Policy Basics

Introduction to Medicaid

Created in 1965, Medicaid provides health coverage to low-income families and individuals, including children, parents, pregnant people seniors, and people with disabilities. It is funded jointly by the federal government and the states. Within federal guidelines, each state has considerable flexibility in how it operates its own Medicaid program. Eligibility and covered benefits vary substantially by state.

Note: Congress is currently considering major changes to Medicaid that would fundamentally alter some of the provisions described here.

Why Is Medicaid Important?

As of January 2025, over 70 million low-income people in the U.S. got their health coverage through Medicaid. The program is an important source of coverage for many populations, covering roughly 2 in 5 children, 1 in 6 non-elderly adults, almost 1 in 6 adults 65 or older, and 2 in 5 non-elderly adults with disabilities. Medicaid is extremely popular, earning a favorable view from three-fourths of the public.

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Over half of Medicaid spending goes to provide services to seniors and people with disabilities, most of it for long-term services and supports like home- and community-based services and nursing home care. Children make up over a third of program enrollees but account for just one-sixth of its spending.

Medicaid is sometimes confused with Medicare, the federally funded and administered health insurance program for people over 65 and some disabled people. The two programs do overlap. Nearly 12 million low-income seniors and people with disabilities — so-called "dual eligibles" — were enrolled in both Medicare and Medicaid in February 2025.

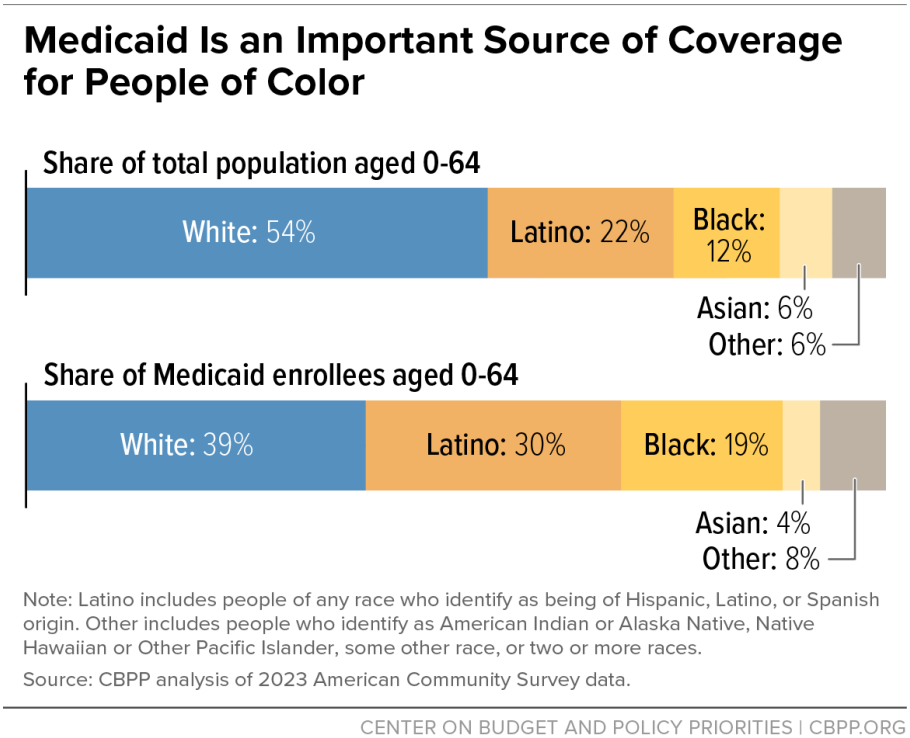
Medicaid is counter-cyclical: in economic downturns its enrollment expands to meet rising need as people lose their jobs and job-based health coverage. Enrollment rose by 10 million people, more than half of them

children, from 2007 to 2011 in response to the Great Recession. It rose by 22 million people from 2020 to 2023 during the COVID-19 pandemic, an increase also due to a congressional requirement that people's Medicaid coverage be maintained during the emergency. This helped drive the U.S. uninsured rate to a record low and prevented millions of people from being uninsured during the pandemic.

