

March 2013

THE MEDICAID PROGRAM AT A GLANCE

Medicaid, the nation's main public health insurance program for low-income people, covers over 62 million Americans, or 1 in every 5 (Figure 1). Medicaid beneficiaries include pregnant women, children and families, individuals with disabilities, and poor Medicare beneficiaries. Without Medicaid, most enrollees would be uninsured or lack coverage for services they need. As a major insurer, Medicaid provides essential funding to safety-net hospitals and health centers that provide care to underserved communities and many of the uninsured. In addition, Medicaid is the main source of coverage and financing for long-term care, including both nursing home and community-based long-term services and supports. Altogether, Medicaid finances 16% of all personal health spending.

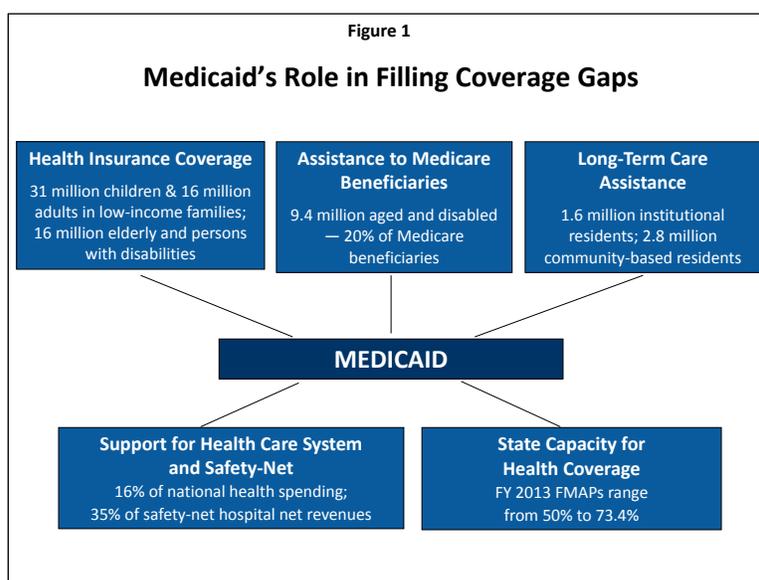
The Medicaid program is administered by states within broad federal rules and is financed jointly by states and the federal government. Medicaid's structure – extensive state flexibility in program design and guaranteed federal matching funds – have enabled the program to evolve, and to respond to economic and demographic changes and emergent needs. Its structure also facilitates state innovation.

Under the Affordable Care Act (ACA), Medicaid will expand in 2014 to reach millions more poor Americans – mostly, uninsured adults. The Medicaid expansion is the foundation of the public-private system of coverage the ACA establishes to reach nearly all the uninsured. However, under the Supreme Court decision on the health reform law, each state will decide whether to implement the Medicaid expansion.

Who does Medicaid cover?

To qualify for Medicaid today, an individual must belong to one of the core eligibility groups under federal Medicaid law: pregnant women, children, adults with dependent children, people with disabilities, and seniors. State Medicaid programs must cover people in these groups up to federally defined income thresholds, but many states have expanded Medicaid beyond the minimum requirements, mostly for children.

As of January 2013, 19 states covered children up to at least 150% of the federal poverty level (FPL) – \$29,295 for a family of three in 2013 – including 11 states with eligibility thresholds between 200% and 300% FPL. All told, Medicaid and the smaller Children's Health Insurance Program (CHIP) cover 1 in every 3 children. By contrast, adult eligibility for Medicaid is much more limited (Figure 2). In 33 states, the eligibility threshold for working parents is set below 100% FPL; in 16 of these states, parents with earnings equal to 50% FPL have too much to qualify for Medicaid. Historically, non-disabled adults without dependent children ("childless adults") have been excluded from Medicaid by federal law, and states wishing to cover them have had to use state-only dollars or obtain a federal waiver to do so.



