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

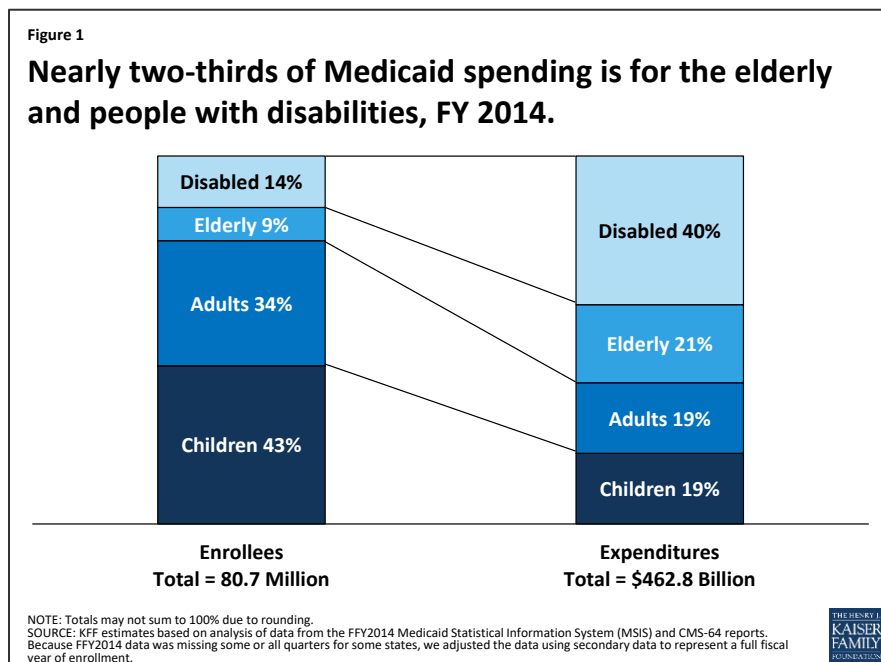
Julia Paradise

Medicaid, the nation’s public health insurance program for low-income children, adults, seniors, and people with disabilities, covers 1 in 5 Americans, including many with complex and costly needs for medical care and long-term services. Most people covered by Medicaid would be uninsured or underinsured without it. The Affordable Care Act (ACA) expanded Medicaid to reach low-income adults previously excluded from the program and provided federal funding to states for the vast majority of the cost of newly eligible adults.

President Trump and other GOP leaders have called for far-reaching changes to Medicaid, including caps on federal funding for the program. In the debate about Medicaid’s future, some critics of the program have made statements that are at odds with data, research, and basic information about Medicaid. To inform policy decisions that may have significant implications for Medicaid, the low-income people it serves, and the states, this brief highlights 10 key Medicaid facts.

## 1. Medicaid is a cost-effective program, providing health coverage for low-income Americans at a lower per-person cost than private insurance could.

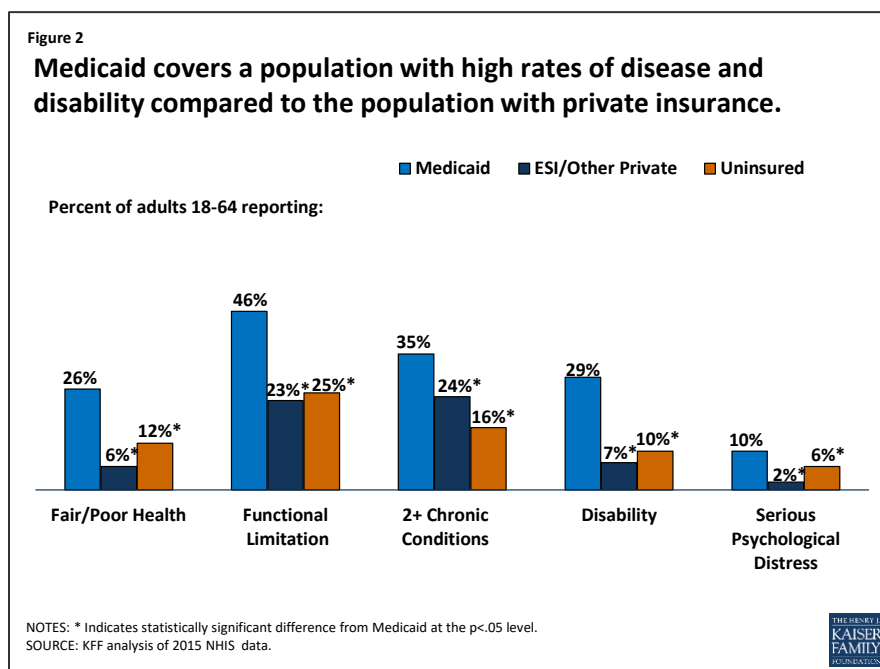
Some say that Medicaid costs too much. Total Medicaid costs are high because Medicaid covers many people with complex needs for both health care and long-term care. Most Medicaid spending is for seniors and people with disabilities (Figure 1). Analysis shows that when the greater health needs of Medicaid enrollees are