Who Is Enrolled in Medicaid?

In 2023 people of color accounted for 46 percent of the non-elderly U.S. population, but 61 percent of non-elderly Medicaid enrollees. This reflects inequities in the nation's economy, education, and other systems that make people of color likelier to have low incomes that qualify for Medicaid. But it also reflects the critical role Medicaid plays in reducing inequities in uninsured rates.

White people make up the single largest racial and ethnic group enrolled in Medicaid. But enrollment rates are higher among Latino, Black, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander adults in comparison to their white and Asian counterparts, who have historically had lower uninsured rates. Medicaid also covers a higher proportion of adults in rural (21 percent) than in urban areas (16 percent), where uninsured rates are generally lower.



Who Is Eligible for Medicaid?

Medicaid is an "entitlement" program: anyone who meets its eligibility rules has a right to enroll. That also means states have guaranteed federal financial support for part of the cost of their Medicaid programs.

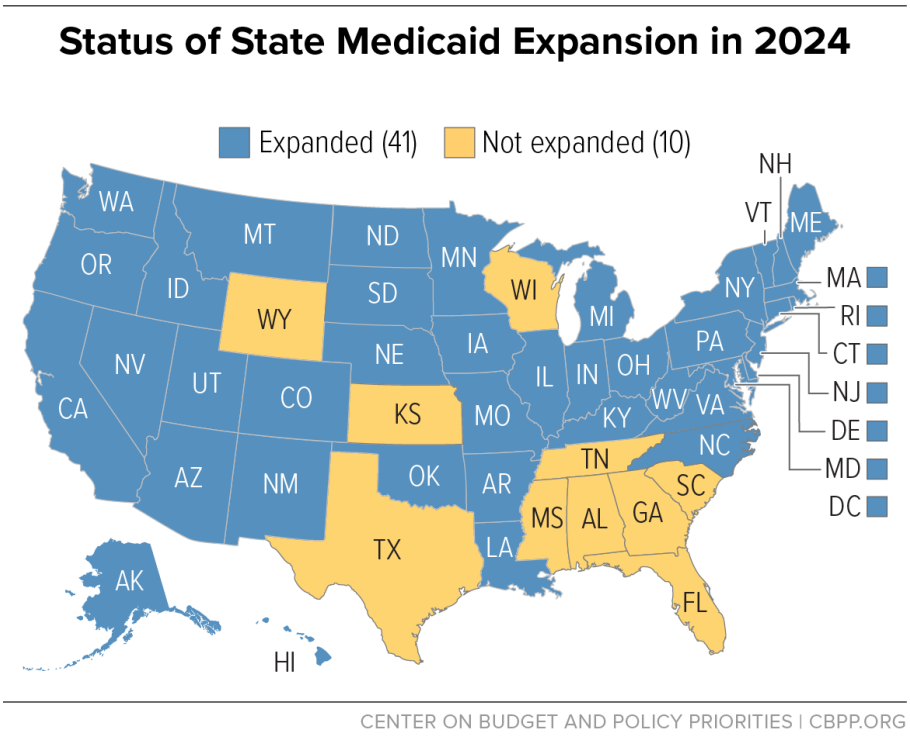
In order to receive federal funding, states must cover certain "mandatory" populations:

- Children through age 18 in families with income below 138 percent of the federal poverty line ($36,777 for a family of three in 2025);
- People who are pregnant and have income below 138 percent of the poverty line;
- Certain parents or caretakers with very low income; and
- Most seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

States may also receive federal Medicaid funds to cover "optional" populations. These include:

- People in the groups listed above whose income exceeds the limits for "mandatory" coverage;
- Seniors and people with disabilities not receiving SSI with income below the poverty level;
- People considered "medically needy," whose high medical expenses reduce their disposable income below the state's regular Medicaid eligibility limit (e.g., people living in nursing homes and people with disabilities receiving care in their communities).
- People with higher income who need long-term services and supports;
- Non-disabled adults under 65 with income below 138 percent of the poverty level ($21,597 for a single individual in 2025), including those without children. This is a state option after a 2012 Supreme Court decision overruled the Affordable Care Act's (ACA) mandatory coverage for this group.

