SOCIAL SECURITY, MEDICARE AND MEDICAID WORK FOR MAINE

www.StrengthenSocialSecurity.org

Our *Social Security, Medicare and Medicaid Work for America* series of 50 state reports includes much information that public officials, members of the press, and advocates will find useful. In addition to providing information about the programs' history, character and vitality, as well as compelling, real-life stories, each report includes statistics about the number of people who receive benefits, the types of benefits they receive and the total amount of funds flowing from these programs into every state, its congressional districts and counties.

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

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

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

ACKNOWLEDGMENTS

Like our Social Security, Medicare and Medicaid, this report is the product of the foresight and hard work of many people. Social Security Works partnered closely with the Alliance for Retired Americans who are coordinating the release of this report in Maine.

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The data presented in this report speaks volumes about the importance of Social Security to families, communities and state and local economies. We hope the report is useful to you as you work to strengthen Social Security in this 77th anniversary year. Please contact the Social Security Works Communications Director, Don Owens, if you have questions about this report: dowens@socialsecurity-works.org.

Nancy Altman and Eric Kingson
Founding Co-directors, Social Security Works
Co-chairs, Strengthen Social Security Coalition

Alliance for Retired Americans

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

SOCIAL SECURITY WORKS.

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

STRENGTHEN SOCIAL SECURITY

The Strengthen Social Security Coalition is made up of more than 320 national organizations and many state organizations, representing more than 50 million Americans. The Coalition is united around core principles, which include that Social Security benefits should not be cut and, instead, should be increased for those who are most disadvantaged, and the belief that our nation's Social Security, Medicare and Medicaid systems are fundamental to the well-being of America's families and to the type of nation we are. www.strengthensocialsecurity.org

INTRODUCTION AND SUMMARY

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

—Franklin D. Roosevelt, August 14, 1935

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

Since then, we have built our Social Security structure carefully and deliberately. In 1939, we added Survivors Insurance benefits for widows and dependent children, eventually extending it to widowers as well. Disability Insurance benefits were added in 1956, followed by Medicare and Medicaid in 1965. The automatic cost-of-living adjustment (COLA) was added in 1972, designed to maintain the purchasing power of benefits no matter how long someone lives. We built, maintained and strengthened these institutions for a reason: to enable working men and women to protect themselves and their families. We built them because we, as a nation, value hard work, personal responsibility, and human dignity; we care for our parents, our children, our spouses, our neighbors and ourselves.

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

FIGURE 1[1]

Social Security, Medicare and Medicaid's Impact on the Economy and Population of Maine

PROGRAM	BENEFICIARIES IN MAINE	PERCENT OF RESIDENTS RECEIVING BENEFITS	AVERAGE BENEFIT	TOTAL ANNUAL BENEFITS[2]
Social Security	299,875	22.6 percent	$12,118	$3.6 billion
Medicare	255,916	19.3 percent	$8,931	$2.3 billion
Medicaid	358,004	27.2 percent	$7,033	$2.5 billion

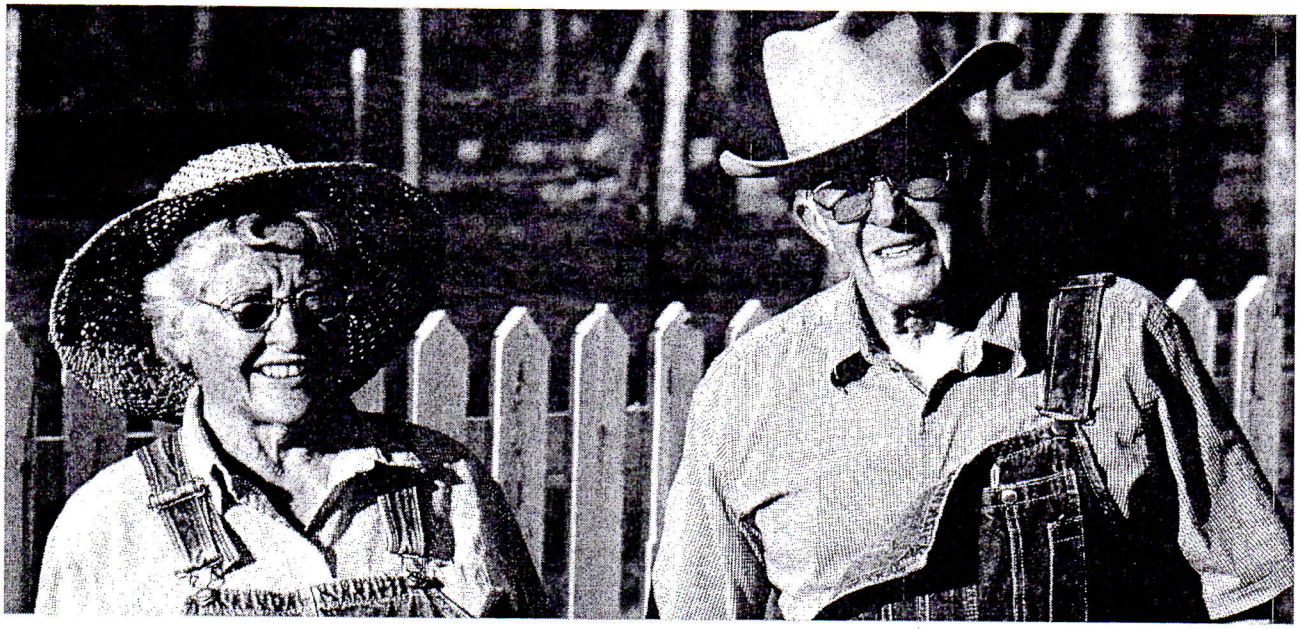
Sources: Social Security Administration, 2011; U.S. Census Bureau; Kaiser Family Foundation, 2011; Economic Policy Institute, 2011.

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

Think, too, of how these institutions, like the nation's highway system, are part of a rich legacy by those who came before, a legacy that keeps working in good times and bad. Throughout the past few difficult years, Social Security, Medicare, and Medicaid have been even more vital than before for Maine residents, and the lifeblood of many small businesses, hospitals and nursing homes and home caregivers. Virtually all of the jobs our Social Security, Medicare, and Medicaid systems support stay in America.

As important as these programs' protections are today, the need for Social Security, Medicare and Medicaid programs will only increase in coming years. The population of persons aged 65 and over is growing. Income growth is slow for most of today's workers. Jobs are less secure, and many workers have sustained substantial losses of home equity and other savings. Furthermore, employers, who historically have offered supplements to Social Security, are increasingly terminating traditional pension plans and either not replacing them, or replacing them with far more risky and inadequate 401(k) savings accounts.

Cutting these programs would threaten our families' economic security and health and deepen our jobs crisis. Indeed, the nation should be thinking about expanding, not cutting, these programs and the protections they provide. They, like our highways, are so fundamental to our family and community life, and, in an increasingly uncertain environment, ever more important to middle-aged and young workers and those who will follow. We are much wealthier as a nation than we were in 1935, 1939, 1956, 1965, or 1972, when these structures were begun and improved. Now it is our turn to maintain and build upon that structure, as those who came before have done. It is our turn to preserve and improve these valuable systems for ourselves and for those who follow. It is our turn to build a legacy for our nation's children and grandchildren so when they become workers, they will have the economic security that Social Security, Medicare, and Medicaid provide.



SOCIAL SECURITY WORKS

We built our Social Security system because it is the most efficient, secure, universal and fair way for Americans to replace wages in the event of death, disability, or old age. For over 75 years, even as our nation has endured wars, political crises and severe economic recessions, Social Security has never missed a payment; it has paid every dollar of earned benefits, on time and in full.

In the wake of the greatest financial crisis since the Great Depression, the risks of investing money on Wall Street or in real estate have never been clearer. Since 2008, millions of Americans have seen their savings wiped out, as the value of 401(k)s and home equity have plummeted. Meanwhile, Social Security continues to prove reliable.

