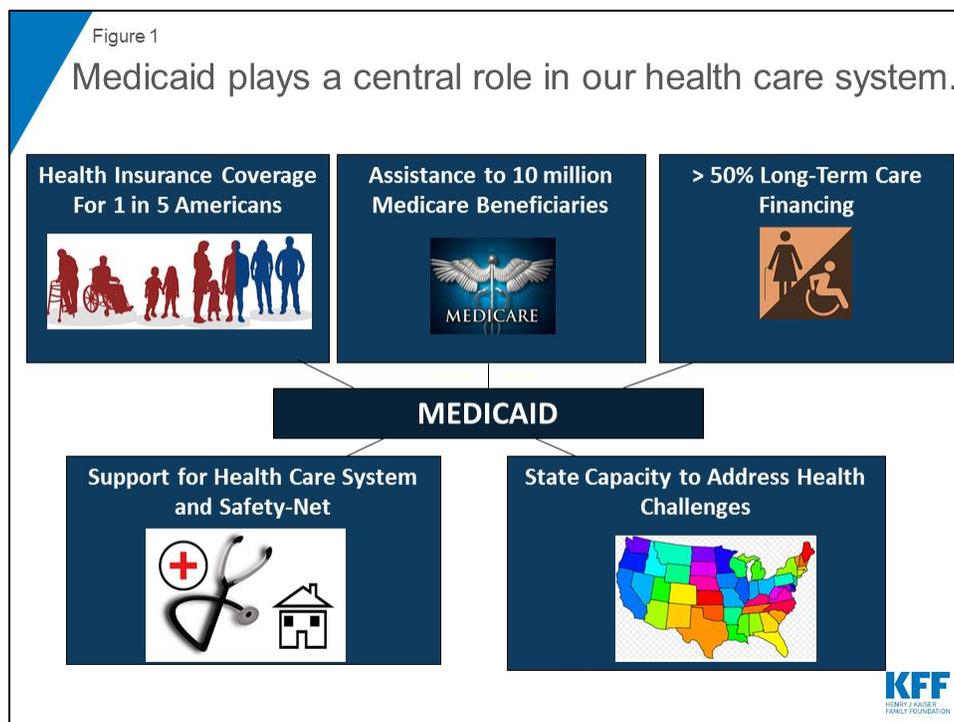


# 10 Things to Know about Medicaid: Setting the Facts Straight

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## 1. Medicaid is the nation's public health insurance program for people with low income

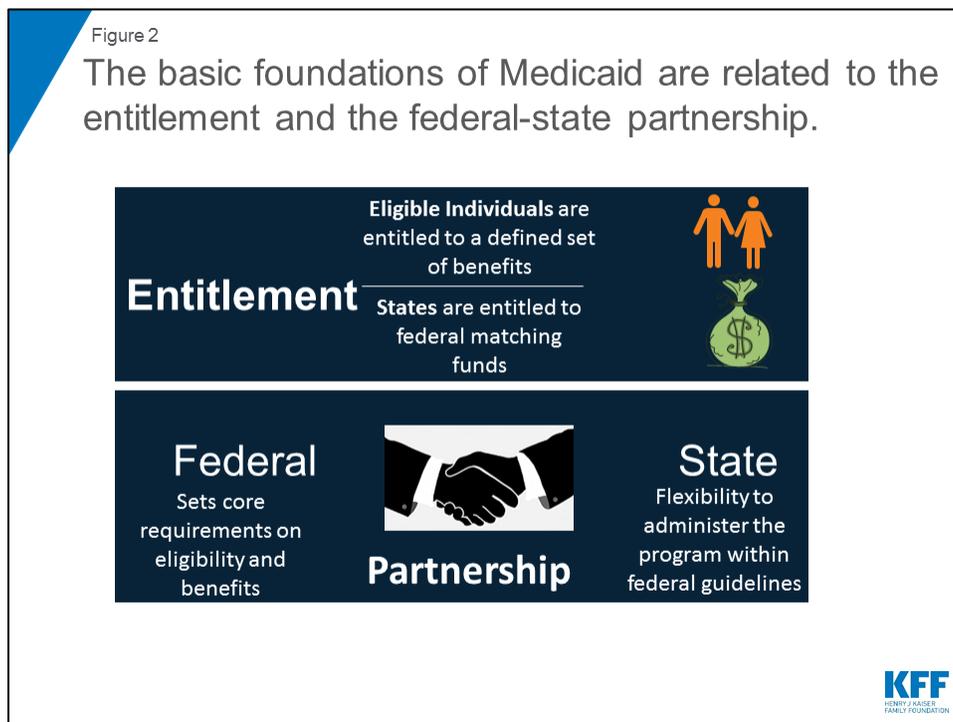
Medicaid is the nation's public health insurance program for people with low income. The Medicaid program covers [1 in 5 low-income Americans](#), including many with complex and costly needs for care. The program is the principal source of long-term care coverage for Americans. The vast majority of Medicaid enrollees lack access to other affordable health insurance. Medicaid covers a broad array of health services and limits enrollee out-of-pocket costs. Medicaid finances nearly a fifth of all personal health care spending in the U.S., providing significant financing for hospitals, community health centers, physicians, nursing homes, and jobs in the health care sector. Title XIX of the Social Security Act and a large body of federal regulations govern the program, defining federal Medicaid requirements and state options and authorities. The Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) is responsible for implementing Medicaid (Figure 1).



