Policy Basics

Introduction to Medicaid

Created in 1965, Medicaid is a public insurance program that provides health coverage to low-income families and individuals, including children, parents, pregnant women, seniors, and people with disabilities; it is funded jointly by the federal government and the states. Each state operates its own Medicaid program within federal guidelines. Because the federal guidelines are broad, states have a great deal of flexibility in designing and administering their programs. As a result, Medicaid eligibility and benefits can and often do vary widely from state to state.

Why is Medicaid Important?

In 2015, Medicaid provided health coverage for 97 million low-income Americans over the course of the year. In any given month, Medicaid served 33 million children, 27 million adults (mostly in low-income working families), 6 million seniors, and 10 million persons with disabilities, according to Congressional Budget Office (CBO) estimates.

Children account for more than two-fifths of Medicaid enrollees but less than one-fifth of Medicaid spending. Only slightly more than one-fifth of Medicaid enrollees are seniors or persons with disabilities, but because they need more (and more costly) health care services, they account for nearly half of Medicaid spending.

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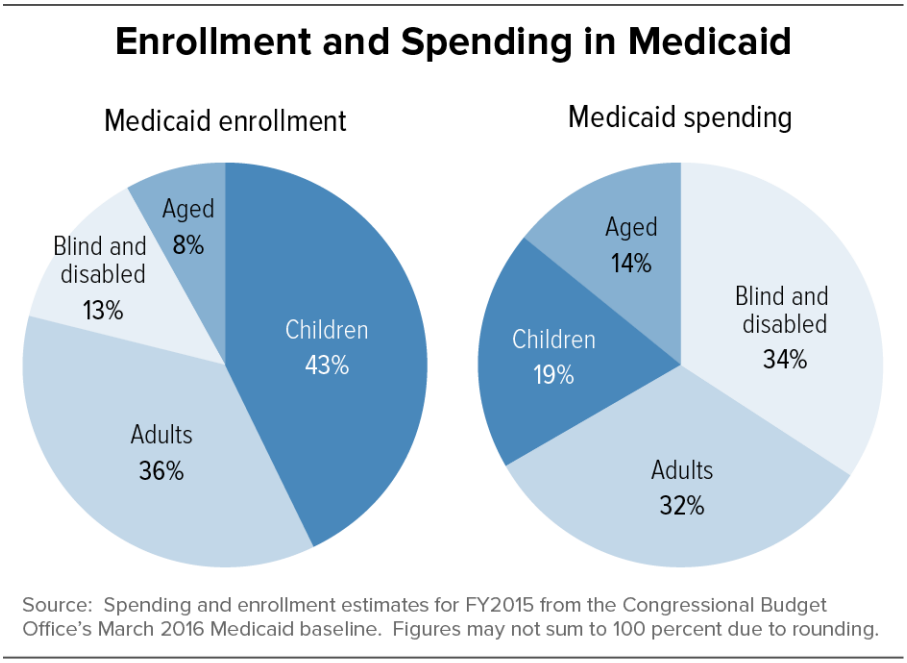
Health reform has changed some aspects of Medicaid eligibility, coverage, and financing. Namely, states now have the option to expand Medicaid eligibility to near-poor non-disabled adults without children. For more details, see “How Has Health Reform Affected Medicaid?” below.

Medicaid is sometimes confused with Medicare, the federally administered, federally funded health insurance program for people over 65 and some people with disabilities. Unlike Medicaid, Medicare is not limited to those with low incomes and resources. Nearly 10 million low-income seniors and people with disabilities — so-called “dual eligibles” — are enrolled in both Medicare and Medicaid.



Who Is Eligible for Medicaid?

Medicaid is an "entitlement" program, which means that anyone who meets eligibility rules has a right to enroll in Medicaid coverage. It also means that states have guaranteed federal financial support for part of the cost of their Medicaid programs.

In order to receive federal funding, states must cover certain "mandatory" populations:

- children through age 18 in families with income below 138 percent of the federal poverty line ($25,975 for a family of three in 2013);
- pregnant women with income below 138 percent of the poverty line;
- parents whose income is within the state's eligibility limit for cash assistance that was in place prior to welfare reform; and
- most seniors and persons with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

States may also receive federal Medicaid funds to cover "optional" populations, including: pregnant women, children, and parents with income above "mandatory" coverage income limits; seniors and persons with disabilities with income below the poverty line; "medically needy" people (those whose income exceeds the state's regular Medicaid eligibility limit but who have high medical expenses, such as for nursing home care, that reduce their disposable income below the eligibility limit); and newly under health reform, near-poor non-disabled adults without children. Because states have broad flexibility to determine which of these

groups to cover and at what income levels, Medicaid eligibility varies significantly from state to state. While 31 states and the District of Columbia have expanded Medicaid under health reform to parents and childless adults up to 138 percent of the poverty line, eligibility levels remain low in the remaining states. In the typical non-expansion state, Medicaid is limited to working parents with incomes up to 44 percent of the poverty line.

