



THE KAISER COMMISSION ON  
**Medicaid and the Uninsured**

## **MEDICAID AND ACCESS TO CARE**

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**Before the U.S. House of Representatives**

**Committee on Energy and Commerce**

**Subcommittee on Health**

**“Making Health Care Work for American Families:**

**Improving Access to Care”**

**March 24, 2009**

## **Making Health Care Work for American Families: Medicaid and Access to Care**

Medicaid is the workhorse of the U.S. healthcare system providing coverage for almost 60 million Americans left out of private health insurance and financing 16 percent of national health spending. Medicaid coverage of the low-income population provides access to a comprehensive scope of benefits with limited cost-sharing that is geared to meet the health needs and limited financial resources of Medicaid's beneficiaries who tend to be sicker and poorer than the privately insured low-income population.

- Medicaid helps to address racial and ethnic disparities in access to care. Because minority Americans are more likely than Whites to be low-income and uninsured, Medicaid provides an important safety net for about 1 in 4 nonelderly African Americans, American Indians/Alaska Natives, and Latinos, and about 1 in 10 Asian/Pacific Americans and Whites. Medicaid covers over a quarter of all children in the U.S., including nearly 1 of every 5 White children, but roughly 2 of every 5 African American and Hispanic children.
- The comprehensive scope of Medicaid benefits is critical given the low-incomes and complex health needs for the population Medicaid serves, including the chronically ill, people with severe disabilities. When the health needs of its beneficiaries are taken into account, Medicaid is a low-cost program; Both adult and child per capita spending are lower in Medicaid than under private insurance.
- Medicaid enrollees tend to fare as well as the privately-insured population on important measures of access to primary care; Uninsured children have significantly higher rates of no usual source of care (32%) compared to only 4% of publicly insured children or 3% of privately insured children.
- Great gains in reducing the share of low-income children who are uninsured have been made through the expansion of Medicaid /CHIP, demonstrating that public programs provide a solid platform from which to expand coverage; Between 1998 and 2007, the uninsured rate among low-income children fell by almost half (28% to 15%).
- Less progress has been made for adults, leaving many uninsured. Over half of the uninsured are low-income adults. Although 44 states have set the Medicaid/CHIP income-eligibility level for children at or above 200% of the federal poverty level, 33 states limit the Medicaid income eligibility for parents to below 100% of the federal poverty level and coverage for childless non-disabled adults remains beyond Medicaid's current scope.

Medicaid provides a strong and tested foundation upon which to build health reform efforts, but could play a stronger role if coverage of the low-income population was improved through expanding eligibility and reducing enrollment barriers; addressing payment rates and administrative burden to boost provider participation; and stabilizing the financing.

Mr. Chairman and members of the Committee on Energy and Commerce, thank you for the opportunity to participate in this hearing on making health care work for American families. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. I am also an Adjunct Professor of Health Policy and Management in the Bloomberg School of Public Health at The Johns Hopkins University. My testimony today will address the role public programs have played in improving access to care and helping to reduce health care disparities, with a focus on the role Medicaid has played for low-income families.

Together, Medicare and Medicaid provide health coverage to over a quarter of our population --- over 80 million Americans (Figure 1). Medicare, as the health financing program for the nation's senior citizens and people with severe disabilities, covers many of those with the greatest health needs due to age and disability. Medicaid, enacted with Medicare in 1965, plays a different and somewhat more complex role as the health and long-term care assistance program for the nation's low-income population.

Medicare has helped to improve access to care for the elderly by easing the financial burden for care and opening up access to the broad range of medical services and new technology that has helped to both extend life and promote better care. Medicare has helped not only to improve access to medical care, but also to reduce racial barriers to care through the enforcement of civil rights legislation leading to the desegregation of health facilities and by providing equal benefits to all beneficiaries without regard to health status, income, racial or ethnic identity, or state of residence. Research has documented that with Medicare, access to care substantially expanded and disparities by race narrowed for the elderly. As the nation now considers health reform, because Medicare covers virtually all of the 37 million elderly Americans, it is the nation's 45 million uninsured under age 65 that are the focus of efforts to broaden coverage.

Medicaid is an equally important part of health coverage today covering almost 60 million low-income Americans and financing 16 percent of national health spending, including 40 percent of spending on long-term care services (Figure 2). Medicaid is the nation's health care safety net providing health coverage to one in four of America's children and many of their parents --- 30 million low-income children and 15 million adults who generally have no access to job-based coverage. It is a particularly important source of coverage for both acute and long-term care for 8 million non-elderly people with disabilities and is an essential adjunct to Medicare for the nearly 9 million low-income elderly and disabled Medicare beneficiaries who depend on Medicaid to help with Medicare premiums, fill in gaps in Medicare benefits, and assist with long-term care needs. Without Medicaid to supplement Medicare, the gains achieved in reducing racial disparities and improving access to care would have been more difficult to attain for many of Medicare's poorest beneficiaries. Medicaid financing provides states with the capacity to provide coverage for their low-income families and helps to support safety net clinics and hospitals for the poor and uninsured.

Medicaid is a critical source of coverage for the low-income population, covering 40 percent of those living in poverty and a quarter of the near poor. (Figure 3). Federal law requires states to provide Medicaid coverage to all children in families with incomes below poverty and states have the option of extending coverage to children at higher income levels through Medicaid and Children's Health Insurance Program (CHIP). However, Medicaid eligibility for parents varies widely across the states and is below poverty in all but 17 states and DC, and, under current federal rules, adults without dependent children are ineligible for Medicaid unless they qualify on the basis of a disability (Figures 4 and 5). As a result, Medicaid now provides coverage to half of all low-income children, but only reaches 20 percent of low-income parents and leaves most poor childless adults uninsured.

