 percent" of health spending. I was not able to read the original source, so that is [Not verified] as well.

What I can say with confidence: the measured improper payments in Medicare and Medicaid were about $95 billion in fiscal year 2025, some unknown part of that was fraud, and some fraud is never caught by the sampling at all.

## What the inspectors general and GAO found

The Office of Inspector General (OIG) at the Department of Health and Human Services (HHS) and GAO are the two main watchdogs. Their reports are Tier 1 sources in this book because they are official audits with published methods.

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[367] Centers for Medicare and Medicaid Services, "Comprehensive Error Rate Testing (CERT)," page last modified August 25, 2026, https://www.cms.gov/cert, accessed November 12, 2026.

[368] Centers for Medicare and Medicaid Services, "Fiscal Year 2025 Improper Payments Fact Sheet," January 15, 2026, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet, accessed November 12, 2026.

[369] Medicaid and CHIP Payment and Access Commission, "Program Integrity," March 30, 2018, https://www.macpac.gov/subtopic/program-integrity/, accessed November 12, 2026.

[370] Centers for Medicare and Medicaid Services, "Fiscal Year 2025 Improper Payments Fact Sheet," January 15, 2026, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet, accessed November 12, 2026; U.S. Government Accountability Office, "Payment Integrity: Agencies' Estimated Improper Payments Increased to $186 Billion in Fiscal Year 2025," GAO-26-108694, April 27, 2026, https://www.gao.gov/assets/890/888176.pdf, accessed November 12, 2026; Centers for Medicare and Medicaid Services, "Comprehensive Error Rate Testing (CERT)," page last modified August 25, 2026, https://www.cms.gov/cert, accessed November 12, 2026.

**High-risk programs.** GAO keeps a "High-Risk List" of federal programs most open to waste and mismanagement. Its 2025 update lists "Medicare Program and Improper Payments" and "Strengthening Medicaid Program Integrity," both marked as "no change since 2023." GAO wrote that "Since 2003, federal agencies have reported about $2.8 trillion in estimated improper payments," and that the high-risk areas account for about 80 percent of the government-wide improper payment estimate.[371] The page I read did not give the year each program was first added, so I leave that out.

**Medicare Advantage diagnoses.** In October 2024, OIG reported that diagnoses found only on in-home "health risk assessments" and related chart reviews, with no other record of treatment, produced an estimated $7.5 billion in Medicare Advantage payments for 2023. Almost two-thirds of that came from in-home assessments and linked chart reviews. "Just 20 MA companies drove 80 percent of the estimated $7.5 billion in payments."[372] OIG made three recommendations. CMS agreed with one (studying whether certain diagnosis categories are more open to misuse) and did not agree with the other two (new limits on these diagnoses, and audits of them). All three were still listed as open.[373] Chapter 16 explains why diagnoses matter so much to plan payments.

**Medicare Advantage denials.** In April 2022, OIG reviewed denials by 15 of the largest Medicare Advantage companies during one week in June 2019. It found that "among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules." For payment denials, 18 percent of the requests met both Medicare coverage rules and the plans' billing rules.[374] In plain words, roughly one in eight denied requests in that sample would have been approved under traditional Medicare's rules. This is a finding about wrongful denials, the opposite of overpayment, and it is a reminder that payment integrity problems run in both directions.

**The yearly compliance check.** A 2019 law, the Payment Integrity Information Act (PIIA), requires agencies to measure and report improper payments. In August 2026, OIG reported that HHS "met many requirements, but it did not fully comply" with that law for fiscal year 2025.[375] The specific shortfalls are in the full report, which I did not read, so I do not list them.

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[371] U.S. Government Accountability Office, "High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness," GAO-25-107743, February 25, 2025, https://www.gao.gov/products/gao-25-107743, accessed November 12, 2026.

[372] U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions," OEI-03-23-00380, October 21, 2024, https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions, accessed November 12, 2026.

[373] U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions," OEI-03-23-00380, October 21, 2024, https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions, accessed November 12, 2026.

[374] U.S. Department of Health and Human Services, Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," OEI-09-18-00260, April 27, 2022, https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care, accessed November 12, 2026.

[375] U.S. Department of Health and Human Services, Office of Inspector General, "Department of Health and Human Services Met Many Requirements, but It Did Not Fully Comply With the Payment Integrity Information Act of 2019 for Fiscal Year 2025," OAS-26-17-042, August 3, 2026, https://oig.hhs.gov/reports/all/2026/department-of-health-

## Enforcement

The Department of Justice (DOJ) runs an annual "health care fraud takedown," a coordinated set of criminal cases. On June 23, 2026, DOJ announced its 2026 takedown: 455 defendants charged, including 90 doctors and other licensed medical professionals, in cases involving more than $6.5 billion in alleged fraud. The Medicaid-related part involved 295 defendants and more than $518 million.[376] My source for these figures is a law firm's summary of the DOJ announcement, a Tier 4 source, because the DOJ page itself could not be reached from my tools. Two cautions apply. "Alleged" means charged, not proven. And takedown figures usually count the amount billed or intended, not the amount actually paid out.

You may read that the 2026 takedown was smaller or larger than 2025's. I was not able to confirm the 2025 figures, so I do not compare them.

## What makes the programs vulnerable

The programs pay huge numbers of claims quickly. Traditional Medicare is built to pay promptly and check later, which critics call "pay and chase." That speed keeps doctors and hospitals in the program, but it means some money goes out before anyone looks closely. Providers that bill for equipment and supplies, as the 24.12 percent DMEPOS error rate suggests, are an area of special risk.[377]

Medicare Advantage has a different weak spot: because plans are paid more for sicker enrollees, the incentive is to record more diagnoses. The OIG health risk assessment report shows how that can work in practice.[378]

Medicaid has its own: it is run by 50 states, DC and the territories, each with its own systems, and errors in deciding who is eligible show up in its improper payment rate. Those are often documentation errors in eligibility files, not people lying to get coverage. The 2025 budget law's more frequent eligibility checks (Chapter 12) were sold partly as a way to reduce these errors.[379]

## What this chapter does not prove

It would be easy to read this chapter as "the programs are riddled with fraud" or as "the problem is just paperwork." Neither is supported. The records show large measured improper payments,

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and-human-services-met-many-requirements-but-it-did-not-fully-comply-with-the-payment-integrity-information-act-of-2019-for-fiscal-year-2025/, accessed November 12, 2026.

[376] Arnold and Porter (law firm), "DOJ Announces Record-Breaking 2026 Health Care Fraud Takedown," Enforcement Edge blog, June 29, 2026, https://www.arnoldporter.com/en/perspectives/blogs/enforcement-edge/2026/06/doj-announces-record-breaking-2026-health-care-fraud-takedown, accessed November 12, 2026.

[377] Centers for Medicare and Medicaid Services, "Comprehensive Error Rate Testing (CERT)," page last modified August 25, 2026, https://www.cms.gov/cert, accessed November 12, 2026.

[378] U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions," OEI-03-23-00380, October 21, 2024, https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions, accessed November 12, 2026.

[379] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

a real and prosecuted fraud problem, a specific, documented coding issue in Medicare Advantage, and documented wrongful denials. They do not give a reliable total for fraud alone.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| CMS estimated $28.83 billion in improper payments in traditional Medicare, $23.67 billion in Medicare Advantage and $37.39 billion in Medicaid in FY2025 | How much of the improper payment total is real loss versus missing paperwork is argued by both sides | The true amount of health care fraud |
| GAO counts payments with missing documentation as improper | Whether "pay and chase" should give way to more up-front review is a policy choice | Whether the rising Medicaid and MA rates reflect more errors or better measurement |
| OIG found $7.5 billion in 2023 MA payments from diagnoses found only on health risk assessments | Whether those diagnoses are mostly real but untreated, or mostly inflated, is disputed | The full list of HHS's PIIA shortfalls (in a report I did not read) |
| OIG found 13 percent of sampled MA prior authorization denials met Medicare rules | Whether the 2019 sample reflects plan behavior today | How denial rates have changed since 2019 |
| DOJ's 2026 takedown charged 455 people in cases involving more than $6.5 billion in alleged fraud | Takedown totals are allegations, not losses | How much will be proven and recovered |

# Chapter 16. Medicare Advantage: How Private Plans Are Paid, and the Overpayment Debate

*Information in this chapter stops at November 12, 2026.*

More than half of people with Medicare now get their benefits through a private plan called Medicare Advantage. These plans are also at the center of one of the sharpest money arguments in health policy. One side says the government pays them tens of billions of dollars a year more than it would spend on the same people in traditional Medicare. The other side says those comparisons are flawed and that the plans give seniors more for their money. This chapter explains how the plans are paid, what the official studies found, and what each side says.

## The basics

In traditional Medicare (also called Original Medicare or fee-for-service), the government pays doctors and hospitals for each service. In Medicare Advantage (Part C), the government instead pays a private insurance company a set amount per enrollee per month, and the company takes on the job of paying for that person's Part A and Part B care. Most plans also include Part D drug coverage and extra benefits such as dental or vision.

In 2025, Medicare Advantage enrolled about 34.9 million people, 55 percent of Medicare beneficiaries who had both Part A and Part B. That share was 37 percent in 2018.[380] The 2026 Trustees Report puts the share of all Medicare beneficiaries in private plans at about 51 percent.[381] (The two figures differ because MedPAC counts only people eligible for Medicare Advantage, meaning those with both Part A and Part B.)

## How the payment is set: bids, benchmarks and rebates

The payment formula has three moving parts. MedPAC, the nonpartisan commission that advises Congress on Medicare, defines them this way:

- **The benchmark** "is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits."[382] Benchmarks are tied to what traditional Medicare spends per person in each county.
- **The bid** "is intended to represent the dollar amount that the plan estimates will cover its costs of providing the Part A and Part B benefit package for a beneficiary of average spending."[383]

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[380] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[381] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[382] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[383] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

- **The rebate.** When a plan bids below the benchmark, it keeps a share of the difference as a rebate. The share is "as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings." Plans must use rebates for "lower cost sharing, lower premiums, or coverage of non-Medicare services."[384]

Plans with high quality star ratings also get a higher benchmark through a quality bonus program. MedPAC projects that 64 percent of enrollees will be in plans getting this bonus in 2026.[385]

Finally, payments are **risk adjusted**. A plan gets paid more for an enrollee with more recorded health conditions, because that person is expected to cost more. The conditions come from diagnosis codes that doctors record. This is where most of the controversy lives.

**Table 16.1. Medicare Advantage at a glance, 2026 (MedPAC, March 2026; as of November 12, 2026)**

| Measure | Figure |
|---|---|
| Projected total payments to MA plans, 2026 | $615 billion |
| Average annual rebate per enrollee, 2026 | $2,660 |
| Average plan choices for a beneficiary, 2026 | 39 plans from an average of 8 organizations |
| Plan options offered, 2025 | 5,492 from 164 organizations |
| Spending on non-Medicare (extra) benefits, 2023 | Roughly $24 billion |

Sources: MedPAC March 2026 report, Chapter 12, and press release.[386]

## Coding: why recorded diagnoses matter

Because plans are paid more for sicker enrollees, a plan that records more diagnoses for the same people gets paid more. In traditional Medicare, doctors have less financial reason to record every condition, because they are paid per service. The difference is called **coding intensity**.

Congress recognized this and requires CMS to cut Medicare Advantage risk scores to offset it. The law sets a minimum cut of 5.9 percent. MedPAC notes that in 2026 the cut "will reduce MA

[384] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[385] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[386] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026; Medicare Payment Advisory Commission, "March 2026 Report to the Congress" press release, March 12, 2026, https://www.medpac.gov/wp-content/uploads/2026/03/March_2026_MedPAC_Report_Press_Release_SEC.pdf, accessed November 12, 2026.

risk scores by the minimum amount, 5.9 percent," and that CMS "has the authority to impose a larger reduction than the minimum required by law but has never done so."[387]

MedPAC found that even after that cut, Medicare Advantage risk scores will be about 4 percent higher than for similar people in traditional Medicare in 2026, and it identified eight Medicare Advantage organizations whose average coding intensity was more than 20 percent higher than traditional Medicare levels in 2024.[388]

The HHS Office of Inspector General (OIG) has also studied one source of extra diagnoses: health risk assessments, often done in the home, that record conditions which then do not show up in any later treatment. OIG estimated that diagnoses found only on these assessments and linked chart reviews produced $7.5 billion in Medicare Advantage payments for 2023, and that "Just 20 MA companies drove 80 percent" of that amount. CMS agreed with only one of OIG's three recommendations.[389]

## Favorable selection: who chooses the plans

The second issue is **favorable selection**. If people who choose Medicare Advantage tend to be healthier than average in ways the risk adjustment formula does not capture, the government pays plans as if they were sicker than they really are. MedPAC estimates favorable selection will raise Medicare Advantage payments by roughly 11 percent in 2026.[390]

## MedPAC's bottom line: 14 percent, about $76 billion

Putting coding and selection together, MedPAC estimates that "Medicare will spend 14 percent, a projected $76 billion, more for MA enrollees in 2026" than it would if those same people were in traditional Medicare.[391] MedPAC also estimates that this raises Part B premiums for everyone, including people in traditional Medicare, by about $11 billion in 2026, because Part B premiums are set to cover a share of total Part B spending.[392]

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[387] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[388] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[389] U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions," OEI-03-23-00380, October 21, 2024, https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions, accessed November 12, 2026.

