# SOCIAL SECURITY, MEDICARE AND MEDICAID WORK FOR MISSOURI




www.socialsecurityworks.org

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

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

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

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

## ACKNOWLEDGMENTS

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

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

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

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

# INTRODUCTION AND SUMMARY

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

—FRANKLIN D. ROOSEVELT, August 14, 1935

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

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

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

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

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

FIGURE 1

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

| PROGRAM | BENEFICIARIES IN MISSOURI | PERCENT OF RESIDENTS RECEIVING BENEFITS | AVERAGE BENEFIT | TOTAL ANNUAL BENEFITS[1] |
|---|---|---|---|---|
| Social Security | 1,246,269 | 20.6 percent | $14,223 | $17.7 billion |
| Medicare | 1,040,491 | 17.3 percent | $9,813 | $10 billion |
| Medicaid | 775,700 | 12.8 percent | $11,539 | $9 billion |

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

# SOCIAL SECURITY WORKS

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

## Social Security Made Dignified Retirement Possible for the Broad Middle Class

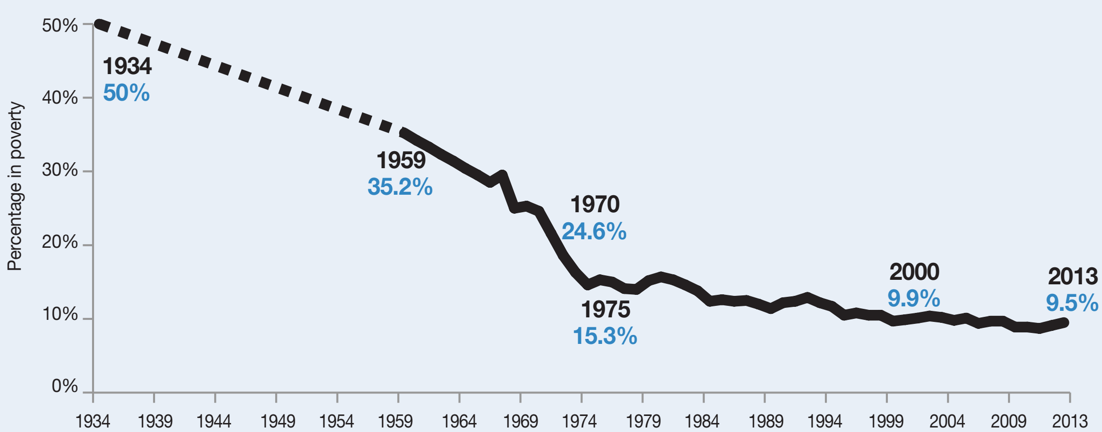
Before the creation of Social Security, poverty among older Americans was pervasive. In 1934, President Roosevelt's Committee on Economic Security estimated that "at least one-half" of all Americans aged 65 and older were poor.[1] These seniors had to rely on family, friends and private charity for support—or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

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

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

FIGURE 2

**Elderly Poverty before and after Social Security, 1934-2013**




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

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

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

## Social Security Provides Critical Protection against Lost Wages Due to Disability

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

### GUS, Wisconsin

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

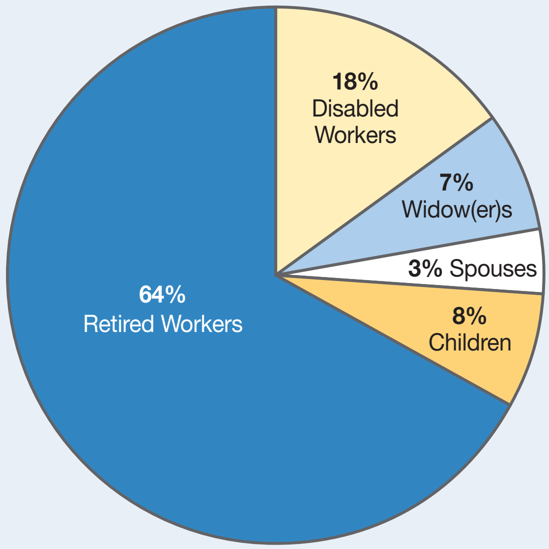
*For his service in this capacity he was awarded the Silver Star, the third highest decoration for valor given by the Army. Sixteen days after he was mustered out of the Army, he returned to his home in Wisconsin—and was in a serious car crash, sustaining a high-level spinal cord injury.*

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

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

FIGURE 3

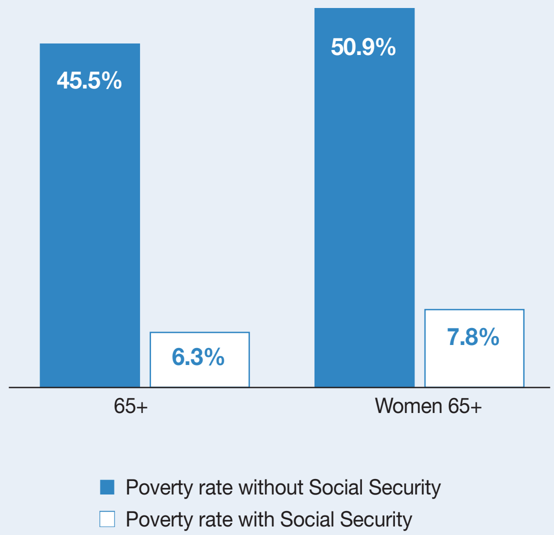
## Missouri's Social Security Beneficiaries, 2014




Source: Social Security Administration, 2015

FIGURE 4

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




Source: Center on Budget & Policy Priorities, 2015

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

### Social Security Works for Missouri's Residents and Economy [Figure 1]

- Social Security provided benefits to 1,246,269 Missourians in 2014, around 1 in 5 (20.6 percent) residents.[18]
- Missourians received Social Security benefits totaling $17.7 billion in 2014, an amount equivalent to 7 percent of the state's total personal income.[19]
- The average Social Security benefit in Missouri was $14,223 in 2014.[20]
- Social Security lifted 570,000 Missourians out of poverty in 2013.[21]

### Social Security Works for Missouri's Seniors[22]

- Social Security provided benefits to 796,376 of Missouri's retired workers in 2014, two-thirds (63.9 percent) of beneficiaries [Figure 3].[23]
- The typical benefit received by a retired worker in Missouri was $15,635 in 2014.[24]
- Social Security lifted 355,000 Missourians aged 65 or older out of poverty in 2013.[25]
- Without Social Security, the elderly poverty rate, as defined by the official poverty level,[26] in Missouri would have increased from 1 in 16 (6.3 percent) to half (45.5 percent) [Figure 4].[27]

### Social Security Works for Missouri's Women

- Social Security provided benefits to 634,764 Missouri women in 2014, 1 in 5 (20.5 percent) Missouri women.[28]
- Social Security provided benefits to 40,659 Missouri spouses in 2014, 1 in 30 (3.3 percent) beneficiaries [Figure 3].[29]
- Social Security lifted 217,000 Missouri women aged 65 or older out of poverty in 2013.[30]
- Without Social Security, the poverty rate of elderly women would have increased from 1 in 13 (7.8 percent) to half (50.9 percent) [Figure 4].[31]

### Social Security Works for Missouri's Widow(er)s

- Social Security provided survivors benefits to 87,551 Missouri widow(er)s in 2014, 1 in 14 (7 percent) Missouri beneficiaries [Figure 3].[32]
- The typical benefit received by a widow(er) in Missouri was $15,587 in 2014.[33]

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

- Social Security provided disability benefits to 222,218 Missouri workers in 2014, 1 in 6 (17.8 percent) Missouri beneficiaries [Figure 3].[35]
- The typical benefit received by a disabled worker beneficiary in Missouri was $12,587 in 2014.[36]

### Social Security Works for Missouri's Children

- Social Security is the primary life and disability insurance protection for 98 percent of Missouri's 1,392,623 children.[37]
- Social Security provided benefits to 99,465 Missouri children in 2014, 1 in 13 (8 percent) Missouri beneficiaries [Figure 3].[38]
- Social Security is the most important source of income for the 119,621 children living in Missouri's grandfamilies, which are households headed by a grandparent or other relative.[39]

## SUSIE, North Dakota

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

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

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

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

## Social Security Works for Missouri's African Americans

- In Missouri, Social Security provided benefits to one-quarter (26 percent) of African American households in 2013, 67,662 households.[40]
- Nationwide, Social Security lifted 1,231,000 African Americans aged 65 or older out of poverty in 2012.[41] Without Social Security, the poverty rate among African American seniors would have increased from 1 in 6 (18 percent) to half (51 percent).[42]
- Nationwide, Social Security provided nearly three-quarters (71.5 percent) of the income of African American elderly couples and unmarried individuals receiving benefits, on average, in 2012. Social Security made up 90 percent of the total income for nearly half (46.4 percent) of these African American elderly households.[43]
- African Americans were 12.6 percent of the population in 2011, but represented 19 percent of disabled worker beneficiaries.[44]

