Messenger

A quarterly publication by the Missouri Catholic Conference

MISSOURI CATHOLIC CONFERENCE

In this issue of *Messenger*, we've provided basic information about the two major U.S. federal health care programs we hear about all the time, but that few of us really understand—Medicare and Medicaid. These programs help the elderly, the disabled, and the poor obtain access to health care and they also play a critical role in how health care is delivered in this country. According to the Center for Medicare and Medicaid Services (CMS), 37.3% of the $3.5 trillion spent on health care in 2017 in the U.S. was paid for by the Medicare and Medicaid programs.

Medicare

Federal health care coverage for: **more than 58.5 million beneficiaries.**

People 65 & up

Certain people under 65 with disabilities

People of any age with end-stage renal disease

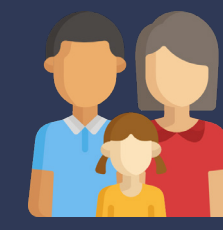
More than 6,100 hospitals

15,000 skilled nursing facilities

1.2 million physicians and other health care practitioners and service providers

Medicaid

Cooperative federal and state health care coverage for: **more than 72 million beneficiaries, including more than 28 million children.**



Low-income adults

Pregnant women

More than 28 million children

info provided by the Centers for Medicare and Medicaid Services | all icons designed by freepik

Good health promotes our well-being, and **access to basic healthcare plays an essential part in leading healthy and productive lives**. According to the social teachings of the Catholic Church, one of the functions of public authority is to promote the common good, "the sum total of social conditions which allow people, either as groups or individuals, to reach their fulfillment more fully and more easily." *(Catechism of the Catholic Church, No. 1906)* This requires public authority to arbitrate between various interests in the name of the common good to "make accessible to each what is needed to lead a truly human life: food, clothing, health, work, education and culture, suitable information, the right to establish a family, and so on." *(Catechism of the Catholic Church No. 1908)* Without Medicare and Medicaid, healthcare and good health would be out of reach for many U.S. citizens. We hope you find the information provided here helpful in understanding their importance to those who depend upon Medicare and Medicaid.

Medicare History & Basics

Medicare was created in 1965 under the Johnson Administration for people over 65 who found it virtually impossible to get private health insurance. Medicare has helped improve the health and longevity of older Americans by making access to health care a universal right for those over 65. Today, Medicare's coverage has expanded beyond older Americans to include people under 65 with certain disabilities and people of any age with end-stage renal disease. Currently, about 58.5 million beneficiaries, (15% of the U.S. population) are enrolled in Medicare, and enrollment is expected to rise to 80 million by 2030. Most U.S. citizens earn the right to enroll in Medicare by working and paying their taxes for a minimum required period. Even if a person hasn't worked long enough to be entitled to Medicare benefits, they may still be eligible to enroll, but the premiums are typically higher. There are four different parts to the Medicare program. Parts A and B are often referred to as Original Medicare. Medicare Part C, or Medicare Advantage, is private health insurance, and Medicare Part D offers coverage for prescription drugs. *See an overview of the four parts in the blue box to the right.*

Much has been said about Medicare's financial outlook and whether it can withstand the influx of beneficiaries now and into the future. Recent headlines proclaimed Medicare is "going broke" and will be out of money by 2026. Closer examination reveals that such statements referred to Part A specifically, which accounts for about 40% of the program's funds. Part A is mostly funded by a 2.9% Medicare tax split between workers and employers; the funds were put into a trust fund, but that reserve is being drained. However, that doesn't mean Medicare will stop paying hospital insurance benefits in 2026. Lawmakers could raise the payroll tax or cut costs by 17%, which could put the fund back in balance. Meanwhile, Medicare Parts B and D are funded very differently—through a combination of enrollee premiums and general revenue. The contributions are adjusted annually, so Medicare's ability to pay benefits is never in question.

As more people age and health care prices increase, Medicare costs also will continue to rise. Policy makers will need to find ways to sustain Medicare. New revenue and reducing the use of unnecessary services are possibilities. Some recent innovations in payment and delivery systems have also shown promise. It may take a combination of these ideas to maintain the integrity of the Medicare system so that it can be enjoyed by future generations. ***For more information about Medicare, visit Medicare.gov or call 1-800-MEDICARE.***

Medicare Part A is hospital insurance. Part A covers inpatient hospital care, limited time in a skilled nursing care facility, limited home health care services, and hospice care. Most Medicare Part A beneficiaries don't have to pay a monthly premium to receive coverage under this part of Medicare. Medicare Part A typically doesn't cover the full amount of your hospital bill, so beneficiaries are responsible for a share of the cost.