## 2. Medicaid is structured as a federal-state partnership

Subject to federal standards, states administer Medicaid programs and have flexibility to determine covered populations, covered services, health care delivery models, and methods for paying physicians and hospitals. States can also obtain Section 1115 waivers to test and implement approaches that differ from what is required by federal statute but that the Secretary of HHS determines advance program objectives. Because of this flexibility, there is significant variation across state Medicaid programs.

The Medicaid entitlement is based on two guarantees: first, all Americans who meet Medicaid eligibility requirements are guaranteed coverage, and second, states are guaranteed federal matching dollars without a cap for qualified services provided to eligible enrollees. The match rate for most Medicaid enrollees is determined by a formula in the law that provides a match of at least 50% and provides a higher federal match rate for poorer states (Figure 2).

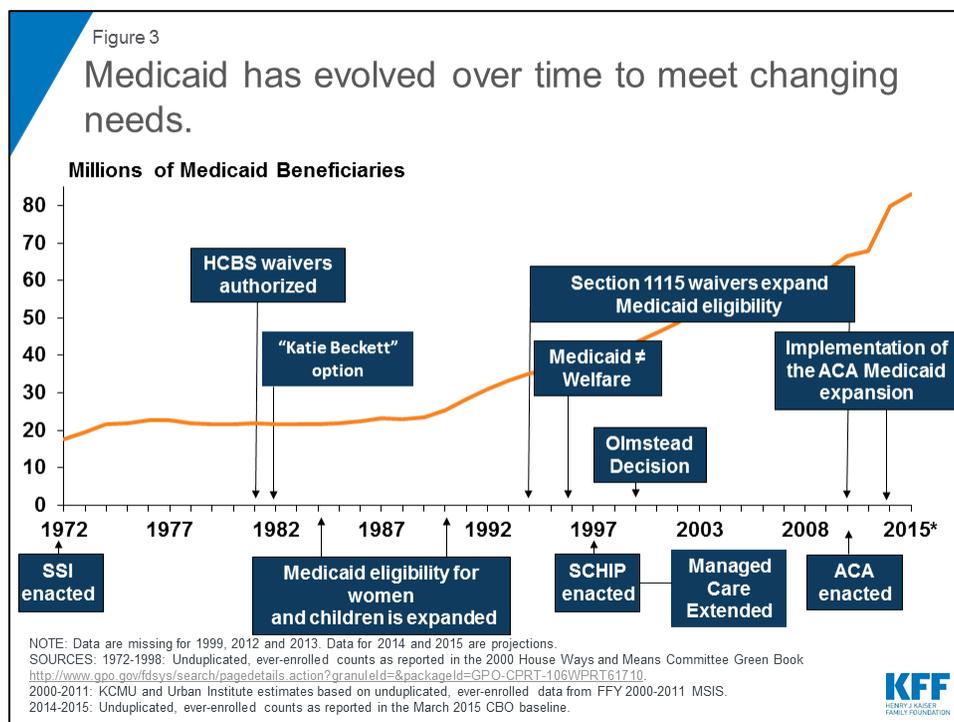


## 3. Medicaid coverage has evolved over time

Under the original 1965 Medicaid law, Medicaid eligibility was tied to cash assistance (either Aid to Families with Dependent Children (AFDC) or federal Supplemental Security Income (SSI) starting in 1972) for parents, children and the poor aged, blind and people with disabilities. States could opt to provide coverage at income levels above cash assistance. Over time, Congress expanded federal minimum requirements and provided new coverage options for states especially for children, pregnant women, and people with disabilities. Congress also required Medicaid to help pay for premiums and cost-sharing for low-income Medicare beneficiaries and allowed states to offer an option to “buy-in” to

Medicaid for working individuals with disabilities. Other coverage milestones included severing the link between Medicaid eligibility and welfare in 1996 and enacting the Children’s Health Insurance Program (CHIP) in 1997 to cover low-income children above the cut-off for Medicaid with an enhanced federal match rate. Following these policy changes, for the first time states conducted outreach campaigns and simplified enrollment procedures to enroll eligible children in both Medicaid and CHIP. Expansions in Medicaid coverage of children marked the beginning of later reforms that [recast Medicaid](#) as an income-based health coverage program.