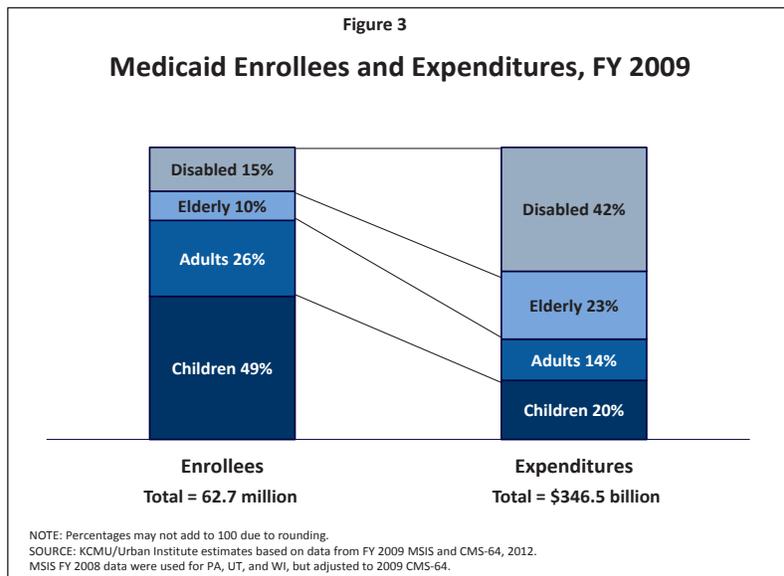
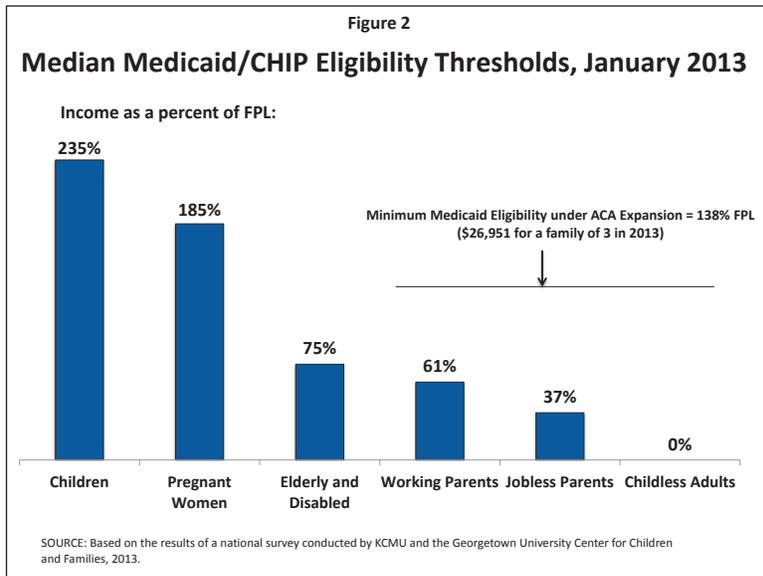
About half of all Medicaid enrollees are children, and non-elderly adults (mostly, working parents) make up another quarter. Seniors and people with disabilities account for the remaining quarter (Figure 3). In FY 2009, Medicaid covered:

- 31 million children;
- 16 million non-elderly adults;
- 6 million seniors; and
- 9 million persons with disabilities (including 1.5 million children).

Over 9 million people covered by Medicaid are “dual eligible”

beneficiaries – low-income seniors and younger people with disabilities who are also covered by Medicare. Dual eligible beneficiaries are very poor and many have very high health and long-term care needs and costs. Medicaid covers their Medicare premiums and cost-sharing and key benefits that Medicare does not cover – most importantly, long-term care.

The ACA expands Medicaid by establishing a new eligibility group for adults under age 65 with income at or below 138% FPL, effective January 1, 2014. These adults make up about half the uninsured. The Supreme Court’s decision on the ACA effectively converted the Medicaid expansion to a state option. Each state will decide whether to adopt it or not. Without the Medicaid expansion, the ACA would reduce the number of uninsured in 2022 by an estimated 15.1 million. If all states adopted the Medicaid expansion, the number of uninsured in 2022 would decline by 25.3 million (48%) – an additional 10.1 million people.



What services does Medicaid cover?

Medicaid covers a wide range of services to meet the needs of the diverse groups it serves. In addition to acute health services, Medicaid covers nursing home care and home and community-based long-term

services and supports that Medicare and most private insurance exclude or sharply limit. State Medicaid programs are required to cover:

- inpatient and outpatient hospital services;
- physician, midwife, and nurse practitioner services;
- laboratory and x-ray services;
- nursing facility and home health care for individuals age 21+;
- early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21;
- family planning services and supplies; and
- rural health clinic/federally qualified health center services.

Many states also offer “optional” services, including prescription drugs (all states), dental care, durable medical equipment, and personal care services. Under EPSDT, children are entitled to all medically necessary Medicaid services, including services considered optional for adults. Premiums are prohibited and cost-sharing is tightly limited for Medicaid beneficiaries at or below 150% FPL. States have more flexibility regarding those at higher income levels, but total premiums and cost-sharing cannot exceed 5% of quarterly or monthly family income for any Medicaid beneficiary.