Not all low-income Americans are eligible for Medicaid. Childless adults over 21 who are not disabled, pregnant, or elderly are generally ineligible for Medicaid in the 19 non-expansion states, no matter how poor they are. In addition, except for legal immigrant children and pregnant women in states that have elected to cover them, legal immigrants are barred from Medicaid for their first five years in this country, even if they meet all of the program's eligibility requirements.

What Services Does Medicaid Cover?

Medicaid does not provide health care directly. Instead, it pays hospitals, doctors, nursing homes, managed care plans, and other health care providers for covered services that they deliver to eligible patients. (Health care providers are not required to participate in Medicaid, and not all do.)

About three-quarters of all Medicaid spending on services pays for acute-care services such as hospital care, physician services, and prescription drugs; the rest pays for nursing home and other long-term care services and supports. Medicaid covers more than 60 percent of all nursing home residents and 40 percent of costs for long-term care services and supports.

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Medicaid also reimburses certain hospitals for the uncompensated costs they incur when they care for low-income uninsured patients. These payments, known as Disproportionate Share Hospital payments, account for about 3 percent of Medicaid services spending. (These figures on services spending are separate from administrative costs, which equal roughly 5 percent of total Medicaid spending.)

Medicaid is a counter-cyclical program: its enrollment expands to meet rising needs during an economic downturn, when people lose their jobs and job-based health coverage. During the last recession and its aftermath, more than 10 million additional people enrolled in Medicaid; more than half were children.

Federal rules require state Medicaid programs to cover certain "mandatory" services, such as: physician, midwife, and certified nurse practitioner services; inpatient and outpatient hospital services; laboratory and x-ray services; family planning services and supplies; rural health clinic/federally qualified health center services; nursing facility and home health care for adults over age 21; and Early and Periodic Screening,

Diagnostic, and Treatment (EPSDT) services for children under age 21. EPSDT guarantees that enrollees under age 21 have access to medically necessary services, regardless of whether the state's Medicaid program otherwise covers these services.

States can — and all do — cover certain additional services as well. Common examples include prescription drugs, dental care, vision services, hearing aids, and personal care services for frail seniors and people with disabilities. These services, though considered "optional" because states are not required to provide them, are critical to meeting the health needs of Medicaid beneficiaries.

States have flexibility to determine the amount, duration, and scope of the services they provide under Medicaid (though the services must be sufficient to achieve the program's goals). For example, states must cover hospital and physician services, but they can limit the number of hospital days or physician visits they pay for. As a result of this flexibility, Medicaid benefits packages vary substantially from state to state.

How Much Does Medicaid Cost? How Is It Financed?

Together, states and the federal government spent about $476 billion on Medicaid services in fiscal year 2014. State policies have a substantial impact on the amount the federal government spends on Medicaid, not only because states are guaranteed federal Medicaid matching funds for the costs of covered services furnished to eligible individuals, but also because states have broad discretion to determine who is eligible, what services they will cover, and what they will pay for covered services.

The federal government contributes at least $1 in matching funds for every $1 a state spends on Medicaid. The fixed percentage the federal government pays, known as the "FMAP," varies by state, with poorer states receiving larger amounts for each dollar they spend than wealthier states. In the poorest states, the federal government pays 73 percent of Medicaid service costs; the national average is between 57 and 60 percent.

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Medicaid is a lean program. It costs Medicaid substantially less than private insurance to cover people of similar health status. This is due primarily to Medicaid's lower payment rates to providers and lower administrative costs. And over the past decade, costs per beneficiary grew much more slowly for Medicaid than for employer-sponsored insurance. The Office of the Actuary at the Centers for Medicare and Medicaid Services projects that Medicaid spending per beneficiary will grow no more rapidly through 2025 than spending per beneficiary with private insurance.

Moreover, with Medicaid costs projected to rise more slowly than CBO estimated in 2010, CBO in 2013 lowered its estimate of projected federal Medicaid spending between 2011 and 2020 by $385 billion.

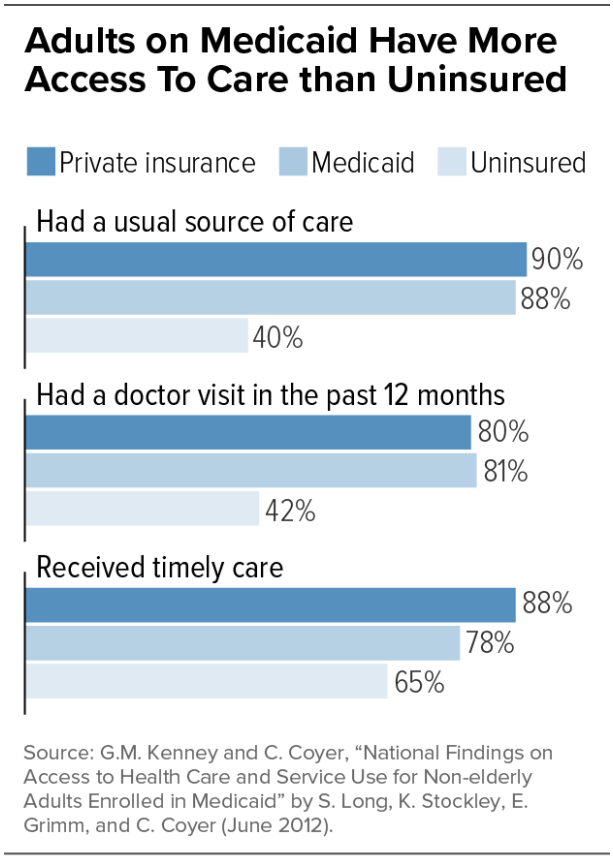
(That figure excludes the effects of the 2012 Supreme Court decision making health reform's Medicaid expansion optional for states.)