## Social Security Works for Missouri's Latinos

- In Missouri, Social Security provided benefits to 1 in 7 (14.6 percent) Latino households in 2013, 8,487 households.[45]
- Nationwide, Social Security lifted 999,000 Latinos aged 65 or older out of poverty in 2012.[46] Without Social Security, the poverty rate among Latino seniors would have increased from 1 in 5 (21 percent) to half (52 percent).[47]
- Nationwide, Social Security provided three-quarters (74.5 percent) of the total income of Latino elderly couples and unmarried individuals receiving benefits, on average, in 2012. Social Security was 90 percent of the income for more than half (52.6 percent) of these Latino elderly households.[48]
- The Social Security Administration estimates that Latinos receive a higher rate of return on their Social Security contributions than the overall population—the highest of any group. That's because they tend to have lower lifetime income, longer life expectancy, higher incidence of disability, and larger families.[49]

## Social Security Works for Missouri's American Indians and Alaska Natives

- In Missouri, Social Security provided benefits to 2 in 7 (29.7 percent) American Indian and Alaska Native households in 2013, 2,841 households.[50]
- Nationwide, Social Security provided 90 percent of the income for 1 in 8 (12 percent) elderly American Indian and Alaska Native married couples, and half (50 percent) of elderly unmarried persons in 2011.[51]
- Since Social Security has a higher income replacement rate for workers with lower earnings, Social Security replaces a larger share of pre-retirement earnings for American Indians and Alaska Natives than for the overall population. The median earnings of working-age American Indians and Alaska Natives is about $34,600, compared to $43,000 for all working-age people. Social Security

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

## Social Security Works for Missouri's Asian Americans, Hawaiian Natives and Pacific Islanders

- In Missouri, Social Security provided benefits to 1 in 8 (12.8 percent) Asian American, Hawaiian Native and Pacific Islander households in 2013, 4,089 households.[53]
- Nationwide, Social Security provided, on average, over two-thirds (67.7 percent) of the total income for Asian American households with beneficiaries aged 65 or older in 2012. Social Security was 90 percent of the income for over 4 in 10 (44.4 percent) Asian American elderly households.[54]
- Nationwide, Asian Americans and Pacific Islanders receive a high rate of return from Social Security because of their long life expectancies. An Asian American or Pacific Islander man aged 65 in 2011, can expect to live until age 85, compared to age 82 for all men. An Asian American or Pacific Islander woman of the same age can expect to live until age 88, compared to age 85 for all women.[55]

## Social Security Works for Missouri's Rural Communities

- Social Security is more important to Missourians living in rural or non-metropolitan counties than to Missourians living in metropolitan counties. One-quarter (24.9 percent) of rural Missourians received Social Security in 2014, compared with 1 in 5 (19.1 percent) metropolitan Missourians.[56]
- Social Security is more important to the local economies of Missouri's rural or non-metropolitan counties than to its metropolitan counties. Total personal income in Missouri's rural counties was $52 billion in 2014 of which $5.1 billion, or 9.7 percent, was from Social Security. By comparison, total personal income in the state's metropolitan counties was $193.7 billion, of which $12.8 billion, or 6.6 percent, was from Social Security.[57]

## Social Security Works for Immigrants

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

## Social Security Works for Same-Sex Couples and Their Families

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

### RUBY, Arizona

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

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

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

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

## Social Security is Fiscally Responsible and Affordable

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

It is only because Social Security is required to project its finances 75 years into the future—an extremely long projection period by virtually any measure—that we even know about its modest long-term shortfall.[69] The 2015 report, signed by Social Security's trustees—the secretaries of the Treasury, Health and Human Services and Labor, the Commissioner of Social Security and two Public Trustees appointed by the President—projects that Social Security can pay all benefits in full and on time for 19 years.[70] After that, if Congress were not to act, it could still pay 79 cents of every dollar of earned benefits.[71]

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

## Rising Inequality Calls for Scrapping Cap, Expanding Benefits

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

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

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

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

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

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

## MIKE, Ohio

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

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

# MEDICARE WORKS

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

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

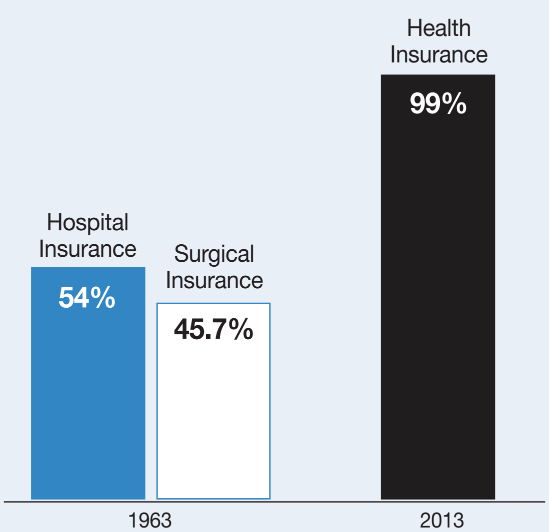
As we celebrate the 50th anniversary of Medicare, it is worth reflecting on the difference it has made in our lives. Before Medicare, roughly half of the elderly were uninsured [Figure 5]. This is because private health insurance companies, which must generate returns for their shareholders, were not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

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

In 1972, Medicare was expanded to include people with disabilities under age 65 who receive Social Security Disability Insurance benefits. People with disabilities are eligible for Medicare after a two-year

FIGURE 5

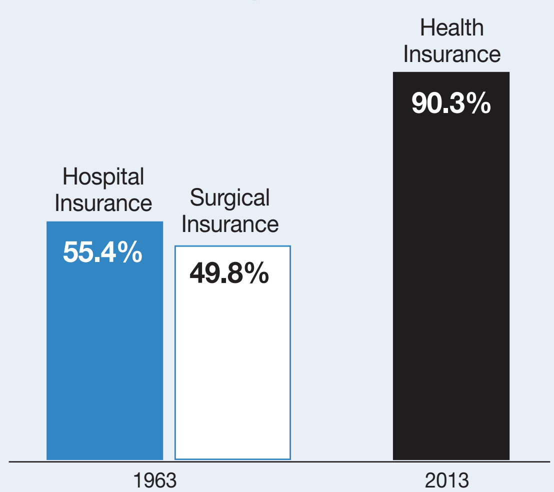
**Americans 65 or Older with Health Insurance,1963 vs. 2013**




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

FIGURE 6

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




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

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

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

waiting period.[89] In 1963, before Medicare, only about half of Americans with disabilities (of all ages) had health insurance [Figure 6]. Today, 90 percent do.

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

## Medicare: One System with Four Parts

Medicare works—for seniors, people with disabilities, people with end-stage renal disease and people with ALS (Lou Gehrig's disease). For all of these populations, the program covers needed hospital, physician, medical testing, pharmaceutical and rehabilitation services, as well as other necessary medical services and equipment.[92] Medicare provided health care coverage to 53.8 million Americans in

2014, of whom 84 percent (45.1 million) were aged 65 or older; and the remaining 16 percent (8.7 million) were severely disabled workers.[93] The average expenditure per Medicare beneficiary in 2014 was $10,641.[94]

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

Medicare Part B, the Supplemental Medical Insurance (SMI) program, helps pay for physician care and related medical services including preventive care, lab tests, and durable medical equipment. One quarter of its costs are funded from premiums (generally deducted from beneficiaries' Social Security checks), and three-quarters from general federal revenues.[97] The 5.5 percent of beneficiaries with incomes above $85,000 ($170,000 for couples) pay significantly higher premiums.[98] For low-income Medicare beneficiaries who are also enrolled in Medicaid, Medicaid can cover Medicare's Part B premium and out-of-pocket costs. Low-income beneficiaries ineligible for full Medicaid benefits may qualify for one of several Medicare Savings Programs, to help cover the cost of Medicare Part B premiums and cost sharing.[99]

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

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

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

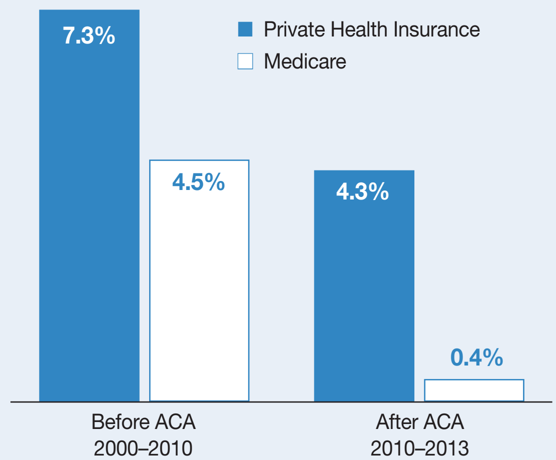
## Medicare Has Lower Administrative Costs than Private Health Insurance

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

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

FIGURE 7

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




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

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

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

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

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

The Affordable Care Act is showing promising initial signs of bending the cost curve throughout our health care system, particularly in Medicare.[114] While the ACA has been implemented only gradually since 2010, the structural reforms contained in the law sent immediate signals to the health care industry that value, not quantity, would be rewarded in the post-ACA world, particularly in the Medicare program.[115] Physicians and hospitals, on the one hand, and Medicare Advantage plans, on the other, quickly began changing how they do business in anticipation of the new value-based system. (Insurers in the individual and group health insurance markets had to become more efficient as well.)