While Medicaid is often viewed in its role as the health insurer of low-income families, it is important to recognize that children and parents in low-income families

comprise the majority (76%) of Medicaid enrollees, but account for less than a third (30%) of program spending (Figure 6). This is largely driven by the difference in spending per enrollee ---\$1,600 per child compared to \$13,500 per person with disabilities and nearly \$12,000 per elderly enrollee -- due to the greater use of both acute and long-term services by the disabled and elderly (Figure 7). More than 45 percent of Medicaid spending for services is attributable to the dual eligibles, the low-income Medicare beneficiaries who also have Medicaid coverage.

Medicaid spending --- like most health spending --- is highly skewed with a small share of enrollees accounting for a large share of the spending. In 2004, the 5 percent of beneficiaries with the highest health and long-term care costs (over \$20,000 annually) accounted for 57 percent of spending (Figure 8). For many of those with the most extensive health needs, including those with severely disabling conditions, Medicaid provides access to diverse services and long-term care options that often exceed the scope of most private insurance. In these multiple roles, Medicaid has contributed both to promoting access to care and improving health outcomes for the poor and near-poor population, but also to assuring comprehensive coverage for the complex and extensive health needs of many of the chronically ill and those with severe disabilities in our society.

### Access to Care for the Low-Income Populations

Medicaid financing has helped move many low-income families from dependence on charity care to financial access to both public and private providers. In doing so, it has offered assistance to millions of low-income children and adults and provided a healthier start in life --- and fewer disparities in life --- to many of the nation's children. The coverage provided by Medicaid has helped to narrow the gaps in access to care faced by those without insurance and promoted broader use of preventive and primary care services.

Maintaining a comprehensive scope of benefits and limited cost-sharing is critical for the population Medicaid serves. Cost-sharing can place a disproportionately heavy burden on the tight budgets of low-income families, affecting access to care and health outcomes adversely. Today, a majority of low-income families on Medicaid receive their health coverage through managed care organizations under contract with the state to provide both comprehensive services and a provider network for beneficiaries.

Medicaid's impact can be seen both in the numbers of people served and the access to care provided. Medicaid's success in improving access to care for the low-income population is most notably reflected in the comparability of Medicaid to private insurance on the many access measures where the uninsured fall far behind. For both children and adults, Medicaid like private insurance links families to a usual source of care -- the key entry point into the health care system. With Medicaid coverage, children and adults utilize the health system similarly to those privately insured and face far fewer financial and access barriers to care than the uninsured. Most notably, uninsured children have significantly higher rates of no usual source of care (32%) compared to only 4 percent of publicly-insured children or 3 percent of privately-insured children (Figure 9). Eighty-nine percent of publicly insured low-income children have had a well-child visit compared to 82 percent of privately insured low-income children, and 11 percent of publicly insured low-income adults report no usual source of care compared to 13 percent of privately insured low-income adults (Figure 10 and 11).

Medicaid's access comparability to private coverage is especially notable given that the Medicaid population is both poorer and sicker than those who are privately insured (Figure 12). Because Medicaid covers a sicker population with more health needs, it is often viewed as more costly than private insurance. However, when the cost per adult and per child for medical care is adjusted for health status, Medicaid spending per person is below that of private insurance. While this is

in part due to lower provider payment rates, it also reflects greater efficiency in program administration and in managing care (Figure 13).

### Medicaid's Role in Addressing Disparities

In addition to providing coverage that helps level the access to care playing field for millions of low-income children and adults, Medicaid has a particularly strong role in reducing access to care disparities by race and ethnicity. Because they are more likely to be low-income and have jobs without health insurance coverage, a higher proportion of African Americans and Latinos have Medicaid coverage (or are uninsured) than Whites and Asian/Pacific Islanders.

Over a quarter (27%) of African Americans and 24 percent of Latinos rely on Medicaid for their health insurance protection in contrast to 12 percent of Whites (Figure 14). Medicaid's role is even more substantial for children -- covering 2 out of every 5 African-American and Latino children compared to 1 out of every 5 White children. Because Medicaid is such an important source of coverage for minority populations, they make up the majority (56%) of Medicaid enrollees. Among Medicaid beneficiaries, one in four (27%) is of Hispanic ethnicity and one in five (22%) is African American (Figure 15).

Medicaid by providing health insurance coverage serves to promote improved access to care that can help to narrow disparities in access to care (Figure 16). For Whites as well as minorities, being uninsured compromises access to care. Having a usual source of care is associated with better access to primary and preventive care and better care coordination within the health care system. Across all racial and ethnic groups, public coverage in contrast to being uninsured has been shown to increase substantially the likelihood that an individual has a usual source of care -- thus improving the chances that barriers to receiving timely care and using the health system effectively will be reduced.

Medicaid also plays an important role as a source of coverage in rural areas where there is less employer-sponsored coverage and higher poverty rates than in urban areas. Nearly a fifth of poor children live in rural areas. As a result, nearly a third (32%) of rural children compared to a quarter (26%) of urban children have Medicaid and CHIP for their health insurance coverage. As Medicaid promotes access to care for the low-income rural population enrolled, it also serves as a critical source of payment for rural providers, and helps fill the gap left by the low level of private insurance in rural areas. By enabling hospitals, doctors, and clinics to get financing support for their services, Medicaid helps maintain the availability of health services for all rural residents and helps sustain rural economies.