That is why our Social Security system is now more important than ever. In a world of risky investment schemes and unpredictable markets, Social Security is a fortress of security and reliability. In this uncertain world, where no one is invulnerable to the tragedy of premature death or serious and permanent disability, Social Security is there to cushion the economic blow of such tragedies. Today, 56 million Americans receive benefits each month—retired and disabled workers, their families, and surviving family members.[3] Its benefits to Maine residents, and all Americans, are very modest, but vital; the average national benefit was $12,982 a year in 2010.[4] These benefits are the building block of the retirement income security for middle class Americans, in 2010 two out of three households aged 65 and over relied on Social Security for half or more of their income, and over 1 out of 3 relied on Social Security for 90 percent or more of their income.[5] The program lifted 20 million Americans out of poverty in 2008, including one million children.[6]

Social Security can pay all benefits in full and on time for the next twenty years. After that, if Congress were not to act, it could still pay more than 75 cents on every dollar of earned benefits.[7] The shortfall is equivalent to 1 percent of Gross Domestic Product (GDP), which is roughly the amount of revenues that would be lost to the federal budget from extending the George W. Bush-era tax cuts benefitting the richest 2 percent of American households—those with taxable income above $250,000 a year.[8]

All we need to maintain our Social Security system is a simple adjustment: have everyone, including millionaires and billionaires, pay the same rate as ordinary Americans. While the vast majority of Americans must make payroll tax contributions on all of their wages, millionaires and billionaires only do so on the first $110,100 of their earnings this year. Asking all Americans to pay the same rate would come very close to closing Social Security's entire projected 75-year funding gap.

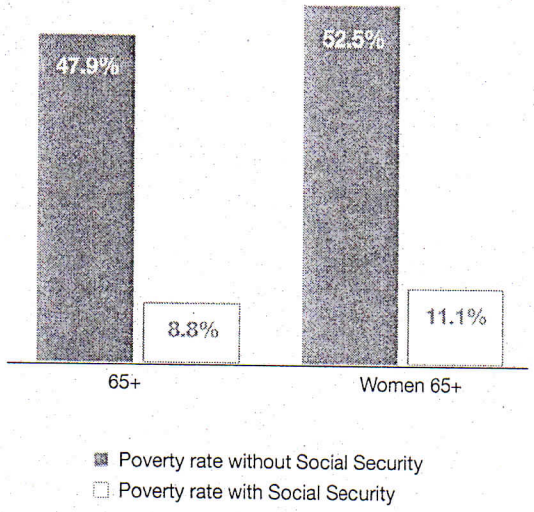
While the federal budget has run a deficit in every year but five over the last half century, Social Security is not allowed to pay benefits unless it has the funds to cover every penny of the cost, and is not allowed to borrow any shortfall.[9] That means that Social Security does not, and, by law, cannot add a penny to the federal deficit or debt (which is simply the accumulation of annual deficits).[10] Maintaining our Social Security system has nothing to do with reducing the federal budget deficit, and therefore should be off the table in deficit talks. It should not be part of any deficit reduction legislation considered by our nation's leaders.

Social Security Works for Maine's Residents and Economy

- Social Security provided benefits to 299,875 people in 2010, 1 out of 4 residents (22.6 percent).[11]
- Maine residents received Social Security benefits totaling $3.6 billion in 2010, an amount equivalent to 7.2 percent of the state's annual GDP (the total value of all goods and services produced).[12]
- The average Social Security benefit in 2010 was $12,118.[13]

FIGURE 2

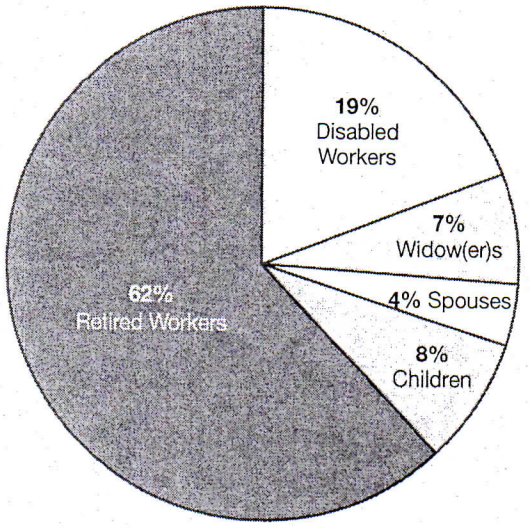
Poverty Rate for Beneficiaries 65 and Older With and Without Social Security, 2006–2008



Source: Center on Budget & Policy Priorities

FIGURE 3

Maine's Social Security Beneficiaries, 2010



Source: Social Security Administration, 2012

- Social Security lifted 119,000 Maine residents out of poverty in 2008.[14]

Social Security Works for Maine's Seniors[15]

- Social Security provided benefits to 185,849 retired workers in 2010, two-thirds (62 percent) of beneficiaries.[16] [Figure 3]
- The typical benefit received by a retired worker in Maine was $12,608 in 2010.[17]
- Social Security provided benefits to 22,473 widow(er)s in 2010, 1 out of 13 (7.5 percent) of all beneficiaries.[18] [Figure 3]
- Social Security lifted out of poverty 78,000 Maine residents aged 65 and older in 2008.[19]
- Without Social Security, the elderly poverty rate in Maine would have increased from 1 out of 11 (8.8 percent) to nearly half (47.9 percent).[20] [Figure 2]

Social Security Works for Maine's Women

- Social Security provided benefits to 149,545 Maine women in 2010, nearly 1 out of 4 women (22 percent).[21]
- Social Security provided benefits to 11,878 spouses in 2010, 1 out of 25 (4 percent) of all beneficiaries.[22] [Figure 3]
- Social Security lifted out of poverty 47,000 Maine women aged 65 and older in 2008.[23]
- Without Social Security, the poverty rate of elderly women would have increased from 1 out of 9 (11.1 percent) to more than half (52.5 percent).[24] [Figure 2]

Social Security Works for Maine's Workers with Disabilities[25]

- Social Security provided disability benefits for 55,525 workers in 2010, 1 out of 5 (18.5 percent) of all beneficiaries.[26] [Figure 3]
- The typical benefit received by a disabled worker beneficiary in Maine was $11,357 in 2010.[27]

Social Security Works for Maine's Children[28]

- Social Security is the major life and disability insurance protection for more than 95 percent of Maine's 274,533 children.[29]

- Social Security provided benefits to 24,150 children in 2010,[30] and it is the most important source of income for the 16,934 children living in Maine's grandfamilies, which are households headed by a grandparent or other relative.[31]

Social Security Works for Maine's African Americans

- In Maine, Social Security provided benefits to 1,272 African Americans in 2009, 1 out of 17 (6.1 percent) of all African American residents.[32]
- Nationwide, Social Security provided nearly three-quarters (73.7 percent) of the income of African American elderly couples and unmarried individuals receiving benefits, on average, in 2010. Social Security was 90 percent of the total income for half (49.4 percent) of these African American elderly households.[33]
- Nationwide, 3 out of 10 (32.1 percent) of all African American beneficiaries received disability benefits in 2009; for white beneficiaries it was about half of that number (15.9 percent).[34]

Social Security Works for Maine's Rural Communities[35]

- Social Security is more important to rural Maine residents than to other Maine residents. Over 1 out of 4 (25.2 percent) rural Maine residents received Social Security compared with 1 out of 5 (20.7 percent) non-rural Maine residents in 2010.[36]
- Social Security is more important to the local economies of Maine's rural counties than to its non-rural counties. Total personal income in Maine's 11 rural counties was $18.4 billion in 2010 of which $1.6 billion, or 8.9 percent, was from Social Security. By comparison, total personal income in the state's 5 non-rural counties was $30.4 billion, of which $2 billion, or 6.6 percent, was from Social Security.[37]

Social Security Works for Maine's Working Families

- Through their hard work and payroll tax contributions, nearly all Maine workers earn Social Security's retirement, disability and survivorship protections for themselves and their families.

ROGER HARE, 84 years
South Portland, ME

Roger Hare enjoyed nearly perfect health for most of his life. Then about ten years ago, he began having trouble. His doctor said he was suffering from bladder stones, a subcategory of kidney stones. He went to Boston and had surgery to remove the stones but following surgery, he still had serious problems. "It's been hell on earth," says Roger. "But I'd be bankrupt without Medicare. I have a stack of Medicare statements an inch thick. Without Medicare, I would have nothing."