How Effective Is Medicaid?

Medicaid has greatly reduced the number of Americans without health insurance. Since health reform's major coverage expansions took effect in 2014, Medicaid has helped to reduce the number of uninsured from 45 million to 29 million. If Medicaid did not exist, most of the tens of millions of Americans whose coverage comes solely through Medicaid would become uninsured. This is because private health insurance is generally not an option for Medicaid beneficiaries: many low-income workers do not have access to coverage through their jobs and cannot afford to purchase coverage in the individual insurance market.

Medicaid coverage provides low-income Americans with access to needed preventive services and medical care. For example, studies show that Medicaid helps patients with chronic diseases such as heart disease, diabetes, and asthma receive medical care that can prevent their conditions from worsening. People who have lost Medicaid coverage are two to three times more likely than Medicaid beneficiaries to report going without medical care because they cannot afford it.

Numerous studies show that Medicaid has helped make millions of Americans healthier by improving access to preventive and primary care and by protecting against (and providing care for) serious diseases (see chart). For example, expansions of Medicaid eligibility for low-income children in the late 1980s and early 1990s led to a 5.1 percent reduction in childhood deaths. Also, expansions of Medicaid coverage for low-income pregnant women led to an 8.5 percent reduction in infant mortality and a 7.8 percent reduction in the incidence of low birth weight.



Notably, a landmark study of Oregon's Medicaid program found that, compared to similar people without coverage, people with Medicaid were more likely to use preventive care, to have a regular office or clinic where they could receive primary care, and to receive diagnosis of and treatment for depression and diabetes. They also were far less likely to experience catastrophic out-of-pocket medical expenses.

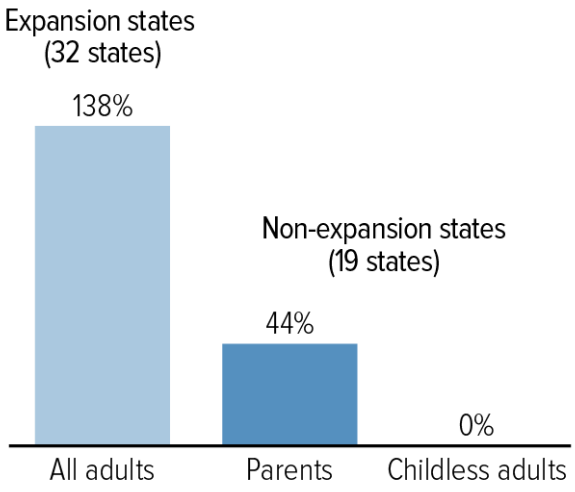
Moreover, Medicaid provides long-term benefits. Children who are eligible for Medicaid do better in school and miss fewer school days due to illness or injury, research shows. They are also more likely to finish high school, attend college, and graduate from college; they earn more as adults; and they experience fewer emergency room visits and hospitalizations.

How Has Health Reform Affected Medicaid?

Medicaid plays an even more important role in insuring low-income Americans under health reform. As noted, the Affordable Care Act (ACA) provides coverage for poor and low-income adults by expanding Medicaid to 138 percent of the poverty line ($26,951 for a family of three). The 2012 Supreme Court decision upholding health reform gave states the choice of whether to expand their programs. As of July 2016, 31 states and the District of Columbia have expanded Medicaid to serve poor and low-income adults.

Medicaid Eligibility for Adults Lagging in Non-Expansion States

Income eligibility threshold in typical state, as share of poverty line



Note. 30 states and the District of Columbia had expanded Medicaid coverage under health reform as of January 2016 when the Kaiser Family Foundation comprehensively evaluated states' Medicaid income-eligibility standards. Since then, Louisiana also has expanded Medicaid coverage and is included among the expansion state group for the purposes of this calculation.

Source. Kaiser Family Foundation and Georgetown Center for Children and Families. Thresholds as of January 2016 with update for Louisiana.

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The expansion is a very good financial deal for states. After picking up all expansion costs for the first three years, the federal government will pay no less than 90 percent of expansion costs on a permanent basis. And by greatly reducing the number of uninsured, the expansion will save states and localities substantial sums on uncompensated care for the uninsured. States will spend just 1.6 percent more on Medicaid with the expansion than they would have without health reform.

By 2026, 15 million more low-income adults will have enrolled in Medicaid and gained access to affordable, comprehensive health coverage due to health reform, CBO estimates.

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