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

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

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

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

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

### Medicare Works for Missouri's Economy.

- Medicare provided $10 billion in benefits to Missourians in 2009—23 percent of all health care spending in the state.[123] The average expenditure per Medicare beneficiary was $9,813 [Figure 1].[124]

### Medicare Works for Missouri's Residents.

- Medicare insured 1,040,491 Missourians in 2012—1 in 6 (17.3 percent) state residents [Figure 1].[125]

### Medicare Works for Missouri's Seniors.

- 833,445 of Missouri's 1,040,491 Medicare beneficiaries were aged 65 or older in 2012—4 in 5 (78.6 percent) beneficiaries.[126]

### Medicare Works for Missouri's People with Disabilities.

- 226,632 of Missouri's 1,040,491 Medicare beneficiaries were people with disabilities in 2012—1 in 5 (21.4 percent) beneficiaries.[127]

### Medicare Works for Missouri's Residents with End-Stage-Renal Disease (ESRD).

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

### Medicare Works for Missouri's Residents with Amyotrophic Lateral Sclerosis (ALS).

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

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

# MEDICAID WORKS

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

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

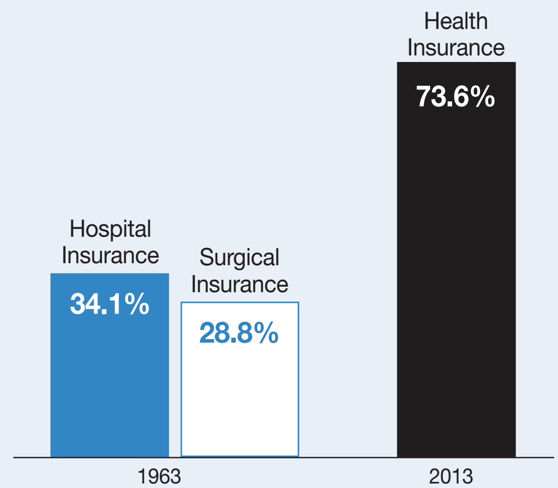
As we celebrate the 50th anniversary of Medicaid, let us recall what a difference it has made. We built our Medicaid system to provide health and long-term care coverage for low-income families, seniors and people with disabilities. In 1963, before Medicaid was created, only 34.1 percent of low-income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

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

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

FIGURE 8

### Low-Income Americans with Health Insurance, 1963 and 2013




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

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

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

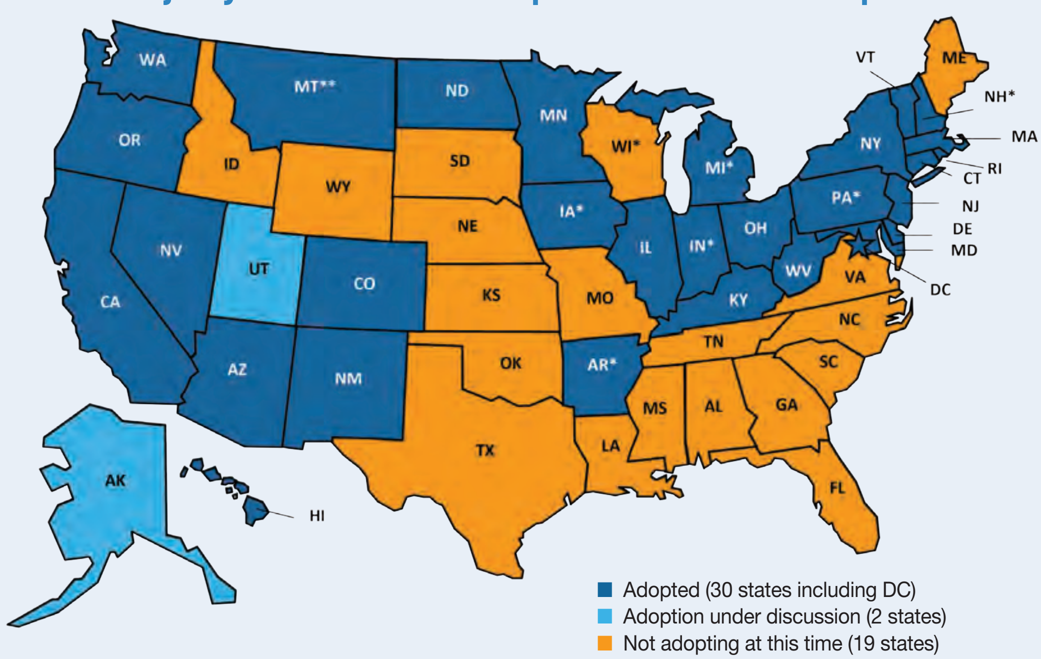
The Affordable Care Act expanded Medicaid eligibility to nearly all individuals with incomes at or below 138 percent of poverty ($16,243 for an individual in 2015), broadly expanding the program to reach low-income adults who were previously excluded from Medicaid. In June 2012, however, the Supreme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

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

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

FIGURE 9

**A Majority of States Have Adopted ACA Medicaid Expansion**




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

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

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

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

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

## Medicaid Works for Missouri's Economy.

- Medicaid covered $9 billion in health care costs for Missouri's low-income residents in 2013—and in 2009, Medicaid spending represented 18.6 percent of all health care spending in the state.[149] The average cost per Medicaid beneficiary in 2013 was $11,539 [Figure 1].[150]

## Medicaid Works for Missouri's Residents.

- Medicaid insured 775,700 Missourians in 2013—1 in 8 (12.8 percent) state residents [Figure 1].[151]

## Medicaid Works for Missouri's Children.

- Medicaid insured 602,000 Missouri children in FY2011—3 in 7 (42.6 percent) children in the state.[152]

## Medicaid Works for Missouri's Seniors.

- 96,300 of Missouri's 775,700 Medicaid beneficiaries were aged 65 or older in 2011—1 in 12 (8.4 percent) beneficiaries.[153]

## Medicaid Works for Missouri's People with Disabilities.

- 215,800 of Missouri's 775,700 Medicaid beneficiaries were people with disabilities in 2011—1 in 5 (18.8 percent) beneficiaries.[154]

## Medicaid Works for Missouri's Long-Term Care Recipients.

- Medicaid provided $2.3 billion in long-term care benefits for Missouri residents in 2013. That includes:
  - o $1.2 billion in home health care services (51.3 percent)
  - o $983.1 million to nursing home facilities (43 percent)
  - o $23.1 million to mental health facilities (1 percent)
  - o $106.1 million to intermediate care facilities for the mentally retarded (4.6 percent).[155]

- Medicaid is the primary payer for the vast majority of Missouri residents who opt for nursing home care. 22,957 of Missouri's 37,329 nursing home residents were Medicaid beneficiaries in 2011—3 in 5 (61.5 percent) nursing home residents.[156] The average annual cost of nursing home care for a semi-private room in Missouri was $54,750 in 2012.[157] Given the high cost of nursing home care, many Missouri residents would not be able to afford it without Medicaid.