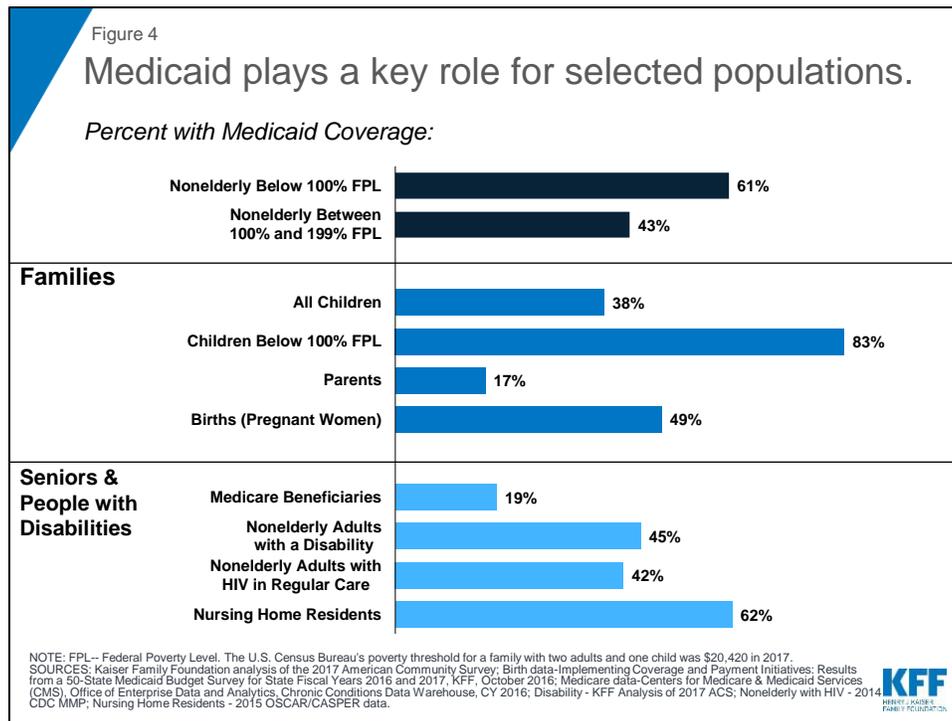
In 2010, as part of a broader health coverage initiative, the Affordable Care Act (ACA) expanded Medicaid to nonelderly adults with income up to 138% FPL (\$17,236 for an individual in 2019) with enhanced federal matching funds (Figure 3). Prior to the ACA, individuals had to be categorically eligible and meet income standards to qualify for Medicaid leaving most low-income adults without coverage options as income eligibility for parents was well below the federal poverty level in most states and federal law excluded adults without dependent children from the program no matter how poor. The ACA changes effectively eliminated categorical eligibility and allowed adults without dependent children to be covered; however, as a result of a 2012 Supreme Court ruling, the ACA Medicaid expansion is effectively optional for states. Under the ACA, all states were required to modernize and streamline Medicaid eligibility and enrollment processes. Expansions of Medicaid have resulted in historic reductions in the share of [children](#) without coverage and, in the states adopting the ACA Medicaid expansion, sharp declines in the share of [adults](#) without coverage. [Many Medicaid adults are working, but few have access to employer coverage and prior to the ACA had no options for affordable coverage.](#)



## 4. Medicaid covers 1 in 5 Americans and serves diverse populations

Medicaid provides health and long-term care for millions of America’s poorest and most vulnerable people, acting as a high risk pool for the private insurance market. In FY 2017, Medicaid covered over [75 million](#) low-income Americans. As [of February 2019, 37 states have adopted the Medicaid expansion](#). Data as of FY 2017 (when fewer states had adopted the expansion) show that [12.6 million were newly eligible in the expansion group](#). Children account for more than [four in ten](#) (43%) of all Medicaid enrollees, and the elderly and people with disabilities account for about one in four enrollees.

