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medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION

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Medicaid Beneficiaries and Access to Care

The plan for near-universal health coverage outlined in the new health care reform law, the Patient Protection and Affordable Care Act (P.L. 111-148), relies on a large expansion of Medicaid to reach fully half the uninsured population expected to gain coverage in the new system's first five years. An estimated 16 million more low-income individuals, mostly adults, will enter the program. Since the larger goal of health coverage is to improve access to care, the evidence on Medicaid beneficiaries' access is of key interest.

Medicaid and the Children's Health Insurance Program (CHIP) have substantially increased coverage among low-income Americans, especially children, narrowing both income-related and racial/ethnic disparities in coverage. Currently, all but seven states cover children in families up to 200% of poverty, or a higher level; eligibility for adults is much more limited, but it will expand greatly under health reform to reach nearly everyone up to 133% of poverty.[1] [2] Abundant research demonstrates that coverage, whether public or private, is a critical mechanism for securing access to needed health care.[3] In addition, evidence shows that Medicaid compares favorably with private coverage in connecting low-income children and adults with key primary and preventive care.[4]

Rates of access to primary and preventive care are high among both publicly and privately insured children. At the same time, provider shortages have translated into shortfalls in access to oral health and specialty care for children system-wide; in Medicaid, these gaps are amplified due to low provider participation.[5] [6] Physician shortages, especially in primary care, also leave growing access gaps for adults.

To help prepare for the increased access pressures that expanded Medicaid and private coverage will generate, the health reform law includes numerous provisions to improve the supply and distribution of the primary care workforce, significantly increases federal funding for community health centers, provides new authorities for innovative care delivery models, and provides federal financing to raise Medicaid payment for primary care services furnished by primary care doctors to 100% of the Medicare rate in 2013 and 2014. In addition, it broadens the scope of activities conducted by the Medicaid and CHIP Payment and Access Commission (MACPAC) to encompass adults as well as children.

The following findings and information provide a current assessment of Medicaid enrollees' access to care and the program's role in facilitating access, and help to frame consideration of the issue in the context of health care reform.

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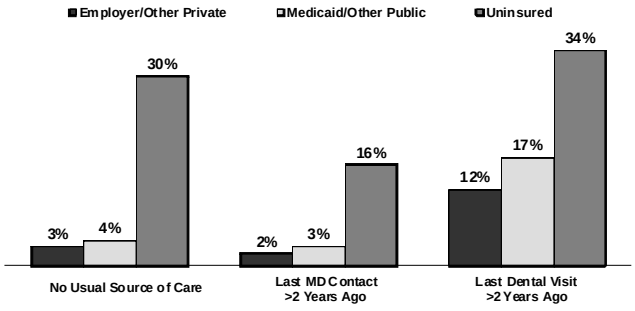
Medicaid has increased access to care and reduced unmet health needs. Both children and adults covered by Medicaid are much more likely to have a usual source of care than people without insurance. Children with Medicaid are also far more likely to have seen a doctor and dentist (Fig. 1) and adults with Medicaid are far more likely to

Figure 1

Children's Access to Care, by Health Insurance Status, 2008

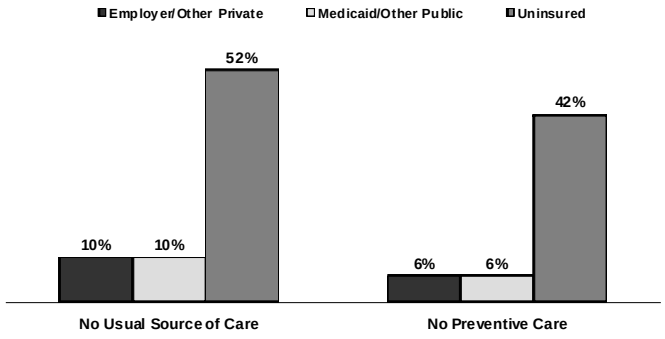


Notes: Questions about dental care were analyzed for children age 2-17. Other questions were analyzed for all children under age 18. MD contact includes other health professionals. Respondents who said usual source of care was emergency room were included in "no usual source of care."
SOURCE: KCMU analysis of 2008 NHIS data.

receive preventive care (Fig. 2). Moreover, across these measures, access in Medicaid and private insurance is roughly equivalent. This is notable given that Medicaid enrollees are sicker and more disabled than the privately insured and in light of concerns about low provider participation in Medicaid, due in part to low Medicaid payment rates.[7] [8]

Figure 2

Non-Elderly Adults' Access to Care by Health Insurance Status, 2008



Note: Respondents who said usual source of care was the emergency room were included in "no usual source of care."
SOURCE: KCMU analysis of 2008 NHIS data.

Medicaid provides comprehensive and affordable coverage. Medicaid's comprehensive scope of benefits and limited cost-sharing are designed to meet the more complex health needs and limited financial means of the low-income population the program serves. In addition to the medical services covered by most private insurance, Medicaid covers an array of supportive and enabling services for high-need populations – such as transportation, durable medical equipment, case management, and habilitation services – that private insurance generally does not cover today and is unlikely to cover under health

care reform (Fig. 3). Medicaid entitles children to a comprehensive set of services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

Figure 3

Medicaid Covers Complex Populations and Provides Key Services Not Covered by Private Insurance

High-Need Populations

- Pre-term births
- Foster care children
- Spinal cord and traumatic brain injuries
- Mental illness
- Intellectual disabilities
- Alzheimer's Disease