As of June 2025, 40 states plus the District of Columbia have implemented the ACA's Medicaid expansion. In June 2024, 17 million low-income adults enrolled in Medicaid and gained access to affordable, comprehensive health coverage due to the ACA. (This number is expected to decline somewhat through 2026 as the "unwinding" of the pandemic-related continuous coverage provision continues to take effect.)



Who Isn't Eligible for Medicaid

Not all people with low incomes are eligible for Medicaid. In the ten states that haven't expanded their programs to cover all low-income adults (as of June 2025), adults over 19 are generally ineligible for Medicaid no matter how low their incomes are unless they are pregnant, caring for children, elderly, or have a disability. In these states, 1.5 million uninsured adults are stuck in the "coverage gap," with no path to affordable coverage because their incomes are too low to qualify for financial help in the ACA marketplaces yet too high to qualify for Medicaid.

In the typical non-expansion state, even parents are ineligible if their income exceeds just 34 percent of the poverty level ($9,061 for a family of three in 2025).

In addition, many people who are not U.S. citizens are ineligible for Medicaid despite having a lawful immigration status. This group includes people with temporary protected status whom the federal government has allowed to live in the country for humanitarian reasons and people granted temporary permission to come to the U.S. for educational purposes, travel, or work in a variety of fields, among others. Also, lawful permanent residents (green card holders) cannot enroll in Medicaid for the first five years, even if they meet all eligibility requirements. (States can extend eligibility to all lawfully present children and pregnant women without a five-year wait.)

Medicaid's purpose is to provide health coverage to those who cannot afford it, including many low-wage workers without job-based coverage, people between jobs, and people who can't work because of a disability or chronic health problem. Contrary to this purpose are policies that take coverage away from people who don't meet work requirements that require people to submit proof of employment or participation in employment-related activities, unless they qualify for limited exemptions.

Evidence shows that these requirements have no impact on employment and lead to large coverage losses, mostly among people who are already working or should be exempt, as enrollees are caught up in administrative burdens and red tape.

In May 2025, the House of Representatives passed a bill that would force the Medicaid expansion population to meet a work requirement (or prove they are exempt) in order to get and keep Medicaid coverage — an action the Congressional Budget Office estimates would take coverage away from 5.2 million adults. CBPP estimates that between 9.7 million and 14.4 million people would be at risk of losing Medicaid coverage under the bill.

What Services Does Medicaid Cover?

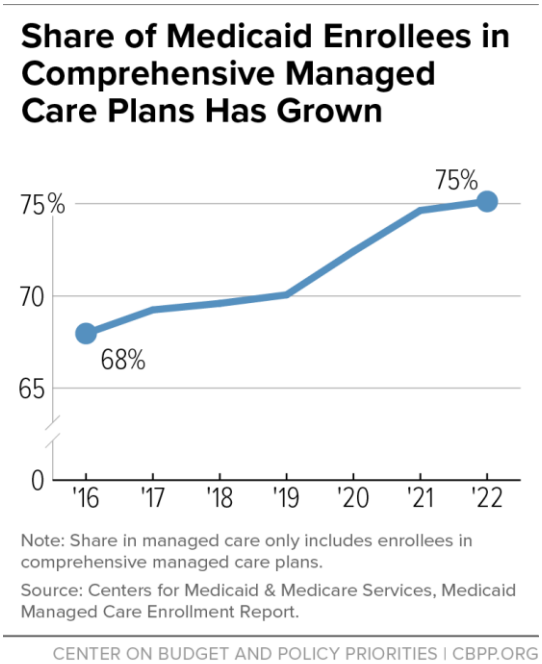
"Mandatory" services. Federal rules require state Medicaid programs to cover certain services like hospital and physician care, laboratory and X-ray services, home health services, and nursing facility services for adults. States must also provide a more comprehensive set of services, known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, for children under age 21. This requires states to ensure that children get regular check-ups and whatever follow-up care they need regardless of whether the care is covered for adults.