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

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

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

# CONCLUSION

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

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

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

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

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

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

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

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

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

# Appendix 1: Social Security Works for Missouri's Congressional Districts

| | | STATE TOTAL | CONGRESSIONAL DISTRICTS 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total annual benefits ($ in millions)* | | $17,850M | $1,876M | $2,523M | $2,324M | $2,152M | $2,127M | $2,122M | $2,334M | $2,391M |
| Number of residents in state/congressional district | | 6,026,255 | 743,002 | 757,748 | 758,554 | 755,505 | 753,557 | 752,997 | 756,384 | 748,508 |
| Number of residents receiving Social Security benefits | | 1,246,269 | 134,535 | 149,030 | 155,606 | 157,015 | 144,942 | 147,841 | 171,629 | 185,671 |
| Percent of residents receiving Social Security benefits | | 20.7% | 18.1% | 19.7% | 20.5% | 20.8% | 19.2% | 19.6% | 22.7% | 24.8% |
| SOCIAL SECURITY BENEFICIARIES BY CATEGORY | *Women* | 634,764 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | *Retired workers* | 796,376 | 78,923 | 110,143 | 100,949 | 100,011 | 92,848 | 98,497 | 109,661 | 105,344 |
| | *Disabled workers* | 222,218 | 30,459 | 14,438 | 26,787 | 28,554 | 27,395 | 22,678 | 30,834 | 41,073 |
| | *Widow(er)s* | 87,551 | 8,789 | 10,787 | 10,174 | 10,928 | 9,446 | 10,827 | 11,905 | 14,695 |
| | *Spouses* | 40,659 | 2,731 | 6,489 | 4,755 | 5,151 | 3,634 | 5,185 | 5,879 | 6,835 |
| | *Children* | 99,465 | 13,633 | 7,173 | 12,941 | 12,371 | 11,619 | 10,654 | 13,350 | 17,724 |

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

# Appendix 2: Social Security, Medicare and Medicaid Data by County in Missouri (Page 1/5)

| | | MISSOURI COUNTY DEMOGRAPHICS, 2013 | | | | | SOCIAL SECURITY BENEFITS, 2013-2014 | | SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014* | | | | | | | MEDICARE & MEDICAID, 2011-2012 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County | Metropolitan/ Non-Metropolitan | 2013 Population | Median Household Income, 2013 | % in Poverty, 2013 | Population over Age 65, 2013 | % of Population over Age 65, 2013 | Annual Total Benefits, 2014 | % of Total Personal Income, 2013 | % of Population Receiving Benefits, 2014 | Total Beneficiaries | Retired Workers | Disabled Workers | Widow(er)s | Spouses | Children | % Receiving Medicare, 2012 | % Receiving Medicaid, 2011 |
| Missouri Total (115 Counties) | N/A | 6,044,171 | $46,905 | 15.8% | 907,777 | 15.0% | $17,850,144,000 | 7.3% | 20.6% | 1,246,270 | 796,375 | 222,220 | 87,550 | 40,660 | 99,465 | 19.2% | 15.5% |
| Adair | Non-Metropolitan | 25,572 | $35,282 | 24.9% | 3,439 | 13.4% | $63,276,000 | 8.0% | 19.0% | 4,865 | 3,095 | 905 | 315 | 135 | 415 | 17.8% | 14.3% |
| Andrew | Metropolitan | 17,445 | $54,185 | 10.1% | 2,978 | 17.1% | $51,540,000 | 6.0% | 20.8% | 3,620 | 2,480 | 500 | 255 | 155 | 230 | 18.6% | 9.7% |
| Atchison | Non-Metropolitan | 5,449 | $43,215 | 13.2% | 1,274 | 23.4% | $20,604,000 | 8.1% | 27.2% | 1,480 | 1,030 | 175 | 140 | 70 | 65 | 27.1% | 11.4% |
| Audrain | Non-Metropolitan | 25,661 | $41,164 | 19.7% | 4,228 | 16.5% | $79,644,000 | 8.8% | 22.2% | 5,685 | 3,575 | 1,055 | 450 | 200 | 405 | 21.0% | 15.6% |
| Barry | Non-Metropolitan | 35,572 | $36,573 | 20.2% | 7,075 | 19.9% | $110,172,000 | 9.5% | 23.9% | 8,505 | 5,420 | 1,610 | 540 | 280 | 655 | 23.6% | 19.8% |
| Barton | Non-Metropolitan | 12,275 | $37,723 | 18.5% | 2,245 | 18.3% | $37,032,000 | 8.9% | 23.5% | 2,885 | 1,730 | 530 | 235 | 125 | 265 | 24.3% | 19.9% |
| Bates | Metropolitan | 16,550 | $38,586 | 21.6% | 3,122 | 18.9% | $48,228,000 | 8.2% | 21.9% | 3,620 | 2,175 | 690 | 345 | 140 | 270 | 24.1% | 16.4% |
| Benton | Non-Metropolitan | 18,932 | $32,563 | 23.1% | 5,296 | 28.0% | $96,660,000 | 16.1% | 36.7% | 6,945 | 4,625 | 1,295 | 435 | 210 | 380 | 34.8% | 19.2% |
| Bollinger | Metropolitan | 12,490 | $37,627 | 19.6% | 2,163 | 17.3% | $37,680,000 | 10.2% | 24.3% | 3,035 | 1,680 | 705 | 225 | 105 | 320 | 24.1% | 22.7% |
| Boone | Metropolitan | 170,773 | $49,118 | 19.8% | 17,238 | 10.1% | $360,672,000 | 5.1% | 14.5% | 24,680 | 15,960 | 4,410 | 1,390 | 645 | 2,275 | 13.2% | 11.7% |
| Buchanan | Metropolitan | 89,631 | $43,461 | 17.8% | 12,809 | 14.3% | $250,536,000 | 7.7% | 19.9% | 17,860 | 11,155 | 3,400 | 1,430 | 555 | 1,320 | 18.9% | 18.8% |
| Butler | Non-Metropolitan | 43,083 | $35,381 | 22.0% | 7,495 | 17.4% | $155,748,000 | 9.9% | 30.0% | 12,920 | 6,720 | 3,205 | 1,085 | 400 | 1,510 | 25.8% | 26.5% |
| Caldwell | Metropolitan | 9,097 | $41,546 | 15.3% | 1,672 | 18.4% | $29,772,000 | 8.3% | 24.0% | 2,180 | 1,440 | 325 | 170 | 105 | 140 | 22.2% | 14.6% |
| Callaway | Metropolitan | 44,359 | $45,573 | 13.8% | 6,114 | 13.8% | $129,312,000 | 9.2% | 20.9% | 9,250 | 5,765 | 1,895 | 575 | 210 | 805 | 18.6% | 13.5% |
| Camden | Non-Metropolitan | 43,862 | $41,314 | 18.0% | 10,608 | 24.2% | $202,920,000 | 13.0% | 30.9% | 13,535 | 9,895 | 1,890 | 755 | 365 | 630 | 26.8% | 13.7% |
| Cape Girardeau | Metropolitan | 77,320 | $44,248 | 15.8% | 11,708 | 15.1% | $225,504,000 | 7.4% | 20.8% | 16,085 | 10,350 | 2,725 | 1,190 | 620 | 1,200 | 18.8% | 13.9% |
| Carroll | Non-Metropolitan | 9,127 | $41,279 | 17.7% | 1,855 | 20.3% | $31,236,000 | 8.1% | 25.7% | 2,345 | 1,445 | 400 | 230 | 100 | 170 | 25.7% | 16.7% |
| Carter | Non-Metropolitan | 6,291 | $30,017 | 23.7% | 1,076 | 17.1% | $15,636,000 | 8.7% | 20.5% | 1,290 | 730 | 295 | 100 | 40 | 125 | 26.4% | 27.4% |
| Cass | Metropolitan | 100,641 | $63,031 | 9.2% | 15,105 | 15.0% | $303,192,000 | 8.0% | 19.8% | 19,935 | 13,795 | 2,835 | 1,350 | 645 | 1,310 | 17.9% | 11.5% |
| Cedar | Non-Metropolitan | 13,913 | $30,816 | 25.5% | 3,336 | 24.0% | $55,116,000 | 13.8% | 31.0% | 4,310 | 2,710 | 775 | 315 | 155 | 355 | 30.8% | 22.6% |
| Chariton | Non-Metropolitan | 7,628 | $40,352 | 16.8% | 1,725 | 22.6% | $26,496,000 | 8.2% | 26.2% | 1,995 | 1,340 | 285 | 160 | 95 | 115 | 26.0% | 14.4% |
| Christian | Metropolitan | 80,899 | $51,394 | 11.4% | 11,201 | 13.8% | $222,636,000 | 8.0% | 19.6% | 15,845 | 10,475 | 2,570 | 1,030 | 510 | 1,260 | 18.0% | 13.0% |
| Clark | Non-Metropolitan | 6,910 | $39,712 | 17.5% | 1,303 | 18.9% | $21,828,000 | 8.7% | 23.6% | 1,630 | 1,040 | 285 | 135 | 65 | 105 | 24.1% | 15.2% |
| Clay | Metropolitan | 230,473 | $60,641 | 10.0% | 28,536 | 12.4% | $606,372,000 | 6.5% | 16.9% | 38,875 | 26,290 | 6,135 | 2,555 | 1,160 | 2,735 | 15.8% | 9.6% |
| Clinton | Metropolitan | 20,571 | $52,461 | 11.5% | 3,390 | 16.5% | $67,812,000 | 8.4% | 22.2% | 4,565 | 3,020 | 710 | 325 | 175 | 335 | 17.8% | 11.0% |
| Cole | Metropolitan | 76,699 | $52,023 | 13.7% | 10,393 | 13.6% | $220,332,000 | 6.6% | 20.4% | 15,675 | 9,990 | 2,440 | 880 | 315 | 2,050 | 17.3% | 12.1% |