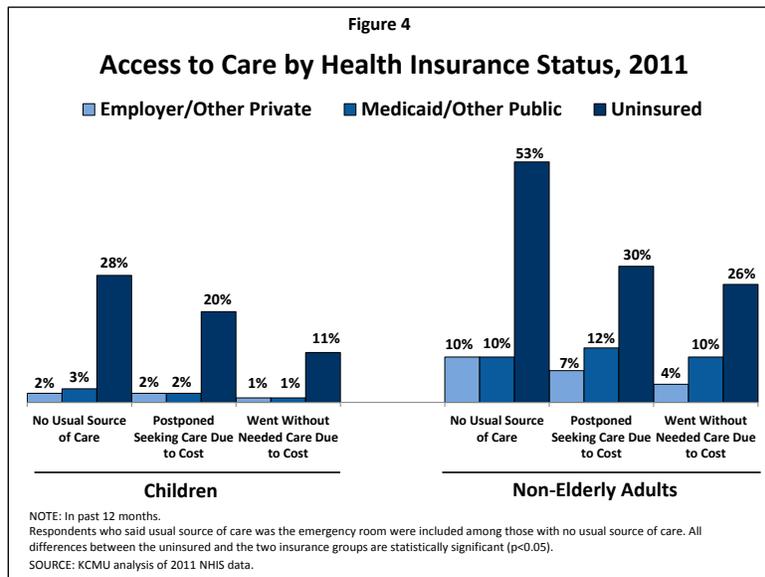
Generally, the same Medicaid benefits must be covered for all enrollees statewide. However, states have flexibility to provide narrower or different benefits for some beneficiaries, modeled on four “benchmark” plans specified in the Medicaid statute. Most people who gain Medicaid eligibility due to the ACA expansion will receive “Alternative Benefit Plans” (ABPs) based on these benchmark plans, but all benchmark coverage must be modified to include the ten “essential health benefits” (EHB) identified in the ACA. States can align their ABPs and traditional Medicaid plans by adding benefits to either package to match the other. People with disabilities, dual eligible beneficiaries, medically frail individuals, and specified other groups are exempt from mandatory enrollment in benchmark benefits (or ABPs, beginning January 1, 2014) and remain entitled to traditional Medicaid benefits.

How is access to care in Medicaid?

Medicaid improves access to care and reduces unmet health needs for the low-income uninsured.

The vast majority of children and adults covered by Medicaid have a usual source of care, while the uninsured fare significantly less well (Figure 4). Similarly, few children and relatively few adults with Medicaid postpone or go without needed care due to cost, in contrast to sizeable shares of the uninsured who report cost barriers to care.

The recent Oregon Health Study, which examined access to care for low-income uninsured adults who gained Medicaid, provided powerful evidence that Medicaid increased the probability of having a usual



source of primary care and the use of preventive care, prescription drugs, and outpatient and hospital care. Medicaid also reduced out-of-pocket costs and medical debt, and adults who gained Medicaid coverage had better self-reported physical and mental health than adults who remained uninsured.¹

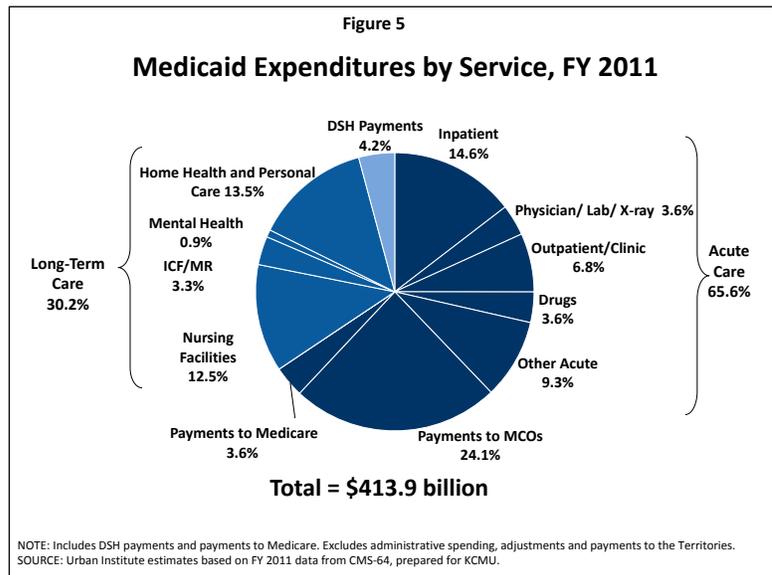
Although access to primary care in Medicaid is quite robust, provider shortages, compounded by low participation in Medicaid by specialists and dentists, in particular, result in gaps in access to care. Geographic disparities in the distribution of the health care workforce, and disadvantages present in underserved communities, such as lack of transportation, also contribute to the access challenges facing Medicaid.