- Social Security is the most valuable disability and life insurance protection for most Maine workers. Nationwide, an estimated 3 out of 10 working aged men and 1 out of 4 working aged women will become severely disabled before reaching retirement age. An estimated 1 out of 11 working aged men and 1 out of 20 working aged women will die before reaching retirement age.[38]
- A 30 year old worker who earns about $30,000 and who has a spouse and two young children, receives Social Security insurance protection equivalent to private disability and life insurance policies worth $465,000 and $476,000, respectively.[39]

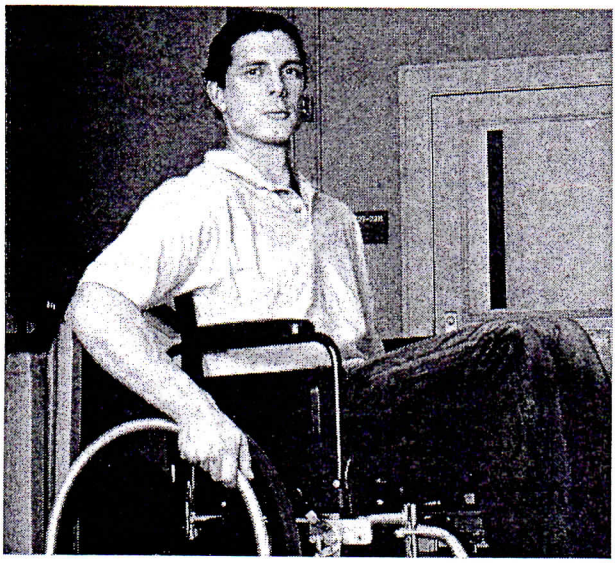
Social Security is a commitment made to all Americans that has withstood the test of time. It represents the best of American values—rewarding hard work, honoring our parents, caring for our neighbors, and taking responsibility for ourselves and our families. Social Security is based on a promise that if you pay in, then you earn the right to guaranteed benefits.

MEDICARE WORKS

We built our Medicare system because it is by far the best way to provide America's seniors and people with disabilities with affordable health care they can count on. For nearly half a century, Medicare has given seniors and people with disabilities access to critical health care. It protects beneficiaries and their families against health-related expenditures that might otherwise overwhelm their finances—or worse, force them to forego medical treatment needed to survive.

Private health insurance companies, which must generate returns for their shareholders, were not—and are not—willing or able to insure seniors and people with disabilities at affordable rates. That is because seniors and people with disabilities have greater medical needs and thus are more costly than the young and healthy. Prior to Medicare, only about half of seniors had health insurance. Those who were insured paid nearly three times as much as younger people, even though they had, on average, only half as much income.[40]

Without Medicare, many people would not be able to afford basic medical services. Medicare beneficiaries are mainly people of modest means. Half had incomes below $22,000 a year in 2010.[41] Already more than one-quarter of many beneficiaries' Social Security benefit is eaten up by out-of-pocket health care costs.[42]



Medicare works—for seniors and people with disabilities, as well as people with end-stage renal disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig's disease). The program provides significant hospital, physician, medical testing, pharmaceutical, rehabilitation, medical equipment and other important services to seniors, people with disabilities and people with ESRD and ALS.[43] Medicare provided health care coverage to 48.7 million Americans in 2011, of whom over 8 out of 10 (40.4 million) were aged 65 or older; and 1 out of 6 (8.3 million) were severely disabled workers.[44] The average benefit per Medicare beneficiary in 2011 was $12,042.[45]

Medicare consists of four parts, each of which provides different medical benefits. Medicare Part A, the Hospital Insurance (HI) program, covers in-patient hospital as well as select kinds of skilled nursing facility services, home health and hospice care. HI is earned during one's working years, and paid for by insurance contributions of 2.9 percent of wages, divided equally between employers and employees.[46*]

Medicare Part B, the Supplemental Medical Insurance (SMI) program, helps pay for physician and preventive care services. SMI is a voluntary program, funded by premiums, generally deducted from beneficiaries' Social Security checks, and from general revenue.[47] (Medicaid covers the premium

* Starting in 2013, the Affordable Care Act levies an "additional 0.9 percentage point Hospital Insurance tax on earned income for households with incomes exceeding $200,000 for singles and $250,000 for married couples filing jointly. In addition, it would add a 3.8 percent Unearned Income Medicare Contribution for such high-income households to unearned income including interest, dividends, annuities, royalties and rents (excluding income from active participation in S corporations)." White House, "Title IX. Revenue Provisions," *Health Reform Details,* 2012. http://www.whitehouse.gov/health-care-meeting/proposal/titleix/targeted-healthcare-tax

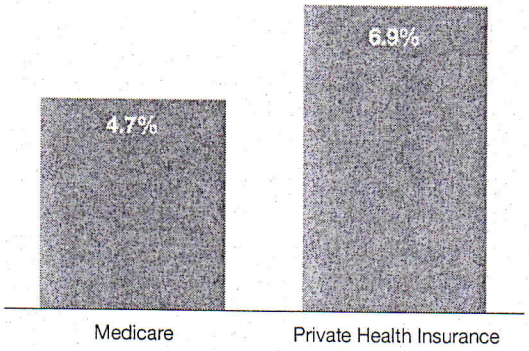
and out-of-pocket costs for those low-income beneficiaries who are enrolled in Medicaid.)

Medicare Part C, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private insurance plan, in lieu of Medicare Parts A and B. These private plans receive payments from Medicare to cover physician and hospital service, and in most cases, prescription drug benefits. Medicare Advantage Plans cost more for the same services as provided under Parts A and B.[48] According to the White House, "Medicare pays Medicare Advantage insurance companies over $1,000 more per person on average than traditional Medicare."[49] These extra costs result not only in higher government outlays but also higher Part B premiums for those enrolled in traditional Medicare. The Patient Protection and Affordable Care Act (ACA) of 2010 includes provisions which seek to make the costs of Part C closer to those of Part A and Part B.[50] About 11.5 million Medicare beneficiaries were enrolled in Medicare Advantage as of April 2010—one-quarter (24.5 percent) of all beneficiaries.[51]

Medicare Part D, the prescription drug benefit, covers most outpatient prescription drugs. Part D benefits are provided by private plans that contract with Medicare and are purchased voluntarily by Medicare beneficiaries. They exist independently, or as part of a Medicare Advantage plan. Part D is funded by beneficiary premiums, generally deducted from beneficiaries' Social Security checks, and from general revenue. In addition, states are required to pay premiums for low-income beneficiaries who are enrolled in Part D programs. 27.6 million beneficiaries were enrolled in a Part D plan in 2010—4 out of 10 (41.7 percent) of all beneficiaries.[52*]

FIGURE 4

Average Annual Increase in Spending on Common Benefits,* 1999–2009



*Common benefits refers to benefits commonly covered by Medicare and private health insurance.

Source: Center for Medicare & Medicaid Services, 2010

As health care costs skyrocket, our Medicare system is more critical than ever. Medicare does a better job of controlling health care costs than private health insurance plans. While Medicare's costs per person increased by about 4.7 percent a year from 1999 to 2009, the costs of similar benefits under private insurance rose 6.9 percent—nearly 50 percent more.[53] [Figure 4] Medicare's superior cost-control record is no coincidence; it is a function of Medicare's concentrated purchasing power. As Professor Jacob Hacker of Yale University notes, Medicare is "capable of using its concentrated purchasing power to pioneer new payment methods that bring down costs." Hacker cites Medicare's implementation of a "prospective payment system" and a "resource-based physician fee schedule" in 1983, and "volume controls" on Medicare physician spending in the 1990s, as examples of Medicare's success in pioneering payment methods that reduced underlying health care costs.[54]

Even though the traditional Medicare program, Parts A and B, covers people who, on average, have more health care claims and more expensive medical conditions than private insurance, its administrative costs are lower than those of private health insurance plans. Medicare's administrative costs were less than 2 percent of its total expenditures in 2011.[55] Private health insurance's administrative

*As of January 1, 2011, the Affordable Care Act ensures that seniors who reach the prescription drug coverage gap, known commonly as the "donut hole," will receive discounts on brand-name and generic prescription drugs covered by Medicare Part D that increase gradually until the coverage gap is completely closed in 2020. Medicare.gov, "Closing the Coverage Gap—Medicare Prescription Drugs Are Becoming More Affordable," January 2012. http://www.medicare.gov/publications/pubs/pdf/11493.pdf

costs, which include additional costs such as advertising, retained profit to insurers and taxes paid by insurers, are generally much higher. The Congressional Budget Office (CBO) estimated that in 2007 these administrative costs varied from about 7 percent for large employer plans with 1,000 or more covered employees to as much as 30 percent for insurance sponsored by very small firms or purchased by individuals.[56] CBO estimated that while Medicare paid about $150 per person enrolled, large employer plans paid about $300 per person enrolled, and small employers and individuals paid roughly $1,000 per person enrolled, on average.[57] The traditional Medicare Program, Parts A & B, is also administered more efficiently than Medicare Advantage, Part C, which is provided by private insurers who contract with Medicare. An analysis by CBO shows that administrative costs accounted for less than 2 percent of expenditures in the traditional Medicare program, compared to 11 percent in the Medicare Advantage program in 2005.[58]

Maintaining our Medicare system is simple. As health care costs increase system-wide, Medicare's costs rise as well. It is primarily as a result of system-wide cost increases, that Medicare has significant long-term funding challenges. The solution is to slow the growth of health care costs for everyone, as other developed countries have done—not to cut Medicare's benefits. Cutting Medicare's benefits simply shifts costs to the sickest and oldest among us, forcing some seniors and people with disabilities to forego treatment, living shorter, less healthy—and more medically costly—lives as a result.