### Medicaid as a Platform for Reform

As the nation moves forward to consideration of how to provide coverage to the over 45 million uninsured Americans, Medicaid's role for the low-income population provides a strong platform on which reform efforts can be built as evidenced by the recent experience with children's coverage. Great gains in reducing the number of uninsured low-income children have been made through the expansion of Medicaid/CHIP; between 1998 and 2007 the uninsured rate among low-income children fell by almost half (28% to 15%) due to expansions in these programs.

The uninsured population is predominantly low-income -- two-thirds of the uninsured have incomes below 200 percent of poverty --- roughly \$44,000 for a family of four (Figure 17). Thus, Medicaid provides the framework for comprehensive and affordable coverage for the low-income population and has been an effective vehicle for improving access and health outcomes for the poor and disadvantaged. It is a tested program with an administrative structure in every state that virtually every state health reform effort has built upon in seeking to broader coverage for their low-income residents.

Medicaid is widely viewed as a cornerstone of state efforts to expand coverage and provides a base for extending coverage that has public support. In surveys of low-income families, over 90 percent of parents with an uninsured child view Medicaid/CHIP as a good program and say they would enroll their child if eligible for public coverage (Figure 18). Public opinion surveys have consistently shown broad support for public coverage programs with 74 percent ranking Medicaid as a very important program compared to 83 percent for Medicare in our 2005 survey of the general public. When asked about approaches to expanding coverage nationally, 70 percent of the public say they favor expanding Medicaid and SCHIP as one way to achieve broader coverage (Figure 19).

To make Medicaid a more effective platform for extending coverage to the low-income population, several options have been raised for reducing gaps and strengthening the program's base. To reach and cover more of the low-income population both expanding eligibility and reducing enrollment barriers could be addressed by: basing Medicaid eligibility solely on income and eliminating the current categorical requirements that exclude childless adults; standardizing income eligibility levels across states for adults to provide a national floor similar to the current requirements for coverage of all children under poverty; and further simplifying enrollment procedures to make coverage more accessible to working families. To improve access to care, greater emphasis could be placed on preventive and primary care combined with improvements in the level of provider payments to promote greater physician participation and assure the availability of care in safety net facilities and medically underserved areas. To meet the health needs of the complex populations served by Medicaid, greater emphasis could be placed on adopting new strategies and technology to better coordinate care and evaluate quality. To underpin these efforts and secure coverage through good and bad economic times, ways to enhance and stabilize federal financing and provide countercyclical aid also need to be addressed.

## Conclusion

The Medicaid program serves a disproportionately low income and disadvantaged population, living in poor and often environmentally and physically hazardous neighborhoods, where poverty and complex social needs combine with a multitude of other factors to shape health outcomes. Health coverage alone cannot be expected to reverse the effects of poverty and deprivation on the health and well-being of America's poorest residents, but Medicaid has demonstrated over the last four and a half decades that it is an important lever to help improve access to health services and hopefully the health of America's poorest children and families.

Medicaid continues to provide coverage beyond that of private insurance or Medicare to the most vulnerable and frail in our society - acute and long term care services for persons with chronic mental illness or developmental disabilities; medical and drug therapy for those with HIV/AIDS; assistance with Medicare's premiums, cost-sharing, and coverage gaps for poor Medicare beneficiaries and home-based and institutional care for those with severe physical and mental disabilities that require long-term care. In the absence of Medicaid, it is hard to envision how these enormous societal needs would be met.

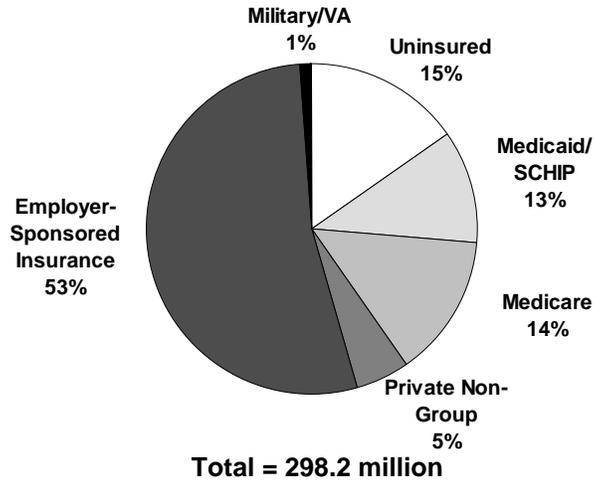
The Medicaid program has an established track record in providing the scope of benefits and range of services to meet the health needs of a low-income population that includes many with chronic illness and severely disabling conditions. Drawing on Medicaid's experience and already substantial coverage of the low-income population offers an appropriate starting point for extending coverage to the low-income uninsured population through health reform.

As the nation moves forward to consider health care reform, strengthening the base that Medicaid provides for the low-income population and those with special health needs will help to provide the foundation on which broader health reforms can be built. I look forward to working with the Committee as your health reform efforts move forward.

Thank you.