Medicaid plays an especially critical role for certain populations covering: nearly half of all births in the typical state; 83% of poor children; [48% of children with special health care needs](#) and 45% of nonelderly adults with disabilities (such as physical disabilities, developmental disabilities such as autism, traumatic brain injury, serious mental illness, and Alzheimer’s disease); and more than six in ten nursing home residents. States can opt to provide Medicaid for [children with significant disabilities](#) in higher-income families to fill gaps in private health insurance and limit out-of-pocket financial burden. Medicaid also assists nearly 1 in 5 [Medicare beneficiaries](#) with their Medicare premiums and cost-sharing and provides many of them with benefits not covered by Medicare, especially long-term care (Figure 4).



## 5. Medicaid covers a broad range of health and long-term care services

Medicaid covers a broad range of services to address the diverse needs of the populations it serves (Figure 5). In addition to [covering the services required by federal Medicaid law, many states elect to cover optional services](#) such as prescription drugs, physical therapy, eyeglasses, and dental care. Coverage for Medicaid expansion adults contains the ACA’s ten “essential health benefits” which include preventive services and expanded mental health and substance use treatment services. Medicaid plays an important role in addressing the opioid epidemic and more broadly in connecting Medicaid beneficiaries to behavioral health services. Medicaid provides comprehensive benefits for children, known as Early Periodic Screening Diagnosis and Treatment (EPSDT) services. EPSDT is especially important for children with disabilities because private insurance is often inadequate to meet their needs. Unlike commercial health insurance and Medicare, Medicaid also covers long-term care including both nursing home care and many home and community-based long-term services and supports. [More than half](#) of all Medicaid spending for long-term care is now for services provided in the home or community that enable seniors and people with disabilities to live independently rather than in institutions.

Given that Medicaid and CHIP enrollees have limited ability to pay out-of-pocket costs due to their modest incomes, [federal rules](#) prohibit states from charging premiums in Medicaid for beneficiaries with income less than 150% FPL, prohibit or limit cost sharing for some populations and services, and limit total out-of-pocket costs to no more than 5% of family income. Some states [have obtained waivers](#) to charge higher premiums and cost sharing than allowed under federal rules. Many of these waivers target expansion adults but some also apply to other groups eligible through traditional eligibility pathways.

Figure 5  
**Medicaid’s benefits reflect the needs of the population it serves.**

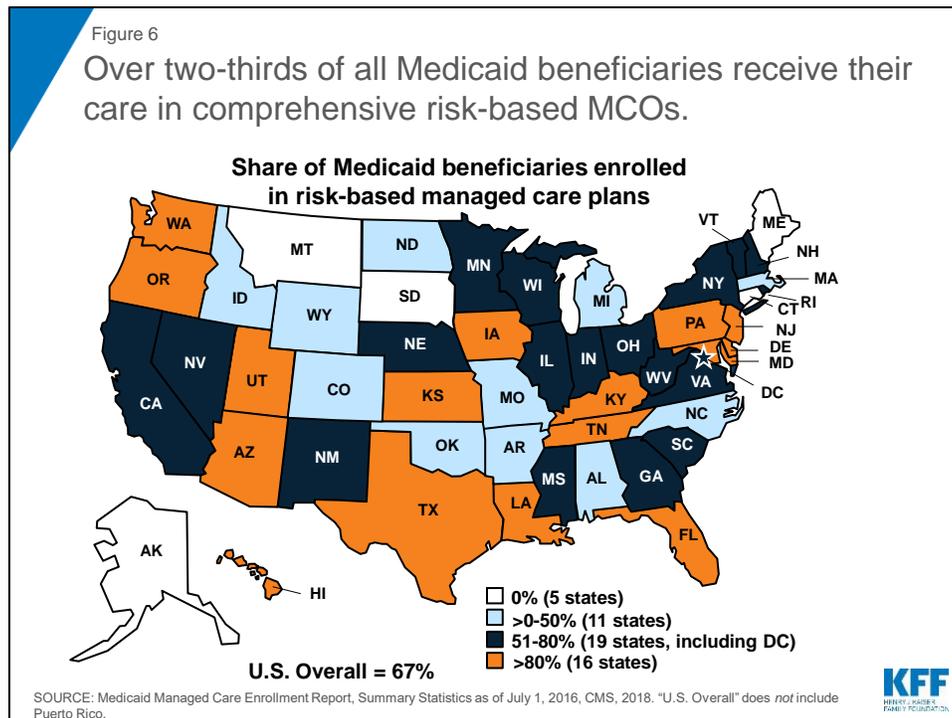
Low-Income Families	<ul style="list-style-type: none"> <li>•Pregnant Women: Pre-natal care and delivery costs</li> <li>•Children: Routine and specialized care for childhood development (immunizations, dental, vision, speech therapy)</li> <li>•Families: Affordable coverage to prepare for the unexpected (emergency dental, hospitalizations, antibiotics)</li> </ul>
Individuals with Disabilities	<ul style="list-style-type: none"> <li>•Child with Autism: In-home therapy, speech/occupational therapy</li> <li>•Cerebral Palsy: Assistance to gain independence (personal care, case management and assistive technology)</li> <li>•HIV/AIDS: Physician services, prescription drugs</li> <li>•Mental Illness: Prescription drugs, physicians services</li> </ul>
Elderly Individuals	<ul style="list-style-type: none"> <li>•Medicare beneficiary: help paying for Medicare premiums and cost sharing</li> <li>•Community Waiver Participant: community based care and personal care</li> <li>•Nursing Home Resident: care paid by Medicaid since Medicare does not cover institutional care</li> </ul>

