Fact Sheet

Taking a Closer Look: Myths about the Medicaid Program and the People It Helps

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Nearly 70 million people, including millions of children and adults with disabilities and low-income older adults, depend on the Medicaid program for access to health care and assistance with long-term services and supports (LTSS), which include basic life functions such as eating, dressing and bathing.

The program, however, is not always well-understood, and misconceptions have emerged that cloud the picture of how crucial Medicaid is to the delivery of health care and LTSS. This *Fact Sheet* takes a closer look at these misconceptions and presents the facts about Medicaid, a vital safety net and lifeline to millions of people with limited income and resources.

Myth 1. Medicaid is unsustainable because our aging population will have expensive LTSS needs.

FACTS: Our population is, in fact, aging—but Medicaid remains well-positioned to help provide older adults the care they need while keeping them in their homes and communities.

As of FY 2016, most (55%) Medicaid LTSS dollars for older adults and people with disabilities go toward nursing facilities.[1] The cost of institutional care is approximately triple that of home and community-based care (HCBS).[2] If states make efforts to balance their LTSS systems by increasing funding for HCBS for older adults and individuals with disabilities (which studies have consistently found people prefer anyway), costs could be contained as demand increases.

Furthermore, age is not necessarily a predictor for future Medicaid expenditures, and that includes with regard to the Boomer generation. Recent analysis of historical Medicaid spending found that in the past when the U.S. population saw increases in the 65+ population similar to that projected for Boomers, Medicaid spending did **not** increase significantly as a result of the aging population.[3]

Myth 2. Hardworking middle-class people who save for their retirement years will not need to rely on Medicaid for LTSS.

FACTS: LTSS is one of the largest risk factors to one's retirement security. Medicare and private health insurance do not cover LTSS expenses, making Medicaid the only "safety net" for many middle-income individuals. To receive Medicaid LTSS, these individuals must become impoverished and deplete almost all of their assets. That, in fact, is a common occurrence because LTSS is expensive and out of reach for most families.[4] In 2017, nursing home services cost approximately $97,452 per year and consumed 231 percent of the median income of an adult age 65 and older. In 10 states, the out-of-pocket cost for nursing home care exceeded $125,000. The median rate of a private one-bedroom unit in an assisted living facility was $45,000—more than the entire income (107 percent) of the typical older family.

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Moreover, while home care is more affordable than nursing home care, the cost of even those services would consume nearly the entire income of the typical older adult household. For a licensed home health aide, hourly home-care agency rates averaged $21.50 in 2017. Based on 30 hours of care per week, that translates to $33,540 annually, consuming more than three-quarters (80 percent) of the median income of older households.[5] Due to these high costs, Medicaid will play a critical role in helping the middle class age with the services and supports they need.

Myth 3. Family caregivers don't care for their own anymore; they simply rely on Medicaid.

FACTS: More than half (52%) of adults 65+ will need some form of LTSS as they age. Less than one-fifth of older adult LTSS users, however, will receive care paid for by Medicaid.[6] Family caregivers take on much of the responsibility for providing the needed support. The estimated economic value of family caregiving in 2013 ($470 billion) exceeded total Medicaid spending ($449 billion) and all out-of-pocket health care spending ($339 billion).[7] Most older adults either pay for care out of pocket or through other payers (e.g., private long-term care insurance)—or rely on family caregivers for help. Even when people enter a nursing home or other institutional setting, family caregivers still often continue to support their relative.

Myth 4. Once you qualify for Medicaid, the government pays for all your care.

FACTS: Medicaid nursing home residents contribute all of their income to help pay for their care, minus a "personal needs allowance" of less than $100 per month in most states. This allowance typically is used to pay for necessities such as laundry, clothing, and toiletries.

Myth 5. The Medicaid expansion is crowding out people who need home and community-based services.

FACTS: Numerous state-level studies have examined the impact of Medicaid expansion. A central finding across these studies is that compared to non-expansion states, those states that expanded Medicaid tend to see improved access to care among all low-income adults, including increased utilization of primary and preventative care, fewer emergency department visits, and increased screening and care for chronic conditions.[8]

In addition, there is no evidence that the Medicaid expansion had a negative impact on long-term services and supports. There is no connection between a state's Medicaid expansion status and whether the state has longer waiting lists for Medicaid home and community-based services. In fact, the expansion population is not eligible for Medicaid LTSS services. Most states (19 out of 32) that expanded Medicaid saw a decrease or no change in their waiting lists, or had no waiting list for HCBS. This trend is similar to non-expansion states, where 11 of 19 states had a decrease or no change in their waiting lists. Furthermore, of states with increases in HCBS waiting lists, expansion states saw a smaller average increase (1,756) than non-expansion states (3,502).[9]

Myth 6. Most Medicaid beneficiaries are not working. Implementing Medicaid work requirements won't impact older adults.

FACTS: The vast majority of people enrolled in Medicaid work but are employed in jobs that do not offer health coverage to their workers. In 2016, 6 in 10 adults enrolled in Medicaid were working. Of those who were not working, more than one-third (36%) were ill or disabled, another 30% were caregiving or raising families, and 15% were students.[10]

About 14 states have requested approval from the federal government to impose work requirements on certain enrollees as a condition of Medicaid coverage. Four states have received approval to date. These work requirements could pose a danger to adults ages 50-64, who are or could be subject to such requirements. Many enrolled adults ages 50–64 who don't work are often ill or disabled or have family caregiving responsibilities, yet they could lose their Medicaid coverage under these work requirements. Furthermore, studies demonstrate that Americans between ages 45 and 64 who are out of work spend more time seeking employment and experience long-term unemployment at rates higher than their younger counterparts,[11] putting them at greater risk for losing health coverage due to a work requirement.

Myth 7. Poverty in America is largely over and most people don't need programs like Medicaid.

FACTS: As of 2017, the official poverty rate in the United States is 12.3%. The poverty rate is measured by the federal government and includes Americans living in households with extremely low incomes. In 2017, the poverty threshold for a single adult age 65+ was $12,752, and for a family of four was $24,858. According to the data, close to 40 million people lived in poverty, including 12.8 million children and 4.7 million adults ages 65+.[12] Medicaid is a critical lifeline for these low-income American individuals and families, many of whom would have no other source of coverage in the program's absence.

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