Figure 1

## Health Insurance Coverage of the Total Population, 2007

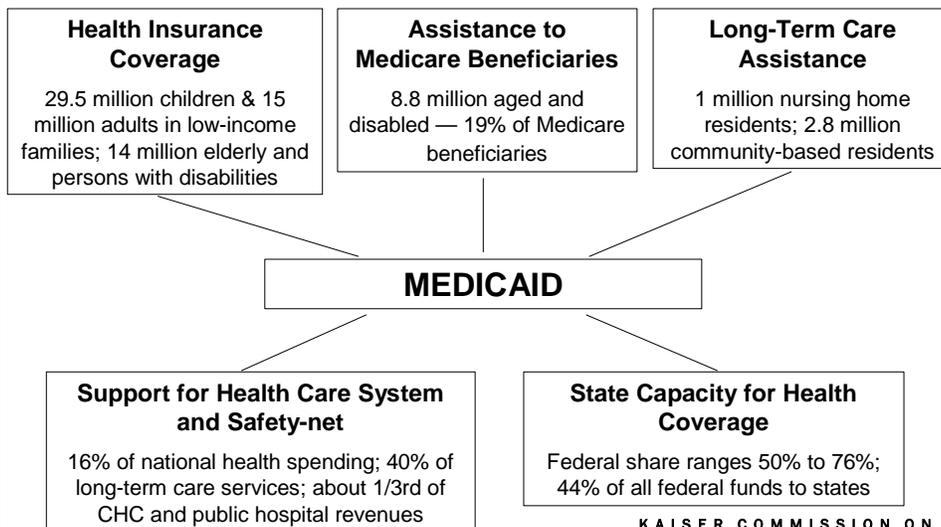


SOURCE: KCMU and Urban Institute analysis of March 2008 CPS.

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Figure 2

## Medicaid Today

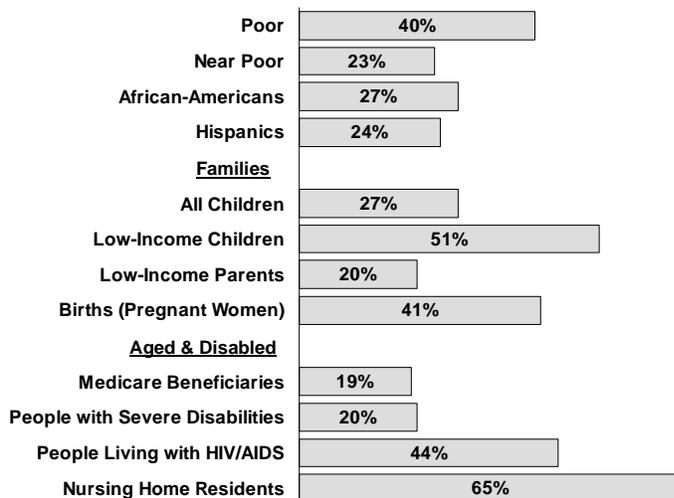


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Figure 3

## Medicaid's Role for Selected Populations

Percent with Medicaid Coverage:

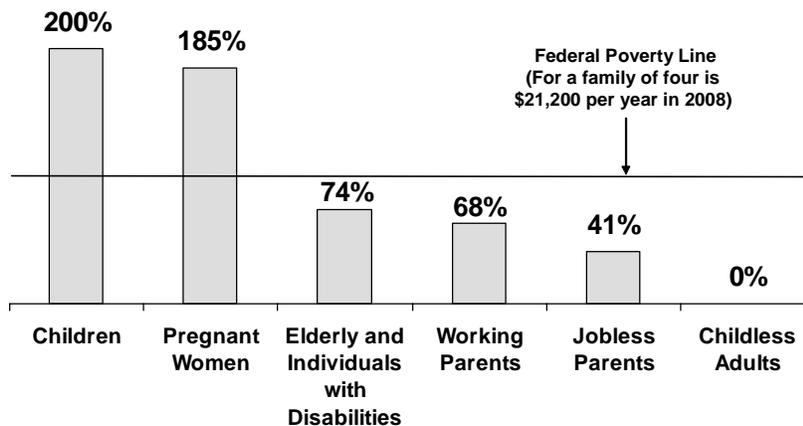


Note: "Poor" is defined as living below the federal poverty level, which was \$17,600 for a family of 3 in 2008. SOURCE: KCMU, KFF, and Urban Institute estimates; Birth data: NGA, MCH Update.

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Figure 4

## Median Medicaid/SCHIP Income Eligibility Thresholds, 2008

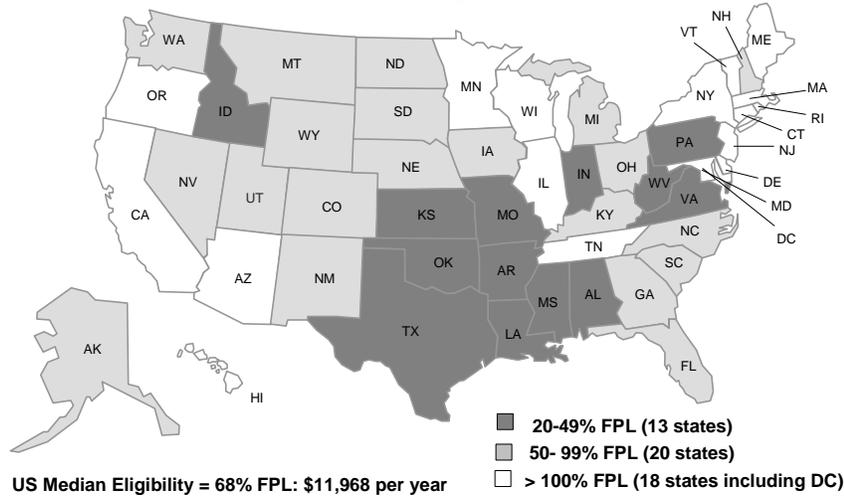


SOURCE: KCMU/Urban Institute analysis of March 2008 CPS.