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## 6. Most Medicaid enrollees get care through private managed care plans

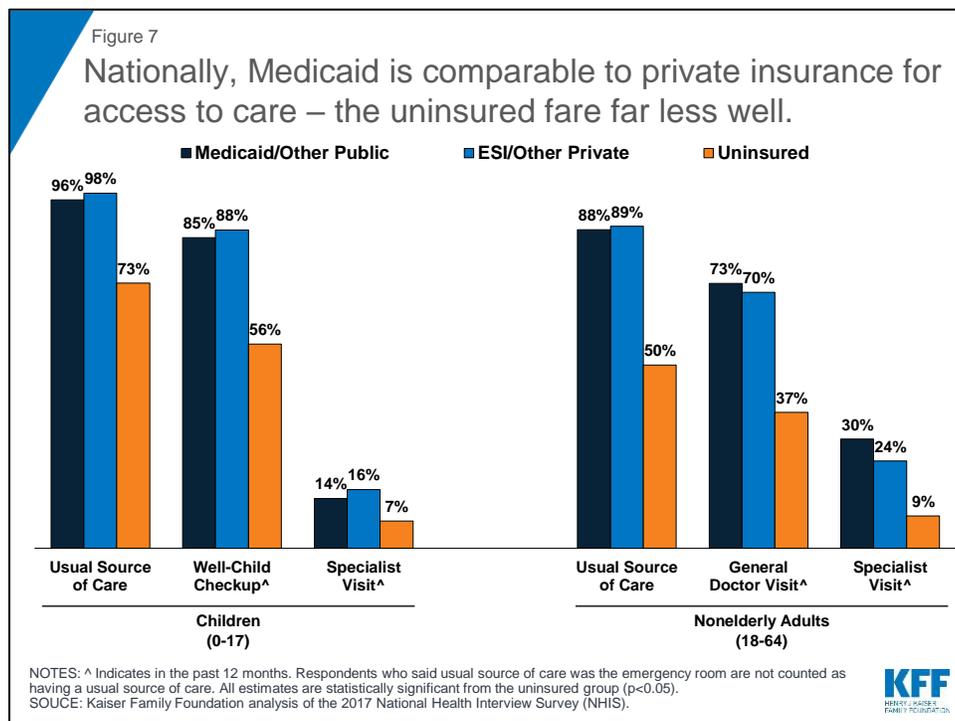
Over two-thirds of Medicaid beneficiaries are enrolled in private managed care plans that contract with states to provide comprehensive services, and others receive their care in the fee-for-service system (Figure 6). Managed care plans are responsible for ensuring access to Medicaid services through their networks of providers and are at financial risk for their costs. In the past, states limited managed care to children and families, but they are increasingly expanding managed care to individuals with complex needs. Close to half the states now cover long-term services and supports through risk-based managed care arrangements. Most states are engaged in a variety of delivery system and payment reforms to control costs and improve quality including implementation of patient-centered medical homes, better integration of physical and behavioral health care, and development of “value-based purchasing” approaches that tie Medicaid provider payments to health outcomes and other performance metrics. Community health centers are a key source of primary care, and safety-net hospitals, including public hospitals and academic medical centers, provide a lot of emergency and inpatient hospital care for Medicaid enrollees.

Medicaid covers a continuum of long-term services and supports ranging from home and community-based services (HCBS) that allow persons to live independently in their own homes or in other community settings to institutional care provided in nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICF-ID). In FY 2016, HCBS represented 57 percent of total Medicaid expenditures on LTSS while institutional LTSS represented 43 percent. This is a dramatic shift from 1995 (two decades earlier) when institutional settings accounted for 82 percent of national Medicaid LTSS expenditures.



