Introduction

Created in 1965, Medicaid is a federal and state-funded program that most people think of as simply a health insurance program for low-income Americans. Today, Medicaid is the largest public or private health insurance program in the United States; this year, 53 million people are expected to be enrolled. Medicaid covers two-thirds of nursing home residents,\(^1\) one in five persons under age 65 with chronic disabilities (including about 70% of poor children),\(^2\) one-third of all births, and half of spending for states’ mental health services.\(^3\)

There are many myths about the program and the people it helps, including the misconception that most Medicaid beneficiaries are on welfare, and about whom and what it covers. This fact sheet aims to shed light on Medicaid—today’s safety net for those who are unable to pay for their health and long-term care. It is one of a set of documents on Medicaid published by the AARP Public Policy Institute (see below).

**Myth # 1: Anyone who is poor can receive Medicaid.**

In 2001, only four in ten people under age 65 in poverty had Medicaid coverage. If an individual doesn’t fit into one of Medicaid’s recognized eligibility categories, he or she cannot get Medicaid, regardless of how poor he or she might be. For example, Medicaid eligibility categories exclude childless adults without disabilities. Further, Medicaid beneficiaries must meet asset, income, and other eligibility requirements.\(^4\)

**Myth # 2: Most Medicaid beneficiaries are on welfare.**

This statement is no longer true. Twenty years ago, most persons on Medicaid—well over three-fourths—were receiving cash welfare assistance. In 2005, the vast majority of all persons enrolled in Medicaid receive no cash welfare assistance.\(^5\) In fact, Medicaid has evolved into a health insurance program that provides a safety net for the working poor and their children who otherwise would not have insurance.

**Myth # 3: Most Medicaid beneficiaries are not working.**

In 2003, over half (59 percent) of all non-institutionalized Medicaid beneficiaries lived in families where one or more persons were working.\(^6\) These individuals were typically employed in low-wage jobs that did not offer employer-sponsored health insurance coverage, or that offered coverage that their workers could not afford. Between 2002 and 2003, the number of people who had employer sponsored health insurance coverage fell by 1.3 million.\(^7\)

**Myth # 4: Hard-working middle class people who save for their future retirement years will not need to rely upon Medicaid for long-term care.**

Medicare and private health insurance do not cover most long-term care expenses in nursing homes or in the community,\(^8\) making Medicaid the “safety net” for many middle income persons. In order to receive Medicaid long-term care services,
these individuals have to become impoverished and deplete almost all of their assets.\(^9\)

The cost of nursing home care averaged over $61,000 per year in urban areas in 2004 for a semi-private room.\(^10\) For services in the community, the average rate charged by agencies for a home health aide in 2004 was $18 per hour.\(^11\)

A recent study estimated that only 27% of persons age 65 and older have sufficient income and assets to pay for two or three years in a nursing home, at a cost of $150,000 or more, without impoverishing themselves.\(^12\)

**Myth # 5: Family caregivers don’t care for their own anymore, and simply rely on Medicaid.**

Over 90% of persons age 65 and older with disabilities who receive help with daily activities are helped by unpaid informal caregivers; these caregivers are overwhelmingly spouses and adult children. A larger proportion of care recipients were relying entirely on their informal caregivers in 1999 than in 1994: 66% compared with 57% in 1994, as a result of a decline in formal, paid care.\(^13\)

**Myth # 6: Medicaid could save lots of money if it cracked down on rich older people who hide their assets to get on Medicaid.**

The great majority of older persons have limited assets to protect. The median net worth of households of persons age 75+ in 2000 was $100,100, including the value of the home. When home value is excluded, their median net worth was just $19,025.\(^14\)

Most states permit beneficiaries to keep no more than about $2,000 in liquid assets, such as money or stocks. Other assets are considered exempt. The value of exempt assets varies by state, but generally includes the home; a modest amount of household goods; a car; a burial plot; and a nominal life insurance policy. Eligibility is denied if the applicant has transferred assets in order to qualify for Medicaid. The state looks back 3 years (5 years for certain trusts) to determine whether asset transfer rules have been abused.