adjusted, [costs per enrollee are lower in Medicaid](#) relative to private insurance; spending per enrollee would be 25% higher if adult Medicaid beneficiaries were instead covered by employer-based insurance, largely because private insurers generally pay providers more than states do. [Growth in Medicaid acute care spending per enrollee has also been low](#) relative to other health spending benchmarks, and federal data show that [Medicaid has constrained per capita spending growth more than Medicare and private insurance](#). States have strong financial incentives to manage Medicaid closely and ensure program integrity because they must pay a large share of Medicaid costs and must also balance their budgets. The [ACA provided increased funding and new tools for both federal and state Medicaid program integrity efforts](#), and [states continue to strengthen their operations](#), using data analytics and predictive modeling, expanding their program integrity activities to managed care, and making other investments.

## 2. Medicaid bolsters the private insurance market by acting as a high-risk pool.

Some say that private insurance could do a better job of covering low-income people than Medicaid. Actually, Medicaid was established to provide health 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. Over time, federal and state 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. Nearly 8 in 10 nonelderly, non-disabled adults are in [working families](#) and a majority are working themselves, but many work in small firms and types of industries that tend to have limited or no job-based coverage options. Among adult Medicaid enrollees who are not working, illness or disability is the main reason. By covering many of the poorest and sickest Americans, Medicaid effectively serves as a high-risk pool for the private health insurance market, taking out the highest-cost people, thereby helping to keep private insurance premiums more affordable (Figure 2).

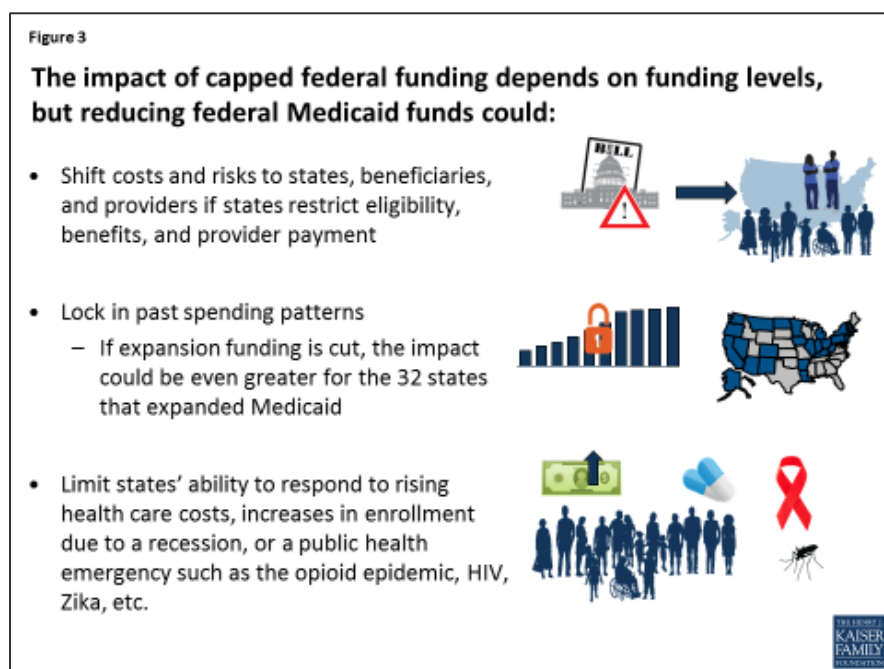


Medicaid also bolsters the private insurance system by providing supplemental coverage for many privately insured [children with special needs](#) and children and [adults with disabilities](#). Medicaid pays for therapies, dental and vision care, and other medical and long-term services and supports needed by many of these individuals but typically not covered by private insurance.