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Figure 5

### Medicaid Eligibility for Working Parents by Income, January 2009

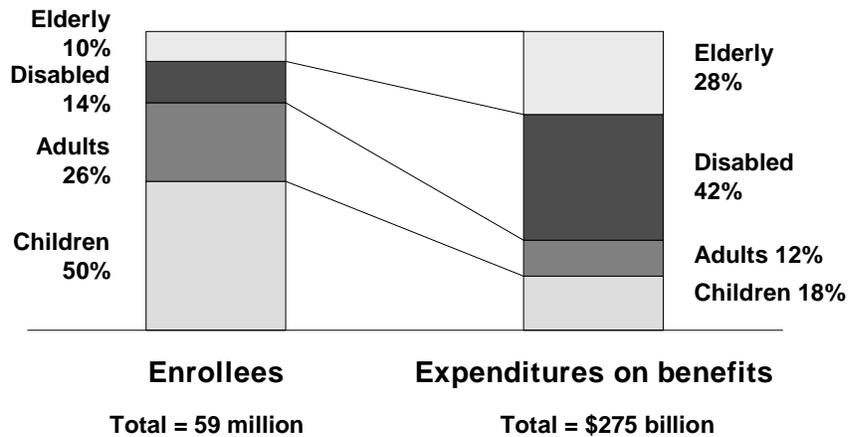


\*The Federal Poverty Line (FPL) for a family of three in 2008 is \$17,600 per year.  
 SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2009.

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Figure 6

### Medicaid Enrollees and Expenditures by Enrollment Group, 2005

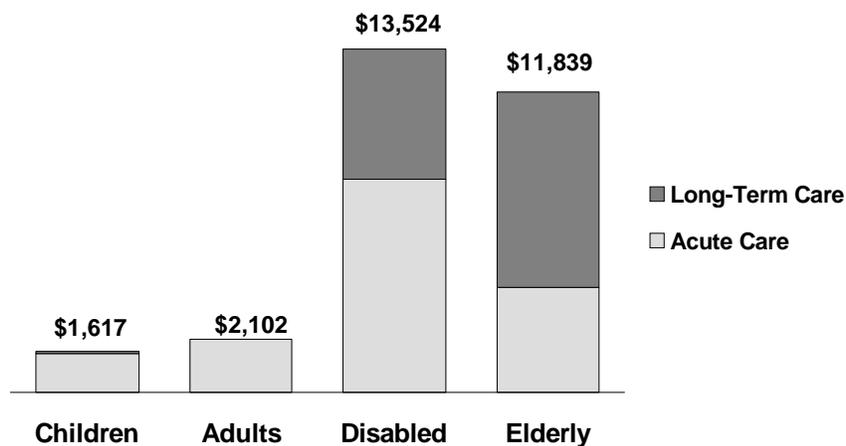


SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data.

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Figure 7

## Medicaid Payments Per Enrollee by Acute and Long-Term Care, 2005

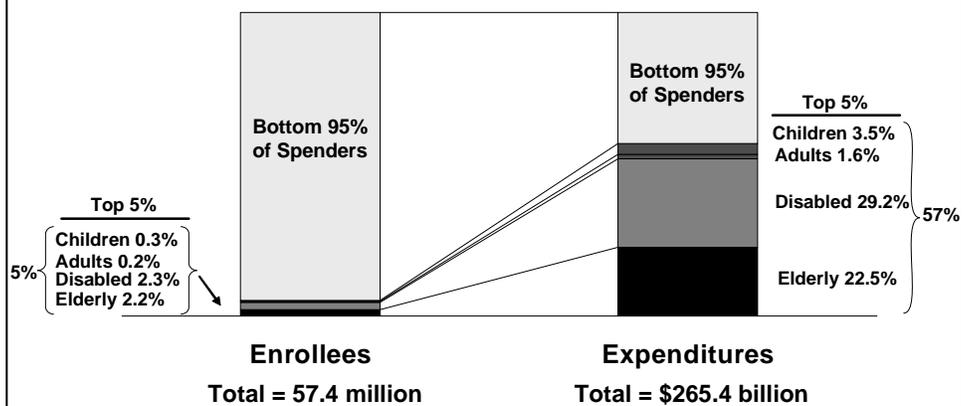


SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data.

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Figure 8

## Top 5% of Enrollees Accounted for More than Half of Medicaid Spending in 2004

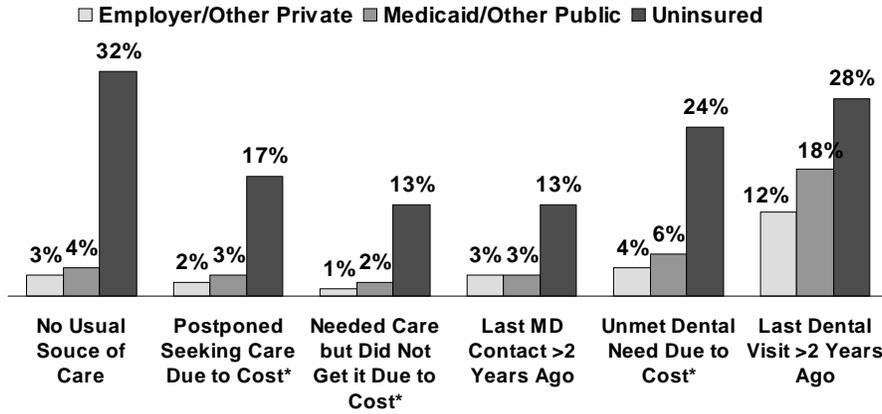


SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on MSIS 2004.