Medicare Part B is medical insurance. Part B benefits cover certain non-hospital medical expenses, such as doctors' office visits, blood tests, x-rays, diabetic screenings, outpatient hospital care, durable medical equipment and many other preventive services. A person pays a monthly premium for this part of Original Medicare. Medicare Part B beneficiaries are usually responsible for a portion of their health care costs.

Medicare Part C (Medicare Advantage) often includes every type of Medicare coverage in one health plan. It's offered by private insurance companies contracted through the Centers for Medicare and Medicaid Services to provide a Medicare benefits package as an alternative to Original Medicare. Enrolling into a Medicare Advantage plan is optional, but to obtain this private insurance, you must also qualify to have Original Medicare, Part A and Part B.

Medicare Part D is optional prescription drug coverage. Medicare Part D is available as a stand-alone prescription drug plan through private insurance, and the monthly fee varies among insurers. A person will share the costs of his or her prescription drugs according to a specific plan in which he is enrolled. Those costs can include a deductible, a flat copayment amount, or a percentage of the full drug cost (called "coinsurance").

Medicaid History & Basics

Like Medicare, Medicaid was created in 1965 during the Lyndon B. Johnson Administration. It was originally created to provide health coverage to low-income families and individuals, including children. Unlike Medicare, Medicaid is funded jointly by the federal government and the states, and each state has a certain degree of flexibility to operate its own program, as long as those programs comply with federal guidelines. Eligibility and benefits, therefore, vary from state to state. The Center for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, can offer "waivers" to states that seek to offer services or operate Medicaid programs outside the standard federal guidelines.

Nearly all states adopted Medicaid programs within four years of its implementation at the federal level. Alaska joined in 1972, and Arizona implemented Medicaid through a waiver program in 1982, bringing the total number of states with Medicaid programs to 50. Over time, states expanded their Medicaid programs to meet new federal requirements. For example, all states extended eligibility to elderly and disabled individuals in 1972. States also met subsequent federal requirements to expand coverage to pregnant women and children with incomes up to 100% of the federal poverty level.

Ensuring adequate health coverage for women of child-bearing age and for children has been a high priority under Medicaid, and funding for these programs has enjoyed bipartisan support. In 1997, Congress created the Children's Health Insurance Program (CHIP). CHIP provides health insurance and preventative care to children of parents with low and moderate incomes that are too high to qualify for Medicaid, but too low to allow them to purchase private insurance. All states implemented state CHIP programs by the year 2000, many by expanding their Medicaid programs.

Missouri Medicaid

Missouri created its Medicaid program in 1967. At the time of implementation, the Missouri program included coverage for outpatient hospital care, physician's services, and professional nursing home care, along with coverage for the blind, permanently disabled, and those on welfare (at the time known as "Aid to Families with Dependent Children").

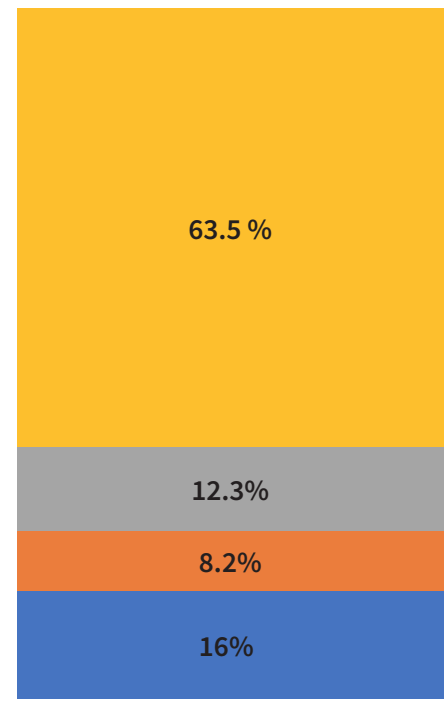
Eligibility for Medicaid in Missouri was significantly curtailed in 2005, due to a state budget shortfall. That year, the Missouri General Assembly reduced Medicaid benefit eligibility for able-bodied parents from those with income at or below 100% of the federal poverty level to those at or below 22% of FPL. This resulted in up to 150,000 Missourians falling off the Medicaid roll.

