Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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Correcting Seven Myths About Medicaid

by Edwin Park and Matt Broaddus

As some states consider whether to adopt health reform's Medicaid expansion and some federal policymakers continue to promote radical structural changes in the program (such as converting it to a block grant or imposing a per capita cap on federal Medicaid funding), critics have propagated a number of myths about Medicaid. This report addresses seven such myths.[1]

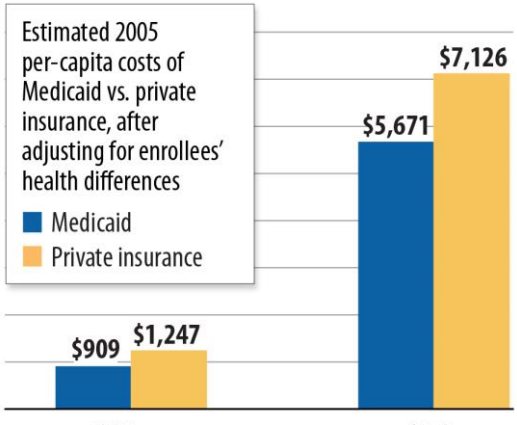
Is Medicaid Efficient?

Some claim that Medicaid is a highly inefficient program whose costs are growing out of control.[2] In fact, Medicaid's costs per-beneficiary are substantially lower than per-beneficiary costs for private insurance, and Medicaid's costs per beneficiary have been growing more slowly than per beneficiary costs under private employer coverage.

Medicaid provides more comprehensive benefits than private insurance at significantly lower out-of-pocket cost to beneficiaries, but its lower payment rates to health care providers and lower administrative costs make the program very efficient. It costs Medicaid much less than private insurance to cover people of similar health status (see Figure 1).

Over the past 30 years, Medicaid costs per beneficiary have essentially tracked costs in the health care system as a whole, public and private. And over the past decade, costs per beneficiary grew much more

Figure 1
Medicaid Costs 27% Less for Children, 20% Less for Adults Than Private Insurance



Source: CBPP analysis using Medical Expenditure Panel Survey data.

[1] See also Matt Broaddus and Edwin Park, "Ryan Poverty Report's Criticism of Medicaid Misrepresents Research Literature," Center on Budget and Policy Priorities, March 31, 2014, http://www.cbpp.org/cms/index.cfm?fa=view&id=4114.

[2] For an example of this assertion, see House Budget Committee Majority Staff, "The War on Poverty: 50 Years Later, A House Budget Committee Report," March 3, 2014, p. 113, http://budget.house.gov/uploadedfiles/war_on_poverty.pdf.

slowly for Medicaid than for employer-sponsored insurance. Medicaid also is expected to grow no more rapidly through 2021 than spending per beneficiary for people with private insurance.

Moreover, the Congressional Budget Office (CBO) now projects that Medicaid spending between 2011 and 2020 will be $311 billion — or 9.2 percent — lower than it projected in August 2010, largely due to slower expected growth in per-beneficiary costs.[3] (These CBO projections exclude health reform's Medicaid expansion.)

Do States Have Much Flexibility to Design Their Own Programs?

Some claim that Medicaid is a rigid, "one-size-fits-all" program and that policymakers need to block-grant it or make other radical changes to give states meaningful control over their Medicaid programs. In reality, Medicaid already provides states with significant flexibility to design their own programs — whom they cover, what benefits they provide, and how they deliver health care services.

The federal government sets minimum standards, including specifying certain categories of people that all states must cover and certain health coverage they must provide. Beyond that, states are free to set their own rules. For example, states have broad flexibility to decide which "optional" categories of low-income people to cover, and up to what income levels. As a result, Medicaid eligibility varies substantially from state to state.

Medicaid benefit packages vary significantly from state to state as well, since states have flexibility to determine whether to cover services like dental and vision care for adults and can determine the amount, duration, and scope of the services they provide.

States also have flexibility over whether Medicaid delivers health care services through managed care, fee-for-service, or other types of delivery systems and how much to pay providers and plans that serve Medicaid beneficiaries.

Do Medicaid Beneficiaries Have Much Better Access to Health Care Than the Uninsured?

Contrary to the highly implausible claim that Medicaid coverage is worse than no coverage at all,[4] 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.

Notably, a landmark study of Oregon's Medicaid program found that, compared to similar people without coverage, people with Medicaid were 40 percent less likely to have suffered a decline in their health in the previous six months.[5] They were also more likely to use preventive care (such as

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[3] Paul Van de Water, "Projected Medicare and Medicaid Spending Has Fallen by $900 Billion," *Off the Charts* blog, May 25, 2013, http://www.offthechartsblog.org/projected-medicare-and-medicaid-spending-has-fallen-by-900-billion/.