A U.S. General Accounting Office (GAO) study in 1993 in Massachusetts found little abuse. Only about 10% of the total number of Medicaid applicants whose cases GAO reviewed involved asset transfers, typically to family members. Three-quarters of these transfers were valued at less than $50,000. “Converting” non-exempt assets, such as money in the bank, into exempt assets, such as by buying a car or paying off a mortgage, was more common than transferring assets. These conversions averaged only $5,600, and in 83% of cases were used to prepay burial costs.\(^15\)

Medicaid does have a program for recovering the value of certain services, including nursing facilities, from the remaining estate. The average amount recovered per estate by Medicaid in 2003 was under $10,000.\(^16\)

While there is little evidence that many older persons are transferring housing assets to qualify for Medicaid, in 1999, roughly 240,000 people age 65 and older reported having sold their homes within the last 5 years to pay medical bills.\(^17\)

**Myth # 7: Once you qualify for Medicaid, the government pays for all of your care.**

Medicaid nursing home residents contribute all of their income each month to help pay for their care, minus a very small “personal needs allowance” of...
between $30 and $50 per month in most states. This allowance is used typically to pay for necessities such as laundry, clothing, and toiletries.

**Myth # 8: Medicaid is providing “Cadillac” services that need to be scaled back.**

Although Medicaid provides some services, such as dental care, that are not typically offered by private sector health insurance plans, it is important to keep in mind that Medicaid serves a poorer, sicker, frailler, and more disabled population than private sector plans do. While persons with higher income are often financially able to subsidize their coverage with their own money, this is not an option for low-income Medicaid beneficiaries.

Medicaid is often the only option for persons with severe disabilities who need long-term care, and the long-term care benefits Medicaid covers are basic, not luxurious. For example, Medicaid reimbursement rates for nursing home care (an average of $118 per day on average in 2002) are considerably lower than those paid by persons paying privately (an average of $143 per day for a semi-private room in 2002).

**Myth #9: Medicaid is unsustainable because of the demographic changes beginning in the next few years.**

Significant demand for long-term care services for the Boomers is 15 to 20 years in the future. The oldest Boomers will turn 65 in 2011, but the median age for admission to a nursing home or assisted living facility is 82-83. The next groups of older people to need long-term care (parents of the Boomers) will be smaller than the groups preceding them, and they have lower rates of widowhood and childlessness. Hence, growth in demand for Medicaid long-term care services for older persons is likely to be slow to negative in the near term. In fact, the number of nursing home residents for whom Medicaid is the primary payer actually declined by 8.6% (from 1,040,000 to 950,000) between 1994 and 2004.

**Note:** This document is one of a set of documents published by the AARP Public Policy Institute that aims to shed light on the Medicaid program. Other documents in the set include:

- *Six Things That You Might Not Know About the Medicaid Program* by Lynda Flowers and Mary Jo Gibson
- *Medicaid Optional Eligibility and Services: Options That Aren't Really Options* by Lynda Flowers
- *Slicing the Long-Term Care Safety Net: Medicaid’s Most Vulnerable at Risk* by Mary Jo Gibson, Wendy Fox-Grage, and Ari Houser
- *The Faces of Medicaid Long-Term Care Beneficiaries* by Wendy Fox-Grage and Mary Jo Gibson

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http://www.aarp.org/ppi
1 Cowles Research Group, computed from CMS Online Survey, Certification, and Reporting (OSCAR) database (2004).
4 Other eligibility criteria that must be met include immigration status and state residency requirements.
8 Medicare covers medically necessary home health care, but beneficiaries must be homebound and need skilled care. It also pays for 21 days of skilled rehabilitative nursing home care for beneficiaries with skilled care needs who have had a prior hospital stay of at least three days, as well as a very limited amount for days 21-100.
9 Most Medicaid nursing home residents are widowed, divorced, or never married. For those with a spouse living in the community, there are some protections for spousal assets. In 2005, the institutionalized spouse can protect up to $1,561 to $2,378 per month in income and $19,020 to $95,100 in assets for the benefit of the community spouse. The exact amount varies by state.
11 Ibid.
17 Data from the 1999 National Long-Term Care Survey, analysis by Brenda Spillman, Urban Institute for AARP Public Policy Institute (2002).