### 3. Federal Medicaid matching funds support states' ability to meet changing coverage needs, such as during economic downturns and public health emergencies.

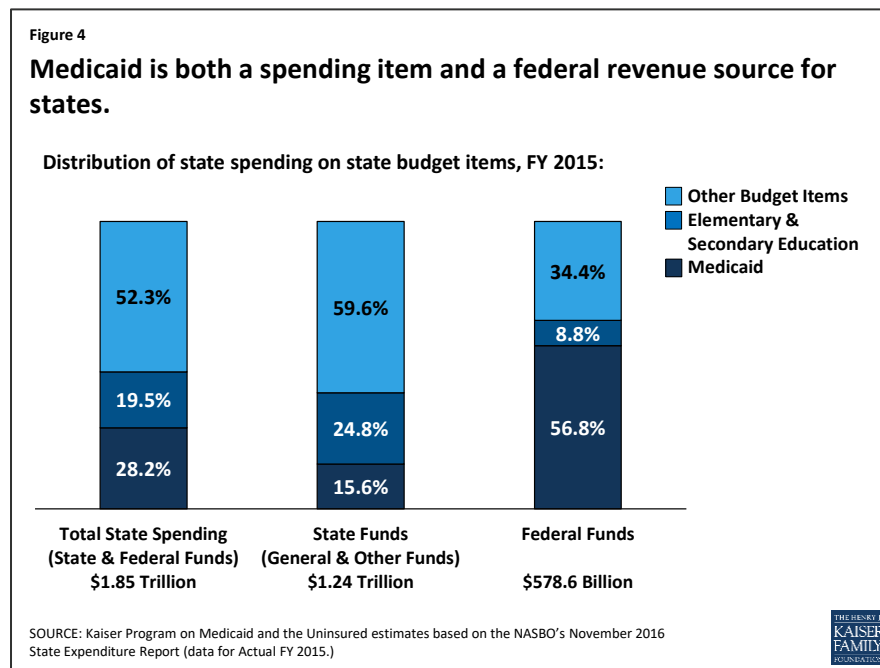
Some argue that federal funding for Medicaid should be capped to remove states' incentives to spend more. The availability of federal matching funds with no pre-set limit does not mean that states have no incentives to constrain spending. On the contrary, because they must spend their own dollars to claim federal matching payments, and are required by their constitutions to balance their budgets, states have a strong interest in running efficient and effective programs. State cost-cutting measures taken in hard economic times have led to lean Medicaid operations, and state Medicaid programs have been leaders in health care delivery and payment reform designed to control costs and improve care. Over 2007-2013, average annual [growth in Medicaid spending per enrollee was less than growth in private health insurance premiums – 3.1% compared to 4.6%](#).

The [guarantee of federal matching funds](#) at least dollar for dollar [enlarges states' financial capacity to respond to changing coverage needs](#). Because federal funds flow to states based on actual needs and costs, Medicaid can respond if there is an economic downturn, or medical costs rise, or there is a public health emergency such as the opioid epidemic or a natural disaster such as Hurricane Katrina. Federal payments to states adjust automatically to reflect the increased costs of the program. Capped federal funding for Medicaid would reduce federal spending, but the burden of the reductions would fall on states. The levers that states have to manage with reduced federal Medicaid funding are cuts in Medicaid eligibility and benefits, which could limit their ability to meet the health needs of their residents, respond to recessionary pressures and emerging health issues, and provide access to new but costly health care technologies, including life-saving drugs, to Medicaid beneficiaries. Federal caps would also lock in states' historical spending patterns, constraining their flexibility to respond to changing resources and priorities (Figure 3).



#### 4. Medicaid is a major spending item in state budgets, but also the largest source of federal funds for states.

Some say that Medicaid is crowding out state spending on education and other state priorities. [Medicaid is a major item in state budgets, but it is also the single largest source of federal funds for states.](#) In FY 2015, Medicaid accounted for more than half (57%) of all federal funds states received. The federal government matches state Medicaid spending at least dollar for dollar and pays more in poorer states, and states receive an enhanced federal match – 95% in 2017 – for Medicaid expansion adults. In FY 2015, Medicaid accounted for 28% of total state spending (i.e., including state spending of federal dollars), but less than 16% of state spending of state funds – a distant second to state funds spending on K-12 education (almost 25%) (Figure 4).