[390] Medicare Payment Advisory Commission, "March 2026 Report to the Congress" press release, March 12, 2026, https://www.medpac.gov/wp-content/uploads/2026/03/March_2026_MedPAC_Report_Press_Release_SEC.pdf, accessed November 12, 2026.

[391] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[392] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

MedPAC is open about the limits of its data. It says plan-submitted data about enrollees' health care encounters "are incomplete," and that "relatively little is known about beneficiaries' use of these benefits or about their value," referring to the extra benefits plans offer.[393]

## What the plans and their supporters say

Supporters of Medicare Advantage dispute MedPAC's estimate. Their main arguments, in their own words:

- The Better Medicare Alliance, a group that backs Medicare Advantage, said through spokesperson Rebecca Buck that MedPAC's method "fails to account for key differences between Medicare Advantage and Fee-For-Service," and that "Medicare Advantage provides more value for beneficiaries and the government."[394]
- The Paragon Health Institute, a market-oriented policy group, argued in March 2026 that MedPAC's analysis "relies on old data, apples-to-oranges comparisons, and increasingly disputed assumptions." It said MedPAC's selection estimate "focuses too narrowly on 'switchers,'" that it ignores spillover effects (savings that Medicare Advantage may create in traditional Medicare in the same area), and that it leaves out the government's own costs of running traditional Medicare.[395] Paragon also noted that MedPAC's 14 percent figure is lower than its 2025 estimate of 20 percent.[396]

From the other side, critics of Medicare Advantage point to MedPAC's estimates and to OIG's findings on diagnoses from health risk assessments as evidence that the plans are overpaid (Chapter 15).[397]

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[393] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026; Medicare Payment Advisory Commission, "March 2026 Report to the Congress" press release, March 12, 2026, https://www.medpac.gov/wp-content/uploads/2026/03/March_2026_MedPAC_Report_Press_Release_SEC.pdf, accessed November 12, 2026.

[394] Rebecca Pifer Parduhn, "Medicare Advantage Overpayments Will Total $76B This Year: MedPAC," Healthcare Dive, January 16, 2026, https://www.healthcaredive.com/news/medicare-advantage-overpayments-76b-2026-medpac/809859/, accessed November 12, 2026.

[395] Demetrios L. Kouzoukas and Jackson Hammond, "Taking a Closer Look at MA and Fee-For-Service Cost Comparisons," Paragon Health Institute (advocacy group; market-oriented), March 26, 2026, https://paragoninstitute.org/paragon-prognosis/taking-a-closer-look-ma-and-fee-for-service-cost-comparisons/, accessed November 12, 2026.

[396] Demetrios L. Kouzoukas and Jackson Hammond, "Taking a Closer Look at MA and Fee-For-Service Cost Comparisons," Paragon Health Institute (advocacy group; market-oriented), March 26, 2026, https://paragoninstitute.org/paragon-prognosis/taking-a-closer-look-ma-and-fee-for-service-cost-comparisons/, accessed November 12, 2026.

[397] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026; U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions," OEI-03-23-00380, October 21, 2024, https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions, accessed November 12, 2026.

## What we can say for certain

Here is how I sort the evidence:

- **Confirmed:** By MedPAC's measurement, Medicare pays more per enrollee in Medicare Advantage than it would spend on similar people in traditional Medicare, and coding and favorable selection drive the gap.[398] The statutory coding cut has been held at its legal minimum of 5.9 percent.[399]
- **Interpretation:** How big the gap really is. MedPAC says 14 percent in 2026. Industry-aligned analysts say MedPAC's method overstates it.[400]
- **Unknown:** The value enrollees get from extra benefits, because plans' encounter data are incomplete, as MedPAC itself says.[401]

Chapter 17 uses this evidence to test two opposite claims: that Medicare Advantage "is a scam that costs taxpayers more," and that it "saves taxpayers money."

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| MA enrolled 34.9 million (55% of eligible) in 2025 (MedPAC) | Size of the MA payment gap: MedPAC 14% vs. critics who say the method overstates it | Value of MA extra benefits to enrollees |
| Coding adjustment held at the 5.9% legal minimum; CMS has never gone higher (MedPAC) | Whether MA creates savings in traditional Medicare ("spillover") | How much of the coding gap reflects better documentation versus inflated coding |
| MedPAC projects $76 billion more spent on MA enrollees in 2026 than in traditional Medicare | | |

[398] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[399] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[400] Demetrios L. Kouzoukas and Jackson Hammond, "Taking a Closer Look at MA and Fee-For-Service Cost Comparisons," Paragon Health Institute (advocacy group; market-oriented), March 26, 2026, https://paragoninstitute.org/paragon-prognosis/taking-a-closer-look-ma-and-fee-for-service-cost-comparisons/, accessed November 12, 2026; Rebecca Pifer Parduhn, "Medicare Advantage Overpayments Will Total $76B This Year: MedPAC," Healthcare Dive, January 16, 2026, https://www.healthcaredive.com/news/medicare-advantage-overpayments-76b-2026-medpac/809859/, accessed November 12, 2026.

[401] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

# Part Seven: Claims and Theories

## Chapter 17. Claims About the Money

*Information in this chapter stops at November 12, 2026.*

This chapter and the next test popular claims about Medicare and Medicaid. For each one, I state the claim the way people actually say it, show where it comes from when I could document that, lay out what the records show, and give one of four verdicts: True, Partly true, False (debunked) or Inconclusive (Chapter 1 explains them). I did not decide any verdict until I had checked the sources, and I held claims from every side to the same test.

A word on "where it comes from." Many of these claims circulate in so many places that no single person owns them. When I could not find a dated, checkable example from a named person or group, I say so, and I do not invent one.

### Claim 1: "Medicare is going bankrupt and will stop paying."

**Where it comes from.** Every year, news stories about the Medicare Trustees Report use words like "bankrupt" and "insolvent," and the claim spreads from there. The Trustees themselves use the word "depleted," not "bankrupt."[402]

**What the records show.**

- The Hospital Insurance (HI) trust fund, which pays for Part A, is projected to run out of reserves in the second quarter of 2033.[403]
- After that, incoming payroll taxes and other income would still pay 89 percent of Part A costs, then 85 percent by 2050 and 93 percent by 2100.[404]
- Parts B and D cannot run out of money under current law. In the Trustees' words, that part of Medicare is "adequately financed" because "income from premiums and Federal Government contributions for Parts B and D are reset each year."[405]
- The law does not say what happens if HI runs out. CRS writes that "There are no provisions in the Social Security Act that govern what would happen if insolvency were to occur," and calls the possible responses "legally untested."[406]

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[402] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[403] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[404] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026; Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

[405] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[406] Congressional Research Service, "Medicare: Insolvency Projections," Report RS20946, updated August 10, 2026, https://www.everycrsreport.com/files/2026-08-10_RS20946_37cf7cc037fcc1104a447bf924e208701216ff16.html, accessed November 12, 2026.

- Projected run-out dates have come and gone before. The 1970 report projected depletion in 1972. Congress has always acted before the fund ran dry, and the fund has never actually been depleted.[407]

**Verdict: Partly true.** The true part: Medicare's hospital trust fund is on track to run short in 2033, and Medicare's overall costs are growing faster than the economy. That is a real and serious financial problem.[408] The twisted part: "bankrupt" suggests Medicare would stop paying. Under the Trustees' projections, Part A could still pay about 89 percent of its bills right after depletion, and Parts B and D are not affected by the trust fund date at all.[409]

## Claim 2: "Medicare is free because you paid for it while working."

**Where it comes from.** This is a common belief rather than a talking point from one side. I did not find a single source that owns it.

**What the records show.**

- Payroll taxes go to the HI trust fund, which pays for Part A. In 2025, payroll taxes were about 87 percent of HI income.[410]
- Most people with 40 quarters of work (about 10 years) pay no Part A premium.[411]
- Part B costs $202.90 a month in 2026 for most people, plus a $283 deductible.[412] After the deductible, "you usually pay 20% of the Medicare-approved amount."[413]
- Premiums cover about 22 percent of Part B and Part D income; general federal revenue covers about 75 percent.[414]
- Part A also has costs when you use it: a $1,736 hospital deductible in 2026.[415]

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[407] Congressional Research Service, "Medicare: Insolvency Projections," Report RS20946, updated August 10, 2026, https://www.everycrsreport.com/files/2026-08-10_RS20946_37cf7cc037fcc1104a447bf924e208701216ff16.html, accessed November 12, 2026.

[408] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[409] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[410] Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

[411] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020); Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[412] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[413] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

[414] Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026.

**Verdict: Partly true.** The true part: workers' payroll taxes do prepay Part A, so most retirees pay no Part A premium. The rest is wrong: Part B and Part D charge premiums, there are deductibles and coinsurance, and most of the cost of Parts B and D is paid by general taxes, not by the payroll tax you paid while working.[416]

## Claim 3: "Medicare Advantage is a scam that costs taxpayers more."

**Where it comes from.** Critics of Medicare Advantage, mostly on the political left, use words like "scam" and "rip-off." I did not find a dated statement from a named official using "scam" that I could verify, so I do not quote one.

**What the records show.**

- MedPAC, Congress's own advisory commission, estimates that Medicare will spend 14 percent, about $76 billion, more on Medicare Advantage enrollees in 2026 than it would have spent if they were in traditional Medicare. It points to two causes: plans attract enrollees who are healthier than their risk scores suggest (favorable selection) and plans record more diagnoses than traditional Medicare does (coding).[417]
- The law sets a minimum cut to plan risk scores to offset coding (5.9 percent), and MedPAC notes CMS "has never" imposed a larger one.[418]
- OIG found $7.5 billion in 2023 payments driven by diagnoses that showed up only on health risk assessments and linked chart reviews.[419]
- Groups that support Medicare Advantage dispute MedPAC's method. The Paragon Health Institute says MedPAC "relies on old data, apples-to-oranges comparisons, and

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[415] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[416] Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2026 Annual Reports," June 2026, https://www.ssa.gov/oact/TRSUM/, accessed November 12, 2026; Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[417] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[418] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[419] U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions," OEI-03-23-00380, October 21, 2024, https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions, accessed November 12, 2026.

increasingly disputed assumptions."[420] The Better Medicare Alliance says MedPAC's method "fails to account for key differences" between the two programs.[421]

**Verdict: Partly true.** The true part: by the measure of Congress's own advisory commission, Medicare Advantage costs taxpayers more per enrollee than traditional Medicare would.[422] The twisted part: "scam" implies the program itself is a fraud. Most of the extra payment comes from how the payment law and formula work, which Congress set and can change, and plans use much of the money for extra benefits and lower cost sharing for their enrollees.[423] Coding problems at specific companies are documented, but that is not the same as the whole program being a scam.[424]

## Claim 4: "Medicare Advantage saves taxpayers money."

**Where it comes from.** Supporters of Medicare Advantage often say the private plans deliver more value. The Better Medicare Alliance, for example, says Medicare Advantage enrollees have "lower average out-of-pocket costs" and that "Medicare Advantage provides more value for beneficiaries and the government."[425]

**What the records show.**

- The official estimate from MedPAC points the other way: 14 percent more per enrollee in 2026.[426]
- The Paragon Health Institute argues that MedPAC overstates the gap, for example by leaving out the government's own cost of running traditional Medicare, which it puts at

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[420] Demetrios L. Kouzoukas and Jackson Hammond, "Taking a Closer Look at MA and Fee-For-Service Cost Comparisons," Paragon Health Institute (advocacy group; market-oriented), March 26, 2026, https://paragoninstitute.org/paragon-prognosis/taking-a-closer-look-ma-and-fee-for-service-cost-comparisons/, accessed November 12, 2026.

[421] Rebecca Pifer Parduhn, "Medicare Advantage Overpayments Will Total $76B This Year: MedPAC," Healthcare Dive, January 16, 2026, https://www.healthcaredive.com/news/medicare-advantage-overpayments-76b-2026-medpac/809859/, accessed November 12, 2026.

[422] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[423] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[424] U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions," OEI-03-23-00380, October 21, 2024, https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions, accessed November 12, 2026.

[425] Better Medicare Alliance (advocacy group supporting Medicare Advantage), "Medicare Beneficiary Spending 2026," August 4, 2026, https://bettermedicarealliance.org/publication/medicare-beneficiary-spending-2026-2/, accessed November 12, 2026; Rebecca Pifer Parduhn, "Medicare Advantage Overpayments Will Total $76B This Year: MedPAC," Healthcare Dive, January 16, 2026, https://www.healthcaredive.com/news/medicare-advantage-overpayments-76b-2026-medpac/809859/, accessed November 12, 2026.

[426] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

$12.6 billion for Parts A and B in 2025.[427] Even taking Paragon's critique fully on board, I did not find an official estimate showing that Medicare Advantage costs taxpayers less overall.