# Appendix 2: Social Security, Medicare and Medicaid Data by County in Missouri (Page 2/5)

| | | MISSOURI COUNTY DEMOGRAPHICS, 2013 | | | | | SOCIAL SECURITY BENEFITS, 2013-2014 | | SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014* | | | | | | | MEDICARE & MEDICAID, 2011-2012 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County | Metropolitan/ Non-Metropolitan | 2013 Population | Median Household Income, 2013 | % in Poverty, 2013 | Population over Age 65, 2013 | % of Population over Age 65, 2013 | Annual Total Benefits, 2014 | % of Total Personal Income, 2013 | % of Population Receiving Benefits, 2014 | Total Beneficiaries | Retired Workers | Disabled Workers | Widow(er)s | Spouses | Children | % Receiving Medicare, 2012 | % Receiving Medicaid, 2011 |
| Cooper | Non-Metropolitan | 17,647 | $44,397 | 15.5% | 2,872 | 16.3% | $53,004,000 | 9.1% | 22.4% | 3,955 | 2,560 | 705 | 260 | 90 | 340 | 20.7% | 13.7% |
| Crawford | Non-Metropolitan | 24,543 | $37,299 | 20.1% | 4,288 | 17.5% | $85,932,000 | 10.3% | 26.5% | 6,495 | 3,740 | 1,465 | 495 | 210 | 585 | 23.1% | 22.1% |
| Dade | Non-Metropolitan | 7,578 | $36,720 | 18.4% | 1,678 | 22.1% | $30,480,000 | 13.4% | 31.0% | 2,350 | 1,515 | 400 | 190 | 90 | 155 | 26.9% | 16.8% |
| Dallas | Metropolitan | 16,535 | $37,540 | 21.7% | 3,139 | 19.0% | $59,904,000 | 11.5% | 28.0% | 4,635 | 2,790 | 1,005 | 355 | 165 | 320 | 24.3% | 20.7% |
| Daviess | Non-Metropolitan | 8,294 | $38,332 | 18.9% | 1,535 | 18.5% | $26,160,000 | 9.4% | 23.3% | 1,935 | 1,345 | 285 | 125 | 85 | 95 | 22.7% | 15.4% |
| DeKalb | Metropolitan | 12,840 | $44,286 | 17.2% | 1,979 | 15.4% | $30,720,000 | 9.0% | 17.4% | 2,230 | 1,505 | 335 | 190 | 75 | 125 | 16.9% | 10.2% |
| Dent | Non-Metropolitan | 15,730 | $34,761 | 23.0% | 3,120 | 19.8% | $52,656,000 | 11.0% | 26.3% | 4,140 | 2,410 | 825 | 345 | 165 | 395 | 25.3% | 22.8% |
| Douglas | Non-Metropolitan | 13,515 | $31,289 | 22.5% | 2,945 | 21.8% | $6,552,000 | 1.8% | 3.9% | 530 | 335 | 100 | 40 | 25 | 30 | 25.2% | 24.4% |
| Dunklin | Non-Metropolitan | 31,712 | $32,050 | 27.0% | 5,356 | 16.9% | $103,152,000 | 9.5% | 27.0% | 8,560 | 4,400 | 2,240 | 725 | 295 | 900 | 25.4% | 35.4% |
| Franklin | Metropolitan | 101,816 | $51,138 | 10.8% | 15,351 | 15.1% | $339,504,000 | 8.8% | 22.7% | 23,070 | 14,475 | 4,305 | 1,635 | 770 | 1,885 | 19.5% | 12.5% |
| Gasconade | Non-Metropolitan | 14,901 | $41,270 | 15.8% | 3,193 | 21.4% | $57,348,000 | 11.0% | 27.7% | 4,130 | 2,750 | 705 | 265 | 155 | 255 | 26.0% | 13.8% |
| Gentry | Non-Metropolitan | 6,775 | $39,265 | 16.1% | 1,364 | 20.1% | $21,300,000 | 8.0% | 25.2% | 1,710 | 1,040 | 270 | 125 | 65 | 210 | 27.8% | 13.8% |
| Greene | Metropolitan | 283,870 | $38,525 | 20.2% | 42,429 | 14.9% | $816,576,000 | 7.8% | 20.6% | 58,385 | 37,045 | 10,730 | 4,155 | 2,075 | 4,380 | 19.4% | 15.5% |
| Grundy | Non-Metropolitan | 10,355 | $37,172 | 21.4% | 2,169 | 20.9% | $32,832,000 | 9.4% | 24.7% | 2,560 | 1,750 | 340 | 230 | 110 | 130 | 25.2% | 17.5% |
| Harrison | Non-Metropolitan | 8,741 | $36,229 | 19.0% | 1,855 | 21.2% | $29,160,000 | 9.3% | 27.1% | 2,370 | 1,585 | 340 | 215 | 105 | 125 | 26.0% | 18.6% |
| Henry | Non-Metropolitan | 22,059 | $39,666 | 18.4% | 4,437 | 20.1% | $92,052,000 | 11.7% | 30.6% | 6,760 | 4,185 | 1,335 | 510 | 215 | 515 | 28.5% | 19.5% |
| Hickory | Non-Metropolitan | 9,305 | $30,040 | 24.7% | 2,913 | 31.3% | $39,384,000 | 16.5% | 32.0% | 2,975 | 2,025 | 470 | 215 | 105 | 160 | 36.1% | 18.3% |
| Holt | Non-Metropolitan | 4,568 | $41,213 | 13.1% | 1,028 | 22.5% | $16,680,000 | 7.5% | 26.8% | 1,225 | 780 | 160 | 150 | 60 | 75 | 25.7% | 12.2% |
| Howard | Non-Metropolitan | 10,257 | $41,356 | 15.9% | 1,679 | 16.4% | $29,640,000 | 7.2% | 21.9% | 2,245 | 1,490 | 385 | 135 | 65 | 170 | 20.9% | 16.2% |
| Howell | Non-Metropolitan | 40,393 | $31,665 | 27.6% | 7,320 | 18.1% | $146,112,000 | 12.1% | 29.6% | 11,950 | 6,990 | 2,485 | 920 | 465 | 1,090 | 25.6% | 24.0% |
| Iron | Non-Metropolitan | 10,344 | $32,994 | 22.0% | 1,906 | 18.4% | $41,604,000 | 13.0% | 31.1% | 3,220 | 1,675 | 840 | 270 | 130 | 305 | 27.4% | 26.4% |
| Jackson | Metropolitan | 679,996 | $46,802 | 17.2% | 90,297 | 13.3% | $1,856,352,000 | 6.5% | 18.4% | 125,220 | 80,650 | 23,305 | 7,960 | 3,095 | 10,210 | 17.3% | 17.7% |
| Jasper | Metropolitan | 116,398 | $40,530 | 18.3% | 15,949 | 13.7% | $321,828,000 | 8.3% | 20.8% | 24,240 | 14,545 | 4,860 | 1,850 | 820 | 2,165 | 19.4% | 19.5% |
| Jefferson | Metropolitan | 221,396 | $55,305 | 11.5% | 28,250 | 12.8% | $664,524,000 | 8.3% | 20.0% | 44,255 | 26,395 | 9,270 | 3,130 | 1,510 | 3,950 | 17.0% | 11.6% |
| Johnson | Non-Metropolitan | 54,572 | $45,011 | 17.7% | 6,251 | 11.5% | $115,488,000 | 6.5% | 15.2% | 8,320 | 5,415 | 1,390 | 555 | 295 | 665 | 13.9% | 11.3% |
| Knox | Non-Metropolitan | 4,067 | $34,894 | 21.3% | 846 | 20.8% | $12,744,000 | 8.0% | 25.8% | 1,050 | 675 | 145 | 85 | 55 | 90 | 25.3% | 13.9% |
| Laclede | Non-Metropolitan | 35,667 | $36,632 | 22.1% | 5,915 | 16.6% | $114,252,000 | 10.6% | 25.6% | 9,145 | 5,395 | 1,875 | 660 | 380 | 835 | 23.4% | 21.7% |
| Lafayette | Metropolitan | 32,943 | $46,878 | 12.7% | 5,738 | 17.4% | $108,888,000 | 8.2% | 23.1% | 7,625 | 5,055 | 1,265 | 540 | 205 | 560 | 22.1% | 15.2% |