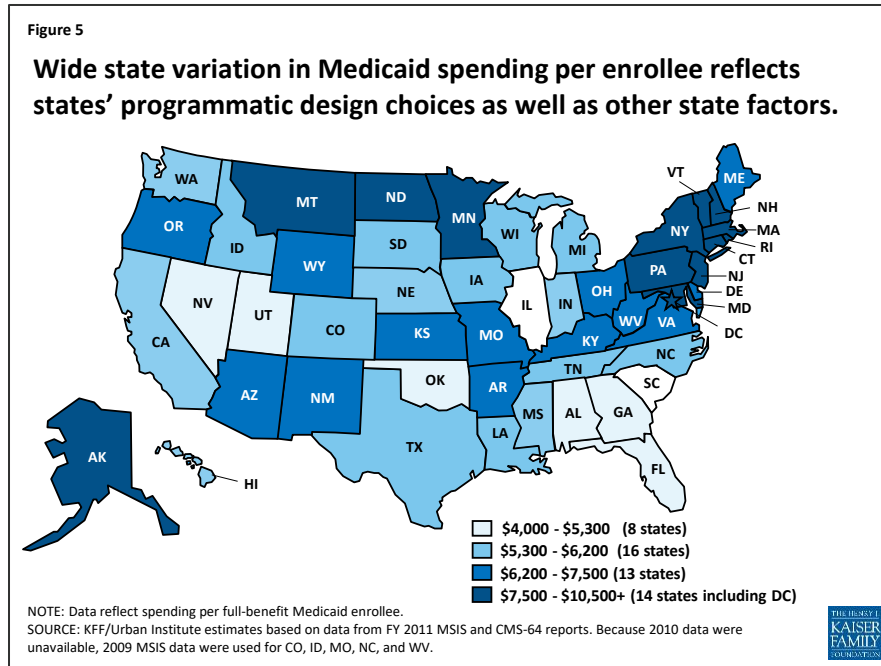


An analysis examining economic and fiscal trends in Medicaid expansion and non-expansion states found that Medicaid expansion states, which typically raise more tax revenues as a share of total taxable resources than non-expansion states, [spend more per capita on both Medicaid and K-12 education.](#) Research shows that the [injection of federal Medicaid matching funds into state economies has a multiplier effect,](#) directly benefiting the health care providers that serve Medicaid beneficiaries, and also indirectly supporting other businesses and industries (e.g., vendors), producing increased state economic activity and output as the funds flow through the system. More recent analyses find [positive effects of the Medicaid expansion](#) on multiple economic outcomes in states, including budget savings, revenue gains, and overall economic growth.

#### 5. States have broad discretion in designing key aspects of their Medicaid programs.

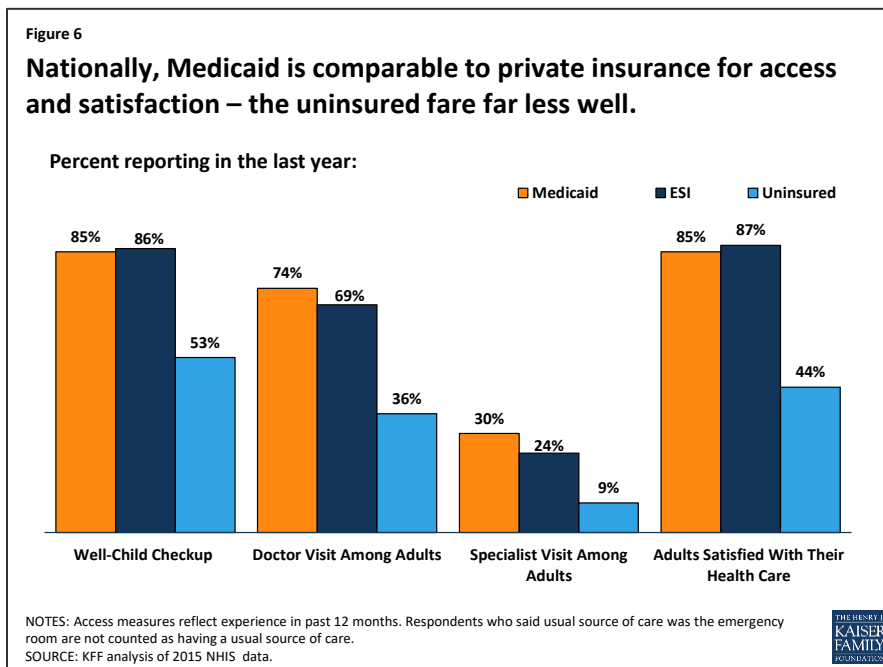
Some say that Medicaid is federally controlled and inflexible, leaving states little room to shape their own programs. In fact, beyond federal minimum requirements for Medicaid, states have and use extensive [flexibility and options](#) to design key dimensions of their Medicaid programs. For example, they can and do elect to cover many [optional services and optional groups.](#) State Medicaid programs vary widely in terms of who is eligible, which services are covered, premiums and cost-sharing requirements, the delivery systems in which beneficiaries get care, and provider payment methods and rates. The different program design choices that states make, reflecting their particular needs, preferences, and priorities, are a large underlying factor in the