In 2007, Missouri changed the name of its program to MO HealthNet. Currently, MO HealthNet is available in Missouri for the elderly and disabled with incomes at or below 75% of the federal poverty level (FPL) ($9,105 for an individual in 2018), pregnant women with incomes at or below 100% of the FPL ($25,100 for a family of four in 2018), and children living in households with income at or below 300% of the FPL. MO HealthNet provides health insurance coverage for two out of every five children (including two of every five children's births),

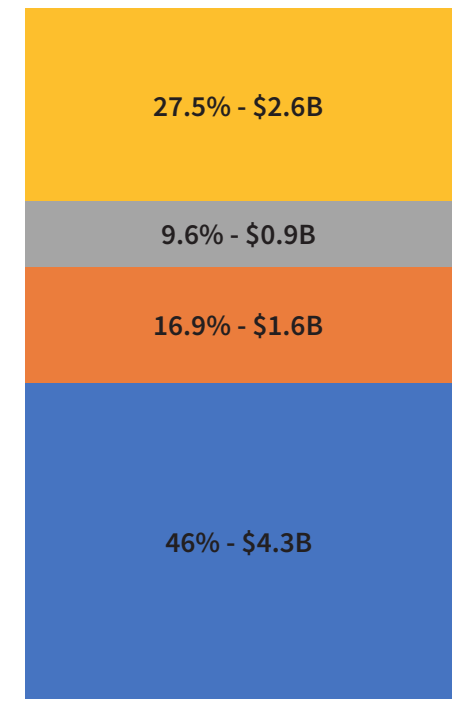
FY18 Medicaid Enrollees & Expenditures

data provided by the MO HealthNet Division (MHD)

Children	620,294
Pregnant women & Custodial Parents	119,919
Seniors	80,509
Persons with disabilities	156,057
TOTAL	976,779



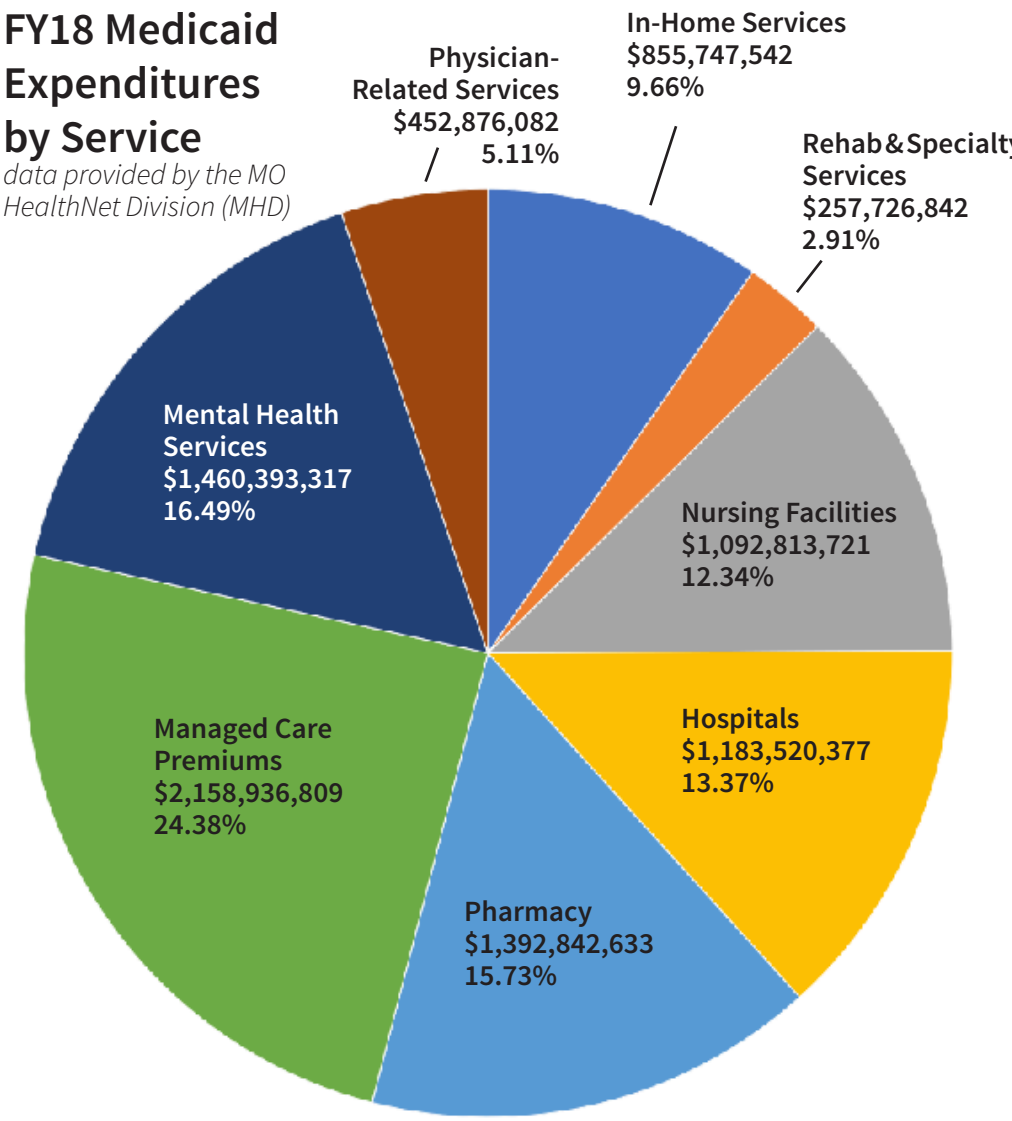
Percent of Enrollees (976,779 Average Monthly Enrollees)