# Appendix 2: Social Security, Medicare and Medicaid Data by County in Missouri (Page 3/5)

| | | MISSOURI COUNTY DEMOGRAPHICS, 2013 | | | | | SOCIAL SECURITY BENEFITS, 2013-2014 | | SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014* | | | | | | | MEDICARE & MEDICAID, 2011-2012 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County | Metropolitan/ Non-Metropolitan | 2013 Population | Median Household Income, 2013 | % in Poverty, 2013 | Population over Age 65, 2013 | % of Population over Age 65, 2013 | Annual Total Benefits, 2014 | % of Total Personal Income, 2013 | % of Population Receiving Benefits, 2014 | Total Beneficiaries | Retired Workers | Disabled Workers | Widow(er)s | Spouses | Children | % Receiving Medicare, 2012 | % Receiving Medicaid, 2011 |
| Lawrence | Non-Metropolitan | 38,185 | $38,724 | 18.6% | 6,596 | 17.3% | $117,552,000 | 10.3% | 24.1% | 9,185 | 5,685 | 1,720 | 635 | 325 | 820 | 22.9% | 17.8% |
| Lewis | Non-Metropolitan | 10,152 | $41,187 | 17.5% | 1,802 | 17.8% | $31,392,000 | 9.1% | 23.3% | 2,370 | 1,525 | 355 | 200 | 90 | 200 | 21.2% | 13.3% |
| Lincoln | Metropolitan | 53,860 | $54,144 | 11.9% | 6,467 | 12.0% | $151,728,000 | 8.7% | 19.4% | 10,450 | 6,015 | 2,325 | 700 | 370 | 1,040 | 16.4% | 15.1% |
| Linn | Non-Metropolitan | 12,368 | $37,773 | 19.6% | 2,483 | 20.1% | $41,604,000 | 9.6% | 26.2% | 3,245 | 2,105 | 545 | 250 | 90 | 255 | 26.3% | 17.8% |
| Livingston | Non-Metropolitan | 14,871 | $38,839 | 17.2% | 2,854 | 19.2% | $46,620,000 | 8.6% | 23.6% | 3,510 | 2,320 | 545 | 285 | 110 | 250 | 22.9% | 15.8% |
| McDonald | Metropolitan | 22,558 | $35,915 | 20.7% | 3,101 | 13.7% | $59,364,000 | 9.9% | 21.2% | 4,775 | 2,780 | 1,035 | 310 | 150 | 500 | 17.5% | 22.4% |
| Macon | Non-Metropolitan | 15,544 | $38,110 | 18.8% | 3,205 | 20.6% | $54,360,000 | 9.8% | 26.4% | 4,110 | 2,710 | 625 | 320 | 170 | 285 | 25.6% | 16.2% |
| Madison | Non-Metropolitan | 12,431 | $33,631 | 21.4% | 2,349 | 18.9% | $45,012,000 | 11.9% | 28.2% | 3,510 | 2,005 | 765 | 280 | 145 | 315 | 26.1% | 23.6% |
| Maries | Non-Metropolitan | 9,018 | $40,404 | 17.5% | 1,725 | 19.1% | $26,424,000 | 8.1% | 22.5% | 2,030 | 1,285 | 400 | 130 | 70 | 145 | 24.0% | 14.5% |
| Marion | Non-Metropolitan | 28,904 | $40,981 | 16.8% | 4,812 | 16.6% | $89,628,000 | 8.3% | 23.5% | 6,805 | 4,100 | 1,275 | 485 | 195 | 750 | 22.5% | 21.6% |
| Mercer | Non-Metropolitan | 3,695 | $38,726 | 17.6% | 733 | 19.8% | $10,812,000 | 9.3% | 23.1% | 855 | 565 | 140 | 65 | 30 | 55 | 24.4% | 14.4% |
| Miller | Non-Metropolitan | 25,092 | $36,552 | 20.5% | 4,386 | 17.5% | $74,364,000 | 10.3% | 22.9% | 5,735 | 3,630 | 1,075 | 385 | 150 | 495 | 20.8% | 19.5% |
| Mississippi | Non-Metropolitan | 14,282 | $31,421 | 36.3% | 2,294 | 16.1% | $42,864,000 | 9.1% | 23.9% | 3,410 | 1,885 | 755 | 335 | 115 | 320 | 22.1% | 27.6% |
| Moniteau | Metropolitan | 15,748 | $46,123 | 14.1% | 2,290 | 14.5% | $41,868,000 | 7.8% | 19.7% | 3,105 | 2,070 | 520 | 220 | 70 | 225 | 18.1% | 12.3% |
| Monroe | Non-Metropolitan | 8,774 | $38,940 | 15.7% | 1,773 | 20.2% | $28,008,000 | 8.6% | 23.6% | 2,070 | 1,380 | 330 | 160 | 70 | 130 | 25.1% | 14.3% |
| Montgomery | Non-Metropolitan | 11,965 | $39,750 | 15.3% | 2,356 | 19.7% | $41,952,000 | 9.7% | 25.4% | 3,045 | 1,905 | 585 | 230 | 125 | 200 | 24.1% | 18.4% |
| Morgan | Non-Metropolitan | 20,265 | $32,761 | 22.0% | 4,777 | 23.6% | $82,416,000 | 10.7% | 29.9% | 6,060 | 4,080 | 1,065 | 390 | 160 | 365 | 30.7% | 19.2% |
| New Madrid | Non-Metropolitan | 18,365 | $34,927 | 23.7% | 3,153 | 17.2% | $62,448,000 | 10.1% | 27.0% | 4,960 | 2,505 | 1,230 | 500 | 215 | 510 | 22.1% | 28.1% |
| Newton | Metropolitan | 58,845 | $41,440 | 16.1% | 10,037 | 17.1% | $176,916,000 | 7.9% | 22.4% | 13,170 | 8,380 | 2,255 | 1,010 | 495 | 1,030 | 20.6% | 18.3% |
| Nodaway | Non-Metropolitan | 23,261 | $41,952 | 18.5% | 3,208 | 13.8% | $54,108,000 | 7.6% | 17.1% | 3,985 | 2,760 | 505 | 335 | 160 | 225 | 16.1% | 7.9% |
| Oregon | Non-Metropolitan | 10,996 | $29,464 | 26.4% | 2,356 | 21.4% | $32,520,000 | 11.1% | 25.5% | 2,805 | 1,615 | 575 | 210 | 150 | 255 | 27.0% | 25.8% |
| Osage | Metropolitan | 13,688 | $48,990 | 10.1% | 2,234 | 16.3% | $37,968,000 | 7.2% | 20.6% | 2,825 | 1,925 | 450 | 170 | 100 | 180 | 18.0% | 9.0% |
| Ozark | Non-Metropolitan | 9,560 | $30,799 | 26.2% | 2,464 | 25.8% | $29,256,000 | 10.9% | 24.1% | 2,300 | 1,485 | 420 | 140 | 90 | 165 | 31.2% | 21.2% |
| Pemiscot | Non-Metropolitan | 17,823 | $28,664 | 31.4% | 2,728 | 15.3% | $52,488,000 | 8.2% | 25.3% | 4,510 | 2,125 | 1,260 | 440 | 120 | 565 | 23.8% | 37.9% |
| Perry | Non-Metropolitan | 19,072 | $53,798 | 12.7% | 3,119 | 16.4% | $60,120,000 | 8.9% | 22.9% | 4,370 | 2,815 | 730 | 330 | 160 | 335 | 20.3% | 14.7% |
| Pettis | Non-Metropolitan | 42,205 | $39,527 | 20.1% | 6,360 | 15.1% | $118,380,000 | 8.2% | 21.4% | 9,035 | 5,585 | 1,760 | 675 | 300 | 715 | 20.2% | 17.8% |
| Phelps | Non-Metropolitan | 44,807 | $38,930 | 16.4% | 6,552 | 14.6% | $119,988,000 | 7.9% | 20.8% | 9,310 | 5,630 | 1,790 | 690 | 330 | 870 | 19.3% | 16.6% |
| Pike | Non-Metropolitan | 18,669 | $39,499 | 19.8% | 3,049 | 16.3% | $54,576,000 | 9.0% | 21.6% | 4,035 | 2,550 | 700 | 345 | 150 | 290 | 20.6% | 15.7% |