wide variation in state Medicaid spending per enrollees (Figure 5). In 2011, Medicaid spending per full-benefit enrollee ranged from \$4,010 in Nevada to \$11,091 in Massachusetts. In addition to the flexibilities and optional state authorities provided by federal Medicaid law, states can obtain Section 1115 demonstration waivers that permit them to test and implement approaches that deviate from federal Medicaid rules if the HHS Secretary determines they advance program objectives. As of January 2017, 37 states had a total of 50 approved Section 1115 waivers.



## 6. Medicaid beneficiaries have robust access to care overall, although access to certain types of specialists is an ongoing challenge for Medicaid and all payers.

Some say that access to care in Medicaid is lacking because 30% of physicians do not accept new Medicaid patients ([about 70% do accept new Medicaid patients](#) versus about 85% who accept new privately insured and Medicare patients). Taken alone, [physician participation rates are a weak measure of access to care](#). A large body of research shows that Medicaid beneficiaries have far better access to care than the uninsured and are [far 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 6). 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. Contributing factors include provider shortages, geographic maldistribution of health care providers, low Medicaid payment rates, and lack of transportation. 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 PCPs who accepted Medicaid reported seeing an [increased number of Medicaid patients](#) since January 2014, when the coverage expansions in the ACA took full effect. [A recent analysis](#) found no consistent evidence that increases in the share of adults with insurance at the local-area level affected access to care for adults in those areas who were already insured, including Medicaid beneficiaries.