## 7. Medicaid facilitates access to care

A large body of research shows that Medicaid beneficiaries have far better access to care than the uninsured and are [less likely to postpone or go without needed care due to cost](#). Moreover, rates of access to care and satisfaction with care among Medicaid enrollees are comparable to rates for people with private insurance (Figure 7). Medicaid coverage of low-income pregnant women and children has contributed to dramatic [declines in infant and child mortality](#) in the U.S. A growing body of research indicates that Medicaid eligibility during childhood is associated with [reduced teen mortality](#), improved [long-run educational attainment](#), [reduced disability](#), and [lower rates of hospitalization and emergency department visits in later life](#). Benefits also include [second-order fiscal effects](#) such as increased tax collections due to higher earnings in adulthood. [Research findings](#) show that state Medicaid expansions to adults are associated with [increased access to care, improved self-reported health, and reduced mortality](#) among adults.



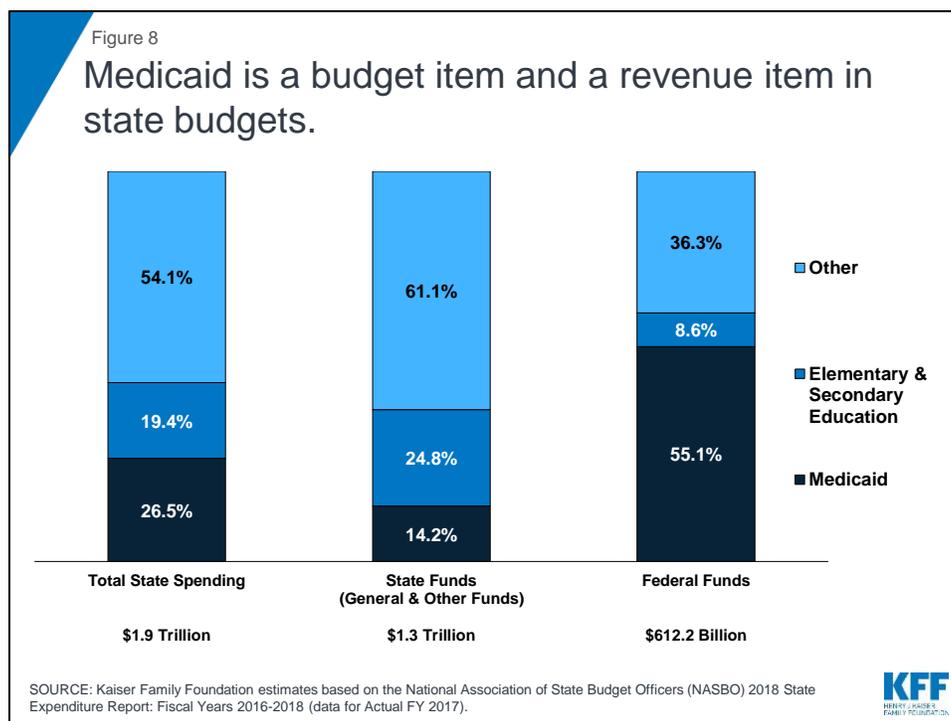
Gaps in access to certain providers, especially [psychiatrists](#), some specialists, and dentists, are ongoing challenges in Medicaid and often in the health system more broadly due to overall provider shortages, and geographic maldistribution of health care providers. However, low Medicaid payment rates have long been associated with lower physician participation in Medicaid, especially among specialists. Managed care plans, which now serve most Medicaid beneficiaries, are responsible under their contracts with states for ensuring adequate provider networks. There is no evidence that physician participation in Medicaid is declining. In a 2015 survey, 4 in 10 primary care providers who accepted Medicaid reported seeing an [increased number of Medicaid patients](#) since January 2014, when the coverage expansions in the ACA took full effect.

Medicaid covers people who are struggling with opioid addiction and enhances state capacity to provide access to early interventions and treatment services. The Medicaid expansion, with enhanced federal funding, has provided states with additional resources to cover many adults with addictions who were previously excluded from the program. [Medicaid covers 4 in 10 nonelderly adults with opioid addiction.](#)

## 8. Medicaid is jointly financed by states and the federal government

Medicaid is [financed jointly](#) by the federal government and states. The federal government matches state Medicaid spending. The federal match rate [varies](#) by state based on a federal formula and ranges from a minimum of 50% to nearly 75% in the poorest state. Under the ACA, the federal match rate for adults newly eligible was 100% for 2014-2016, phasing down gradually to 90% in 2020 and thereafter (93% in 2019). The federal matching structure provides states with resources for coverage of their low-income residents and also permits state Medicaid programs to respond to demographic and economic shifts, changing coverage needs, technological innovations, public health emergencies such as the opioid addiction crisis, and disasters and other events beyond states' control. The guaranteed availability of federal Medicaid matching funds eases budgetary pressures on states during recessionary periods when enrollment rises. Federal matching rates do not automatically adjust to economic shifts but Congress has twice raised them temporarily during downturns to strengthen support for states.