More than **60 percent of all nursing home residents** rely on Medicaid, and Medicaid provides more than 60 percent of the funding for long-term care services and supports.

"Optional" services. States can — and all do — cover other services, too. All states cover prescription drugs, and most cover other common optional benefits including dental care, vision services, hearing aids, and home- and community-based services, including personal care services for certain seniors and people with disabilities. These services, though optional, are critical to meeting the health needs of Medicaid beneficiaries.

Almost 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. More than 60 percent of all nursing home residents use Medicaid, and Medicaid provides more than 60 percent of funding for long-term care services and supports.

Medicaid does not always provide health care directly. A growing share of enrollees, 68 percent in 2016 versus 75 percent in 2022, get their care through managed care plans. In these plans, state Medicaid agencies pay Managed Care Organizations a set amount per member per month to provide health care services to Medicaid enrollees. This health care delivery system aims to manage cost, usage, and quality.



For other enrollees, state Medicaid programs pay hospitals, doctors, nursing homes, 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.)

How Is Medicaid Financed? What Are Key Spending Trends?

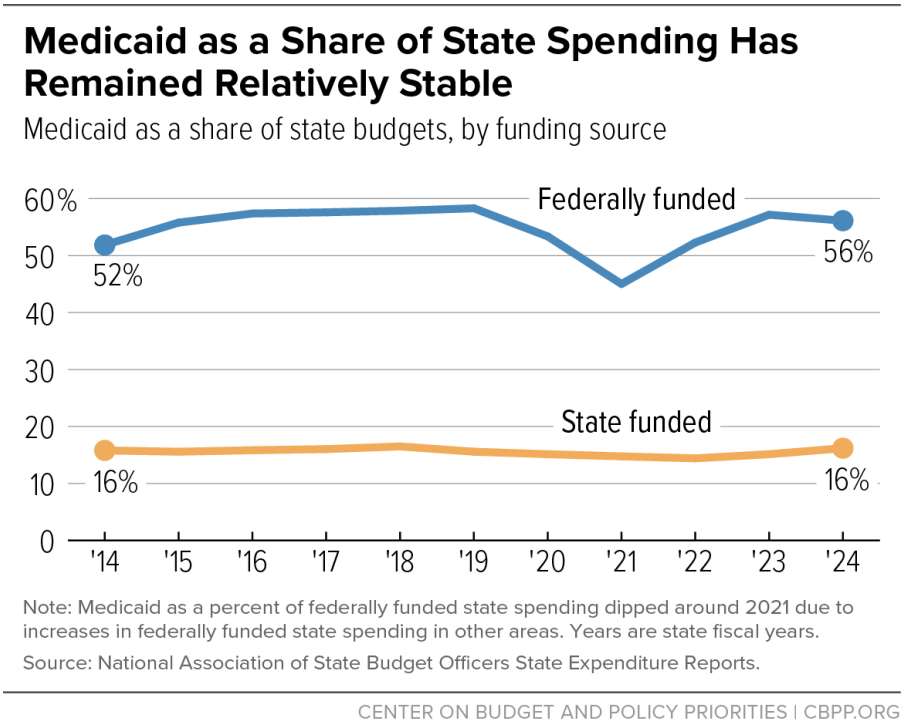
The federal government partners with states to cover the cost of providing Medicaid coverage to each person who is eligible.

The federal government contributes at least $1 in matching funds for every $1 a state spends on Medicaid. What's known as the "FMAP" — the fixed percentage the federal government pays for most Medicaid services, other than for the low-income adult expansion group — varies by state. States whose residents have lower incomes get larger amounts for each dollar they spend than wealthier states. In fiscal year 2025, the federal government paid up to 77 percent of Medicaid service costs in the lowest-income states; the national average was 60 percent.