Medicare Works for Maine's Economy

- Medicare provided $2.3 billion in benefits in 2009—20.4 percent of all health care spending in the state.[59] The average expenditure per Medicare beneficiary was $8,929.[60]

Medicare Works for Maine Residents

- Medicare insured 255,916 Maine residents in 2009—1 out of 5 (19.4 percent) state residents.[61]

Medicare Works for Maine's Seniors

- 203,322 of Maine's 255,916 Medicare beneficiaries were aged 65 or older in 2009—8 out of 10 (79.4 percent) beneficiaries.[62]

Medicare Works for Maine's People with Disabilities

- 53,688 of Maine's 255,916 Medicare beneficiaries were people with disabilities in 2009—1 out of 5 (21 percent) beneficiaries.[63]

Medicare Works for Maine's Residents with End-Stage-Renal Disease (ESRD)

- End-stage-renal disease (ESRD) occurs when a person's kidneys stop functioning at a level needed for everyday life. People suffering from ESRD generally must undergo dialysis treatment or receive a kidney transplant, which are both prohibitively expensive.[64]

Medicare Works for Maine's Residents with Amyotrophic Lateral Sclerosis (ALS)

- Amyotrophic Lateral Sclerosis, more commonly known as ALS, or Lou Gehrig's disease, is a nervous system disease that gradually shuts down all muscles in a person's body, eventually resulting in death from respiratory failure.[65] Many Maine residents with ALS would impoverish themselves or their families without the help of Medicare.

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

MEDICAID WORKS

We built our Medicaid system to provide health care for low-income families, children, seniors and people with disabilities. For nearly half a century, Medicaid has provided critical health coverage for low-income Americans. While Medicaid originally only insured Americans receiving cash welfare assistance, Congress expanded it over the years to help insure those left behind by the private insurance system.* It is a lifeline for those who have nowhere else to go.[66] Medicaid insured 62.6 million Americans in 2009.[67] Like Medicare, it is an important source of funding for rural hospitals and inner-city health care facilities.

Medicaid is essential because private health insurance is unaffordable for millions of Americans. Private health insurance costs have risen dramatically in recent years. Average annual premiums for a family with employer-sponsored health insurance rose to $15,073 in 2011—a 9 percent increase from the previous year.[68]

SOCIAL SECURITY, MEDICARE AND MEDICAID WORK FOR MAINE

Medicaid is especially crucial to people in need of community- and institutionally-based long-term care services. Medicare does not cover most long-term care costs, and private insurance plans that cover long-term care are often prohibitively expensive. As a result, many individuals exhaust their assets under the weight of steep long-term care costs, and have nowhere to turn but Medicaid. In short order, long-term care patients and their families can go from the middle class to a life of poverty in which they need assistance.

Two-thirds of all Medicaid spending is for seniors and people with disabilities.[69] One out of every four seniors and people with disabilities depended on Medicaid in 2010—16 million people. That includes 15.4 percent of all seniors (6.3 million) and 44.6 percent of people with disabilities (9.8 million).[70]

Medicaid is also crucially important to children, who are about half of its beneficiaries nationwide.[71] More than one in four of the nation's children receive their health insurance through Medicaid.[72]

Maintaining our Medicaid system, like our Medicare system, is simple. As health care costs increase system-wide, Medicaid's costs rise as well. It is primarily as a result of system-wide cost increases that Medicaid has significant long-term funding challenges. The solution is to slow the growth of health care costs for everyone, as other developed countries have done—not to cut Medicaid's benefits. Cuts in federal funding to Medicaid will shift costs to states, if they have the funds to pick up the shortfall, or worse, to individuals and families who can least

*The Affordable Care Act's expansion of Medicaid and Children's Health Insurance Program (CHIP) eligibility alone is projected to result in the enrollment of an additional 32 million Americans in Medicaid and CHIP by 2022. Congressional Budget Office, "Table 3. March 2012 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act,* March 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf

afford it. More troubling still, it may make life-saving medical care inaccessible for those who need it.

Medicaid Works for Maine's Economy

- Medicaid provided $2.5 billion in benefits in 2009—22.5 percent of all health care spending in the state.[73] The average expenditure per Medicaid beneficiary was $7,033.[74]

Medicaid Works for Maine Residents

- Medicaid insured 358,004 Maine residents in 2009—1 out of 4 (27.2 percent) state residents.[75]

Medicaid Works for Maine's Children

- Medicaid insured 130,862 children in 2009—nearly half (48.4 percent) children in the state.[76]

Medicaid Works for Maine's Seniors

- 60,768 of Maine's 358,004 Medicaid beneficiaries were aged 65 or older in 2009—1 out of 6 (17 percent) beneficiaries.[77]

Medicaid Works for Maine's People with Disabilities

- 66,288 of Maine's 358,004 Medicaid beneficiaries were people with disabilities in 2009—1 out of 5 (18.5 percent) beneficiaries.[78]

Medicaid Works for Maine's Long-Term Care Residents

- Medicaid provided $776 million in long-term care benefits for Maine residents in 2009. That includes:
  - $406 million in home health care services (52.3 percent)
  - $254 million to nursing home facilities (32.7 percent)
  - $53 million to mental health facilities (6.9 percent)
  - $63 million to intermediate care facilities for the intellectually disabled (8.1 percent).[79]
- Medicaid insured the vast majority of Maine residents who opt for nursing home care. 4,150 of Maine's 6,420 nursing home residents were Medicaid beneficiaries in 2010—2 out of 3 (64.6 percent) residents.[80] The average annual cost of nursing home care for a semi-private room in Maine was $89,800 in 2010.[81] Given the high cost of nursing home care, many Maine residents would not be able to afford it without Medicaid.

Medicaid Works for Maine During Economic Recessions

- Because Medicaid eligibility is contingent upon having low income, the program expands to accommodate those who have lost jobs or earnings during a recession. Nationwide, between June 2008 and June 2009, the height of the Great Recession, monthly Medicaid enrollment rose by 3.3 million. That amounts to a 79 percent increase from the average annual enrollment rate between 2000 and 2007. While there are several factors that fuel Medicaid enrollment, experts believe that job losses and resulting losses of employer-based insurance and declining income, cause more people to qualify for Medicaid.[82]

As financially strapped states cut Medicaid, the last thing the nation's seniors, people with disabilities, and low-income children need is for the federal government to cut the program at the national level. Like Social Security and Medicare, this vital program should be strengthened, not cut.

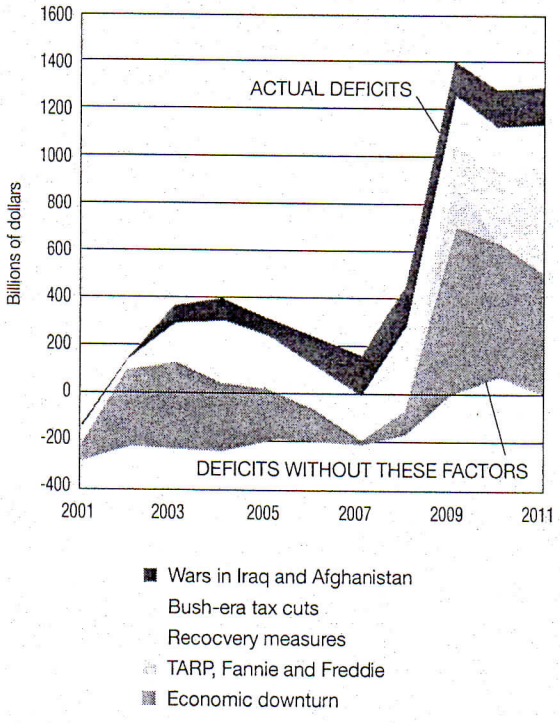
CONCLUSION

The large run-up in federal deficits in recent years resulted primarily from huge tax cuts in 2001 and 2003; the unpaid costs of the Iraq and Afghanistan wars; the Great Recession, which dramatically reduced tax collections and increased unemployment compensation and other spending; the economic stimulus and recovery spending; and the Wall Street bank bailout.[83] [Figure 5] By law, Social Security can only pay benefits if it has the income to cover its costs. Its income is primarily the result of insurance contributions paid by hardworking Americans and their employers. It does not have borrowing authority which is why it never has and never will contribute to federal budget deficits.