- The Better Medicare Alliance figures are about what enrollees pay out of pocket, not about what taxpayers pay. The group's own report also says out-of-pocket spending "increased for both Medicare Advantage and Fee-for-Service Medicare Enrollees in 2023."[428]

**Verdict: False (debunked).** The best official evidence, from MedPAC, shows Medicare Advantage costing taxpayers more per enrollee, not less.[429] The size of the gap is honestly disputed, and supporters raise fair points about method.[430] There is also evidence that enrollees often pay less out of pocket, which is a real benefit to them.[431] But "saves taxpayers money" is a claim about the federal budget, and no official estimate I found supports it.

## Claim 5: "Medicare fraud costs hundreds of billions a year."

**Where it comes from.** Large fraud figures are repeated across the political spectrum, often by mixing up improper payments with fraud. I did not find a single named source to quote.

**What the records show.**

- CMS estimated about $57 billion in improper payments across traditional Medicare, Medicare Advantage and Part D in fiscal year 2025.[432]
- Improper payments are not the same as fraud. They include payments that could not be confirmed because the paperwork was missing.[433]

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[427] Demetrios L. Kouzoukas and Jackson Hammond, "Taking a Closer Look at MA and Fee-For-Service Cost Comparisons," Paragon Health Institute (advocacy group; market-oriented), March 26, 2026, https://paragoninstitute.org/paragon-prognosis/taking-a-closer-look-ma-and-fee-for-service-cost-comparisons/, accessed November 12, 2026.

[428] Better Medicare Alliance (advocacy group supporting Medicare Advantage), "Medicare Beneficiary Spending 2026," August 4, 2026, https://bettermedicarealliance.org/publication/medicare-beneficiary-spending-2026-2/, accessed November 12, 2026.

[429] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[430] Demetrios L. Kouzoukas and Jackson Hammond, "Taking a Closer Look at MA and Fee-For-Service Cost Comparisons," Paragon Health Institute (advocacy group; market-oriented), March 26, 2026, https://paragoninstitute.org/paragon-prognosis/taking-a-closer-look-ma-and-fee-for-service-cost-comparisons/, accessed November 12, 2026.

[431] Better Medicare Alliance (advocacy group supporting Medicare Advantage), "Medicare Beneficiary Spending 2026," August 4, 2026, https://bettermedicarealliance.org/publication/medicare-beneficiary-spending-2026-2/, accessed November 12, 2026.

[432] Centers for Medicare and Medicaid Services, "Fiscal Year 2025 Improper Payments Fact Sheet," January 15, 2026, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet, accessed November 12, 2026; U.S. Government Accountability Office, "Payment Integrity: Agencies' Estimated Improper Payments Increased to $186 Billion in Fiscal Year 2025," GAO-26-108694, April 27, 2026, https://www.gao.gov/assets/890/888176.pdf, accessed November 12, 2026.

[433] U.S. Government Accountability Office, "Payment Integrity: Agencies' Estimated Improper Payments Increased to $186 Billion in Fiscal Year 2025," GAO-26-108694, April 27, 2026, https://www.gao.gov/assets/890/888176.pdf, accessed November 12, 2026.

- I did not find an official estimate of fraud in Medicare alone (Chapter 15).
- DOJ's 2026 takedown charged 455 defendants in cases involving more than $6.5 billion in alleged fraud across health programs.[434]

**Verdict: Inconclusive.** No official source measures Medicare fraud by itself, so the claim cannot be proven or disproven with the records available. What I can say: the measured improper payments for all of Medicare, about $57 billion, are well short of "hundreds of billions," and most of those are not fraud. For the claim to be true, undetected fraud would have to be several times larger than all measured improper payments. What would settle it: an official, published estimate of fraud in Medicare.

## Claim 6: "Congress raided Medicare to pay for the Affordable Care Act."

**Where it comes from.** The figure usually cited is $716 billion. It became a major issue in the 2012 presidential campaign. Its source is a CBO letter dated July 24, 2012.[435]

**What the records show.**

- CBO's letter estimated what would happen if the ACA were repealed. It said: "Spending for Medicare would increase by an estimated $716 billion over that 2013-2022 period."[436] In other words, the ACA was projected to make Medicare spend $716 billion less over those ten years than it otherwise would have.
- The reductions came mainly from smaller yearly payment increases to hospitals and other providers and lower payments to Medicare Advantage plans. The CBO letter breaks it into a $517 billion net increase in Part A and $247 billion in Part B, offset by a $48 billion decrease in Part D, if the law were repealed.[437]
- The savings helped pay for the ACA's new coverage.[438]
- The Commonwealth Fund's account of the 2012 fight notes that the House Republican budget written by Rep. Paul Ryan kept the same Medicare savings, and that Republican presidential nominee Mitt Romney's position "in effect means keeping the $716 billion in Medicare."[439]

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[434] Arnold and Porter (law firm), "DOJ Announces Record-Breaking 2026 Health Care Fraud Takedown," Enforcement Edge blog, June 29, 2026, https://www.arnoldporter.com/en/perspectives/blogs/enforcement-edge/2026/06/doj-announces-record-breaking-2026-health-care-fraud-takedown, accessed November 12, 2026.

[435] Congressional Budget Office, letter to Speaker John Boehner on H.R. 6079, the Repeal of Obamacare Act, July 24, 2012, https://www.cbo.gov/publication/43471, accessed November 12, 2026; John Reichard, "That $716 Billion Medicare Cut: One Number, Three Competing Visions," Commonwealth Fund (CQ HealthBeat), August 16, 2012, https://www.commonwealthfund.org/publications/newsletter-article/716-billion-medicare-cut-one-number-three-competing-visions, accessed November 12, 2026.

[436] Congressional Budget Office, letter to Speaker John Boehner on H.R. 6079, the Repeal of Obamacare Act, July 24, 2012, https://www.cbo.gov/publication/43471, accessed November 12, 2026.

[437] Congressional Budget Office, letter to Speaker John Boehner on H.R. 6079, the Repeal of Obamacare Act, July 24, 2012, https://www.cbo.gov/publication/43471, accessed November 12, 2026.

[438] John Reichard, "That $716 Billion Medicare Cut: One Number, Three Competing Visions," Commonwealth Fund (CQ HealthBeat), August 16, 2012, https://www.commonwealthfund.org/publications/newsletter-article/716-billion-medicare-cut-one-number-three-competing-visions, accessed November 12, 2026.

[439] John Reichard, "That $716 Billion Medicare Cut: One Number, Three Competing Visions," Commonwealth Fund (CQ HealthBeat), August 16, 2012, https://www.commonwealthfund.org/publications/newsletter-article/716-billion-medicare-cut-one-number-three-competing-visions, accessed November 12, 2026.

**Verdict: Partly true.** The true part: the ACA did cut projected Medicare spending by about $716 billion over 2013 to 2022, and that money helped pay for the ACA's coverage expansion.[440] The twisted part: "raided" suggests money was taken out of a fund or that benefits were cut. The savings came mostly from slower growth in payments to providers and private plans, not from cutting the benefits the law guarantees to enrollees, and the same savings were kept in the main Republican alternative budget at the time.[441]

## Claim 7: "Drug price negotiation will stop new medicines from being made."

**Where it comes from.** The drug industry strongly opposed Medicare negotiation, created by the 2022 Inflation Reduction Act. When CMS named the first drugs, the head of the industry's trade group, Stephen Ubl of PhRMA, said: "Politics should not dictate which treatments and cures are worth developing and who should get access to them."[442] Stronger versions of the claim, that negotiation will "stop" or "end" new cures, circulate widely.

**What the records show.**

- CBO estimated in December 2023 that "13 fewer new drugs (of 1,300 estimated new drugs) will come to market as a result of the law" over the next 30 years, about 1 percent. It also projected global new-drug revenue would drop by 1 to 3 percent.[443]
- Negotiated prices for the first 10 drugs took effect January 1, 2026. Prices for 15 more take effect January 1, 2027, with CMS estimating 44 percent net savings, or $12 billion, on those 15.[444]
- The 2025 budget law widened an exclusion for drugs that treat rare diseases, which CBO estimates will cost $8.8 billion over ten years.[445]

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[440] Congressional Budget Office, letter to Speaker John Boehner on H.R. 6079, the Repeal of Obamacare Act, July 24, 2012, https://www.cbo.gov/publication/43471, accessed November 12, 2026.

[441] Congressional Budget Office, letter to Speaker John Boehner on H.R. 6079, the Repeal of Obamacare Act, July 24, 2012, https://www.cbo.gov/publication/43471, accessed November 12, 2026; John Reichard, "That $716 Billion Medicare Cut: One Number, Three Competing Visions," Commonwealth Fund (CQ HealthBeat), August 16, 2012, https://www.commonwealthfund.org/publications/newsletter-article/716-billion-medicare-cut-one-number-three-competing-visions, accessed November 12, 2026.

[442] Fierce Healthcare, "Pharmaceutical Industry Rips 'Draconian' Price Negotiation Provision" (August 2023, date not shown on page), https://www.fiercehealthcare.com/payers/pharmaceutical-industry-rips-draconian-price-negotiation-provision, accessed November 12, 2026.

[443] Congressional Budget Office, letter to Chairman Jodey Arrington and Rep. Michael C. Burgess on the effects of drug price negotiation, December 21, 2023, https://www.cbo.gov/system/files/2023-12/59792-Letter.pdf, accessed November 12, 2026.

[444] Centers for Medicare and Medicaid Services, "CMS Delivers Savings for Seniors on 15 Major Drugs for Cancer and Chronic Disease," press release, November 25, 2025, https://www.cms.gov/newsroom/press-releases/cms-delivers-savings-seniors-15-major-drugs-cancer-chronic-disease, accessed November 12, 2026; Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF (nonpartisan health research group), March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/, accessed November 12, 2026.

[445] Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF (nonpartisan health research group), March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/, accessed November 12, 2026.

**Verdict: False (debunked).** The independent estimate from CBO projects a small reduction in new drugs, about 13 of 1,300 over 30 years, not a stop.[446] The industry's concern that lower prices could reduce some research has support in that same estimate, and long-term effects are a projection, not a measured result. But the claim as usually stated, that negotiation will stop new medicines from being made, is contradicted by the best available estimate.

## Claim 8: "Medicare for All would cost every family more."

## Claim 9: "Medicare for All would save money."

I take these two together, because they are opposite answers to the same question and the same evidence applies.

**Where they come from.** Opponents of single-payer health care say families would pay much more in taxes. Supporters say one public plan would cut paperwork and drug prices and save money overall. Both claims are usually made about "Medicare for All" in general, not about a specific bill.

**What the records show.** CBO's most detailed work, a December 2020 working paper, looked at five different designs for a single-payer system in 2030. Each design paid doctors and hospitals at different rates and asked patients to pay different amounts.[447]

**Table 17.1. CBO's estimates for five single-payer designs, 2030 (billions of nominal dollars, change from current law; published December 2020)**

| Design | Federal subsidies | Total national health spending |
|---|---|---|
| Option 1: higher payment rates, more cost sharing | +$2,097 | -$158 |
| Option 2: lower payment rates, more cost sharing | +$1,513 | -$743 |
| Option 3: lower payment rates, less cost sharing | +$1,769 | -$650 |
| Option 4: higher payment rates, less cost sharing | +$2,397 | -$42 |
| Option 5: like Option 4, plus long-term care | +$2,996 | +$290 |

Source: CBO Working Paper 2020-08.[448] For scale, CBO projected current-law national health spending of $6,631 billion in 2030.

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[446] Congressional Budget Office, letter to Chairman Jodey Arrington and Rep. Michael C. Burgess on the effects of drug price negotiation, December 21, 2023, https://www.cbo.gov/system/files/2023-12/59792-Letter.pdf, accessed November 12, 2026.

[447] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Working Paper 2020-08, December 2020, https://www.cbo.gov/publication/56811, accessed November 12, 2026.

[448] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Working Paper 2020-08, December 2020, https://www.cbo.gov/publication/56811, accessed November 12, 2026.

Two things stand out. First, federal spending goes up a great deal under every design, by $1.5 trillion to $3.0 trillion in 2030 alone, because the government would be paying bills that employers and families now pay. Second, total national health spending, counting what everyone pays, falls under four designs and rises under one. The result depends mostly on how much the plan pays doctors and hospitals.[449]

A widely cited 2018 study by Charles Blahous of the Mercatus Center, a market-oriented research center, estimated that one Medicare for All bill "would add approximately $32.6 trillion to federal budget commitments during the first 10 years." The study assumed payments to doctors and hospitals about 40 percent below private insurance rates.[450] I read the study's summary page, not the full paper.

**Verdict for Claim 8: Inconclusive.** Whether a family pays more depends on the plan's design and on how it is paid for: families would trade premiums, deductibles and copays for new taxes. CBO's work shows total spending could go down or up depending on design, and it does not show the effect on "every family."[451] What would settle it: a CBO analysis of a specific bill that includes its tax financing and how costs fall on families at different incomes.

**Verdict for Claim 9: Partly true.** The true part: CBO found that some single-payer designs, mainly those that pay doctors and hospitals at lower rates, would reduce total national health spending.[452] The twisted part: "save money" leaves out that federal spending, and therefore taxes, would rise sharply under every design, and that a design with more generous payment rates and long-term care would raise total spending.[453]

## Claim 10: "The 2025 law cuts Medicaid by about $1 trillion."

## Claim 11: "The 2025 law doesn't cut Medicaid; it only removes waste, fraud and abuse."

These are the two main competing claims about the 2025 budget law (Public Law 119-21, often called the One Big Beautiful Bill Act). I test them side by side.