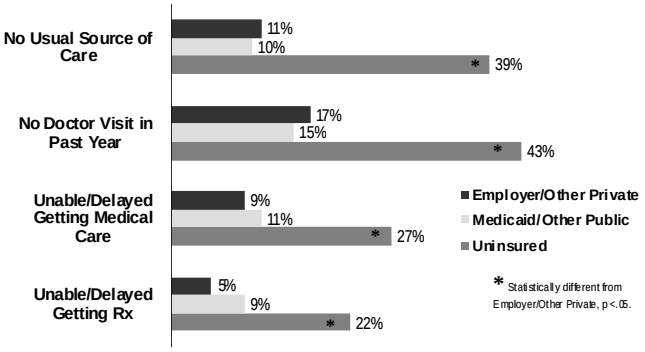
Key Medicaid Services

- EPSDT
- Inpatient / outpatient mental health services
- Transportation
- Durable medical equipment
- Case management
- Personal assistance
- Habilitation services
- Institutional care

The enabling services included among Medicaid's benefits strengthen access for the 60% of poor adults enrolled in Medicaid who have chronic conditions. Adults with chronic conditions fare at least as well in Medicaid as in private insurance (Fig. 4). Many of the uninsured who will be helped under health care reform are very low-income and have significant health needs, much like the current Medicaid population.[9]

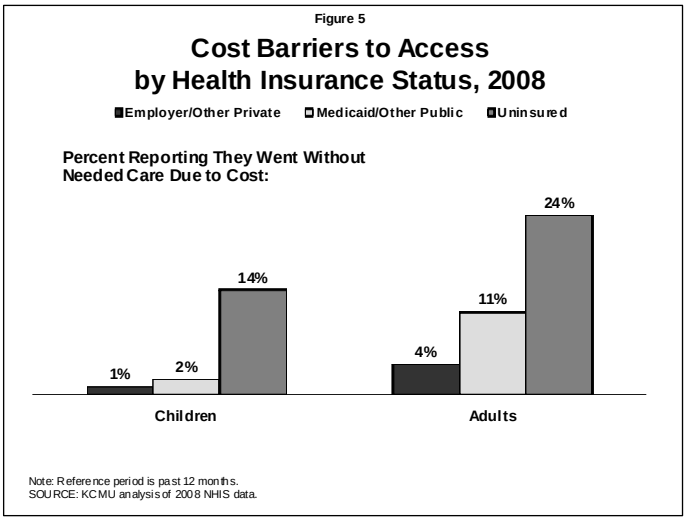
Figure 4

Access Problems Among Poor Adults with Chronic Conditions, by Health Insurance Status



Note: Adults age 19-64 below 100% FPL. Excludes adults who changed coverage or had more than one type of coverage in a year.
SOURCE: KCMU analysis of MEPS (3 pooled years 2004-2006).

Medicaid protects against high out-of-pocket costs. Even if they receive help with premiums, low-income people can find cost-sharing and deductibles to pose difficult barriers to seeking care.[10] Amounts that may be manageable for families at higher income levels can mount up quickly, impeding access for those with more limited finances. Recent research shows that, under the most popular insurance offered under the Federal Employees Health Benefits Program (FEHBP), a family with a relatively healthy child may still face significant out-of-pocket costs; families with more extensive needs for care or lower income may face much heavier out-of-pocket burdens.[11] Medicaid's strict limits on cost-sharing help to ensure that, for the low-income people the program serves, cost is not an obstacle to obtaining care (Fig. 5).



States have built delivery systems designed to serve the Medicaid population and address its special needs. State Medicaid programs have decades of experience developing and improving care delivery systems for the low-income populations they cover. Most Medicaid enrollees receive their care through managed care arrangements, and many states have built strong care delivery networks by contracting with community health centers and other safety-net providers located in the underserved communities where low-income people reside. Seeking both to improve care for their medically complex enrollees and to spend Medicaid dollars effectively, a number of states have pioneered care coordination and delivery approaches that have gained attention as model systems for improving quality for those with chronic conditions and disabilities.[12]

Public coverage is associated with improved quality and outcomes for low-income children, and parents of enrolled children report high satisfaction. Enrollment in public coverage is associated with improved quality of care among previously uninsured children. For example, after enrolling in New York's CHIP, children with asthma had fewer emergency department visits and hospitalizations.[13] Improvements in both physical and social health outcomes, including school attendance, for both healthy and chronically ill children, have been linked to public coverage.[14] Parents of children enrolled in Medicaid report high satisfaction with the program's benefits, providers and access, and Medicaid is viewed positively by the majority of the public.[15] [16]

The health reform law outlines a multi-pronged strategy for strengthening access both overall and in Medicaid. The expansion of coverage under health reform through Medicaid and subsidies for private insurance in the exchanges brings access issues to the fore. The success of health reform will ultimately be measured by the ability of Americans to obtain the care they need. The health reform law includes an array of provisions aimed at preparing our health care system for the new demands on it. Some, related to improving the workforce, seek to address access gaps in our overall system but, in effect, also target the more acute access problems in low-income communities. Other provisions strengthen the safety-net. The provision for increased Medicaid payment rates for primary care responds directly to a key cause of low provider participation in Medicaid, and uses that program lever to improve access as millions of new enrollees join the program. MACPAC's agenda reflects the national priority attached to ensuring adequate access to care in Medicaid and CHIP. Finally, in addition to

requiring states to provide newly eligible adults with a benchmark or benchmark-equivalent package that includes the essential health benefits available in the exchange, the law appears to permit states to define a benchmark plan that would cover a more comprehensive benefit package, similar to current Medicaid benefits. As implementation of health care reform proceeds, ensuring that Medicaid enrollees can gain access to the care they need will be an important focus of policy development.

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