Growth in spending per enrollee from 2019 through 2032 is projected to be similar for Medicaid, Medicare, and private insurance.

So long as the state contributes its share, the federal government shares in all allowable Medicaid costs. This is a fundamental feature of Medicaid, which provides a stable source of funding for states. Medicaid is states' single largest source of federal funds, making up over 50 percent of federally funded state spending in every year from 2014 to 2024, besides a temporary dip in 2021 due to pandemic-era spending. Policies

that would cap or otherwise limit the federal government's obligation to match state spending would significantly reduce state funding.



States have flexibility in how they finance their share of Medicaid costs, although they can't use other federal funds as their own share. Today, all but one state use taxes on providers or managed care plans to help finance a portion of the non-federal share of Medicaid costs.

Medicaid Expansion: A Very Good Financial Deal for States

Much like the federal government pays subsidies for people seeking coverage on the ACA marketplace, it pays almost all the cost of covering the Medicaid expansion population, to help states cover low-income adults *without* disrupting state budgets. This policy has been very effective: in most states, adopting Medicaid expansion has had little to no net budget impact. After picking up all expansion costs for the first three years that the expansion was in effect, the federal government permanently pays 90 percent of expansion costs.

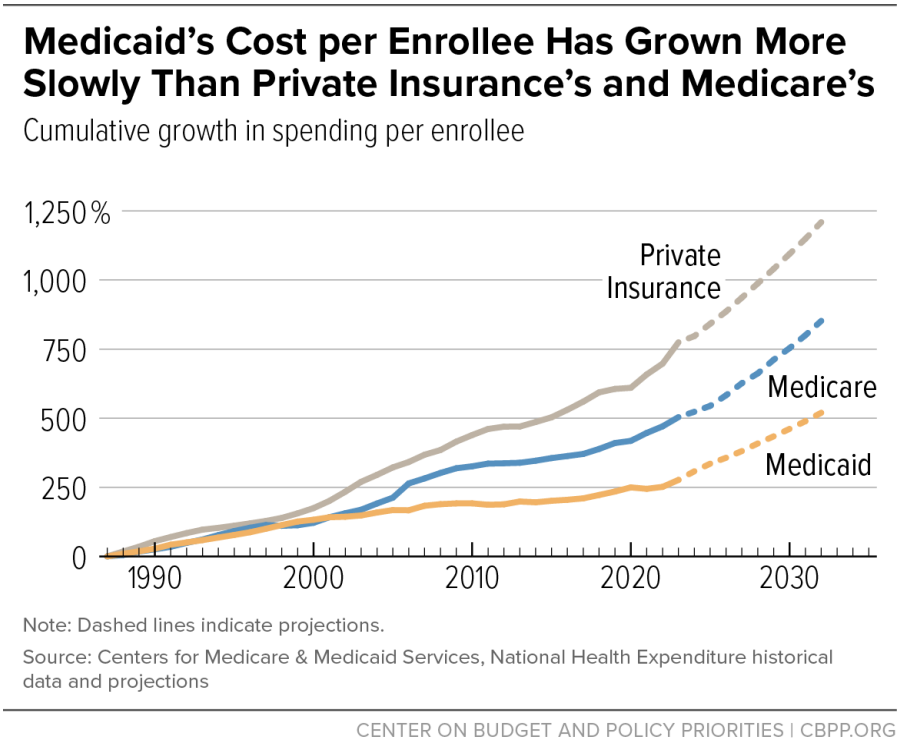
Because of savings in mental health programs, criminal legal systems, and other budget areas, as well as revenue increases, many states have been able to expand Medicaid at little to no net cost, with many states producing net savings. Also, by greatly reducing the number of people who are uninsured, the expansion has saved providers and localities substantial sums on uncompensated care.