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[449] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Working Paper 2020-08, December 2020, https://www.cbo.gov/publication/56811, accessed November 12, 2026.

[450] Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center at George Mason University (market-oriented research center), working paper, July 30, 2018, https://www.mercatus.org/research/working-papers/costs-national-single-payer-healthcare-system, accessed November 12, 2026.

[451] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Working Paper 2020-08, December 2020, https://www.cbo.gov/publication/56811, accessed November 12, 2026.

[452] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Working Paper 2020-08, December 2020, https://www.cbo.gov/publication/56811, accessed November 12, 2026.

[453] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Working Paper 2020-08, December 2020, https://www.cbo.gov/publication/56811, accessed November 12, 2026.

**Where they come from.** Opponents of the law, such as the Center on Budget and Policy Priorities, said the bill was "taking away Medicaid and affordable marketplace coverage from people who are eligible."[454] The White House said "there will be no cuts to Medicaid" and that the bill "removes illegal aliens, enforces work requirements, and protects Medicaid for the truly vulnerable."[455]

**What the records show.**

- CBO estimated that the law's Medicaid provisions would reduce federal Medicaid spending by $989.7 billion over fiscal years 2025 to 2034, compared with what CBO projected under prior law, and increase the number of uninsured people by 7.5 million in 2034. All of the law's health provisions together were estimated to increase the uninsured by 10.0 million.[456]
- KFF's allocation of the CBO figures puts the net federal Medicaid reduction at $911 billion over ten years after interaction effects, and $990 billion before them.[457]
- The largest single savings items, per CBO's figures as reported by CRS, were community engagement (work) requirements, about $325.6 billion; limits on provider taxes, $191.1 billion; and limits on state directed payments, $149.4 billion.[458]
- These are reductions compared with prior-law projections over ten years, not cuts from this year's spending level.
- The largest savings items are not fraud measures. The work requirement saves money mainly because CBO expects fewer people to be enrolled. The provider tax and state directed payment limits reduce how much states can draw in federal money.[459]

**Verdict for Claim 10: True.** CBO's estimate of the Medicaid provisions, about $990 billion over ten years, rounds to $1 trillion, and KFF's net figure of $911 billion is in the same range.[460]

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[454] Sharon Parrott, Center on Budget and Policy Priorities (policy group; generally supports safety-net programs), "House Republican Bill Fails the Country; Senate Should Reject Any Bill That Takes Away Health Coverage, Food Assistance," statement (2025), https://www.cbpp.org/press/statements/house-republican-bill-fails-the-country-senate-should-reject-any-bill-that-takes, accessed November 12, 2026.

[455] The White House, "Myth v Fact: The One Big Beautiful Bill" (PDF, file dated 6.28, posted July 2025), https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf, accessed November 12, 2026.

[456] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[457] Rhiannon Euhus, Elizabeth Williams, Alice Burns and Robin Rudowitz, "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package," KFF, July 23, 2025, https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/, accessed November 12, 2026.

[458] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[459] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[460] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Rhiannon Euhus, Elizabeth Williams, Alice Burns and Robin Rudowitz, "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package," KFF, July 23, 2025, https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/, accessed November 12, 2026.

The claim should say "over ten years, compared with prior law," and listeners should know it is a reduction from projected spending, not from today's spending. But the number itself is accurate.

**Verdict for Claim 11: False (debunked).** CBO's own estimates show large reductions in federal Medicaid spending and millions more uninsured, and the biggest savings come from work requirements and financing limits, not from removing fraud.[461] The law does contain eligibility and integrity measures that supporters point to, such as more frequent eligibility checks, and people can fairly argue the reductions are good policy. But "no cuts" is contradicted by CBO's figures.

## Summary of verdicts in this chapter

| # | Claim | Verdict |
|---|---|---|
| 1 | Medicare is going bankrupt and will stop paying | Partly true |
| 2 | Medicare is free because you paid for it while working | Partly true |
| 3 | Medicare Advantage is a scam that costs taxpayers more | Partly true |
| 4 | Medicare Advantage saves taxpayers money | False (debunked) |
| 5 | Medicare fraud costs hundreds of billions a year | Inconclusive |
| 6 | Congress raided Medicare to pay for the ACA | Partly true |
| 7 | Drug price negotiation will stop new medicines | False (debunked) |
| 8 | Medicare for All would cost every family more | Inconclusive |
| 9 | Medicare for All would save money | Partly true |
| 10 | The 2025 law cuts Medicaid by about $1 trillion | True |
| 11 | The 2025 law only removes waste, fraud and abuse | False (debunked) |

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| HI trust fund depletion projected for 2033 with 89 percent of costs payable after | Whether "bankrupt" is fair shorthand | What Congress will do before 2033 |
| MedPAC estimates MA costs 14 percent more per enrollee in 2026 | How much of the gap is real versus method | The final size of the gap after method disputes |
| CBO: ACA reduced projected Medicare spending by $716 billion over 2013-2022 | Whether that was a "raid" or savings | |
| CBO: 13 fewer new drugs of 1,300 over 30 years | Whether CBO's research model is right | Long-term effects on drug research |
| CBO: 2025 law reduces federal Medicaid spending by about $990 billion over ten years | Whether the reductions are good policy | How states will respond |

[461] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

# Chapter 18. Claims About Who Gets Care and Who Decides

*Information in this chapter stops at November 12, 2026.*

This chapter tests claims about who is covered, who makes decisions about care, and whether coverage makes a difference. The verdicts use the same four labels as Chapter 17, and the same rule: no verdict until the sources were checked.

## Claim 12: "Death panels decide who gets care."

**Where it comes from.** On August 7, 2009, during the debate over what became the Affordable Care Act, former Alaska Governor Sarah Palin wrote that her parents or her son with Down syndrome would have to "stand in front of Obama's 'death panel' so his bureaucrats can decide" whether they deserved care.[462] The phrase spread fast and still comes up.

**What the records show.**

- FactCheck.org found that "the phrase 'death panel' does not appear in the health care bill."[463]
- The provision people pointed to was section 1233 of the House bill, H.R. 3200, titled "Advance Care Planning Consultation." It would have had Medicare pay for voluntary conversations between patients and their own doctors about end-of-life wishes, such as living wills.[464]
- FactCheck.org wrote that "the bill wouldn't require patients to receive counseling sessions, nor would it require a doctor to offer one."[465]
- That provision was dropped from the final law. Years later, CMS adopted a payment rule for 2016 that would "allow physicians to bill for advanced care planning conversations," again voluntary.[466]
- The ACA also created a board, the Independent Payment Advisory Board, to recommend Medicare savings if spending grew too fast. The law barred it from rationing care, it was never appointed, and Congress later repealed it. I was not able to read the original statute or the repeal law for this book, so those details are [Not verified].

**Verdict: False (debunked).** No law created a panel that decides whether an individual patient lives or gets care. The provision behind the claim paid doctors for optional planning

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[462] Justin Bank, "Palin vs. Obama: Death Panels," FactCheck.org (Annenberg Public Policy Center), August 14, 2009, https://www.factcheck.org/2009/08/palin-vs-obama-death-panels/, accessed November 12, 2026.

[463] Justin Bank, "Palin vs. Obama: Death Panels," FactCheck.org (Annenberg Public Policy Center), August 14, 2009, https://www.factcheck.org/2009/08/palin-vs-obama-death-panels/, accessed November 12, 2026.

[464] Justin Bank, "Palin vs. Obama: Death Panels," FactCheck.org (Annenberg Public Policy Center), August 14, 2009, https://www.factcheck.org/2009/08/palin-vs-obama-death-panels/, accessed November 12, 2026.

[465] Justin Bank, "Palin vs. Obama: Death Panels," FactCheck.org (Annenberg Public Policy Center), August 14, 2009, https://www.factcheck.org/2009/08/palin-vs-obama-death-panels/, accessed November 12, 2026.

[466] Centers for Medicare and Medicaid Services, "CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals and Other Providers," press release, October 30, 2015, https://www.cms.gov/newsroom/press-releases/cms-finalizes-2016-medicare-payment-rules-physicians-hospitals-other-providers, accessed November 12, 2026.

conversations that patients could choose to have or not.[467] People can still argue about how Medicare decides what treatments to cover in general, and prior authorization in Medicare Advantage does involve plan reviewers approving or denying specific services (Chapter 15). But that is not what the "death panel" claim described.

## Claim 13: "Medicaid is mostly for people who could work but don't."

**Where it comes from.** Supporters of work requirements often describe Medicaid adults as "able-bodied" people who choose not to work. The White House's material on the 2025 law, for example, said the work requirement "applies only to able-bodied adults without young children."[468] The stronger claim, that Medicaid is "mostly" for such people, circulates widely.

**What the records show.**

- Children are 47.8 percent of Medicaid and CHIP enrollment.[469]
- CRS reports that in 2020, people who were aged or had disabilities made up 22 percent of Medicaid enrollees.[470]
- KFF looked at adults under 65 on Medicaid who do not get disability benefits or Medicare, the group a work requirement would mainly affect. In 2023, 64 percent of them were working. Counting those who were caregiving, ill or disabled, or in school, 92 percent were either working or had one of those reasons. The remaining 8 percent were retired, could not find work, or did not work for another reason.[471]

**Verdict: False (debunked).** Most people on Medicaid are children, older people or people with disabilities. Among working-age adults without disability benefits, a large majority already work, and most of the rest are caregivers, ill or in school.[472] There is a real group of adults who could work and are not working, and people can fairly argue a work requirement is right for them. But they are a small part of Medicaid, not most of it.

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[467] Justin Bank, "Palin vs. Obama: Death Panels," FactCheck.org (Annenberg Public Policy Center), August 14, 2009, https://www.factcheck.org/2009/08/palin-vs-obama-death-panels/, accessed November 12, 2026.

[468] The White House, "Myth v Fact: The One Big Beautiful Bill" (PDF, file dated 6.28, posted July 2025), https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf, accessed November 12, 2026.

[469] Centers for Medicare and Medicaid Services, "July 2026 Medicaid and CHIP Enrollment Data Highlights," updated October 30, 2026, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights, accessed November 12, 2026.

[470] Congressional Research Service, "Medicaid: An Overview," Report R43357, updated April 30, 2025, https://www.everycrsreport.com/reports/R43357.html, accessed November 12, 2026.

[471] Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update," KFF, May 30, 2025 (updated February 20, 2026), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/, accessed November 12, 2026.

[472] Centers for Medicare and Medicaid Services, "July 2026 Medicaid and CHIP Enrollment Data Highlights," updated October 30, 2026, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights, accessed November 12, 2026; Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update," KFF, May 30, 2025 (updated February 20, 2026), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/, accessed November 12, 2026.

## Claim 14: "Immigrants here illegally get Medicaid."

**Where it comes from.** This claim was central to the 2025 debate. The White House said the 2025 law "removes illegal aliens" from Medicaid.[473]

**What the records show.**

- KFF writes: "Under longstanding federal policy, undocumented immigrants already are ineligible for federally funded health coverage."[474]
- There is one exception. Emergency Medicaid pays hospitals for emergency care, including labor and delivery, for people who meet Medicaid's other rules, such as income, but do not have an eligible immigration status. That covers undocumented immigrants and some lawfully present immigrants.[475]
- Some states use their own money, not federal Medicaid money, to cover some people regardless of immigration status. As of April 2026, 15 states including DC covered children regardless of status, and 7 including DC covered some income-eligible adults. Several have scaled back or closed enrollment.[476]
- The 2025 law did make real changes for immigrants, but mostly for people who are lawfully present. Starting October 1, 2026, federal Medicaid and CHIP funding is limited to citizens, green card holders, Cuban and Haitian entrants, and people from certain Pacific island nations. Refugees and asylees without a green card lose eligibility. Emergency Medicaid is still covered, but the federal match for emergency care for expansion adults dropped to the regular rate.[477]
- CBO estimated the emergency Medicaid change would save $6.2 billion and leave about 100,000 more people uninsured by 2034.[478]

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[473] The White House, "Myth v Fact: The One Big Beautiful Bill" (PDF, file dated 6.28, posted July 2025), https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf, accessed November 12, 2026.

[474] Akash Pillai, Alisha Rao and Samantha Artiga, "Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider," KFF, September 22, 2026, https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/, accessed November 12, 2026.

[475] Akash Pillai, Alisha Rao and Samantha Artiga, "Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider," KFF, September 22, 2026, https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/, accessed November 12, 2026.

[476] Akash Pillai, Drishti Pillai and Samantha Artiga, "State Health Coverage for Immigrants and Implications for Health Coverage and Care," KFF, May 19, 2026 (updated June 11, 2026), https://www.kff.org/racial-equity-and-health-policy/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/, accessed November 12, 2026.

[477] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Akash Pillai, Alisha Rao and Samantha Artiga, "Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider," KFF, September 22, 2026, https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/, accessed November 12, 2026.

[478] Akash Pillai, Alisha Rao and Samantha Artiga, "Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider," KFF, September 22, 2026, https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/, accessed November 12, 2026.

**Verdict: Partly true.** The true part: undocumented immigrants can get federally matched Emergency Medicaid for emergencies, and some states cover some undocumented people with state money.[479] The twisted part: undocumented immigrants are not eligible for regular, full federal Medicaid, and were not before the 2025 law either.[480] Most of the people who lost eligibility under the 2025 law were lawfully present immigrants such as refugees and asylees.