Likewise, large anticipated yearly increases in health care expenditures, public and private, reflect long-term structural problems in the nation's health care system. Compared to other industrial democracies, the United States expends roughly twice as much per person on health care generally without providing coverage for all our citizens. While the nation's recent health care reform is expected to bend the cost curve and to expand coverage, health care expenditures are still expected to rise for many years, well in excess of inflation. That's bad for consumers, employers and the economy, but it is not the fault of Medicare and Medicaid. In fact, Medicare is the most efficient part of the health care system, averaging just 2 percent and in administrative costs compared to about 7 percent for large group plans and as much as 30 percent for plans purchased by individuals.[84]

FIGURE 5

Causes of Recent Run-Up in Federal Deficits



Source: Center for Economic and Policy Research, 2012

To reduce the federal debt, Congress should be looking at its causes. It should not cut Social Security, Medicare, and Medicaid, which were built to protect working persons and their families against lost wages and the high cost of health care, and which are so vital to the economic security of our nation.

Social Security, Medicare and Medicaid represent the best of America's values, including caring for aging parents and neighbors, reward for hard work, personal responsibility and dignity. In Maine, these programs spend about $8.4 billion a year, providing benefits to an average of nearly 1 out of 4 residents for each program.[85] It is no surprise that poll after poll shows that Americans overwhelmingly support these programs and do not want to see them cut. Cutting them would be weaken the economic security of all Americans. While that would be bad policy anytime, it would be disastrous in this time of widespread economic loss.

The old, the disabled and today's workers have a stake in preserving these foundational systems—for themselves, their families, their children and grandchildren. And politicians have the opportunity to maintain and improve these paramount achievements for future generations, just as previous Congresses and presidents have done for us.

Appendix 1: Social Security Works for Maine's Congressional Districts

		STATE TOTAL	CONGRESSIONAL DISTRICTS	
			1	2
Total annual benefits ($ in millions)*		$3,590M	$1,768M	$1,822M
Number of residents in state/congressional district		1,328,361	668,515	659846
Number of residents receiving Social Security benefits		299,875	142,220	157,655
Percent of residents receiving Social Security benefits		22.6%	21.3%	23.9%
SOCIAL SECURITY BENEFICIARIES BY CATEGORY	***Women***	149,545	N/A	N/A
	Retired workers	185,849	92,401	93,448
	Disabled workers	55,525	23,222	32,303
	Widow(er)s	22,473	10,363	12,110
	Spouses	11,878	5,445	6,433
	Children	24,150	10,789	13,361

Sources: US Census Bureau, *Profile of General Population and Housing Characteristics: 2010,* 2011.
SSA, "Maine," *Congressional Statistics, December 2010,* 2011.
SSA, "Table 5.J5.1: Number by state or other area and sex, December 2010. *Annual Statistical Supplement, 2011,* February 2012

*The annual benefits for the Congressional districts were calculated by taking the monthly benefits and multiplying by 12. The state annual benefits number is the sum of the congressional district numbers and is not necessarily consistent with state totals cited elsewhere in the report

Appendix 2: Social Security, Medicare, and Medicaid Data by County, in Maine's Counties

	MAINE COUNTY DEMOGRAPHICS, 2010						SOCIAL SECURITY BENEFITS, 2010		SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2010*						MEDICARE
County	Population	Rural-Urban Continuum Code (2003)	Median Household Income	% in Poverty	Population over Age 65	% of Population Over Age 65	% of Population Receiving Benefits	Total Annual Benefits	Total Beneficiaries	Retired Workers	Disabled Workers	Widow(er)s	Spouses	Children	% Receiving Medicare, 2010
Total (16 counties)	1,328,361	N/A	$45,882	13.1%	211,080	15.9%	22.6%	$3,635,662,000	299,875	185,849	55,525	22,473	11,878	24,150	19.8%
Androscoggin	107,702	3	$41,831	14.6%	15,184	14.1%	21.8%	$277,819,000	23,505	13,995	5,205	1,500	635	2,170	19.4%
Aroostook	71,870	7	$36,344	14.0%	13,651	19.0%	27.8%	$222,160,000	19,975	11,350	4,155	1,800	980	1,690	24.6%
Cumberland	281,674	2	$57,424	10.3%	40,157	14.3%	18.9%	$695,867,000	53,360	34,755	8,595	4,105	2,055	3,855	17.4%
Franklin	30,768	6	$39,034	15.6%	5,160	16.8%	23.4%	$86,295,000	7,215	4,590	1,275	500	280	570	18.3%
Hancock	54,418	6	$41,106	14.0%	9,937	18.3%	23.7%	$161,568,000	12,905	8,815	1,755	980	620	735	20.3%
Kennebec	122,151	4	$44,725	11.7%	18,960	15.5%	24.4%	$338,630,000	29,820	17,145	6,355	2,040	1,095	3,180	20.7%
Knox	39,736	7	$42,593	13.7%	7,594	19.1%	25.6%	$126,739,000	10,185	6,830	1,400	795	455	705	23.1%
Lincoln	34,457	8	$45,520	12.7%	7,393	21.5%	27.5%	$120,978,000	9,490	6,640	1,150	730	450	520	23.9%
Oxford	57,833	6	$38,789	15.0%	9,843	17.0%	25.0%	$171,363,000	14,450	8,620	2,955	1,045	560	1,275	20.1%
Penobscot	153,923	3	$42,602	16.0%	22,253	14.5%	21.8%	$396,258,000	33,585	18,680	7,490	2,835	1,560	3,020	19.5%
Piscataquis	17,535	8	$34,420	16.6%	3,564	20.3%	28.2%	$57,263,000	4,950	2,960	1,030	370	185	400	25.2%
Sagadahoc	35,293	2	$52,071	10.5%	5,788	16.4%	21.8%	$99,470,000	7,680	5,045	1,220	590	335	490	18.6%
Somerset	52,228	6	$36,249	18.6%	8,537	16.3%	23.0%	$136,959,000	12,010	6,920	2,730	855	445	1,060	20.9%
Waldo	38,786	6	$37,986	15.6%	6,280	16.2%	23.6%	$107,367,000	9,150	5,645	1,685	725	385	710	19.8%
Washington	32,856	7	$32,847	19.4%	6,426	19.6%	28.2%	$104,281,000	9,270	5,810	1,640	780	395	645	24.1%
York	197,131	2	$54,076	10.3%	30,353	15.4%	21.5%	$532,645,000	42,325	28,050	6,885	2,825	1,445	3,120	18.7%

*State totals do not equal the sum of county figures, because individual county figures provided by SSA are rounded.

Population: US Census Bureau, "Profile of General Population and Housing Characteristics: 2010," *2010 Demographic Profile Data*, 2010. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Rural-Urban Continuum Codes: United States Department of Agriculture, Economic Research Service (ERS), "Measuring Rurality: Rural-Urban Continuum Codes," 2003. http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx ERS designates counties as rural or urban based on population density, grading them on a scale of 1 to 9, with 1 being the most urban and 9 being the most rural. Counties are considered rural if they are designated 4 or higher.

Median Household Income: US Census Bureau, *Table 1: 2010 Poverty and Median Income Estimates - Counties*, November 2011. http://www.census.gov/did/www/saipe/data/statecounty/data/2010.html

Percentage of Households in Poverty: US Census Bureau, *Table 1: 2010 Poverty and Median Income Estimates - Counties*, November 2011. http://www.census.gov/did/www/saipe/data/statecounty/data/2010.html

Population Aged 65 or Older: US Census Bureau, "Age Groups and Sex: 2010," *2010 Census Summary File 1*, 2011. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP1&prodType=table

Total Annual Social Security Benefits: Bureau of Economic Analysis (BEA), Regional Economic Accounts: Local Area Personal Income, "Old-Age, Survivors and Disability Insurance (OASDI) benefits," in CA 35 Personal current transfer receipts, http://bea.gov/regional/reis/. BEA data were used for total annual Social Security benefits rather than the figures available from the SSA in order to be consistent with the denominator of "Personal income," which came from BEA. For other purposes in the report, such as calculating the average benefit and average retirement benefit in rural counties, SSA data were used.

Social Security Beneficiaries by Characteristic: Social Security Administration (SSA), "Table 4. Number of beneficiaries in current-payment status, by county, type of benefit, and sex of beneficiaries aged 65 or older, December 2010," *OASDI Beneficiaries by State and County, 2010*, June 2011. http://www.ssa.gov/policy/docs/statcomps/oasdi_sc/2010/index.html

Percentage of Population Receiving Medicare: Center for Medicare and Medicaid Services (CMS), "Beneficiaries Receiving Medicare: Total Beneficiaries by State and County," 2010. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2010.pdf

Endnotes

[1] Complete citations for the sources of the numbers included in Figure 1 can be found where the numbers appear elsewhere in the report. All of the statistical data used in Figure 1, as well as the rest of the report, are the most current data available. Some data were available in more recent years than others. For sets of data partially available for one year and partially available for another, the most recent common year was chosen. As a result, nearly all numbers relating to Social Security date to 2010, nearly all numbers relating to Medicare date to 2009, and nearly all numbers relating to Medicaid date to FY2009. When data from other years are used, the report says so explicitly.