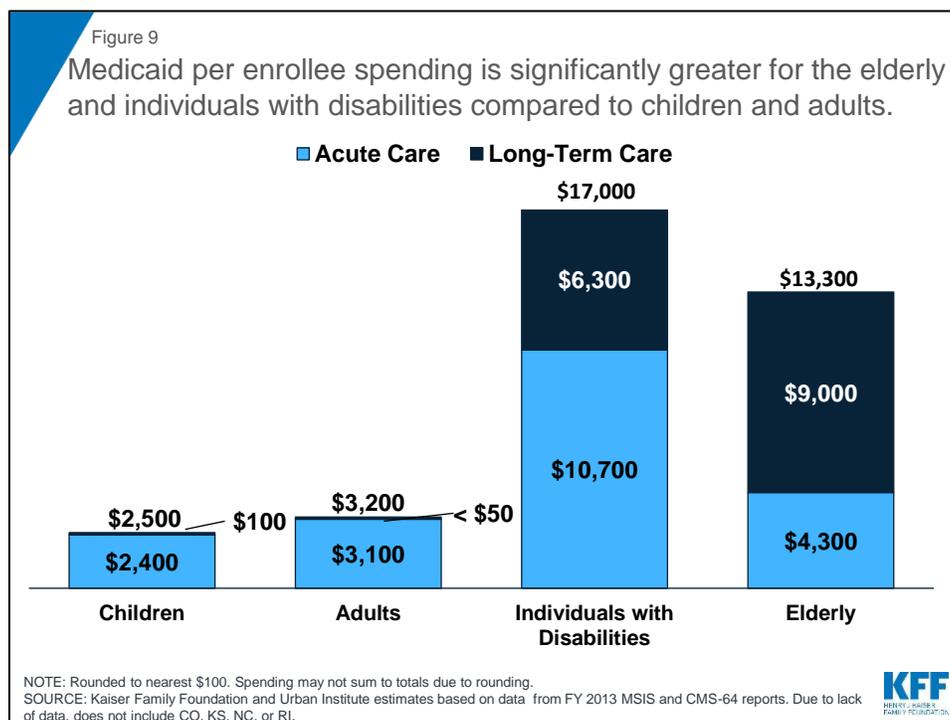
Total federal and state Medicaid spending was [\\$577 billion](#) in FY 2017. Medicaid is the third-largest domestic program in the federal budget, after Social Security and Medicare, accounting for [9.5% of federal spending in FY 2017](#). In 2017, Medicaid was the second-largest item in state budgets, after elementary and secondary education (Figure 8).



Federal Medicaid matching funds are the largest source of federal revenue (55.1%) in state budgets. Accounting for state and federal funds, Medicaid accounts for 26.5% of total state spending. Because Medicaid plays a large role in state budgets, states have an interest in cost containment and program integrity. [Enrollment and spending](#) increased significantly following implementation of the ACA, but have moderated in more recent years. While slower caseload growth helped to [mitigate Medicaid spending growth in FYs 2018 and 2019](#), higher costs for prescription drugs, long-term services and supports and behavioral health services, and policy decisions to implement targeted provider rate increases were cited as factors putting upward pressures on Medicaid spending.