More on Spending Trends

From 2014 to 2024, nationwide state spending on Medicaid, as a share of total state spending, has remained stable at around 14 to 16 percent, even as 40 states expanded Medicaid to adults with low incomes. Any policy that cuts the 90 percent federal match would shift costs to states and threaten coverage for millions. That's particularly because nine states have laws on the books that would immediately end the expansion if the matching rate drops, and three other states have provisions that would at least require the state to reexamine their expansions.

Medicaid is a lean program. It costs Medicaid substantially less than private insurance or Medicare to cover people of similar health status. This is due primarily to Medicaid's lower payment rates to providers and lower administrative costs.

Over the past 30 years, Medicaid costs per enrollee have trended lower than for private insurance and Medicare. Medicaid spending per enrollee is projected to grow more quickly from 2023 to 2025 after a substantial dip due to pandemic-related policies, but long-term growth trends from 2019 through 2032 are projected to be similar for Medicaid, Medicare, and private insurance.



How Effective Is Medicaid?

If Medicaid did not exist, most of the tens of millions of Medicaid enrollees would be uninsured. Private health insurance is generally not an option for Medicaid beneficiaries: many low-income workers do not have access to coverage for themselves and their families through their jobs and cannot afford to purchase coverage in the individual market.

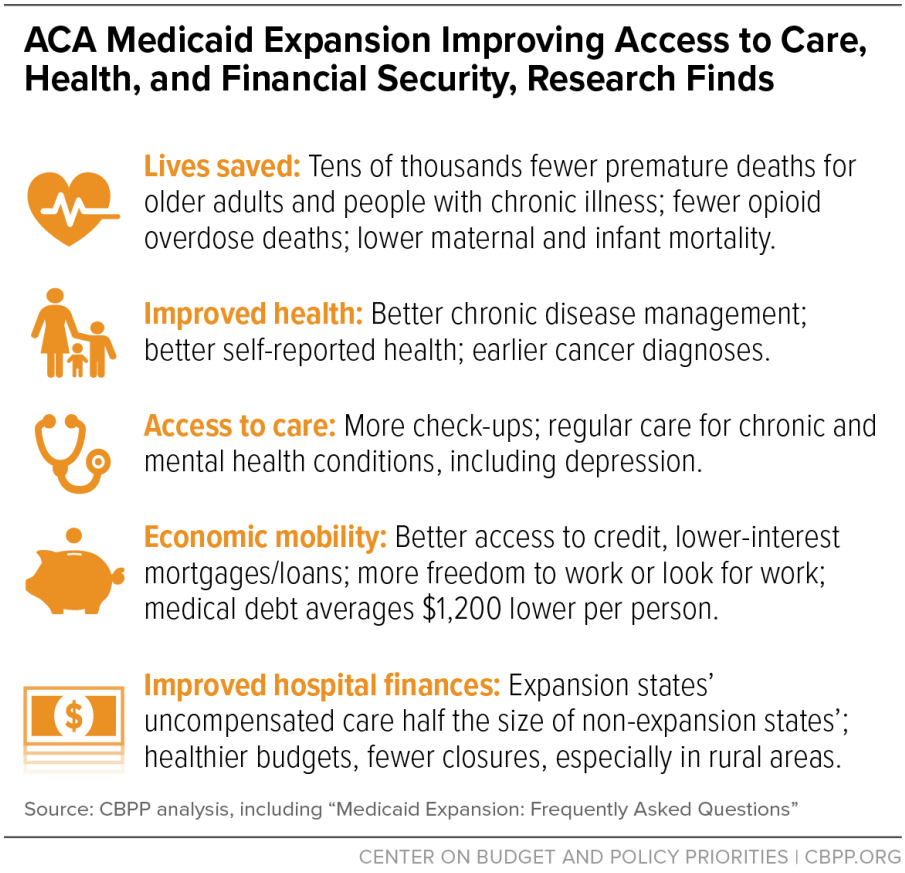
The creation of Medicaid, subsequent coverage expansions to children and pregnant women in the 1980s and '90s, and the ACA's expansion of Medicaid to low-income adults have all led to far lower shares of people without health coverage. Between the 2014 major ACA coverage expansions until 2023 (the latest year such data are available), Medicaid has helped reduce the number of people who are uninsured from 45 million to 26 million.