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Figure 9

### Children's Access to Care, by Health Insurance Status, 2007



\* In the past 12 months

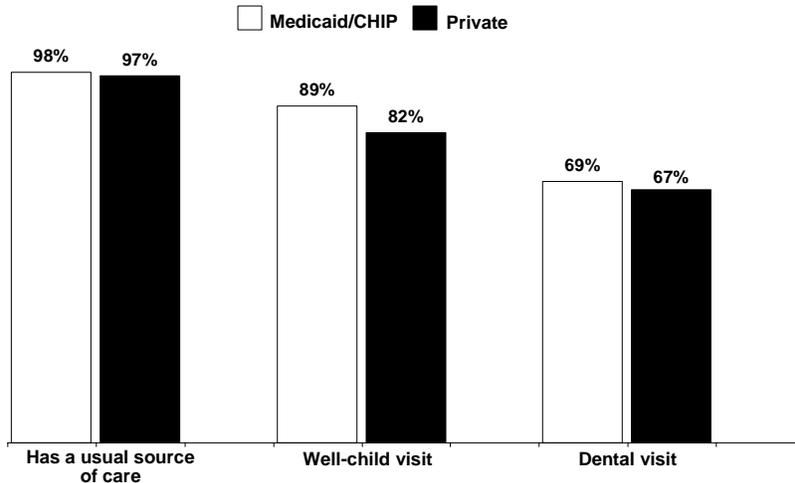
Questions about dental care were analyzed for children age 2-17. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.

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SOURCE: KCMU analysis of 2007 NHIS data.

Figure 10

### Access to Care for Low-Income Children: Public vs. Private Insurance

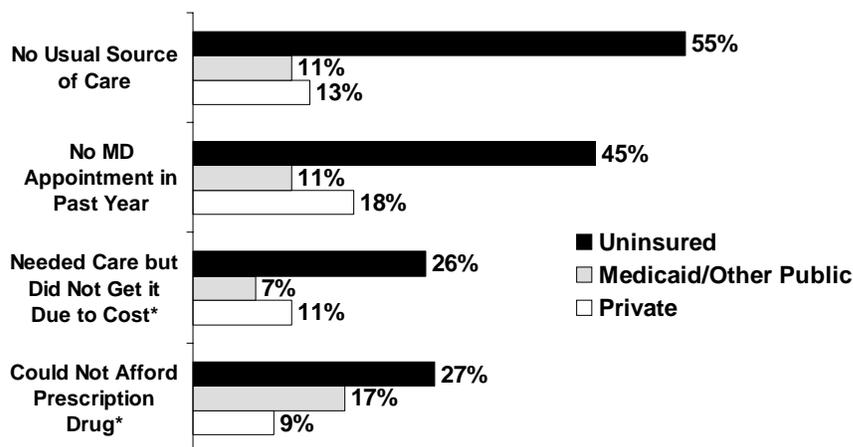


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SOURCE: Kaiser Survey of Children's Health Coverage, 2007.

Figure 11

### Barriers to Health Care Among Low-Income Nonelderly Adults, by Insurance Status, 2007

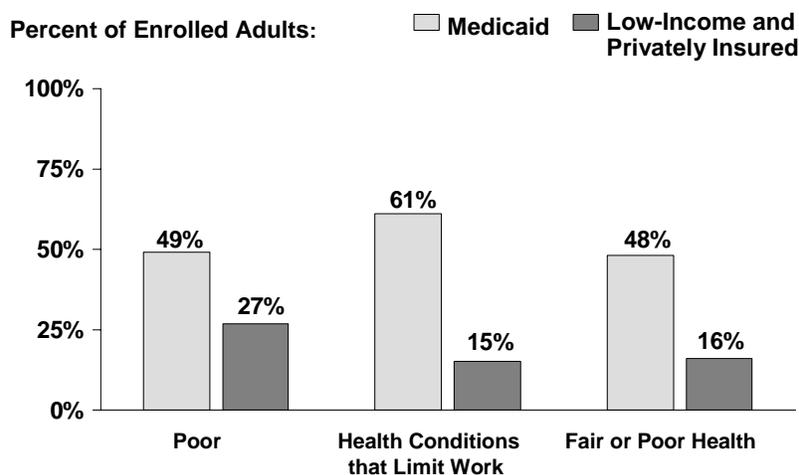


\* In the past 12 months  
 Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.  
 SOURCE: KCMU analysis of 2007 NHIS data.