# Appendix 2: Social Security, Medicare and Medicaid Data by County in Missouri (Page 4/5)

| | | MISSOURI COUNTY DEMOGRAPHICS, 2013 | | | | | SOCIAL SECURITY BENEFITS, 2013-2014 | | SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014* | | | | | | | MEDICARE & MEDICAID, 2011-2012 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County | Metropolitan/ Non-Metropolitan | 2013 Population | Median Household Income, 2013 | % in Poverty, 2013 | Population over Age 65, 2013 | % of Population over Age 65, 2013 | Annual Total Benefits, 2014 | % of Total Personal Income, 2013 | % of Population Receiving Benefits, 2014 | Total Beneficiaries | Retired Workers | Disabled Workers | Widow(er)s | Spouses | Children | % Receiving Medicare, 2012 | % Receiving Medicaid, 2011 |
| Platte | Metropolitan | 93,310 | $68,411 | 7.7% | 11,709 | 12.5% | $245,916,000 | 5.5% | 16.2% | 15,135 | 10,710 | 1,975 | 915 | 465 | 1,070 | 14.9% | 7.1% |
| Polk | Metropolitan | 30,974 | $38,023 | 20.0% | 5,175 | 16.7% | $98,964,000 | 10.8% | 24.8% | 7,675 | 4,740 | 1,380 | 610 | 310 | 635 | 20.8% | 19.9% |
| Pulaski | Non-Metropolitan | 53,748 | $49,499 | 15.1% | 3,967 | 7.4% | $78,036,000 | 3.6% | 12.2% | 6,535 | 3,575 | 1,405 | 560 | 260 | 735 | 10.6% | 9.9% |
| Putnam | Non-Metropolitan | 4,875 | $34,106 | 17.9% | 1,132 | 23.2% | $17,376,000 | 11.0% | 28.4% | 1,385 | 945 | 205 | 100 | 60 | 75 | 27.2% | 14.9% |
| Ralls | Non-Metropolitan | 10,192 | $49,393 | 11.4% | 1,888 | 18.5% | $36,660,000 | 9.1% | 26.0% | 2,655 | 1,785 | 435 | 170 | 105 | 160 | 22.8% | 11.7% |
| Randolph | Non-Metropolitan | 24,940 | $38,988 | 22.4% | 3,772 | 15.1% | $69,912,000 | 7.8% | 21.6% | 5,375 | 3,020 | 1,235 | 420 | 180 | 520 | 20.7% | 20.5% |
| Ray | Metropolitan | 23,039 | $52,430 | 13.2% | 3,809 | 16.5% | $75,912,000 | 8.5% | 22.4% | 5,170 | 3,345 | 880 | 370 | 200 | 375 | 20.3% | 12.9% |
| Reynolds | Non-Metropolitan | 6,599 | $32,089 | 23.3% | 1,512 | 22.9% | $24,576,000 | 13.0% | 28.9% | 1,905 | 1,080 | 410 | 170 | 90 | 155 | 27.2% | 25.7% |
| Ripley | Non-Metropolitan | 14,032 | $30,843 | 23.6% | 2,725 | 19.4% | $47,508,000 | 12.2% | 28.2% | 3,960 | 2,175 | 965 | 300 | 135 | 385 | 26.7% | 33.0% |
| St. Charles | Metropolitan | 373,495 | $70,468 | 6.4% | 47,721 | 12.8% | $1,040,340,000 | 6.4% | 17.1% | 63,730 | 44,685 | 8,300 | 4,275 | 2,120 | 4,350 | 15.1% | 6.2% |
| St. Clair | Non-Metropolitan | 9,487 | $30,612 | 26.4% | 2,407 | 25.4% | $37,512,000 | 12.8% | 29.9% | 2,840 | 1,755 | 550 | 245 | 110 | 180 | 29.8% | 20.1% |
| Ste. Genevieve | Non-Metropolitan | 17,778 | $48,266 | 12.3% | 3,021 | 17.0% | $62,460,000 | 9.5% | 24.5% | 4,355 | 2,740 | 825 | 305 | 150 | 335 | 21.2% | 12.5% |
| St. Francois | Non-Metropolitan | 66,215 | $37,696 | 20.7% | 9,874 | 14.9% | $213,012,000 | 10.9% | 24.0% | 15,900 | 8,550 | 3,910 | 1,275 | 505 | 1,660 | 22.1% | 20.5% |
| St. Louis | Metropolitan | 1,001,444 | $59,284 | 10.9% | 161,009 | 16.1% | $3,199,896,000 | 5.6% | 19.8% | 198,715 | 138,165 | 26,460 | 13,965 | 7,280 | 12,845 | 19.1% | 11.3% |
| Saline | Non-Metropolitan | 23,252 | $38,230 | 18.4% | 3,877 | 16.7% | $66,948,000 | 7.1% | 21.4% | 4,970 | 3,170 | 895 | 320 | 150 | 435 | 21.2% | 23.1% |
| Schuyler | Non-Metropolitan | 4,358 | $36,029 | 21.2% | 879 | 20.2% | $11,964,000 | 10.1% | 22.7% | 990 | 630 | 160 | 90 | 45 | 65 | 24.3% | 15.8% |
| Scotland | Non-Metropolitan | 4,921 | $36,511 | 17.6% | 909 | 18.5% | $12,036,000 | 6.9% | 19.6% | 965 | 630 | 140 | 95 | 40 | 60 | 20.9% | 13.1% |
| Scott | Non-Metropolitan | 39,290 | $40,441 | 18.4% | 6,279 | 16.0% | $128,232,000 | 8.3% | 25.2% | 9,910 | 5,425 | 2,260 | 845 | 325 | 1,055 | 24.3% | 25.7% |
| Shannon | Non-Metropolitan | 8,297 | $26,538 | 31.5% | 1,580 | 19.0% | $22,896,000 | 10.9% | 23.8% | 1,975 | 1,105 | 450 | 185 | 65 | 170 | 25.3% | 26.1% |
| Shelby | Non-Metropolitan | 6,177 | $40,420 | 17.2% | 1,224 | 19.8% | $21,924,000 | 9.2% | 27.4% | 1,695 | 1,120 | 240 | 140 | 85 | 110 | 24.8% | 17.3% |
| Stoddard | Non-Metropolitan | 29,780 | $37,689 | 16.3% | 5,619 | 18.9% | $104,460,000 | 9.9% | 27.8% | 8,270 | 4,750 | 1,850 | 640 | 310 | 720 | 26.2% | 22.3% |
| Stone | Non-Metropolitan | 31,297 | $39,018 | 16.1% | 8,415 | 26.9% | $157,800,000 | 13.6% | 35.4% | 11,070 | 8,070 | 1,480 | 590 | 340 | 590 | 30.1% | 14.9% |
| Sullivan | Non-Metropolitan | 6,448 | $37,039 | 16.5% | 1,191 | 18.5% | $19,488,000 | 8.4% | 25.0% | 1,610 | 1,040 | 280 | 120 | 50 | 120 | 24.4% | 19.0% |
| Taney | Non-Metropolitan | 53,575 | $34,860 | 19.7% | 10,245 | 19.1% | $232,356,000 | 15.1% | 32.3% | 17,285 | 11,630 | 2,900 | 1,075 | 530 | 1,150 | 24.0% | 17.0% |
| Texas | Non-Metropolitan | 25,636 | $34,266 | 25.4% | 4,912 | 19.2% | $87,612,000 | 12.7% | 28.2% | 7,230 | 4,480 | 1,350 | 510 | 265 | 625 | 22.6% | 20.5% |
| Vernon | Non-Metropolitan | 20,949 | $35,090 | 21.5% | 3,639 | 17.4% | $67,212,000 | 9.6% | 25.0% | 5,235 | 3,180 | 1,030 | 350 | 150 | 525 | 22.3% | 19.3% |
| Warren | Metropolitan | 32,999 | $52,517 | 11.7% | 5,394 | 16.3% | $111,168,000 | 9.6% | 22.3% | 7,370 | 4,810 | 1,285 | 470 | 230 | 575 | 19.4% | 14.4% |
| Washington | Non-Metropolitan | 25,172 | $33,491 | 26.2% | 3,771 | 15.0% | $74,760,000 | 10.9% | 23.6% | 5,945 | 2,885 | 1,620 | 445 | 270 | 725 | 20.6% | 28.6% |