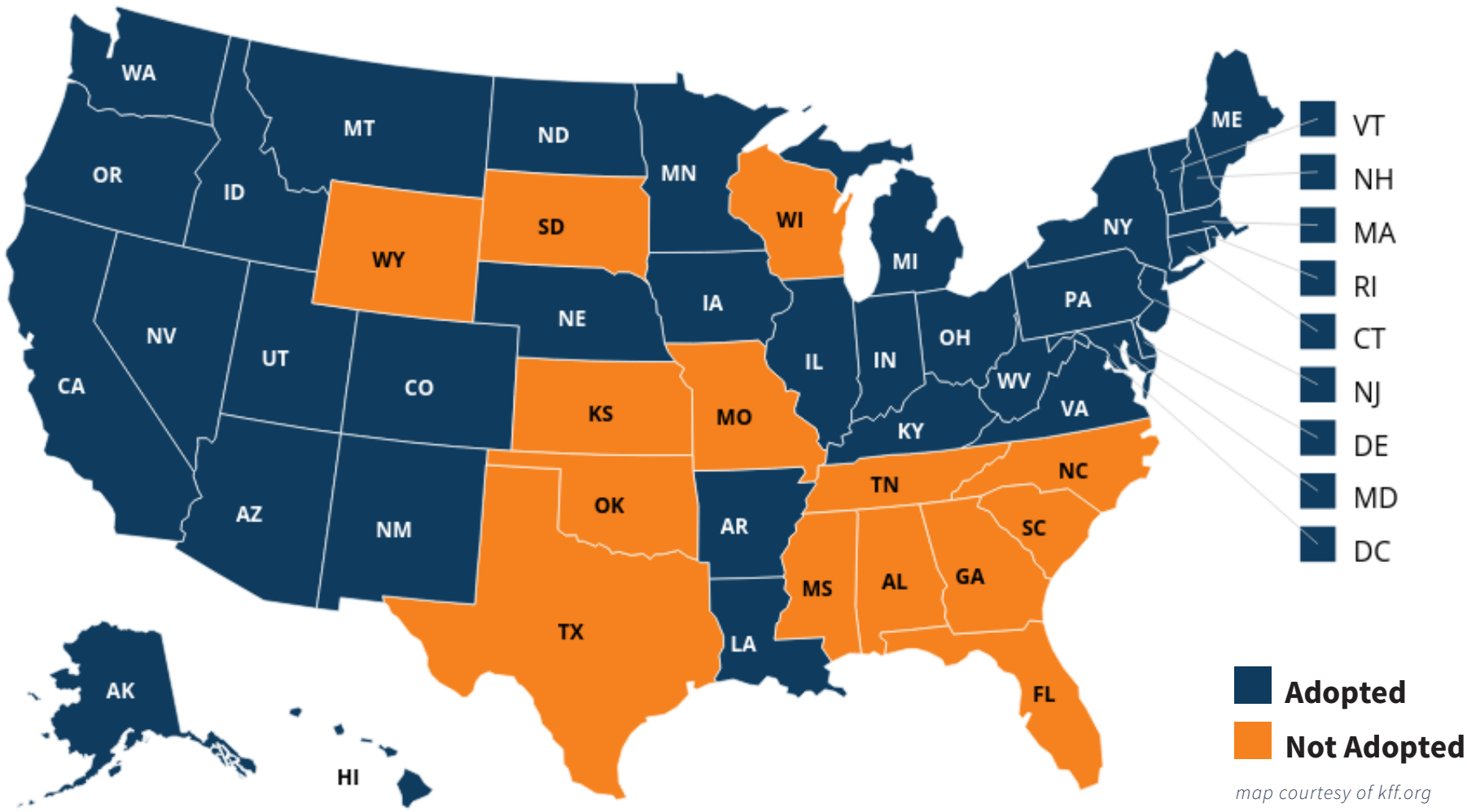
Percent of Expenditures (9.4B)