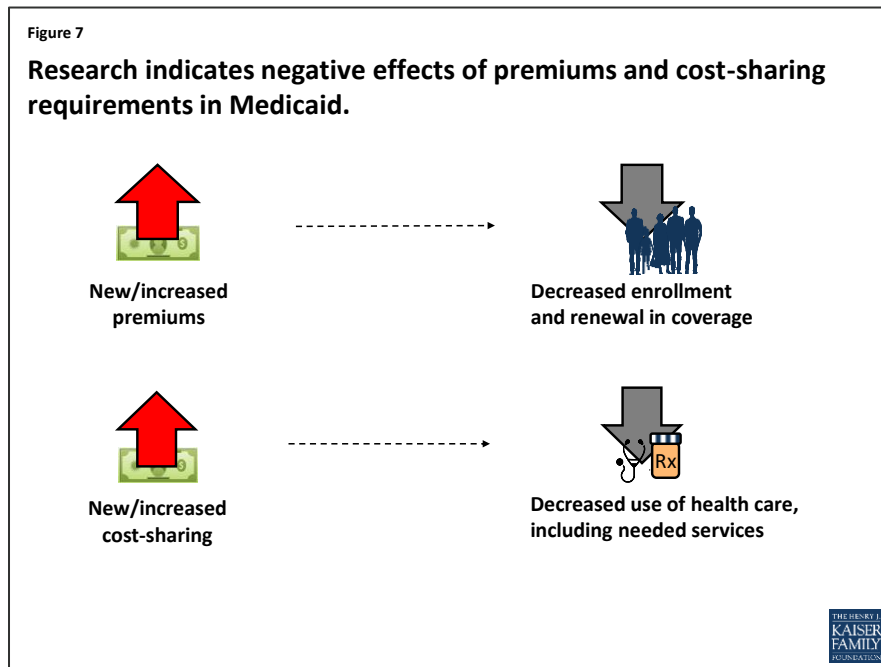


## 7. Medicaid keeps coverage and care affordable for low-income Americans.

Some say that Medicaid enrollees should pay more for their health care and have more “skin in the game” to restrain utilization. Federal law limits Medicaid premiums and cost-sharing to minimize financial barriers to coverage and care for low-income people: total out-of-pocket costs for a family are limited to 5% of the family’s income. [Research](#) shows that average spending greatly exceeds average income in low-income households, suggesting that these households accrue debt even as they earn. Therefore, [even small amounts of spending on health care can crowd out other necessities or push low-income families further into debt](#). A family of three living at 138% FPL (the eligibility threshold for adults in Medicaid expansion states) has income of \$28,180. Out-of-pocket costs totaling just 3% of their income – about \$845 – would leave this family with less than \$27,500 to pay for housing, utilities, food, clothing, transportation, school supplies, and other necessities. The same family living in one of the [non-expansion states, where the median eligibility limit for parents is 44% FPL](#), would be left with about \$8,700 to meet these basic costs.

[Numerous studies](#) have shown significant declines in enrollment in coverage after the implementation of new or higher premiums, as well as shorter spells of enrollment and reduced rates of renewal (Figure 7). Many who lose coverage become uninsured. Cost-sharing has been shown to lead to significant reductions in use of services, including essential and effective services like screenings and preventive care, prescription drugs, inpatient care, and other care key to health outcomes. Cost-sharing can have a particularly large impact on [people with lower income and significant health care needs](#), as small copays add up quickly. Medicaid providers frequently report difficulty collecting cost-sharing, which effectively reduces their reimbursement; states do not collect much revenue from premiums, and state [savings are largely attributable to decreased enrollment and reduced use of services – often, needed services](#). The [Oregon Health Insurance Experiment \(OHIE\)](#) showed that gaining Medicaid virtually eliminated catastrophic out-of-pocket medical spending among previously uninsured adults and reduced financial hardship. Federal action to reduce financial protections in Medicaid would run counter to the empirical evidence that premiums and cost-sharing impede coverage and access to care, and preempt waiver initiatives underway in numerous states to further test these policies.