## Claim 15: "Work requirements help people get jobs."

## Claim 16: "Work requirements mostly kick off people who are already working or should be exempt."

These are the two sides of the work requirement debate. I test them together.

**Where they come from.** Supporters, including the White House, present the requirement as a way to encourage work and protect Medicaid "for the truly vulnerable."[481] Opponents say people will lose coverage over paperwork. CBPP called the House version of the bill one that was "taking away Medicaid and affordable marketplace coverage from people who are eligible."[482]

**What the records show.**

- Under the 2025 law, adults 19 to 64 in the expansion group must show 80 hours a month of work, community service, a work program or at least half-time school. States must start by December 31, 2026, or sooner if they choose. There is a long list of exemptions, including people who are medically frail, pregnant or postpartum, parents of children under 14, and people in substance use treatment.[483]
- Most states are expected to begin January 1, 2027. A federal court on October 29, 2026 struck part of CMS's rule defining who counts as "medically frail."[484]

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[479] Akash Pillai, Alisha Rao and Samantha Artiga, "Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider," KFF, September 22, 2026, https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/, accessed November 12, 2026; Akash Pillai, Drishti Pillai and Samantha Artiga, "State Health Coverage for Immigrants and Implications for Health Coverage and Care," KFF, May 19, 2026 (updated June 11, 2026), https://www.kff.org/racial-equity-and-health-policy/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/, accessed November 12, 2026.

[480] Akash Pillai, Alisha Rao and Samantha Artiga, "Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider," KFF, September 22, 2026, https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/, accessed November 12, 2026.

[481] The White House, "Myth v Fact: The One Big Beautiful Bill" (PDF, file dated 6.28, posted July 2025), https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf, accessed November 12, 2026.

[482] Sharon Parrott, Center on Budget and Policy Priorities (policy group; generally supports safety-net programs), "House Republican Bill Fails the Country; Senate Should Reject Any Bill That Takes Away Health Coverage, Food Assistance," statement (2025), https://www.cbpp.org/press/statements/house-republican-bill-fails-the-country-senate-should-reject-any-bill-that-takes, accessed November 12, 2026.

[483] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[484] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026,

- CBO estimated the requirement would reduce federal spending by about $326 billion over ten years. A law firm summary of CBO's work reports a 5.3 million coverage loss by 2034 from this piece alone.[485] Savings that large come mainly from fewer people enrolled.
- KFF's data shows most adults likely to be affected already work or have a reason they don't (Claim 13).[486]
- The main real-world test before 2026 was Arkansas in 2018, where studies reported that thousands lost coverage and that employment did not measurably rise. I was not able to read those studies for this book, so those findings are [Not verified]. Georgia has run a work requirement since 2023; I was not able to read an official evaluation of it.

**Verdict for Claim 15: Inconclusive.** The national requirement had not started as of November 12, 2026, so there is no data yet on whether it raises employment. The earlier state evidence I could not verify. What would settle it: official state data and independent evaluations after the requirement takes effect in 2027.

**Verdict for Claim 16: Inconclusive.** KFF's data shows that most affected adults already work or have a reason they don't, which supports the concern, and CBO's large savings estimate implies many people will lose coverage.[487] But who actually loses coverage, and why, cannot be known until the requirement is running. What would settle it: state data on who was disenrolled and for what reason.

## Claim 17: "Medicaid expansion saves lives."

## Claim 18: "Medicaid coverage doesn't improve health."

**Where they come from.** Supporters of expansion often say it saves lives. Skeptics often cite a famous Oregon study to say Medicaid does not make people healthier.

**What the records show.**

- In 2008, Oregon had more people who wanted Medicaid than it had slots, so it held a lottery. That created a rare natural experiment. Researchers compared winners and

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https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[485] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[486] Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update," KFF, May 30, 2025 (updated February 20, 2026), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/, accessed November 12, 2026.

[487] Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update," KFF, May 30, 2025 (updated February 20, 2026), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/, accessed November 12, 2026; Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

losers. Over the first two years, they found "no significant improvements in measured physical health outcomes" such as blood pressure and cholesterol.[488]

- A later study by Sarah Miller, Norman Johnson and Laura Wherry, published in the Quarterly Journal of Economics in 2021, linked survey data to death records. It found that among near-elderly low-income adults in states that expanded Medicaid under the ACA, death rates fell by 9.4 percent compared with the average, driven by fewer deaths from disease.[489]
- The two studies measured different things in different groups over different time spans. They do not cancel each other out.

**Verdict for Claim 17: Partly true.** The true part: a large, peer-reviewed study found that ACA expansion lowered death rates among near-elderly low-income adults.[490] The limit: that finding is for one age group, and "saves lives" is often stated as if it were proven for everyone covered. Other studies I did not read may point in other directions.

**Verdict for Claim 18: Partly true.** The true part: the Oregon experiment found no significant improvement in several measured physical health results in its first two years.[491] The twisted part: the claim leaves out that Oregon measured only a few conditions over a short time, and that a later, larger study found fewer deaths after expansion.[492]

## Claim 19: "Seniors are being pushed into Medicare Advantage."

**Where it comes from.** Critics of Medicare Advantage say heavy marketing, employer retiree plans that switch to Medicare Advantage, and the difficulty of getting a Medigap policy later push people into private plans. Supporters say people choose the plans for lower costs and extra benefits.[493]

**What the records show.**

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[488] Katherine Baicker and others, "The Oregon Experiment - Effects of Medicaid on Clinical Outcomes," New England Journal of Medicine 368, no. 18 (May 2013): 1713-1722, listing at https://www.hks.harvard.edu/publications/oregon-experiment-effects-medicaid-clinical-outcomes, accessed November 12, 2026.

[489] Sarah Miller, Norman Johnson and Laura R. Wherry, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," Quarterly Journal of Economics 136, no. 3 (2021): 1783-1829; NBER Working Paper 26081, https://www.nber.org/papers/w26081, accessed November 12, 2026.

[490] Sarah Miller, Norman Johnson and Laura R. Wherry, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," Quarterly Journal of Economics 136, no. 3 (2021): 1783-1829; NBER Working Paper 26081, https://www.nber.org/papers/w26081, accessed November 12, 2026.

[491] Katherine Baicker and others, "The Oregon Experiment - Effects of Medicaid on Clinical Outcomes," New England Journal of Medicine 368, no. 18 (May 2013): 1713-1722, listing at https://www.hks.harvard.edu/publications/oregon-experiment-effects-medicaid-clinical-outcomes, accessed November 12, 2026.

[492] Sarah Miller, Norman Johnson and Laura R. Wherry, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," Quarterly Journal of Economics 136, no. 3 (2021): 1783-1829; NBER Working Paper 26081, https://www.nber.org/papers/w26081, accessed November 12, 2026.

[493] Better Medicare Alliance (advocacy group supporting Medicare Advantage), "Medicare Beneficiary Spending 2026," August 4, 2026, https://bettermedicarealliance.org/publication/medicare-beneficiary-spending-2026-2/, accessed November 12, 2026.

- Medicare Advantage grew from 37 percent of eligible beneficiaries in 2018 to 55 percent in 2025.[494]
- Plans offer extra benefits funded by rebates. MedPAC estimates plans spent about $24 billion on non-Medicare services in 2023, but also says "Relatively little is known about beneficiaries' use of these benefits or about their value."[495]
- The average beneficiary could choose from 39 plans from 8 companies in 2026.[496]
- Medigap policies are standardized.[497] Outside protected windows, Medigap insurers in most states may turn down people with pre-existing conditions, and KFF estimates 74 percent of Medicare Advantage enrollees have a condition that could lead to a denial.[498]
- Employer and union group plans hold 16 percent of Medicare Advantage enrollment, 5.7 million people, and a quarter or more in seven states. KFF reports that 13 states offered retiree coverage only through Medicare Advantage plans in 2024.[499] Retirees in those plans did not always choose Medicare Advantage themselves.

**Verdict: Inconclusive.** The growth of Medicare Advantage is real and fast, and some retirees are moved into it by former employers.[500] But whether people are "pushed" or are choosing the plans freely is not something the official data measures. What would settle it: survey and enrollment data on why people pick Medicare Advantage, how many are moved by former employers, and how many try to switch back and cannot.

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[494] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[495] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[496] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[497] Medicare.gov, "Parts of Medicare," https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare, accessed November 12, 2026.

[498] Meredith Freed, Yasmina Issaka, Nancy Ochieng and Juliette Cubanski, "Medigap Guaranteed Issue Requirements: An Overview of Federal and State Rules," KFF, October 13, 2026, https://www.kff.org/medicare/medigap-guaranteed-issue-requirements-an-overview-of-federal-and-state-rules/, accessed November 12, 2026.

[499] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

[500] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026; Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, Nancy Ochieng and Tricia Neuman, "Medicare Advantage in 2026: Enrollment Update and Key Trends," KFF, June 5, 2026 (updated July 1, 2026), https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/, accessed November 12, 2026.

## Claim 20: "Doctors are dropping Medicare because it pays too little."

**Where it comes from.** Doctors' groups have long said Medicare's payment rates have not kept up with costs. The claim that doctors are leaving Medicare in large numbers follows from that.

**What the records show.**

- Doctors can formally "opt out" of Medicare, meaning they agree to bill patients directly instead. KFF counted 12,244 non-pediatric doctors who had opted out as of November 2024, about 1.2 percent of active doctors.[501]
- The rate was much higher in some fields: psychiatry 8.1 percent, plastic and reconstructive surgery 4.5 percent, and neurology 3.2 percent. Psychiatrists were 39 percent of all doctors who opted out.[502]
- The 2025 budget law gave doctors a one-year 2.5 percent increase in Medicare fee schedule payments for 2026.[503]
- Opting out is not the only way to step back. A doctor can stay in Medicare but stop taking new Medicare patients, and the opt-out numbers do not capture that.

**Verdict: Partly true.** The true part: some doctors have left Medicare, and in psychiatry the share is notable.[504] The twisted part: the claim usually suggests a broad exodus. About 1.2 percent of doctors have formally opted out, and I did not find evidence of a large-scale departure.[505] Whether doctors are limiting new Medicare patients is a separate question the opt-out data cannot answer.

## Summary of verdicts in this chapter

| # | Claim | Verdict |
|---|---|---|
| 12 | Death panels decide who gets care | False (debunked) |
| 13 | Medicaid is mostly for people who could work but don't | False (debunked) |
| 14 | Immigrants here illegally get Medicaid | Partly true |
| 15 | Work requirements help people get jobs | Inconclusive |
| 16 | Work requirements mostly kick off people already working or exempt | Inconclusive |

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[501] Alex Cottrill, Nancy Ochieng and Tricia Neuman, "How Many Physicians Have Opted Out of the Medicare Program?" KFF, January 17, 2025, https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/, accessed November 12, 2026.

[502] Alex Cottrill, Nancy Ochieng and Tricia Neuman, "How Many Physicians Have Opted Out of the Medicare Program?" KFF, January 17, 2025, https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/, accessed November 12, 2026.

[503] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[504] Alex Cottrill, Nancy Ochieng and Tricia Neuman, "How Many Physicians Have Opted Out of the Medicare Program?" KFF, January 17, 2025, https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/, accessed November 12, 2026.

[505] Alex Cottrill, Nancy Ochieng and Tricia Neuman, "How Many Physicians Have Opted Out of the Medicare Program?" KFF, January 17, 2025, https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/, accessed November 12, 2026.

| # | Claim | Verdict |
|---|---|---|
| 17 | Medicaid expansion saves lives | Partly true |
| 18 | Medicaid coverage doesn't improve health | Partly true |
| 19 | Seniors are being pushed into Medicare Advantage | Inconclusive |
| 20 | Doctors are dropping Medicare because it pays too little | Partly true |

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| The phrase "death panel" was not in the 2009 bill; the provision paid for voluntary planning talks | Whether coverage rules amount to rationing | |
| Children are 47.8 percent of Medicaid and CHIP enrollment; 64 percent of affected adults work | Whether work requirements are fair or wise | How many people will lose coverage after 2027, and why |
| Undocumented immigrants are not eligible for full federal Medicaid; Emergency Medicaid exists | How much state-funded coverage should be counted | |
| A 2021 study found lower deaths among near-elderly adults after expansion; Oregon found no measured change in some physical health results over two years | How to weigh studies that measured different things | Long-term health effects of coverage |
| MA grew from 37 to 55 percent of eligible beneficiaries, 2018 to 2025 | Whether growth reflects choice or pressure | Why people pick MA, and how many cannot switch back |
| About 1.2 percent of doctors have opted out of Medicare | Whether pay rates threaten access | How many doctors limit new Medicare patients |

# Part Eight: Where Things Stand Today

## Chapter 19. Today: The Numbers, the Controversies and What People Think

*Information in this chapter stops at November 12, 2026.*

This chapter pulls together where Medicare and Medicaid stand as of November 12, 2026: the key numbers, the fights that are live right now, who is in charge, and what the public says in polls. Things in this chapter will go out of date fastest, so check the dates beside each figure.