FY18 Medicaid Expenditures by Service

data provided by the MO HealthNet Division (MHD)



Status of State Action on Medicaid Expansion



map courtesy of kff.org

one in four persons with a disability, and one in 12 seniors.

In terms of MO HealthNet enrollment in fiscal year 2018, 63.5% are children, 16% are Missourians with disabilities, 8.2% are seniors, and 12.3% are pregnant women and custodial parents. In the same fiscal year, 27.5% of MO HealthNet dollars were spent on children, 46% on the disabled, 16.9% on seniors, and 9.6% on pregnant women and custodial parents (see graphic on pg. 3).

In fiscal year 2018, Missouri provided MO HealthNet coverage to 1,061,195 Missouri citizens at a cost of $10.6 billion. By comparison, in fiscal year 2008, Missouri provided MO HealthNet coverage to 840,088 Missouri citizens at a total cost of $6.4 billion. *The graphic on pg. 3 shows how Medicaid dollars were spent in FY 2018.*

In 2010, Congress passed the Affordable Care Act (ACA) which provided for expansion of the Medicaid program starting in fiscal year 2014. States participating in the expansion were required to increase Medicaid eligibility for able-bodied adults to those making up to 138% of the FPL. The new law provided that for the first three years of expansion (2014-2016), the federal government would provide 100% of the funding for the expansion. After that, the feds would cover 90%, and the states would have to cover the remaining 10% of new enrollees (currently, states cover 35% of Medicaid expenditures). To date, 36 states and the District of Columbia have expanded Medicaid under the ACA. *See above graphic.*

The Republican-led state legislature has opposed expanding Medicaid in Missouri since passage of the ACA, due to concerns about increased enrollment and the corresponding impact on the state budget. During the Greitens administration, a comprehensive review of Missouri's Medicaid program was ordered to be performed by an outside organization, and a report following that review was released in early March 2019. The report found Missouri's program "outdated in most aspects compared to other peer states" with numerous opportunities for improvement.

MO HealthNet Director Todd Richardson, former Speaker of the Missouri House, has been traveling throughout the state since being appointed as director in October to assess the current status of Missouri's Medicaid program, how to improve it, and how to make it sustainable. He has recently expressed concerns about the rising cost of the Medicaid program as a percentage of the state budget, and about the disparity of medical care and reimbursement rates in rural areas as compared with urban areas in Missouri, noting that several of Missouri's small rural hospitals have closed in the last decade. He is expected to propose changes to the program going forward.

The Missouri Catholic Conference supports efforts to reform and expand Medicaid in order to provide health coverage to those Missourians in need, particularly to those currently without health insurance. Bills proposing Medicaid expansion are filed each year in the state legislature, but aren't heard in committee. Arguments in favor of and in opposition to expanding Medicaid are made in the House and Senate during debate on the annual budget, but expansion has never been seriously considered as an option. Idaho, Nebraska, and Utah voters approved Medicaid expansion at the ballot box in the November 2018 election, and two initiative petitions were recently filed with the Missouri Secretary of State's office to put the issue of Medicaid expansion on the November 2020 ballot. MO HealthNet is vital to both the individuals and health systems that rely upon it, and the state must ensure that this program is available to those in need going forward.