# Appendix 2: Social Security, Medicare and Medicaid Data by County in Missouri (Page 5/5)

| | | MISSOURI COUNTY DEMOGRAPHICS, 2013 | | | | | SOCIAL SECURITY BENEFITS, 2013-2014 | | SOCIAL SECURITY BENEFICIARIES BY CHARACTERISTIC, 2014* | | | | | | | MEDICARE & MEDICAID, 2011-2012 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County | Metropolitan/ Non-Metropolitan | 2013 Population | Median Household Income, 2013 | % in Poverty, 2013 | Population over Age 65, 2013 | % of Population over Age 65, 2013 | Annual Total Benefits, 2014 | % of Total Personal Income, 2013 | % of Population Receiving Benefits, 2014 | Total Beneficiaries | Retired Workers | Disabled Workers | Widow(er)s | Spouses | Children | % Receiving Medicare, 2012 | % Receiving Medicaid, 2011 |
| Wayne | Non-Metropolitan | 13,404 | $31,208 | 26.3% | 2,927 | 21.8% | $43,800,000 | 11.6% | 27.1% | 3,635 | 1,970 | 875 | 290 | 145 | 355 | 29.0% | 26.3% |
| Webster | Metropolitan | 36,466 | $44,069 | 19.5% | 5,208 | 14.3% | $103,008,000 | 9.6% | 21.6% | 7,890 | 4,650 | 1,590 | 600 | 335 | 715 | 20.4% | 15.7% |
| Worth | Non-Metropolitan | 2,090 | $37,832 | 15.0% | 510 | 24.4% | $6,588,000 | 8.7% | 25.8% | 540 | 370 | 75 | 50 | 25 | 20 | 27.1% | 12.0% |
| Wright | Non-Metropolitan | 18,473 | $29,605 | 29.1% | 3,452 | 18.7% | $65,412,000 | 13.5% | 29.3% | 5,410 | 3,175 | 1,105 | 420 | 235 | 475 | 27.5% | 27.2% |
| St. Louis city | Metropolitan | 318,416 | $34,346 | 27.2% | 35,576 | 11.2% | $704,880,000 | 5.8% | 17.1% | 54,465 | 30,145 | 14,085 | 3,465 | 930 | 5,840 | 16.6% | 28.3% |

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

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

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

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

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

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

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

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

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

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

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

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

# Endnotes

1 The committee described this figure as “a conservative estimate.” Committee on Economic Security, “Report of the Committee on Economic Security,” January 15, 1935. http://www.ssa.gov/history/reports/ces5.html
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3 Gary V. Engelhardt and Jonathan Gruber, “Social Security and the Evolution of Elderly Poverty,” National Bureau of Economic Research Working Paper No. 10466, May 2004. http://www.nber.org/papers/w10466
4 Total annual benefits in 2014: $812,045,000. Social Security Administration (SSA), *Annual Statistical Supplement, 2015*, “Table 5.J1—Estimated total annual benefits paid, by state or other area and program, 2014,” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html. Total beneficiaries as of December 2014: 57,978,610. SSA, ibid., “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014.” Total U.S. population 2014: 318,857,056. U.S. Census Bureau, “Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014,” *2014 Population Estimates*, 2015. http://factfinder2.census.gov/
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7 SSA, ibid*., 2015*, “Table 5.F4—Number of children and total monthly benefits, by type of benefit, December 1940–2014, selected years,” accessed June 25, 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5f.html#table5.f4 Disabled children may receive benefits indefinitely as long as the disability was incurred before reaching age 22.
8 Average benefit found by dividing total spending by total beneficiaries. Total annual benefits from SSA, ibid., “Table 5.J1—Estimated total annual benefits paid, by state or other area and program, 2015 (in millions of dollars),” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html. Total beneficiaries from SSA, ibid*.,* “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014.” Average retired worker benefit found by multiplying average monthly retired worker benefit by 12. SSA, ibid*.*, “Table 5.J6—Percentage distribution of monthly benefit for retired workers, by state or other area and monthly benefit, December 2014.”
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21 Unpublished tabulations by the Center on Budget and Policy Priorities (CBPP) for Social Security Works of data from the U.S. Census Bureau, Current Population Survey, March 2014.State estimates are based on a three-year average (for 2010-2012) to improve their reliability; the national data are for 2012.
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23 SSA, ibid., “Table 5.J2—Number, by state or other area, program, and type of benefit, December 2014,” July 2015. http://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j2
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51 SSA, *Social Security Is Important to American Indians and Alaska Natives*, June 2015. http://www.ssa.gov/news/press/factsheets/amerindian-alt.pdf This is the most recent statistically valid data available.
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# KEY FACTS ABOUT SOCIAL SECURITY, MEDICARE AND MEDICAID IN MISSOURI

### Social Security Works for Missouri's Residents and Economy

- Social Security provided benefits to 1,246,269 Missourians in 2014, 1 in 5 (20.6 percent) residents.
- Missourians received Social Security benefits totaling $17.7 billion in 2014, an amount equivalent to 7 percent of the state's total personal income [Figure 1 in full report].
- The average Social Security benefit in Missouri was $14,223 in 2013.
- Social Security lifted 570,000 Missourians out of poverty in 2013.

### Social Security Works for Missouri's Seniors

- Social Security provided benefits to 796,376 Missouri retired workers in 2014, two-thirds (63.9 percent) of beneficiaries [Figure 3 in full report].
- Social Security lifted 355,000 Missouri residents aged 65 and older out of poverty in 2013. Without Social Security, the elderly poverty rate in Missouri would have increased from 1 in 16 (6.3 percent) to half (45.5 percent) [Figure 4 in full report].

### Social Security Works for Missouri's Workers with Disabilities

- Social Security provided disability benefits to 222,218 workers in 2014, 1 in 6 (17.8 percent) Missouri beneficiaries [Figure 3 in full report].

Social Security Works for Missouri's Women

- Social Security provided benefits to 634,764 Missouri women in 2014, 1 in 5 (20.5 percent) Missouri women.
- Social Security lifted 217,000 Missouri women aged 65 and older out of poverty in 2013. Without Social Security, the poverty rate of elderly women would have increased from 1 in 13 (7.8 percent) to half (50.9 percent) [Figure 4 in full report].

### Social Security Works for Missouri's Children

- Social Security provided benefits to 99,465 Missouri children in 2014, 1 in 13 (8 percent) Missouri beneficiaries [Figure 3 in full report].

### Social Security Works for Missouri's People of Color

- Social Security provided benefits to one-quarter (26 percent) of African American households in Missouri in 2013, 67,662 households.
- Social Security provided benefits to 1 in 7 (14.6 percent) Latino households in Missouri in 2013, 8,487 households.
- Social Security provided benefits to 2 in 7 (29.7 percent) American Indian and Alaska Native households in Missouri in 2013, 2,841 households.
- Social Security provided benefits to 1 in 8 (12.8 percent) Asian American, Hawaiian Native, and Pacific Islander households in Missouri in 2013, 4,089 households.

### Social Security Works for Missouri's Rural Communities

- One-quarter (24.9 percent) of rural or non-metropolitan Missourians received Social Security in 2014, compared with 1 in 5 (19.1 percent) metropolitan Missourians.

### Medicare Works for Missouri's Residents and Economy

- 1,040,491 Missourians received Medicare benefits in 2012—1 in 6 state residents.
- Medicare provided $10 billion in benefits to Missourians in 2009—23 percent of all health care spending in the state. The average expenditure per Medicare beneficiary was $9,813 [Figure 1 in full report].

### Medicare Works for Missouri's Seniors and People with Disabilities

- 833,445 of Missouri's 1,040,491 Medicare beneficiaries were aged 65 or older in 2012—4 in 5 beneficiaries.
- 226,632 of Missouri's 1,040,491 Medicare beneficiaries were people with disabilities in 2012—1 in 5 beneficiaries.

### Medicaid Works for Missouri's Residents and Economy

- 775,700 Missourians received Medicaid benefits in 2013—1 in 8 state residents.
- A total of $9 billion in Medicaid benefits were paid to Missourians in 2013. In 2009, Medicaid spending was 18.6 percent of all health care spending in the state. The average expenditure per Medicaid beneficiary in 2013 was $11,539 [Figure 1 in full report].

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

- 96,300 of Missouri's 775,700 Medicaid beneficiaries were aged 65 or older in 2011—1 in 12 beneficiaries.
- 215,800 of Missouri's 775,700 Medicaid beneficiaries were people with disabilities in 2011—1 in 5 beneficiaries.
- Medicaid provided $2.3 billion in long-term care benefits for Missouri residents in 2013. In 2011 Medicaid provided nursing home care for 22,957 nursing home residents, 3 in 5 state residents enrolled in nursing homes.