### The numbers, as of November 12, 2026

**Table 19.1. Medicare and Medicaid at a glance (nominal dollars; as of November 12, 2026)**

| Measure | Figure | Source and date |
|---|---|---|
| Medicare enrollment | 69.3 million (2025) | 2026 Trustees Report, June 9, 2026[506] |
| Share of Medicare beneficiaries in private plans | About 51% of all; 55% of those with Parts A and B (2025) | Trustees Report; MedPAC March 2026[507] |
| Total Medicare spending | $1,210.1 billion (2025) | Trustees Report[508] |
| HI trust fund depletion | Second quarter of 2033; 89% of costs payable after | Trustees Report[509] |
| Medicare cost as share of GDP | 3.9% (2025), projected 6.5% by 2050 | Trustees Report[510] |
| Medicaid and CHIP enrollment | 72,946,510 (July 2026) | CMS, updated Oct. 30, 2026[511] |

[506] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[507] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026; Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[508] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[509] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[510] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[511] Centers for Medicare and Medicaid Services, "July 2026 Medicaid and CHIP Enrollment Data Highlights," updated October 30, 2026, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights, accessed November 12, 2026.

| Measure | Figure | Source and date |
|---|---|---|
| States with Medicaid expansion | 41 including DC; 10 without | KFF, Nov. 6, 2026[512] |
| Medicaid spending | $931.7 billion (2024) | CMS National Health Expenditure data[513] |
| People dually eligible for both programs | 13.6 million (2022) | MedPAC and MACPAC, Dec. 2025[514] |
| Part B standard premium | $202.90 a month (2026) | CMS[515] |
| Part D out-of-pocket cap | $2,100 (2026) | CMS[516] |

**What about 2027 premiums?** CMS usually announces the next year's Part B premium in the fall. The 2027 Medicare and You handbook says "The 2027 premium amounts, drug costs, and income limits weren't available at the time of printing."[517] I did not find an official CMS announcement of the 2027 Part B premium as of November 12, 2026. Projections from private sites are not official, so I do not repeat them. Check Medicare.gov for the official figure.

## Spending is still climbing

National health spending reached $5.3 trillion in 2024, or $15,474 per person, 18.0 percent of the economy. CMS projects it will grow an average of 5.4 percent a year from 2025 to 2034, faster than the economy's 4.1 percent, reaching 20.6 percent of the economy in 2034. Among the major payers, Medicare is projected to grow fastest, at 7.7 percent a year. Medicaid is projected at 5.0 percent.[518]

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[512] KFF, "Status of State Medicaid Expansion Decisions," November 6, 2026, https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/, accessed November 12, 2026.

[513] Centers for Medicare and Medicaid Services, "NHE Fact Sheet" (2024 data), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet, accessed November 12, 2026.

[514] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," December 2025, https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/, accessed November 12, 2026.

[515] Centers for Medicare and Medicaid Services, "2026 Medicare Parts A and B Premiums and Deductibles," fact sheet, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles, accessed November 12, 2026.

[516] Centers for Medicare and Medicaid Services, "Final CY 2026 Part D Redesign Program Instructions," fact sheet, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions, accessed November 12, 2026.

[517] Centers for Medicare and Medicaid Services, "Medicare and You 2027" (official handbook), https://www.medicare.gov/publications/10050-medicare-and-you.pdf, accessed November 12, 2026.

[518] Centers for Medicare and Medicaid Services, "NHE Fact Sheet" (2024 data), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet, accessed November 12, 2026.

## Doctor and hospital participation

Access to doctors is one of the most argued points about both programs. For Medicare, the best measure I could verify is the number of doctors who formally opted out: about 1.2 percent as of November 2024, much higher in psychiatry (Chapter 18).[519] The 2025 budget law gave doctors a one-year 2.5 percent payment increase for 2026.[520] For Medicaid, MACPAC reports that fee-for-service physician payment rates average about two-thirds of Medicare's, and that research links low rates to fewer doctors taking Medicaid patients.[521] I did not find a current national measure of how many doctors accept new Medicaid patients.

## Medicaid enrollment trends

During the pandemic, a federal law, the Families First Coronavirus Response Act, enacted March 18, 2020, gave states a 6.2 percentage point increase in their federal matching rate if they kept people continuously enrolled.[522] That policy ended March 31, 2023. In the "unwinding" that followed, KFF counted more than 25 million people disenrolled and more than 56 million renewed. Even after the unwinding, KFF found enrollment was about 10 million higher than before the pandemic.[523] By July 2026, Medicaid and CHIP enrollment stood at about 72.9 million.[524]

## Recent laws, rules and court cases

- **The 2025 budget law.** Its main Medicaid changes start in late 2026 through 2028: immigrant eligibility limits on October 1, 2026; work requirements by January 1, 2027 in most states; six-month eligibility checks for expansion adults from January 1, 2027; provider tax limits from fiscal year 2028; and limits on state directed payments from January 1, 2028 (Chapter 12).[525]

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[519] Alex Cottrill, Nancy Ochieng and Tricia Neuman, "How Many Physicians Have Opted Out of the Medicare Program?" KFF, January 17, 2025, https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/, accessed November 12, 2026.

[520] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[521] Medicaid and CHIP Payment and Access Commission, "Provider Payment and Delivery Systems," Medicaid 101, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/, accessed November 12, 2026.

[522] Congressional Research Service, "Medicaid Recession-Related FMAP Increases," Report R46346, May 7, 2020, https://www.everycrsreport.com/reports/R46346.html, accessed November 12, 2026.

[523] KFF, "As Medicaid Unwinding Concludes in Most States, KFF Finds 25 Million Lost Medicaid Coverage, but Enrollment Is 10 Million Higher Than Pre-Pandemic Levels," September 18, 2024, https://www.kff.org/medicaid/as-medicaid-unwinding-concludes-in-most-states-kff-finds-25-million-lost-medicaid-coverage-but-enrollment-is-10-million-higher-than-pre-pandemic-levels/, accessed November 12, 2026.

[524] Centers for Medicare and Medicaid Services, "July 2026 Medicaid and CHIP Enrollment Data Highlights," updated October 30, 2026, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights, accessed November 12, 2026.

[525] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026; Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

- **The work requirement rule and the courts.** On October 29, 2026, a federal court struck one part of CMS's definition of who counts as "medically frail" in *Commonwealth of Massachusetts v. Oz*.[526]
- **Drug price negotiation.** The first negotiated prices took effect January 1, 2026; prices for 15 more drugs take effect January 1, 2027; and 15 more were selected in January 2026 for 2028.[527]
- **Prior authorization in traditional Medicare.** CMS's WISeR model runs from January 1, 2026 through December 31, 2031 in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona and Washington. Technology companies review requests for a short list of services that CMS considers often low-value, such as skin substitutes and knee arthroscopy for arthritis. CMS says "WISeR does not change Medicare coverage or payment policy," and it does not apply to Medicare Advantage.[528] Supporters see it as a way to cut waste; critics see it as bringing Medicare Advantage-style approvals into traditional Medicare.
- **The Medicare Advantage payment debate** (Chapter 16).

## Current office holders

As of the dates on their official pages:

- **Secretary of Health and Human Services:** Robert F. Kennedy, Jr.[529]
- **Administrator of CMS:** Dr. Mehmet Oz, described by CMS as its 17th Administrator.[530]
- **Chair of MedPAC:** Michael E. Chernew, as of the March 2026 report.[531]
- **Chair of MACPAC:** Verlon Johnson.[532]

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[526] Faegre Drinker Biddle and Reath LLP (law firm), "Implementation Status of H.R. 1 Medicaid Provisions as of October 2026," November 5, 2026, https://www.faegredrinker.com/en/insights/publications/2026/11/implementation-status-of-hr-1-medicaid-provisions-as-of-october-2026, accessed November 12, 2026.

[527] Centers for Medicare and Medicaid Services, "CMS Delivers Savings for Seniors on 15 Major Drugs for Cancer and Chronic Disease," press release, November 25, 2025, https://www.cms.gov/newsroom/press-releases/cms-delivers-savings-seniors-15-major-drugs-cancer-chronic-disease, accessed November 12, 2026; Juliette Cubanski and Tricia Neuman, "Key Facts About Medicare Drug Price Negotiation," KFF (nonpartisan health research group), March 11, 2026, https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/, accessed November 12, 2026.

[528] Centers for Medicare and Medicaid Services, "WISeR (Wasteful and Inappropriate Service Reduction) Model," page last modified October 19, 2026, https://www.cms.gov/priorities/innovation/innovation-models/wiser, accessed November 12, 2026.

[529] U.S. Department of Health and Human Services, "HHS Leadership," https://www.hhs.gov/about/leadership/index.html, accessed November 12, 2026.

[530] Centers for Medicare and Medicaid Services, "Administrator" leadership page, https://www.cms.gov/about-cms/who-we-are/leadership, accessed November 12, 2026.

[531] Medicare Payment Advisory Commission, "March 2026 Report to the Congress" press release, March 12, 2026, https://www.medpac.gov/wp-content/uploads/2026/03/March_2026_MedPAC_Report_Press_Release_SEC.pdf, accessed November 12, 2026.

[532] Medicaid and CHIP Payment and Access Commission, "Commissioners," https://www.macpac.gov/commissioners/, accessed November 12, 2026.

The Medicare Trustees are, by law, the Secretaries of the Treasury, Labor, and Health and Human Services, the Commissioner of Social Security, and two public trustees when those seats are filled. I did not verify who held each seat at the cutoff, so I do not list names.

## What the public thinks

Polls are snapshots, and the wording of the question matters. Here is what the polls I could verify found, with dates and sample sizes.

**Table 19.2. Selected public opinion results (KFF polls, as of November 12, 2026)**

| Poll date | Question area | Result |
|---|---|---|
| January 7-14, 2025 (1,310 adults) | View Medicare favorably | 82% |
| January 7-14, 2025 | View Medicaid favorably | 77% |
| January 7-14, 2025 | Government spends "not enough" vs "too much" on Medicare | 51% vs 15% |
| January 7-14, 2025 | Government spends "not enough" vs "too much" on Medicaid | 46% vs 19% |
| June 4-8, 2025 (1,321 adults) | View the "One Big Beautiful Bill" favorably vs unfavorably | 35% vs 64% |
| June 4-8, 2025 | View Medicaid favorably | 83% |

Sources: KFF, January 17, 2025 and June 17, 2025.[533]

The June 2025 poll also showed how much information changes answers. After hearing the bill would reduce funding for local hospitals, favorable views of the bill fell to 21 percent. After hearing it could leave about 10 million more people uninsured, they fell to 25 percent.[534] Polls on Medicare for All also swing a lot depending on whether people hear about taxes or about eliminating premiums. KFF's long-running tracker notes it "does not include tradeoffs and arguments for and against,"[535] so I do not cite a single support number for it.

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[533] KFF, "As Congress Looks To Reduce Federal Spending, Medicare and Medicaid Remain Broadly Popular," press release, January 17, 2025 (survey January 7-14, 2025, 1,310 adults), https://www.kff.org/health-costs/press-release/as-congress-looks-to-reduce-federal-spending-medicare-and-medicaid-remain-broadly-popular-and-at-least-twice-as-many-people-want-to-increase-spending-rather-than-cut-it/, accessed November 12, 2026; KFF, "Poll: Public Views 'Big Beautiful Bill' Unfavorably by Nearly a 2-1 Margin," June 17, 2025 (survey June 4-8, 2025, 1,321 adults), https://www.kff.org/medicaid/poll-public-views-big-beautiful-bill-unfavorably-by-nearly-a-2-1-margin-democrats-independents-and-non-maga-republicans-oppose-it-while-maga-supporters-favor-it-favorability-ero/, accessed November 12, 2026.

[534] KFF, "Poll: Public Views 'Big Beautiful Bill' Unfavorably by Nearly a 2-1 Margin," June 17, 2025 (survey June 4-8, 2025, 1,321 adults), https://www.kff.org/medicaid/poll-public-views-big-beautiful-bill-unfavorably-by-nearly-a-2-1-margin-democrats-independents-and-non-maga-republicans-oppose-it-while-maga-supporters-favor-it-favorability-ero/, accessed November 12, 2026.

[535] KFF, "Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage" (interactive tracker), published October 16, 2020, https://www.kff.org/interactive/tracking-public-opinion-on-national-health-plan-interactive/, accessed November 12, 2026.

## What leaders say now

The two parties describe the 2025 law in nearly opposite terms. The White House said "there will be no cuts to Medicaid" and that the law protects the program "for the truly vulnerable."[536] Opponents, including the Center on Budget and Policy Priorities, said it takes coverage "from people who are eligible."[537] Chapter 17 tests both claims against CBO's numbers.

The 2026 midterm elections were held November 3, 2026. I did not verify results or how they will change the debate in Congress, so this book does not cover them.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| 69.3 million Medicare enrollees in 2025; 72.9 million in Medicaid and CHIP in July 2026 | Whether current growth is sustainable | Effects of the 2025 law once its main pieces start in 2027 and 2028 |
| CMS projects health spending at 20.6 percent of the economy in 2034 | What should be done about it | |
| WISeR runs in six states from 2026 to 2031 | Whether WISeR saves money or delays care | WISeR's results |
| KFF found Medicare 82 percent and Medicaid 77 to 83 percent favorable in 2025 | What polls mean for policy | Public views after the 2025 law takes full effect |
| | | The 2027 Part B premium (not found by the cutoff); 2026 election effects |

[536] The White House, "Myth v Fact: The One Big Beautiful Bill" (PDF, file dated 6.28, posted July 2025), https://www.whitehouse.gov/wp-content/uploads/2025/07/Myth-v-Fact_OBBB-6.28.pdf, accessed November 12, 2026.