Medicaid enrollees receive their care mostly from private providers. Two-thirds receive all or most of their care in managed care arrangements, predominantly capitated managed care organizations (MCOs), and many others receive at least some services through capitated plans. Increasingly, states are enrolling beneficiaries with more complex needs, including individuals with disabilities and dual eligible beneficiaries, in MCOs.

How much does Medicaid cost?

In FY 2011, total Medicaid spending excluding administration (5%, data not shown) totaled about \$414 billion (Figure 5). Two-thirds of spending was attributable to acute care and one-third went toward long-term care; 4% was attributable to supplemental payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients, known as “DSH” payments.

Roughly two-thirds of Medicaid spending is attributable to elderly disabled beneficiaries although they make up just one-quarter of all Medicaid enrollees. Further, almost 40% of Medicaid spending is attributable to dual eligible beneficiaries; most of their spending is for long-term care. The high Medicaid spending on these groups reflects their high needs and intensive use of both acute and long-term care services (Figure 6).



How is Medicaid financed?

States and the federal government share the cost of Medicaid. The federal government matches state Medicaid spending according to a formula in federal law. The federal match rate, known as the Federal

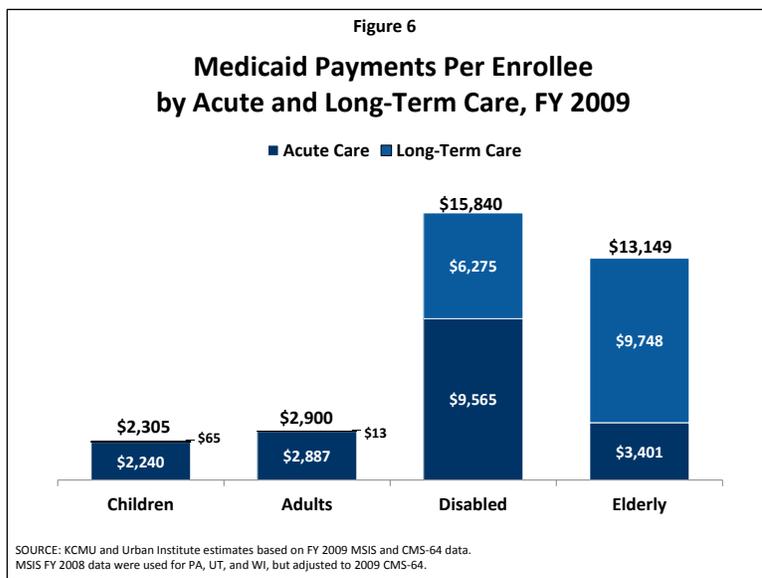
¹ Finkelstein A et al. *The Oregon Health Insurance Experiment: Evidence from the First Year*, NBER Working Paper 17190, July 2011. <http://www.nber.org/papers/w17190>

Medical Assistance Percentage, or FMAP, varies based on state per capita income. The FMAP ranges from a federal floor of 50% to 73.4% currently in the poorest state, Mississippi. The federal government funds about 57% of Medicaid costs overall.

Under the ACA, the federal government will finance 100% of the costs states incur to cover adults who are newly eligible for Medicaid in the first three years of reform (2014-2016) and at least 90% of the costs thereafter. If all states implemented the expansion, the federal government would pay 93% of the overall total increase in Medicaid costs during the decade 2013-2022 and states would pay 7%, but this distribution would vary by state.

Looking ahead

For over 62 million low-income Americans, including children and adults with chronic illnesses and disabilities and elderly and disabled Medicare beneficiaries, Medicaid ensures access to health and long-term care that would otherwise be out of reach financially. Already an integral source of coverage and care, Medicaid will play an even larger role when the ACA is fully implemented, reaching millions more low-income people and anchoring the public-private system the ACA creates to cover nearly all the uninsured.



This publication (#7235-06) is available on the Kaiser Family Foundation’s website at www.kff.org.

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid’s role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation’s Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission’s work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.