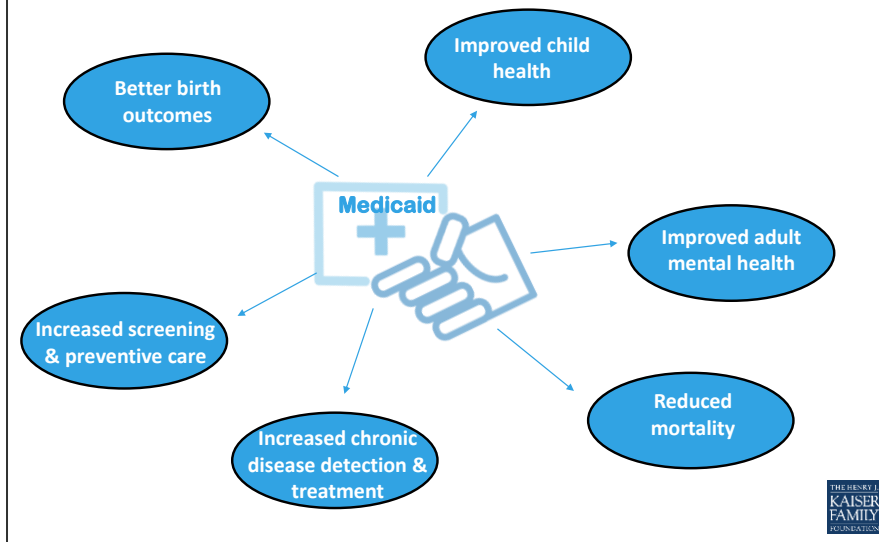


## 8. Evidence of Medicaid’s impact on health outcomes is growing.

Some say that having Medicaid is worse than being uninsured. In fact, [research shows consistently that Medicaid improves access to care](#) for both children and adults with low income. Access to screening and preventive care in Medicaid translates into well-child care, earlier detection of health and developmental problems in children, and earlier diagnosis of cancer, diabetes, mental illness, and other chronic conditions in people of all ages. Access to primary care providers and specialists, prescription drugs, and other services improves the likelihood that Medicaid enrollees will get treatment for both their acute and chronic conditions. Expansions of Medicaid pregnant women and children have led to [improved birth outcomes and child health](#), and there is [growing evidence](#) that Medicaid expansions to adults are associated with increased use of screening services and preventive care, prescription drugs, inpatient care, and other services key to improving health outcomes (Figure 8). The [OHIE](#), which used a uniquely rigorous study design, found that uninsured adults who gained Medicaid coverage through a state lottery reported improved self-rated mental health and had a 30% reduction in clinically observed rates of depression relative to the comparison group of adults who remained uninsured. Medicaid also increased diabetes detection and use of diabetes medication, though the effect on control of diabetes, hypertension, and high cholesterol was not statistically significant. Research has also found that Medicaid expansions for adults were associated with [significant reductions in mortality](#). A [new study](#) shows meaningful impacts of the Medicaid expansion on mental health for low-income parents. Some Medicaid critics, citing a small sample of observational clinical studies, have asserted that Medicaid beneficiaries have worse outcomes than the uninsured. However, a group of [distinguished health services researchers commenting in a leading medical journal](#) wrote that these studies lack a causal model explaining the observed data and, outlining numerous analytic problems with the critics’ interpretation of the findings, effectively discredited their argument.

Figure 8

### Evidence of Medicaid's impacts on health outcomes is growing.

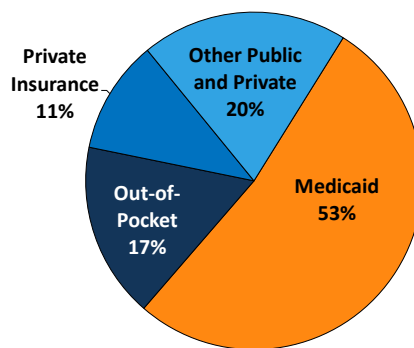


### 9. Medicaid is the primary payer for long-term care for seniors and people with disabilities.

Some assume that Medicare, the federal health insurance program for seniors and people with disabilities, covers long-term care. In fact, Medicare coverage of long-term care is extremely limited. Medicaid is essentially the only public or private insurance program that covers long-term care. Six in 10 nursing home residents are covered by Medicaid, and Medicaid's role in providing access to community-based long-term services and supports (LTSS) for both seniors and people with disabilities is hard to overstate. The program is the largest single source of payment for long-term care, financing half of total spending in this sector, including both nursing home care and home and community-based services (HCBS) (Figure 9). Over time, states have been working to rebalance their LTSS systems by devoting a greater percentage of their long-term care spending to HCBS relative to nursing home care, and Medicaid has been instrumental in expanding access to community-based LTSS, advancing efforts to increase community integration of seniors and individuals with disabilities.

Figure 9

### Medicaid is the primary payer for long-term services and supports(LTSS), 2015.



Total National LTSS Spending = \$331.2 billion

NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care (\$77.7 billion in 2015). All home and community-based waiver services are attributed to Medicaid.

SOURCE: KFF estimates based on 2015 National Health Expenditure Accounts data from CMS, Office of the Actuary.





In addition to covering LTSS, [Medicaid also makes Medicare work for nearly 10 million poor Medicare beneficiaries](#) (1 in 5 of all Medicare beneficiaries), known as “dual eligibles,” by helping with their Medicare premiums and out-of-pocket costs and covering vision and dental care and other benefits that Medicare does not cover. In the debate about the ACA Medicaid expansion to low-income adults, some have argued that state choices to adopt the expansion come at the cost of Medicaid’s neediest beneficiaries, but the research does not bear this out. A [recent study found no evidence for the](#) claim that Medicaid expansion leads to longer waiting lists for Medicaid HCBS waivers for seniors and people with disabilities. The study found that waiting lists for these waivers pre-date the ACA Medicaid expansion, and that there appears to be no relationship between a state’s Medicaid expansion status and changes in its HCBS waiver waiting list.

## 10. Medicaid is popular with the American public as well as with enrollees themselves.

Some say that Medicaid is a poor and broken program. The majority of Americans say that Medicaid is a very important program. [More than half \(56%\)](#) report that they, a child of theirs, or another family member or friend has been enrolled in Medicaid; the same percentage say that Medicaid is important for them and their family (Figure 10). Most Medicaid enrollees say the program is working well for the low-income people it covers and the vast majority feel well-protected financially. Focus group research has shown [high levels of satisfaction](#) with Medicaid among parents with children in the program. [Two-thirds of Americans do not support caps on federal funding for Medicaid](#), the vast majority (84%) say that continuing federal funding for Medicaid expansion is important, and few (12%) want decreased federal spending on Medicaid.