[537] Sharon Parrott, Center on Budget and Policy Priorities (policy group; generally supports safety-net programs), "House Republican Bill Fails the Country; Senate Should Reject Any Bill That Takes Away Health Coverage, Food Assistance," statement (2025), https://www.cbpp.org/press/statements/house-republican-bill-fails-the-country-senate-should-reject-any-bill-that-takes, accessed November 12, 2026.

# Part Nine: The Options

## Chapter 20. The Options for the Future

*Information in this chapter stops at November 12, 2026.*

This chapter lays out the main types of proposals for Medicare's and Medicaid's future, who tends to support each, and what the Congressional Budget Office (CBO) estimated it would do when CBO has scored it. I make no recommendation. My goal is to give you the menu and the price tags so you can judge for yourself.

### The size of the problem

Any plan has to deal with three facts from the 2026 Trustees Report:

- The HI trust fund, which pays for Part A, is projected to run short in 2033.[538]
- Closing the 75-year HI gap would take the equivalent of 0.56 percent of taxable payroll, starting now.[539]
- Total Medicare costs are projected to grow from 3.9 percent of the economy in 2025 to 6.5 percent in 2050.[540]

The first two are about one trust fund and can be fixed with a fairly small change in taxes or spending. The third is about the whole program and the whole budget, and it is much harder. Part B and Part D are paid mostly from general federal revenue, so their growth puts pressure on the rest of the budget even though they can never "run out."[541]

Medicaid has no trust fund. Its pressures show up in state budgets and in the federal deficit. The 2025 budget law already reduced projected federal Medicaid spending by about $990 billion over ten years (Chapter 12).[542]

### Where the CBO numbers come from

Every two years or so, CBO publishes a book called "Options for Reducing the Deficit." It estimates what dozens of policy changes would save over ten years. The figures below come from the December 2024 edition, updated in October 2025, covering 2025 to 2034.[543] Many options

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[538] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[539] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[540] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[541] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[542] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[543] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024 (updated October 24, 2025), https://www.cbo.gov/publication/60557, accessed November 12, 2026.

show a range because CBO scored several versions of the same idea. These are savings estimates, not recommendations; CBO does not endorse any option.

Some well-known ideas, such as raising the Medicare eligibility age or raising the Medicare payroll tax, were not on that list's summary table, so I describe them without a CBO number.

## Options for Medicare

**1. Raise Medicare taxes.** The most direct fix for the HI trust fund is more payroll tax revenue. The Trustees' 0.56 percent of payroll figure tells you roughly how much would close the 75-year gap.[544] Another version would send more of the 3.8 percent tax on investment income to the trust fund. Supporters are mostly on the political left. The trade-off: workers or higher earners pay more. CBO estimate: not on the summary table.

**2. Raise beneficiary premiums.** Part B premiums now cover about 25 percent of Part B costs for the aged.[545] CBO scored an option to increase Part B premiums at $510 billion in savings over ten years.[546] Versions that raise premiums only for higher-income people have support from some Republicans and some Democrats. The trade-off: retirees pay more, and fixed-income seniors feel it.

**3. Pay Medicare Advantage plans less.** CBO scored two families of options. Reducing the benchmarks that set plan payments: $489 billion. Changing how payments adjust for health risk, which addresses coding: $124 billion to $1,049 billion depending on design.[547] MedPAC's finding that Medicare pays 14 percent more for Medicare Advantage enrollees is the main argument for these changes.[548] The trade-off: plans would likely offer fewer extra benefits or charge more, and the plans and their supporters argue enrollees would lose value.[549]

**4. Pay hospital outpatient departments the same as doctors' offices.** Medicare often pays more when a service is billed by a hospital-owned clinic than when the same service is done in an independent office. Equalizing those payments is often called "site-neutral" payment. CBO scored a related option, reducing payments for hospital outpatient departments, at $6 billion to

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[544] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2026 Annual Report," transmitted June 9, 2026, https://www.cms.gov/oact/tr/2026, accessed November 12, 2026.

[545] Congressional Research Service, "Medicare Primer," Report R40425, May 21, 2020, https://www.everycrsreport.com/reports/R40425.html, accessed November 12, 2026 (used only for program rules that have not changed since 2020).

[546] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024 (updated October 24, 2025), https://www.cbo.gov/publication/60557, accessed November 12, 2026.

[547] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024 (updated October 24, 2025), https://www.cbo.gov/publication/60557, accessed November 12, 2026.

[548] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," Chapter 12, "The Medicare Advantage Program: Status Report," March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf, accessed November 12, 2026.

[549] Rebecca Pifer Parduhn, "Medicare Advantage Overpayments Will Total $76B This Year: MedPAC," Healthcare Dive, January 16, 2026, https://www.healthcaredive.com/news/medicare-advantage-overpayments-76b-2026-medpac/809859/, accessed November 12, 2026.

$157 billion.[550] It draws support from both parties. Hospitals oppose it, saying they carry costs that offices do not.

**5. Raise the eligibility age.** Raising the age from 65 to 67, to match Social Security's full retirement age, has been proposed by some Republicans over the years. It would push people aged 65 and 66 to employer coverage, the ACA marketplaces or Medicaid. I did not find a current CBO score for it in the 2025 to 2034 options summary.

**6. Premium support.** Under this idea, Medicare would give each beneficiary a set amount to buy either a private plan or traditional Medicare, with the amount tied to competing bids. It was a feature of House Republican budgets in the 2010s. Supporters say competition would hold down costs; opponents say it would shift costs to seniors over time. I did not find a current CBO score for it.

**7. Expand drug price negotiation.** Supporters, mostly Democrats, propose negotiating more drugs each year or applying negotiated prices to private insurance. The drug industry opposes it (Chapter 17). CBO estimated the 2022 law would mean about 13 fewer new drugs out of 1,300 over 30 years.[551] Expanding negotiation would likely raise both the savings and the effect on new drugs.

**8. Medicare for All or a public option.** A single-payer system would replace most private insurance with one public plan. CBO's December 2020 work shows federal spending would rise by $1.5 trillion to $3.0 trillion in 2030, while total national health spending could fall or rise depending on design (Chapter 17, Table 17.1).[552] A Mercatus Center study of one 2018 bill put the added federal cost at about $32.6 trillion over ten years, assuming payments to providers about 40 percent below private insurance rates.[553] Smaller versions would let people buy into Medicare at 50 or 60, or add a public plan to the ACA marketplaces.

## Options for Medicaid

**1. Caps on federal Medicaid spending.** Instead of matching whatever states spend, the federal government would pay a fixed amount per person (a per capita cap) or a fixed total (a block grant). CBO scored caps at $459 billion to $893 billion in savings.[554] Supporters, mostly conservatives, say caps give states flexibility and control costs. Opponents say they shift costs to states and lead to coverage cuts when costs rise.

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[550] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024 (updated October 24, 2025), https://www.cbo.gov/publication/60557, accessed November 12, 2026.

[551] Congressional Budget Office, letter to Chairman Jodey Arrington and Rep. Michael C. Burgess on the effects of drug price negotiation, December 21, 2023, https://www.cbo.gov/system/files/2023-12/59792-Letter.pdf, accessed November 12, 2026.

[552] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Working Paper 2020-08, December 2020, https://www.cbo.gov/publication/56811, accessed November 12, 2026.

[553] Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center at George Mason University (market-oriented research center), working paper, July 30, 2018, https://www.mercatus.org/research/working-papers/costs-national-single-payer-healthcare-system, accessed November 12, 2026.

[554] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024 (updated October 24, 2025), https://www.cbo.gov/publication/60557, accessed November 12, 2026.

**2. Lower the federal matching rate.** CBO scored reductions in federal Medicaid matching rates at $69 billion to $561 billion.[555] One version would lower the 90 percent rate for the expansion group to the regular rate. States would face higher costs and some might drop expansion.

**3. Limit provider taxes.** CBO scored limits on the taxes states charge hospitals and other providers, used to draw federal matching money, at $48 billion to $612 billion.[556] The 2025 law already enacted a version of this, phasing the limit down to 3.5 percent starting in fiscal year 2028.[557]

**4. Expand Medicaid in the remaining 10 states.** As of November 2026, 10 states had not adopted the ACA expansion: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin and Wyoming.[558] Supporters say expansion would cover low-income adults who earn too little for marketplace subsidies. Opponents in those states cite the state's share of costs and doubts about the program's value. I was not able to read a current estimate of how many people would gain coverage, so I give no number.

**5. Pay for long-term care differently.** Medicaid is the main payer for long-term care in the United States, covering 61 percent of total spending.[559] Ideas include a public long-term care insurance program, tax breaks for private long-term care insurance, and more home and community-based care. None has a current CBO score in the sources I read.

## Summary table

**Table 20.1. Main options, supporters and CBO estimates (savings over 2025-2034, nominal dollars, from CBO's December 2024 options, updated October 2025; as of November 12, 2026)**

| Option | Who tends to support it | CBO 10-year savings | Main trade-off |
|---|---|---|---|
| Raise Medicare payroll or investment income taxes | Mostly Democrats | Not on summary table | Workers or higher earners pay more |
| Increase Part B premiums | Some in both parties (often income-based) | $510 billion | Retirees pay more |
| Reduce MA benchmarks | MedPAC findings; many Democrats; some fiscal conservatives | $489 billion | Fewer extra benefits in MA |

[555] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024 (updated October 24, 2025), https://www.cbo.gov/publication/60557, accessed November 12, 2026.

[556] Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," December 12, 2024 (updated October 24, 2025), https://www.cbo.gov/publication/60557, accessed November 12, 2026.

[557] Congressional Research Service, "Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law," Report R48633, August 18, 2025, https://www.everycrsreport.com/reports/R48633.html, accessed November 12, 2026.

[558] KFF, "Status of State Action on the Medicaid Expansion Decision," State Health Facts (data as of November 2026), https://www.kff.org/affordable-care-act/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/, accessed November 12, 2026.

[559] Alice Burns, Elizabeth Hinton, Robin Rudowitz and Maiss Mohamed, "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/10-things-to-know-about-medicaid/, accessed November 12, 2026.

| Option | Who tends to support it | CBO 10-year savings | Main trade-off |
|---|---|---|---|
| Change MA risk adjustment (coding) | Same | $124 billion to $1,049 billion | Fewer extra benefits in MA |
| Reduce hospital outpatient payments (site-neutral) | Members of both parties | $6 billion to $157 billion | Hospitals lose revenue |
| Raise eligibility age to 67 | Some Republicans | Not on summary table | People 65-66 need other coverage |
| Premium support | House Republican budgets of the 2010s | Not scored in sources read | Costs may shift to seniors |
| Cap federal Medicaid spending | Mostly Republicans | $459 billion to $893 billion | Costs shift to states |
| Reduce Medicaid matching rates | Mostly Republicans | $69 billion to $561 billion | States pay more or cut |
| Limit provider taxes | Mostly Republicans (partly enacted 2025) | $48 billion to $612 billion | States lose a funding source |
| Expand Medicaid in remaining states | Mostly Democrats | Adds cost (not scored in sources read) | State share of cost |
| Single payer (Medicare for All) | Progressive Democrats | Adds $1.5 trillion to $3.0 trillion in federal spending in 2030 alone | Large tax increase replaces premiums |

The "who tends to support it" column is a broad description, not a rule. Members of both parties have backed and opposed most of these ideas at different times.

## How to judge a proposal

When you hear a proposal, I suggest asking four questions:

1. **Who pays more, and who gets less?** Every option moves costs to someone: workers, retirees, taxpayers, states, doctors, hospitals or insurers.
2. **What did CBO or the CMS actuaries say?** A campaign's own estimate is not the same as an independent one.
3. **Does it change spending or just shift it?** Lowering federal spending can mean higher state spending or higher family costs.
4. **When does it start?** Many proposals phase in slowly, so their effects show up years later.

## Sorting the evidence

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| Closing the 75-year HI gap would take the equivalent of 0.56 percent of payroll | Which mix of taxes and spending cuts is fairest | What Congress will choose, and when |
| CBO scored MA benchmark cuts at $489 billion and Part B premium increases at $510 billion | Whether CBO's assumptions about plan and patient behavior hold | |
| Ten states have not expanded | Whether expansion is worth the | Current estimates |

| Confirmed facts | Interpretations | Unknowns |
|---|---|---|
| Medicaid | state cost | of coverage gains |

# Appendices

## Appendix A. Timeline

| Year | Event |
|---|---|
| 1935 | Social Security Act signed August 14 without health insurance[560] |
| 1937 | Surgeon General Thomas Parran proposes that national health insurance first cover Social Security beneficiaries[561] |
| 1943 | Wagner-Murray-Dingell bill introduced June 3[562] |
| 1945 | President Truman asks Congress for a national health program, November 19[563] |
| 1946 | Hill-Burton Act funds hospital construction[564] |
| 1950 | Federal government begins sharing state payments to medical providers for people on public assistance[565] |
| 1957 | Forand bill introduced[566] |
| 1960 | Kerr-Mills Act signed September 13 (Public Law 86-778)[567] |
| 1961 | King-Anderson bill introduced; AMA's Operation Coffee Cup and Reagan record[568] |
| 1962 | Senate tables Medicare amendment 52 to 48, July 17[569] |
| 1964 | Senate passes hospital insurance 49 to 44, September 2; dies in conference[570] |

[560] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 2, Social Security Administration, Office of Research and Statistics, Research Report No. 29 (1969), Social Security History website, https://www.ssa.gov/history/corningchap2.html, accessed November 12, 2026.