[4] For example, see House Budget Committee Majority Staff, "The War on Poverty: 50 Years Later, A House Budget Committee Report," March 3, 2014, p. 105, http://budget.house.gov/uploadedfiles/war_on_poverty.pdf.

[5] Amy Finkelstein, Sarah Taubman, *et al.,* "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper No. 17190, July 2011, http://www.nber.org/papers/w17190.

cholesterol screenings), to have a regular office or clinic where they could receive primary care, and to receive diagnosis of and treatment for depression and diabetes.[6] In addition, research published in the *New England Journal of Medicine* reported that expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York reduced mortality by 6.1 percent.[7]

Moreover, people with Medicaid in Oregon were 40 percent less likely than those without insurance to go into medical debt or leave other bills unpaid in order to cover medical expenses. In fact, the latest research from Oregon found that Medicaid coverage "nearly eliminated catastrophic out-of-pocket medical expenditures."[8]

Urban Institute researchers also have found that Medicaid provides beneficiaries with access to health care services that is comparable to — but less costly than — what they would receive through employer-sponsored insurance. If these beneficiaries were uninsured, they would be significantly less likely to have a usual source of care and more likely to forgo needed health care services.[9]

How Would the Medicaid Expansion Encourage Work Among Poor Families?

Claims by House Budget Committee Chairman Paul Ryan and others that health reform creates a "poverty trap" that discourages poor families are sharply in conflict with reality.[10] In states that have adopted the ACA's Medicaid expansion, poor parents can earn substantially more and still retain Medicaid. The Medicaid expansion significantly *reduces* work disincentives among working-poor parents rather than increasing them.

Before health reform's major coverage expansions took effect this year, Medicaid eligibility for working parents cut off at just 61 percent of the poverty line in the typical state, or roughly $14,550 for a family of four.[11] As a result, a poor parent would lose Medicaid if she worked more hours or took a higher-paying job, though her children would still be eligible for Medicaid or the Children's Health Insurance Program (CHIP). She could receive transitional Medicaid for a limited time but would likely end up uninsured if her employer didn't offer job-based coverage (very low-wage jobs mostly don't come with health coverage) or she couldn't afford it.

See also Judy Solomon, "Does Medicaid Matter? New Study Shows How Much," *Off the Charts* blog, July 7, 2011, http://www.offthechartsblog.org/does-medicaid-matter-new-study-shows-how-much/.

[6] Katherine Baicker, Sarah Taubman *et al.,* "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine*; May 2, 2013, 368:1713-1722.

[7] Benjamin Sommers, Katherine Baicker, and Arnold Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine*; September 13, 2012, 367:1025-1034.

[8] Baicker, Taubman *et al.*

[9] Teresa Coughlin *et al.,* "What Difference Does Medicaid Make?" Kaiser Commission on Medicaid and the Uninsured, May 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf.

[10] Suzy Khimm, "Paul Ryan: Obamacare is a 'poverty trap,'" MSNBC, February 5, 2014, http://www.msnbc.com/msnbc/paul-ryan-obamacare-poverty-trap.

[11] Martha Heberlein *et al.,* "Getting Into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," Kaiser Family Foundation, January 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf.

Now, in the 26 states and the District of Columbia that have expanded Medicaid under the ACA, the Medicaid eligibility level for working parents is 138 percent of the poverty line, or about $32,910 for a family of four. If a family's income rises above $32,910, the working parent can get subsidized coverage through the new health insurance marketplaces. Far from being a "poverty trap," health reform's Medicaid expansion enables tens of millions of working parents to seek higher wages or to work more hours *without* forgoing health coverage. As CBO states, "some people who would have been eligible for Medicaid under prior law — in particular, working parents with very low income — will work more as a result of the [Affordable Care Act's] provisions."[12]

Expansion of coverage to non-disabled, low-income adults *without* children, most of whom have never been eligible for Medicaid, is likely to have little effect on work incentives. Using data from the Oregon Health Study, researchers found no statistically significant difference between a group of low-income adults selected for Medicaid and a control group that remained on a waiting list and uninsured, either in the share with earnings or in the amount of earnings.[13] The evidence does not support claims that enrolling in Medicaid will discourage these people from working.[14]

Ironically, some who inaccurately claim the Medicaid expansion discourages work also support proposals to repeal health reform and block-grant Medicaid, which would *increase* work disincentives — particularly among poor parents with serious medical conditions and other ongoing health care needs — by limiting Medicaid to non-elderly or disabled adults with extremely low incomes. Medicaid income limits for working parents would likely be even lower under a block grant with a reduced federal funding level than they were prior to health reform.[15] Working parents thus would have an incentive to cut their hours and earnings in order to retain Medicaid as states cut back their Medicaid programs to fit within their shrunken block-grant funding allocations.