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Figure 12

### Medicaid Enrollees are Poorer and Sicker Than the Low-Income Privately-Insured



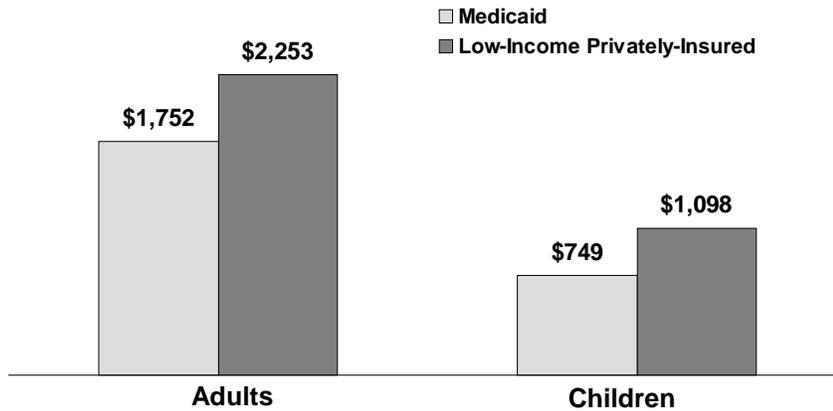
SOURCE: Coughlin et al., "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs*, July/August 2005.

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Figure 13

## Per Capita Spending For Medicaid Enrollees vs. Low-Income Privately-Insured

Samples adjusted for health differences



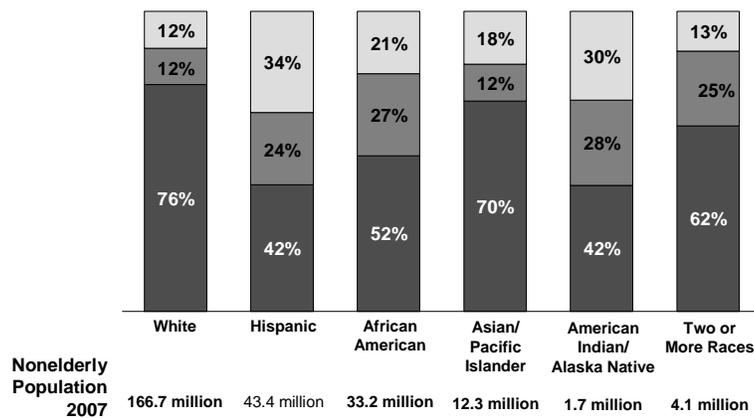
SOURCE: Hadley and Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, Winter 2003/2004.

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Figure 14

## Health Insurance Status, by Race/Ethnicity: Total Nonelderly Population, 2007

■ Private (Employer and Individual) ■ Medicaid and Other Public □ Uninsured



NOTE: "Other Public" includes Medicare and military-related coverage. All racial groups non-Hispanic.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of the March 2008 Current Population Survey.

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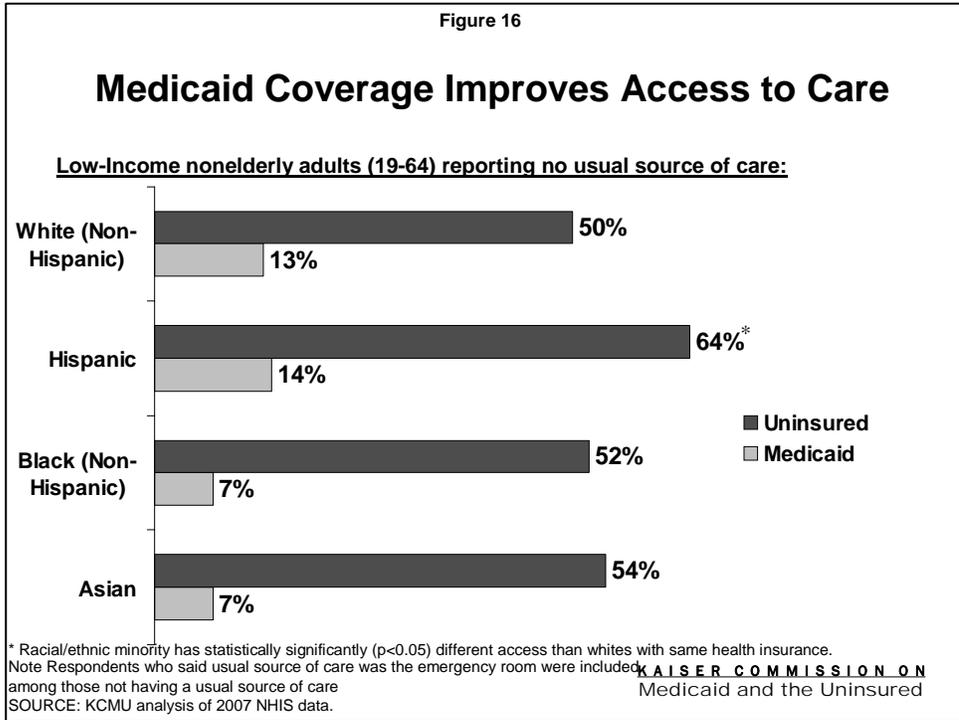
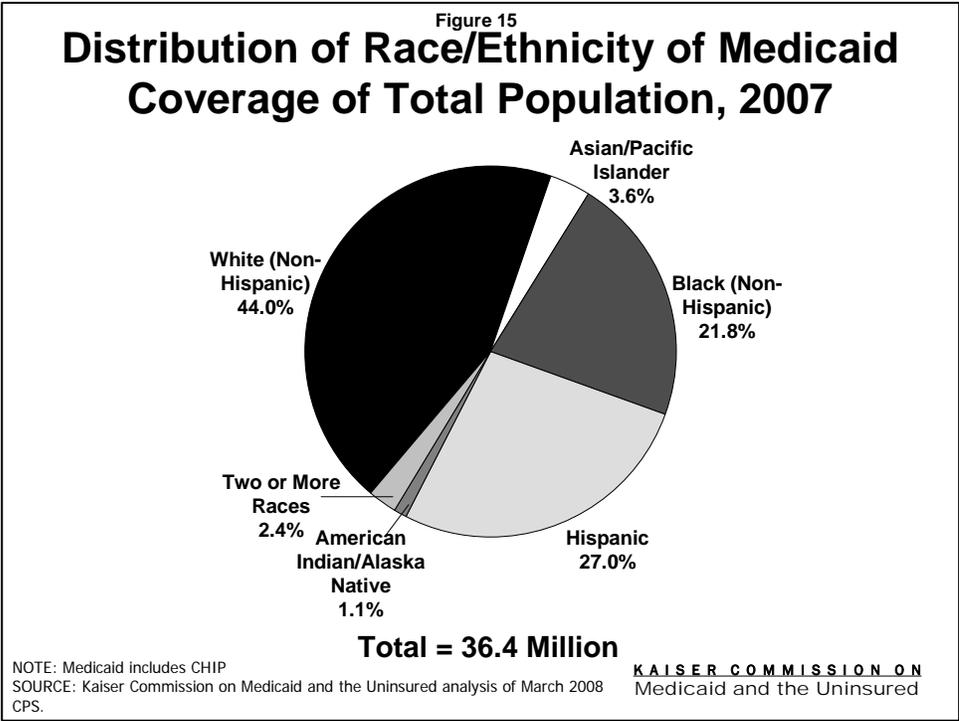
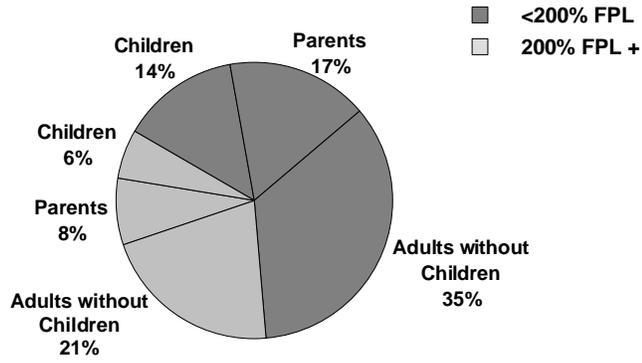