[2] While Social Security and Medicare benefits are funded entirely by the federal government, Medicaid is partially funded by state governments, and sometimes local governments.

[3] There were 56 million beneficiaries nationwide as of May 2012. Except where otherwise noted, the rest of the Social Security data referenced in this report date to 2010, the most recent common year in which those data were available. Total Social Security beneficiaries in individual states dating to 2010 will not add up to this figure. Social Security Administration (SSA), "Table 2. Social Security Benefits, May 2012," *Monthly Statistical Snapshot, May 2012,* June 2012. http://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/#table2

[4] Average annual benefit amounts calculated by dividing total annual benefits by total beneficiaries. Total annual benefits from SSA, "Table 5.J1 Estimated total annual benefits paid, by state or other area and program, 2010 (in millions of dollars), Annual Statistical Supplement, 2011 [herein, *Ann. Stat. Supp.*], February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j2 Total beneficiaries from SSA, "Table 5.J2 Number, by state or other area, program, and type of benefit, December 2010," *Ann. Stat Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j1

[5] Households refers to "aged units," which are married couples living together of whom at least one is aged 65 or older, or unmarried persons aged 65 or older. SSA, Table 9.A1, *Income of the Population, 55 or Older, 2010,* August 2012. http://www.ssa.gov/policy/docs/statcomps/income_pop55/2010/sect09.html#table9.a1

[6] Center on Budget & Policy Priorities (CBPP), "Social Security Keeps 20 Million Americans Out of Poverty, A State-by-State Analysis," August, 2010. http://www.cbpp.org/files/8-11-10socsec.pdf

[7] Social Security Trustees, *2012 Annual Trustees Report,* April 25, 2012, p. 11. http://www.ssa.gov/oact/tr/2012/tr2012.pdf

[8] CBPP, "What the 2012 Trustees Report Shows About Social Security," Figure 1, May 10, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=3774

[9] White House, Office of Management and Budget, *Table 1.1 Summary of Receipts, Outlays and Surpluses or Deficits: 1789-2017,* 2012. http://www.whitehouse.gov/omb/budget/Historicals

[10] Social Security does not contribute to the deficit, because benefits can only be paid from revenue collected by the Social Security trust funds—the Old-Age and Survivors Insurance (OASI) trust fund and Disability Insurance (DI) trust fund—which are completely separate from the general budget. Social Security Trustees, Table II.B1, *2012 Annual Trustees Report,* April 25, 2012, p. 6. http://www.ssa.gov/oact/tr/2012/tr2012.pdf In 2010 and 2011 The General Fund transferred money to the Social Security trust funds in order to replace revenue lost due to a temporary two-percentage-point payroll tax reduction. The payroll tax cut, and the General Fund transfer that resulted, was a temporary stimulus measure that will expire at the end of the year. It never fundamentally changed Social Security's self-sustaining funding structure.

The trust funds do not have borrowing authority, and therefore, cannot deficit-spend. In the event that trust fund revenues fall short of what is needed to pay 100 percent of benefits, then, by law, benefits could not be paid in full and on time. That is why, if Congress does nothing to shore up the program's finances by 2033, Social Security will only have sufficient revenue to pay about three-quarters of scheduled benefits through 2086. Social Security Trustees, Table II.B1, *2012 Annual Trustees Report,* April 25, 2012, p. 11. http://www.ssa.gov/oact/tr/2012/tr2012.pdf This modest funding shortfall is often cited as evidence that the program is financially unsustainable, or "in deficit." In fact, it is just the opposite: it attests to Social Security's self-sustaining funding structure that bars it from deficit-spending or borrowing from the general budget in any way.

[11] Total beneficiaries from SSA, "Table 5.J2 Number, by state or other area, program, and type of benefit, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j2 State population data from U.S. Census Bureau, "Profile of General Population and Housing Characteristics: 2010," *2010 Demographic Profile Data,* 2011. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1&prodType=table

[12] Total annual benefits from SSA, "Table 5.J1 Estimated total annual benefits paid, by state or other area and program, 2010 (in millions of dollars), *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j1 Benefits' equivalent percentage of Gross Domestic Product (GDP) calculated using state GDP figures from Bureau of Economic Analysis, "Gross Domestic Product by State (millions of current dollars)," September 29, 2011. http://bea.gov/iTable/iTable.cfm?ReqID=70&step=1&isuri=1&acrdn=1

[13] Average benefit found by dividing total spending by total beneficiaries. Total annual benefits from Social Security Administration (SSA), "Table 5.J1 Estimated total annual benefits paid, by state or other area and program, 2010 (in millions of dollars), *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j1 Total beneficiaries from SSA, "Table 5.J2 Number, by state or other area, program, and type of benefit, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j2

[14] CBPP, "Social Security Keeps 20 Million Americans Out of Poverty, A State-by-State Analysis," August, 2010. http://www.cbpp.org/files/8-11-10socsec.pdf Total number of state residents lifted out of poverty, which does not appear in CBPP's report, was made available to Social Security Works by the report's authors, Arloc Sherman and Paul N. Van de Water. The state-level data reflect average from 2006-2008, and therefore do not add up to the national totals, which date to 2008.

[15] For the purposes of this analysis, "seniors" describes individuals aged 65 or older. Herein, all references to "seniors" will reflect this definition.

[16] SSA, "Table 5.J2—Number, by state or other area, program and type of benefit, December 2010," *Ann. Stat. Supp.*, February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j2

[17] For the purposes of this analysis, "typical" is used to describe the "median" benefit. Herein, all references to "typical" will reflect this description. Monthly median benefit multiplied by 12 to calculate annual figure. SSA, "Table 5.J6—Percentage distribution of monthly benefit for retired workers, by state or other area and monthly benefit, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j6

[18] SSA, "Table 5.J2—Number, by state or other area, program, and type of benefit, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j2

[19] CBPP, "Social Security Keeps 20 Million Americans Out of Poverty, A State-by-State Analysis," August, 2010. http://www.cbpp.org/files/8-11-10socsec.pdf The state-level data reflect average from 2006-2008, and therefore do not add up to the national totals, which date to 2008.

[20] CBPP, "Social Security Keeps 20 Million Americans Out of Poverty, A State-by-State Analysis," August, 2010. http://www.cbpp.org/files/8-11-10socsec.pdf The state-level data reflect average from 2006-2008, and therefore do not add up to the national totals, which date to 2008.

[21] SSA, "Table 5.J5.1—Number, by state or other area, race, and sex, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j5.1 Percentage of women receiving benefits calculated using total female population from U.S. Census Bureau, "Age groups and Sex: 2010," *2010 Census Summary File 2.* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP1&prodType=table

[22] SSA, "Table 5.J2—Number, by state or other area, program, and type of benefit, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j2

[23] CBPP, Ibid. The number and percentage of women aged 65 or older lifted out of poverty, which do not appear in CBPP's report, were made available by the report's authors, Arloc Sherman and Paul N. Van de Water. The state-level data reflect average from 2006-2008, and therefore do not add up to the national totals, which date to 2008.

[24] CBPP, Ibid. The number and percentage of women aged 65 or older lifted out of poverty, which do not appear in CBPP's report, were made available by the report's authors, Arloc Sherman and Paul N. Van de Water. The state-level data reflect average from 2006-2008, and therefore do not add up to the national totals, which date to 2008.

[25] The number of Social Security disability beneficiaries cited here includes only those disabled workers receiving disability benefits. It does not include those disabled workers and "disabled adult children" who receive Old-Age (retirement) and Survivors benefits. Herein, any use of the term "disabled worker" will refer only to those disabled workers receiving disability benefits.

[26] SSA, "Table 5.J8—Percentage distribution of disabled workers, by state or other area and monthly benefit, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j8

[27] Monthly median benefit multiplied by 12 to calculate annual figure. SSA, Ibid.

[28] Unless otherwise specified as children under 18 to the exclusion of all others, the term "children" used in this section is consistent with the Social Security Administration's use of the term to include three groups: "children under age 18;" "students aged 18-19," which refers to children ages 18 and 19 who are matriculated in an institution of secondary education; and "disabled adult children," which refers to those adults who have been disabled since before they reached age 18.