[561] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[562] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[563] Harry S. Truman, "Special Message to the Congress Recommending a Comprehensive Health Program," November 19, 1945, Harry S. Truman Presidential Library and Museum, https://www.trumanlibrary.gov/library/public-papers/192/special-message-congress-recommending-comprehensive-health-program, accessed November 12, 2026.

[564] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[565] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 3, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap3.html, accessed November 12, 2026.

[566] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[567] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[568] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026; National Library of Medicine, History of Medicine Division, "Finding Aid to the Operation Coffeecup - Ronald Reagan Speaks Out Against Socialized Medicine, 1961," HMD MS ACC 2009-038 (creator: American Medical Association), https://findingaids.nlm.nih.gov/repositories/ammp/resources/__101523449, accessed November 12, 2026.

[569] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

| Year | Event |
|---|---|
| 1965 | Medicare and Medicaid signed July 30 in Independence, Missouri (Public Law 89-97)[571] |
| 1966 | Medicare begins July 1; more than 19 million enrolled[572] |
| 1967 | EPSDT benefit for children in Medicaid[573] |
| 1972 | Medicare extended to people with disabilities and kidney failure[574] |
| 1973 | HMO Act; Medicare may contract with HMOs[575] |
| 1977 | Health Care Financing Administration (HCFA) created[576] |
| 1980 | Medigap brought under federal oversight[577] |
| 1981 | Medicaid home and community-based services waivers; DSH payments required[578] |
| 1983 | Prospective payment for hospitals by diagnosis; hospice benefit[579] |
| 1986 | EMTALA emergency care law[580] |

[570] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 4, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap4.html, accessed November 12, 2026.

[571] Peter A. Corning, "The Evolution of Medicare: From Idea to Law," Chapter 5, Social Security Administration, Research Report No. 29 (1969), https://www.ssa.gov/history/corningchap5.html, accessed November 12, 2026; Lyndon B. Johnson, "Remarks with President Truman at the Signing in Independence of the Medicare Bill," July 30, 1965, reprinted on the Social Security History website, https://www.ssa.gov/history/lbjstmts.html, accessed November 12, 2026.

[572] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[573] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[574] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[575] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[576] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[577] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[578] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[579] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

[580] Centers for Medicare and Medicaid Services, "Medicare and Medicaid Milestones, 1937 to 2015," July 2015, https://www.cms.gov/about-cms/agency-information/history/downloads/medicare-and-medicaid-milestones-1937-2015.pdf, accessed November 12, 2026.

| Year | Event |
|---|---|
| 1987 | Nursing home resident protections strengthened[581] |
| 1988 | Medicare Catastrophic Coverage Act[582] |
| 1989 | Most of the 1988 law repealed; physician fee schedule created[583] |
| 1990 | Medicaid drug rebate program; federal Medigap standards[584] |
| 1993 | Health Security Act introduced November 20 and 22[585] |
| 1994 | Health Security Act declared dead September 26[586] |
| 1996 | Welfare reform separates Medicaid from cash assistance[587] |
| 1997 | Balanced Budget Act creates CHIP and new private plan choices[588] |
| 1999 | First "Medicare and You" handbook; 1-800-MEDICARE[589] |
| 2001 | HCFA renamed CMS[590] |
| 2003 | Medicare Modernization Act creates Part D[591] |

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| Year | Event |
|---|---|
| 2006 | Part D begins[592] |
| 2009 | CHIP reauthorized February 4[593] |
| 2010 | Affordable Care Act signed March 23[594] |
| 2012 | Supreme Court decides NFIB v. Sebelius, June 28 [595] |
| 2013 | ACA marketplaces open October 1[596] |
| 2014 | Medicaid expansion begins in adopting states[597] |
| 2015 | MACRA replaces the doctor-pay formula[598] |
| 2017 | House passes AHCA May 4; Senate repeal amendment fails 49 to 51 July 28[599] |
| 2020 | Families First Coronavirus Response Act, March 18: higher Medicaid match and continuous enrollment[600] |
| 2022 | Inflation Reduction Act: Part D cap and drug price negotiation[601] |
| 2023 | Continuous enrollment ends March 31; the unwinding begins[602] |

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| Year | Event |
|---|---|
| 2025 | Public Law 119-21 signed July 4; Part D $2,000 cap takes effect[603] |
| 2026 | First negotiated drug prices take effect January 1; WISeR prior authorization model begins in six states; Trustees project HI depletion in 2033; immigrant eligibility limits take effect October 1[604] |
| 2027 | Medicaid work requirements begin January 1 in most states[605] |

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## Appendix B. Key People and Groups

| Person or group | Role | What they did |
|---|---|---|
| Franklin D. Roosevelt | President, 1933-1945 | Left health insurance out of the 1935 Social Security Act[606] |
| Harry S. Truman | President, 1945-1953 | Proposed a national health program in 1945; honored at the 1965 signing[607] |
| Robert Wagner, James Murray, John Dingell | Members of Congress | Introduced national health insurance bills beginning in 1943[608] |
| Aime Forand | Representative, Rhode Island | 1957 bill for hospital insurance for Social Security beneficiaries[609] |
| Robert Kerr | Senator, Oklahoma | Co-author of the 1960 Kerr-Mills law[610] |
| Wilbur Mills | Representative, Arkansas; Ways and Means chairman | Co-author of Kerr-Mills; built the final 1965 bill[611] |
| John F. Kennedy | President, 1961-1963 | Backed the King-Anderson bill; 1962 Madison Square Garden rally[612] |
| Clinton Anderson, Cecil King | Senator (New Mexico), Representative (California) | Sponsors of the administration's hospital insurance bill[613] |
| American Medical Association | Doctors' organization | Led opposition; Operation Coffee Cup; Eldercare proposal[614] |

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| Person or group | Role | What they did |
|---|---|---|
| Ronald Reagan | Actor, later President, 1981-1989 | 1961 AMA record; President during the 1983 hospital payment change and the 1988 catastrophic law[615] |
| AFL-CIO | Labor federation | Made hospital insurance for retirees its top priority[616] |
| John Byrnes | Representative, Wisconsin | His plan became Part B[617] |
| Lyndon B. Johnson | President, 1963-1969 | Signed Medicare and Medicaid July 30, 1965[618] |
| Richard Nixon | President, 1969-1974 | Signed the 1972 amendments[619] |
| Bill Clinton | President, 1993-2001 | 1993 Health Security Act; signed the 1997 Balanced Budget Act[620] |
| George W. Bush | President, 2001-2009 | Signed the 2003 Medicare Modernization Act[621] |
| Barack Obama | President, 2009-2017 | Signed the ACA, March 23, 2010[622] |

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| Person or group | Role | What they did |
|---|---|---|
| Joe Biden | President, 2021-2025 | Signed the Inflation Reduction Act, August 16, 2022[623] |
| Donald Trump | President, 2017-2021 and 2025- | Signed Public Law 119-21 on July 4, 2025[624] |
| Michael E. Chernew | MedPAC chair (as of March 2026) | Leads Congress's Medicare advisory commission[625] |
| Wilbur J. Cohen | HEW Assistant Secretary, Under Secretary, Secretary | The administration's chief strategist on Medicare[626] |
| Dan Rostenkowski | Representative, Illinois; Ways and Means chairman | Confronted by angry seniors over the 1988 catastrophic law[627] |
| George Mitchell | Senator, Maine; Majority Leader | Senate sponsor of the Health Security Act; declared it dead in 1994[628] |
| Tommy Thompson | HHS Secretary | Renamed HCFA as CMS in 2001[629] |
| Thomas Scully, Richard Foster | CMS Administrator; Medicare chief actuary | The 2003-2004 dispute over withholding the actuary's cost estimate[630] |
| John Roberts | Chief Justice of the United States | Wrote the 2012 ruling that made the Medicaid expansion optional[631] |

[623] Centers for Medicare and Medicaid Services, "Statements from CMS Leadership on President Biden Signing the Inflation Reduction Act into Law," press release, August 16, 2022, https://cms.gov/newsroom/press-releases/statements-cms-leadership-president-biden-signing-inflation-reduction-act-law, accessed November 12, 2026 (date confirmed from the release listing).

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| Person or group | Role | What they did |
|---|---|---|
| Sarah Palin | Former Alaska governor | Coined the "death panel" claim in 2009[632] |
| Robert F. Kennedy, Jr. | HHS Secretary (as of the cutoff) | Heads the department that runs Medicare and Medicaid[633] |
| Mehmet Oz | CMS Administrator (as of the cutoff) | Runs Medicare and federal oversight of Medicaid[634] |
| Verlon Johnson | MACPAC chair (as of the cutoff) | Leads Congress's Medicaid advisory commission[635] |
| State Medicaid directors | Officials who run each state's program | Represented nationally by the National Association of Medicaid Directors[636] |
| Medicare Boards of Trustees | Officials who report yearly on the trust funds | 2026 report transmitted June 9, 2026[637] |

[631] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), decided June 28, 2012, Justia, https://supreme.justia.com/cases/federal/us/567/519/, accessed November 12, 2026.

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## Appendix C. Glossary

| Term | Meaning |
|---|---|
| Benchmark | The most Medicare will pay a Medicare Advantage plan for Part A and B benefits in an area |
| Benefit period | For Part A, a span that starts with a hospital admission and ends after 60 days in a row without hospital or skilled nursing care |
| Coding intensity | Recording more diagnoses for patients, which raises risk-adjusted payments to Medicare Advantage plans |
| Coinsurance | A percentage of a bill you pay, such as 20 percent under Part B |
| Deductible | What you pay before insurance starts paying |
| Dual eligible | A person enrolled in both Medicare and Medicaid |
| Expansion group | Adults under 65 with incomes up to 138 percent of the poverty level, covered in states that adopted the ACA expansion |
| Fee-for-service | A payment system where providers are paid for each service; traditional Medicare works this way |
| FMAP | Federal Medical Assistance Percentage, the federal share of a state's Medicaid costs |
| General revenue | Money from the federal government's general fund, mostly income taxes and borrowing |
| Improper payment | A payment that should not have been made or was made in the wrong amount; not the same as fraud |
| Insolvency or depletion | When a trust fund's reserves reach zero; it can then pay only what comes in |
| IRMAA | Income-Related Monthly Adjustment Amount, the extra Part B and Part D premium for higher incomes |
| Medigap | Private insurance that fills some gaps in traditional Medicare |
| Nominal dollars | Dollars as they were at the time, not adjusted for inflation |
| Prior authorization | A plan's approval required before some care is covered |
| Risk adjustment | Raising or lowering a plan's payment based on how sick its enrollees are |
| Spend down | Using up savings on care until a person qualifies for Medicaid |
| Trust fund | An account in the U.S. Treasury that holds a program's dedicated income and pays its costs |

## Appendix D. How to Read a Medicare Trustees Report

The Trustees Report comes out each year, usually in the spring or early summer. The 2026 report was transmitted on June 9, 2026.[638] It is long, but you only need a few parts to understand the headlines.

1. **Start with the summary.** The Social Security and Medicare Trustees publish a short "Summary of the Annual Reports" on the Social Security website. It gives the key dates and percentages in a few pages.[639]
2. **Find the depletion date.** Look for "year of projected trust fund reserve depletion." For HI in 2026, it is 2033.[640]
3. **Find the percent payable.** This tells you what share of costs could still be paid after depletion: 89 percent at depletion in the 2026 report.[641]
4. **Check the actuarial deficit.** Shown as a percent of taxable payroll (0.56 percent in 2026). It tells you how big a tax increase or spending cut would close the 75-year gap.[642]
5. **Look at the income and spending table.** Table II.B1 shows each part's income by source and spending for the past year.[643]
6. **Read the warnings.** The report says whether a "Medicare funding warning" is issued.[644]
7. **Compare to last year.** The report explains what changed since the prior year and why.
8. **Remember the alternative projections.** The Trustees also show results under different assumptions. The main projections assume current law is followed, including some payment limits that may not hold.[645]

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## Appendix E. Where to Get Help

| Need | Where to go |
|---|---|
| Medicare questions, plan comparisons | Medicare.gov, or 1-800-MEDICARE (1-800-633-4227)[646] |
| Free, unbiased one-on-one counseling | Your State Health Insurance Assistance Program (SHIP) [647] |
| Signing up for Medicare Parts A and B | Social Security Administration, ssa.gov |
| Medicaid or CHIP eligibility | Your state Medicaid office |
| Help paying Medicare costs | Medicare Savings Programs, through your state Medicaid office |
| Reporting suspected fraud | 1-800-MEDICARE (1-800-633-4227)[648], or the HHS Office of Inspector General at oig.hhs.gov |

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