Figure 17

## The Nonelderly Uninsured, by Age and Income Groups, 2007



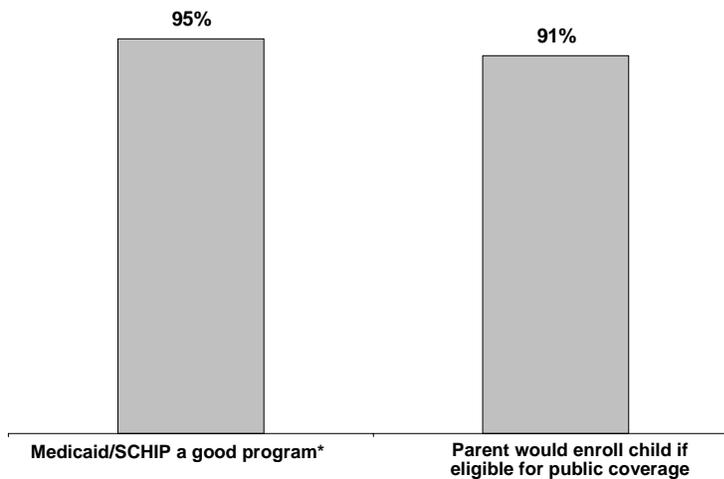
Total = 45.0 million uninsured

Low-income includes those with family incomes less than 200% of the federal poverty level.  
SOURCE: KCMU/Urban Institute analysis of March 2008 CPS.

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Figure 18

## Views of Public Coverage Among Low-Income Parents with an Uninsured Child



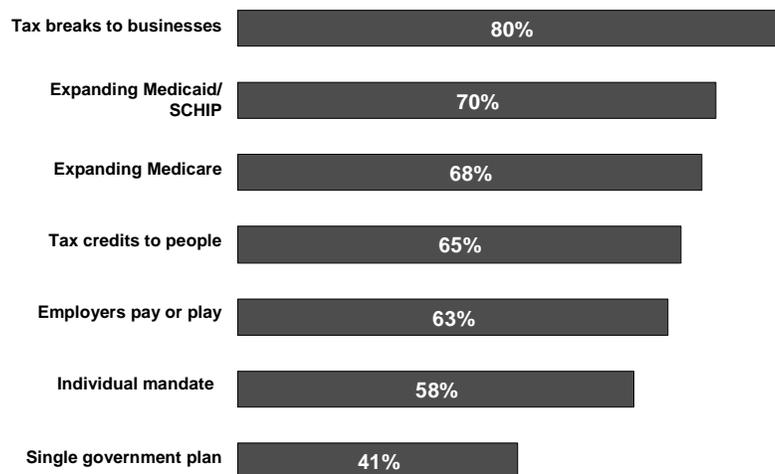
\*Based on those who have heard of Medicaid/SCHIP  
SOURCE: Kaiser Survey of Children's Health Coverage, 2007.

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Figure 19

## Options for Expanding Coverage

Percent of registered voters who favor each way to expand coverage:



Note: Not exact wording of options  
SOURCE: Kaiser Health Tracking Poll: Election 2008 (conducted Sep. 8-13, 2008)

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