[29] U.S. Census Bureau, "Age Groups and Sex: 2010," *2010 Summary File 2, 2011.* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF2_QTP1&prodType=table Data on percentage of children insured from SSA, "Survivors Benefits," 2011, p. 4. http://ssa.gov/pubs/10084.pdf

[30] SSA, "Table 5.J10—Number of children, by state or other area and type of benefit, December 2010," *Ann. Stat. Supp.,* February 2012. http://www.ssa.gov/policy/docs/statcomps/supplement/2011/5j.html#table5.j10

[31] Association of American Retired Persons (AARP), "Grandfacts: State fact sheets for grandparents and other relatives raising children," 2011. http://www.aarp.org/relationships/friends-family/grandfacts-sheets/

[32] SSA, "Table 5.J5.1—Number, by state or other area, race, and sex, December 2009," *Annual Statistical Supplement, 2010,* 2010. http://www.ssa.gov/policy/docs/statcomps/supplement/2010/5j.html#table5.j5.1 African American population from U.S. Census Bureau, "Selected Population Profile in the United States," *2007-2009 American Community Survey 3-Year Estimates.* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_3YR_S0201&prodType=table

[33] SSA, Table 9.A3, *Income of the Population 55 or Older, 2010, March 2012.* http://www.ssa.gov/policy/docs/statcomps/income_pop55/2010/sect09.html#table9.a3

[34] SSA, "Table 5.A1—Number and average monthly benefit, by type of benefit and race, December 2009," *Annual Statistical Supplement, 2010,* February 2011. http://www.ssa.gov/policy/docs/statcomps/supplement/2010/5a.html#table5.a1

[35] U.S. Department of Agriculture's Economic Research Service (ERS), designates counties as rural or urban based on population density, grading them on a scale of 1 to 9, with 1 being the most urban and 9 being the most rural. Counties are considered rural if they are designated 4 or higher. For the purposes of this report, the authors used both the ERS's 9-point scale, and the binary abbreviation of these codes, which codes rural counties "0" and urban counties "1."

[36] County-level population data from U.S. Census Bureau, "Profile of General Population and Housing Characteristics: 2010, 2010 Demographic Profile Data. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1&prodType=table Beneficiary data from SSA, "Table 4. Number of beneficiaries in current payment status, by county, type of benefit, and sex of beneficiaries aged 65 or older, December 2010," *OA SDI Beneficiaries by State and County, 2010,* August 2011. http://www.ssa.gov/policy/docs/statcomps/oasdi_sc/index.html

[37] Total personal income: Bureau of Economic Analysis (BEA), Regional Economic Accounts: Local Area Personal Income, "Personal income" in *CA 05N Personal income by major source and earnings by NAIC S industry.* http://bea.gov/regional/reis/ Social Security income: BEA, Regional Economic Accounts: Local Area Personal Income, "Old-age, Survivors and Disability insurance (OASDI) benefits" in *CA 35 Personal current transfer receipts.* http://bea.gov/regional/reis/ BEA data were used for total annual Social Security benefits rather than the figures available from the SSA in order to be consistent with the denominator of "Personal income," which came from BEA. For other purposes in the report, such as calculating the average benefit and average retirement benefit in rural counties, SSA data were used.

[38] SSA, Office of the Chief Actuary, Robert Baldwin and Sharon Chu. "Actuarial Note 2011.6: A Death and Disability Life Table for Insured Workers Born in 1991," February 2012. The term "retirement age" refers to the Full Retirement Age at which workers become eligible for full retirement benefits for Social Security. http://www.ssa.gov/OACT/NOTES/ran6/index.html

[39] SSA, Office of the Chief Actuary, Orlo R. Nichols, "The Insurance Value and Potential Survivor and Disability Benefits for an Illustrative Worker," Memo to Alice Wade, Deputy Chief Actuary of Social Security, August 2008. http://socialsecurity-works.org/wp-content/uploads/2012/03/Illustrative_Survivor_and_Disabilitycase_2008.pdf

[40] National Academy of Social Insurance (NASI), "Medicare Finances: Findings of the 2011 Trustees' Report," May 2011, p. 1. http://www.nasi.org/sites/default/files/research/Medicare_Finances_Findings_of_the_2011_Trustees_Report.pdf

[41] Kaiser Family Foundation (KFF), "Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?" June 2011. http://www.kff.org/medicare/upload/8172.pdf

[42] Social Security Works calculation based on projected out-of-pocket health care costs in 2014 under current law, and projected Social Security benefits of retired worker with average earnings of $43,560. Out-of-pocket costs projection from KFF, Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform, p. 9-10, July 2011. http://www.kff.org/medicare/upload/8169.pdf The estimated Social Security benefit is a projection for 2015, the closest date to 2014 available. Social Security Trustees, "Table VI.F10.—Annual Scheduled Benefit Amounts for Retired Workers With Various Pre-Retirement Earnings Patterns Based on Intermediate Assumptions, Calendar Years 2011-85," in *2011 Trustees' Report,* p. 201, May 13, 2011. http://www.ssa.gov/oact/tr/2011/tr2011.pdf

[43] People with severe disabilities become eligible for Medicare coverage only after receiving Social Security Disability Insurance (DI) benefits for 24 months. People with End-Stage-Renal Disease (ESRD) and Lou Gehrig's disease become eligible for Medicare as soon as they qualify for Medicare. Kaiser Family Foundation (KFF), Medicare: a Primer, April 2010, p. 2. http://www.kff.org/medicare/upload/7615-03.pdf

[44] There were 48.7 million beneficiaries nationwide in 2011. Except where otherwise noted, the rest of the Medicare data referenced in this report date to 2009, the most recent common year in which those data were available. Total Medicare beneficiaries in individual states dating to 2009 will not add up to this figure. Medicare Trustees, *2012 Medicare Trustees Report,* April 23, 2012, p. 6. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf

[45] Average expenditure per beneficiary is "average benefit per enrollee." Medicare Trustees, *2012 Medicare Trustees Report,* "Table II.B1—Medicare Data for Calendar Year 2011," p. 10. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf

[46] KFF, *Medicare: a Primer,* April 2010, p. 1. http://www.kff.org/medicare/upload/7615-03.pdf

[47] KFF, Ibid.

[48] Medicare Payment Advisory Board (Medpac), Report to the Congress: Medicare Payment Policy, Chapter 4, March 2010. http://www.medpac.gov/chapters/Mar10_Ch04.pdf

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

[50] White House, Office of the Press Secretary, Ibid.

[51] KFF, *Medicare: a Primer,* April 2010, p. 1. http://www.kff.org/medicare/upload/7615-03.pdf Percentage of total Medicare beneficiaries enrolled in Medicare Advantage calculated using total Medicare beneficiaries figure for 2010 in source.

[52] KFF, Ibid. Percentage calculation done by the author.

[53] Center for Medicare & Medicaid Services (CMS), Table 13, National Health Expenditure Data. https://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf Presentation of data done according to the method employed by Jacob S. Hacker for Figure 2 in *The Case for Public Plan Choice in National Health Reform,* 2009. http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf

[54] Hacker, *The Case for Public Plan Choice in National Health Reform,* 2009, p. 6. http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf

[55] Medicare Trustees, *2012 Medicare Trustees Report,* "Table II.B1—Medicare Data for Calendar Year 2011," p. 10. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf Figure reflects total administrative expenses of Medicare Parts A, B, and D, but not Part C, for which that information was not available.

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

[57] CBO, Ibid, p. 94. http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

[58] Medicare Advantage's administrative costs are expected to decline from the figure cited above as a result of reforms passed in the Patient Protection and Affordable Care Act (ACA) of March 2010. CBO, "Designing a Premium Support System for Medicare," December 2006, p. 12. http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf

[59] KFF, "Medicare Spending Estimates by State of Residence (in millions), 2009," December 2011. http://www.statehealthfacts.org/comparemaptable.jsp?ind=620&cat=6 Total health care spending from: KFF, "Health Care Expenditures by State of Residence (in millions), 2009," December 2011. http://www.statehealthfacts.org/comparemaptable.jsp?ind=592&cat=5

[60] Average benefit found by dividing total spending by total beneficiaries. KFF, "Medicare Spending Estimates by State of Residence (in millions), 2009," December 2011. http://www.statehealthfacts.org/comparemaptable.jsp?ind=620&cat=6 KFF, "Total Number of Medicare Beneficiaries, 2009," 2010. http://www.statehealthfacts.org/comparemaptable.jsp?yr=92&typ=1&ind=290&cat=6&sub=74

[61] KFF, "Total Number of Medicare Beneficiaries, 2009," 2010. http://www.statehealthfacts.org/comparemaptable.jsp?yr=92&typ=1&ind=290&cat=6&sub=74 State population data from U.S. Census Bureau, "General Demographic Characteristics," *2009 Population Estimates.* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2009_DP1&prodType=table

[62] KFF, "Distribution of Medicare Beneficiaries by Eligibility Category, 2009," 2010. http://www.statehealthfacts.org/comparetable.jsp?ind=293&cat=6 2009 was the most current year with data available on the breakdown of Medicare beneficiaries by category.