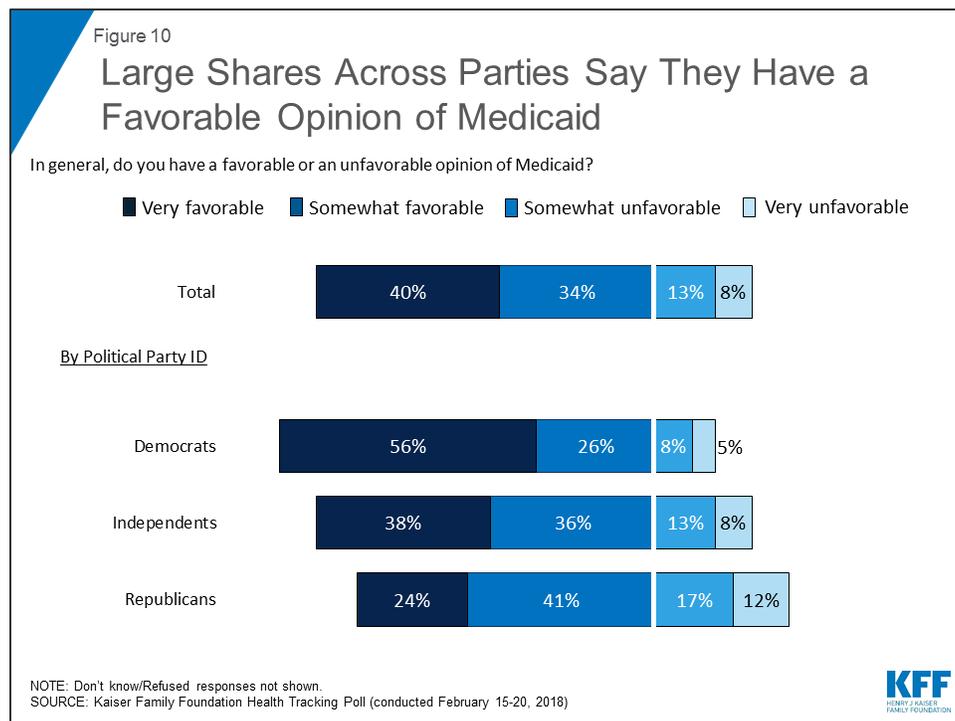
## 9. Medicaid spending is concentrated on the elderly and people with disabilities

Seniors and people with disabilities make up 1 in 4 beneficiaries but account for almost two-thirds of Medicaid spending, reflecting high per enrollee costs for both acute and long-term care (Figure 9). Medicaid is the primary payer for institutional and community-based long-term services and support – as there is limited coverage under Medicare and few affordable options in the private insurance market. Over half of Medicaid spending is attributable to the highest-cost five percent of enrollees. However, on a per-enrollee basis, Medicaid is low-cost compared to private insurance, largely due to lower Medicaid payment rates for providers. [Analysis](#) shows that if adult Medicaid enrollees had job-based coverage instead, their average health care costs would be more than 25% higher. Medicaid spending per enrollee has also been [growing more slowly](#) than private insurance premiums and other health spending benchmarks.



## 10. The majority of the public holds favorable views of Medicaid

[Public opinion polling](#) suggests that Medicaid has broad support. Seven in ten Americans say they have ever had a connection with Medicaid including three in ten who were ever covered themselves. Even across political parties, majorities have a favorable opinion of Medicaid and say that the program is working well (Figure 10). In addition, polling shows that [few Americans want decreases in federal Medicaid funding](#). In addition to broad-based support, Medicaid has very strong support among those who are disproportionately served by Medicaid including [children with special health care needs](#), seniors, and people with disabilities.



## Conclusion

Medicaid provides comprehensive coverage and financial protection for millions of Americans, most of whom are in working families. Despite their low income, Medicaid enrollees experience rates of access to care comparable to those among people with private coverage. In addition to acute health care, Medicaid covers costly long-term care for millions of seniors and people of all ages with disabilities, in both nursing homes and the community. Medicaid bolsters the private insurance market by acting as a high-risk pool providing coverage for many uninsured people who were excluded from the private, largely employment-based health insurance system because of low income, poor health status, or disability. Medicaid also supports Medicare by helping low-income Medicare beneficiaries pay for premiums and cost-sharing and providing long-term services and supports that are not covered by Medicare.

Accounting for one-fifth of health care spending, Medicaid funding is a major source of support for hospitals and physicians, nursing homes, and jobs in the health care sector. The guarantee of federal matching funds on an open-ended basis allows states the flexibility to use Medicaid to address health priorities such as addressing the opioid epidemic. The financing structure also provides support for states to allow Medicaid to operate as safety net when economic shifts and other dynamics cause coverage needs to grow.

As Medicaid plays a large role in both federal and state budgets and is the primary source of coverage for low-income Americans, it is a constant source of debate. Efforts to repeal and replace the ACA also included fundamental reforms to Medicaid to cap federal financing through a block grant or per capita cap. Such proposals were narrowly defeated in 2017. Important Medicaid issues to [watch in 2019](#) include Medicaid expansion developments and continued focus on changing the program through Medicaid demonstration waiver activities, including those focused on work requirements and other eligibility restrictions as well as potential waivers to reshape Medicaid financing. In addition, other areas in Medicaid to watch are reforms in benefits, payment and delivery systems, efforts to address social determinants of health, efforts to control prescription drug costs, and expand capacity to address the opioid epidemic and provide community based long-term care services. Congress and states could also consider broader health reform that could expand the role of public programs in health care including Medicare for All or Medicaid buy-in programs that could have significant implications for Medicaid.