Is Health Reform's Medicaid Expansion a Good Deal for States?

Health reform calls for states to expand Medicaid to all non-elderly near-poor individuals (though the 2012 Supreme Court ruling upholding health reform made this expansion optional for states).

While some have claimed that the Medicaid expansion will cripple state budgets, in reality it will cover millions of low-income people at a very modest cost to states — and savings in state-funded services for the uninsured will offset part (and possibly all) of that cost.

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[12] Congressional Budget Office, "Labor Market Effects of the Affordable Care Act: Updated Estimates," February 2014, http://cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf.

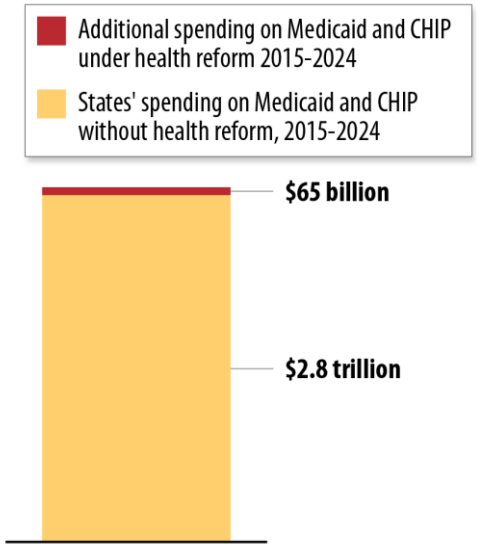
[13] Matt Broaddus, "Medicaid Coverage Doesn't Discourage Employment New Study Shows," *Off the Charts* blog, October 28, 2013, http://www.offthechartsblog.org/medicaid-coverage-doesnt-discourage-employment-new-study-shows/.

[14] A study of Tennessee's Medicaid program found increases in employment among some adults after losing Medicaid, which might suggest that expanding Medicaid reduces work. But Urban Institute researcher Austin Nichols points out that the study doesn't have the same unbiased experimental evidence as the Oregon study, since the comparison group used in the Tennessee study lived in neighboring states. After examining the research literature, Nichols concluded: "The best guess is that Medicaid expansions have no effect on labor supply." See Austin Nichols, "Newer Evidence is Not Always Better Evidence", Urban Institute, February 5, 2014, http://blog.metrotrends.org/2014/02/urban-institute-experts-cbos-aca-report/.

[15] Edwin Park and Matt Broaddus, "Ryan Block Grant Would Cut Medicaid by More than One-Third by 2023 and More After That," Center on Budget and Policy Priorities, March 26, 2013, http://www.cbpp.org/cms/index.cfm?fa=view&id=3941.

- The federal government will pick up an average of *nearly 92 percent* of the cost of the Medicaid expansion over its next ten years (2015-2024), according to CBO.
- States will spend just *2.5 percent* more on Medicaid with the expansion than they would have without health reform, CBO found under an assumption that roughly half the states elect to expand Medicaid (see Figure 2).
- This 2.5 percent figure overstates the net impact on state budgets because it doesn't reflect the large *savings* that states and localities will realize in health care spending for the uninsured. The Urban Institute estimates that states will save between *$26 and $52 billion* in this area from 2014 through 2019. The Lewin Group estimates the state and local savings at $101 billion.[16] (Both of these estimates assume all states adopt the Medicaid expansion.)

Figure 2
Medicaid Expansion Raises State Medicaid and CHIP Spending by Only 2.5 Percent



Source: CBPP analysis of the Congressional Budget Office's February 2014 Medicaid and CHIP baselines.

In the Absence of Medicaid, Would Medicaid Beneficiaries Have Access to Private Coverage?

Another myth regarding health reform's Medicaid expansion is that it will force large numbers of people out of private coverage.[17] The overwhelming majority of people who would get coverage under the Affordable Care Act's Medicaid expansion are low-income and uninsured individuals who generally can't afford private health care. Many of them work in low-wage jobs for small firms or service industries that typically don't offer health insurance benefits. And unsubsidized coverage in the individual insurance market would be unaffordable for most of those who are eligible for Medicaid under the Medicaid expansion.

- 81 percent of workers earning less than 138 percent of the poverty line — the threshold for qualifying for Medicaid under health reform — do not get coverage through their employer (see Figure 3).
- The median annual cost of single coverage in the pre-health reform individual market, including premiums and out-of-pocket costs, would have consumed more than *one-third* of the total

[16] January Angeles, "How Health Reform's Medicaid Expansion Will Impact State Budgets," Center on Budget and Policy Priorities, revised July 25, 2012, http://www.cbpp.org/cms/?fa=view&id=3801.