[63] KFF, "Distribution of Medicare Beneficiaries by Eligibility Category, 2009," 2010. http://www.statehealthfacts.org/comparetable.jsp?ind=293&cat=6 2009 was the year with the most current data available on the breakdown of Medicare beneficiaries by category.

[64] National Institutes of Health, U.S. National Library of Medicine (NLM), "End-stage kidney disease," 2011. http://www.nlm.nih.gov/medlineplus/ency/article/000500.htm

[65] NLM, "Amyotrophic Lateral Sclerosis," 2011. http://www.nlm.nih.gov/medlineplus/amyotrophiclateralsclerosis.html

[66] KFF, *Medicaid: a Primer,* June 2010, p. 3. http://www.kff.org/medicaid/upload/7334-04.pdf

[67] In the case of Medicaid, "2009" refers to data from FY2009. Except where otherwise noted, Medicaid data referenced in this report date to FY2009, the most recent common year in which those data were available. KFF, "Total Medicaid Enrollment FY2009," 2012. http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4

[68] KFF, *Employer Health Benefits: 2011 Annual Survey,* September 27, 2012, p. 1. http://ehbs.kff.org/pdf/2011/8225.pdf

[69] KFF, *Medicaid: a Primer,* June 2010, p. 23. http://www.kff.org/medicaid/upload/7334-04.pdf

[70] Families USA, Tables 1-2, Cutting Medicaid: Harming Seniors and People with Disabilities Who Need long-Term Care, May 2011, pp. 3-4. http://familiesusa2.org/assets/pdfs/long-term-care/Cutting-Medicaid.pdf

[71] KFF, *Medicaid: a Primer, June* 2010, p. 23. http://www.kff.org/medicaid/upload/7334-04.pdf

[72] KFF, *Medicaid: a Primer,* June 2010, p. 1. http://www.kff.org/medicaid/upload/7334-04.pdf

[73] As noted previously, aside from the total national Medicaid enrollees included in the introduction of the Medicaid section of this report, all Medicaid figures, unless otherwise noted, date to FY2009, the most recent common year in which data were available. KFF, "Total Medicaid Spending, FY2009," 2012, Unpublished; Data provided to Social Security Works by Lindsay Donaldson, Research Associate at the Kaiser Family Foundation. Medicaid's percent of total health care found by dividing total Medicaid spending by total health care expenditures. KFF, "Health Care Expenditures by State of Residence (in millions), 2009", 2010. http://www.statehealthfacts.org/comparemaptable.jsp?ind=592&cat=5 Medicaid spending figure includes portion of funding that comes from state and local governments.

[74] Average found by dividing total spending by total beneficiaries. KFF, "Total Medicaid Spending, FY2009," 2012, Unpublished; Data provided to Social Security Works by Lindsay Donaldson, Research Associate at the Kaiser Family Foundation. KFF, "Total Medicaid Beneficiaries 2009", 2010. http://www.statehealthfacts.org/comparetable.jsp?ind=198&cat=4

[75] KFF, "Total Medicaid Enrollment FY 2009," 2012. http://www.statehealthfacts.org/comparetable.jsp?ind=198&cat=4 State population data from U.S. Census Bureau, "General Demographic Characteristics," *2009 Population Estimates.* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2009_DP1&prodType=table

[76] KFF, "Distribution of Medicaid Enrollees by Enrollment Group, FY2009," 2012. http://www.statehealthfacts.org/comparemaptable.jsp?ind=200&cat=4 Children's population data from U.S. Census Bureau, "Children Characteristics," *2009 American Community Survey 1-Year Estimates.* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_1YR_S0901&prodType=table

[77] KFF, "Distribution of Medicaid Enrollees by Enrollment Group, FY2009", 2012. http://www.statehealthfacts.org/comparemaptable.jsp?typ=1&ind=200&cat=4&sub=52.

[78] KFF, "Distribution of Medicaid Enrollees by Enrollment Group, FY2009", 2012. http://www.statehealthfacts.org/comparemaptable.jsp?typ=1&ind=200&cat=4&sub=52.

[79] KFF, "Medicaid Long-Term Care Funding by Category, FY2009," 2012, Unpublished; Data provided to Social Security Works by Lindsay Donaldson, Research Associate at the Kaiser Family Foundation.

[80] Data on Medicaid's coverage of nursing home residents, as well as the cost of nursing home rooms in each state, date to 2010. Had 2009 data been available, they would have been used for the sake of consistency with the other state-level benefit and beneficiary data. Families USA, Table 3, *Cutting Medicaid: Harming Seniors and people With Disabilities Who Need Long-Term Care,* May 2011. http://familiesusa2.org/assets/pdfs/long-term-care/Cutting-Medicaid.pdf

[81] Families USA, Table 5, *Cutting Medicaid: Harming Seniors and people With Disabilities Who Need Long-Term Care,* May 2011. http://familiesusa2.org/assets/pdfs/long-term-care/Cutting-Medicaid.pdf

[82] KFF, *Medicaid: a Primer,* June 2010, p. 25.

[83] Center for Economic and Policy Research (CEPR), "U.S. Budget Deficits 2001-2011." Analysis of Congressional Budget Office data. First published here.

[84] Medicare Trustees, *2012 Medicare Trustees Report,* "Table II.B1—Medicare Data for Calendar Year 2011," p. 10. Figure reflects total administrative expenses of Medicare Parts A, B, and D, but not Part C, for which that information was not available. Congressional Budget Office (CBO), "Key Issues in Analyzing Major Health Insurance Proposals," December 2008, p. 70. http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

[85] Total benefits figure reflects the sum of total annual spending by Social Security, Medicare and Medicaid in the state, each of which are individually sourced in the report. Average ratio of residents receiving benefits from either Social Security, Medicare or Medicaid, is an average of the percentages of residents receiving benefits from each of the three programs.

KEY FACTS ABOUT SOCIAL SECURITY, MEDICARE & MEDICAID IN MAINE

Social Security, Medicare and Medicaid work for Maine residents of all ages and backgrounds.

This report, *Social Security, Medicare & Medicaid Work for Maine* shows that:

Social Security Works for Maine's Residents and Economy

- Social Security provided benefits to 299,875 Maine residents in 2010, 1 out of 4 residents, including 185,849 retired workers, 55,525 disabled workers, 22,473 widow(er)s, 11,878 spouses, and 24,150 children. [Figure 4]
- Social Security provided benefits totaling over $3.6 billion in 2010, an amount equivalent to 7.2 percent of the state's annual GDP (the total value of all goods and services produced).
- The average Social Security benefit in 2010 was $12,118.
- Social Security lifted 119,000 Maine residents out of poverty in 2008.

Social Security Works for Maine's Women

- Social Security provided benefits to 149,545 women residents in 2010, nearly 1 out of 4 women.
- Without Social Security, the poverty rate of elderly women would increase from 11.1 percent to 52.5 percent.

Medicare Works for Maine's Residents and Economy

- 255,916 Maine residents received Medicare benefits in 2009—1 out of 5 state residents.
- Medicare provided $2.3 billion in benefits in 2009—20.4 percent of all health care spending in the state. The average Medicare benefit was $8,929.

Medicare Works for Maine's Seniors and People with Disabilities

- 203,322 of Maine's 255,916 Medicare beneficiaries were aged 65 or older in 2009—8 out of 10 beneficiaries.
- 53,688 of Maine's 255,916 Medicare beneficiaries were people with disabilities in 2009—1 out of 5 beneficiaries.

Medicaid Works for Maine's Residents and Economy

- 358,004 Maine residents received Medicaid benefits in FY2009—1 out of 4 state residents.
- A total of $2.5 billion in Medicaid benefits were paid in FY2009—22.5 percent of all health care spending in the state. The average Medicaid benefit is $7,033.

Medicaid Works for Maine's Seniors, People with Disabilities and Long-Term Care Residents

- 60,768 of Maine's 358,004 Medicaid beneficiaries were aged 65 or older in 2009—1 out of 6 beneficiaries.
- 66,288 of Maine's 358,004 Medicaid beneficiaries were people with disabilities in 2009—1 out of 5 beneficiaries.
- Medicaid provided $776 million in long-term care benefits for Maine residents in 2009, including providing nursing home care for 4,150 nursing home residents, 2 out of 3 of state residents enrolled in nursing homes.