Medicaid is also effective in improving access to care; in reducing medical debt and supporting financial stability among low-income families; and in improving health and education outcomes. Additionally, Medicaid coverage has long-term benefits for children. Children with 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.

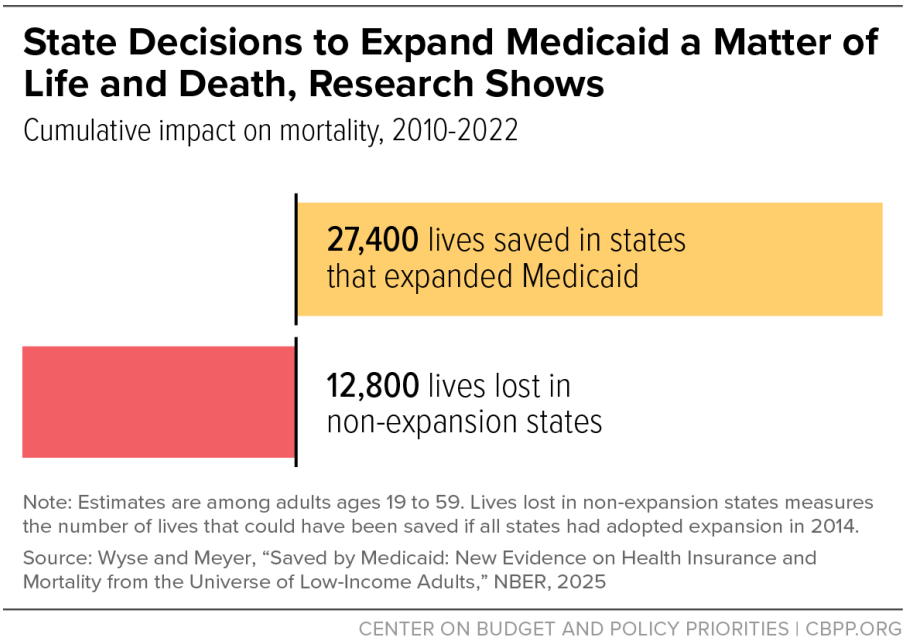
When parents with low incomes access coverage, through Medicaid or Medicaid expansion, children benefit. Research shows coverage for parents and other adults has positive effects on children including higher child coverage rates, lower rates of infant mortality and higher birth weights, and improved school and health outcomes. Additionally, when all members of the family have health insurance, children, along with the entire family, benefit from improved financial security.

Some of the clearest evidence comes from the ACA expansion of Medicaid coverage to low-income adults, where we can directly compare outcomes in states that did and did not adopt the expansion. Once states adopted expansion, more low-income adults had a

personal physician and got more check-ups and other preventive care, plus regular care for chronic conditions. Those gaining Medicaid under expansion had their Medical debt fall by an average $1,200, another study finds. And low-income adults in expansion states gained better access to credit, including lower-interest mortgages and auto loans, and were less likely to be evicted from their homes. Meanwhile, a battery of studies collectively show that Medicaid coverage leads to improvements in overall self-reported health, reduces the share of adults with low incomes screening positive for depression, improves diabetes and hypertension control, and reduces one-year mortality among patients diagnosed with end-stage renal disease.



Perhaps most striking, several rigorous studies have found that Medicaid expansion saves lives. One study estimates that expansion has saved over 27,000 lives, while decisions not to expand in the remaining non-expansion states cost almost 13,000 lives.



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To learn more about Medicaid expansion and its benefits to states, see: Medicaid Expansion Frequently Asked Questions. To learn more about proposals that would undermine the above successes of Medicaid, see: "House Republican Health Agenda Cuts Coverage, Raises People's Costs."