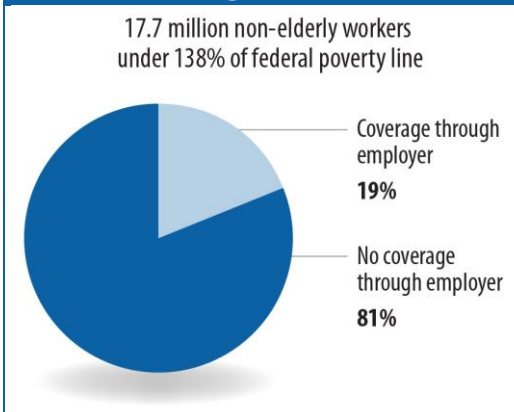
[17] For an example of this assertion, see House Budget Committee Majority Staff, *The War on Poverty: 50 Years Later, A House Budget Committee Report,* March 3, 2014, p. 110, http://budget.house.gov/uploadedfiles/war_on_poverty.pdf.

income of a family of three at the poverty line, making such coverage essentially unaffordable.

States that expanded Medicaid before health reform by raising income eligibility levels for adults reduced the ranks of the uninsured without undermining private coverage.[18] In states that expanded Medicaid, about the same proportion of Medicaid-eligible adults had private coverage as in states that did not expand, but the expansion states had a much lower proportion of uninsured low-income residents.

Figure 3

Fewer Than 1 in 5 Low-Income Workers Get Health Insurance Through Their Job



Source: CBPP analysis using 2012 Census Bureau data

Is Medicaid Participation Strong?

Some have said that many people who are eligible for Medicaid don't enroll in the program, in part because of the "stigma."[19] In reality, Medicaid participation is quite high, particularly among children in states that have made concerted efforts to simplify and streamline their enrollment processes. The research also suggests that claims of "stigma" heavily reducing Medicaid enrollment are dubious.

The Urban Institute finds that 65.6 percent of low-income adults with children who are eligible for Medicaid are enrolled,[20] a relatively strong participation rate compared to some other programs.[21]

In addition, 87.2 percent of eligible *children* participate in Medicaid or CHIP, according to the Urban Institute.[22] That is an exceedingly high rate for a means-tested program; in a number of states, children's Medicaid participation approaches the participation rates for universal social insurance programs like Medicare Part B.[23] Since CHIP's enactment in 1997, states have taken a number of steps to boost Medicaid and CHIP enrollment among eligible children, such as adopting streamlined application procedures. Health reform requires states to take additional steps to

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[18] Matt Broaddus and January Angeles, "Medicaid Expansion in Health Reform Not Likely to 'Crowd Out' Private Insurance," Center on Budget and Policy Priorities, June 22, 2010, http://www.cbpp.org/cms/?fa=view&id=3218.

[19] For example, see House Budget Committee Majority Staff, "The War on Poverty: 50 Years Later, A House Budget Committee Report," March 3, 2014, p. 109 http://budget.house.gov/uploadedfiles/war_on_poverty.pdf.

[20] Genevieve Kenney, *et al.,* "Medicaid/CHIP Participation Among Children and Parents," Urban Institute, December 2012, http://www.urban.org/UploadedPDF/412719-Medicaid-CHIP-Participation-Among-Children-and-Parents.pdf.

[21] Government Accountability Office, "Means-Tested Programs: Information on Program Access Can Be an Important Management Tool," March 2005, http://www.gao.gov/assets/250/245577.pdf.

[22] Genevieve Kenney, Nathaniel Anderson and Victoria Lynch, "Medicaid/CHIP Participation Rates Among Children: An Update," Urban Institute, September 2013, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407769.

[23] Dahlia Remler, and Sherry Glied, "What Other Programs Can Teach Us: Improving Participation in Health Insurance Programs," *American Journal of Public Health*, January 2003, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.1.67.

increase the percentage of eligible children enrolling.

Focus groups with low-income, uninsured adults that the Kaiser Family Foundation conducted also bear on this issue. They found no evidence that Medicaid carries a "stigma." Rather, adults in Nevada, Texas, Florida and Ohio — all states with very limited Medicaid eligibility before the ACA — said they were eager to enroll in Medicaid. While they wished their financial circumstances were better, they wanted affordable coverage and often couldn't get it from their employers. Furthermore, focus group members with previous experience with Medicaid (often because their children were eligible) spoke favorably of it as affordable and covering a broad set of services and medications.[24]

[24] Kaiser Family Foundation, "Faces of the Medicaid Expansion: Experiences of Uninsured Adults who Could Gain Coverage," November 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8385.pdf.