kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

March 2004

Medicaid: A Lower-Cost Approach to Serving a High-Cost Population

Medicaid is our nation's principal provider of health insurance coverage for low-income Americans. The program is generally the only source of health coverage available to the 38 million low-income children and adults who are enrolled. Discussions about Medicaid spending and financing are a perennial feature of policy, legislative, and budget deliberations at both the federal and state level. Some contend that Medicaid is excessively costly and argue that the private sector could provide coverage more efficiently. Others maintain that, for the population covered and the services provided, Medicaid is, in fact, an effective vehicle for providing coverage.

New research conducted by Jack Hadley and John Holahan of the Urban Institute examines this issue and shows that Medicaid is a lower-cost approach to providing coverage when compared with private insurance – once the poor health status of Medicaid's beneficiaries is taken into account.[1] The study brings new empirical evidence to bear in the debate concerning the efficiency of Medicaid versus private health insurance as a mechanism for covering low-income children and adults.

The researchers sought to assess whether, for non-elderly adults and children with incomes below 200 percent of the federal poverty level, Medicaid is a high-cost program relative to private health insurance. Using statistical methods to control for differences between the demographic, socio-economic and health characteristics of those with Medicaid and those with private insurance, the investigators examined whether health care spending would be lower under private coverage than through Medicaid.[2] This policy brief highlights the key findings from this study.

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[1] For more details on the findings and methodology described in this issue paper, see Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, Vol. 40, No. 4, Winter 2003/2004. This research was supported by the Kaiser Commission on Medicaid and the Uninsured.

[2] Hadley and Holahan based their analysis on pooled data from the Medical Expenditure Panel Surveys (MEPS) conducted in 1996, 1997, 1998, and 1999. The expenditure data were inflated to 2001 dollars using the annual percentage increase in the National Health Accounts.

Study Highlights

The Medicaid Population is Much Poorer and Sicker than the Low-Income Privately Insured Population

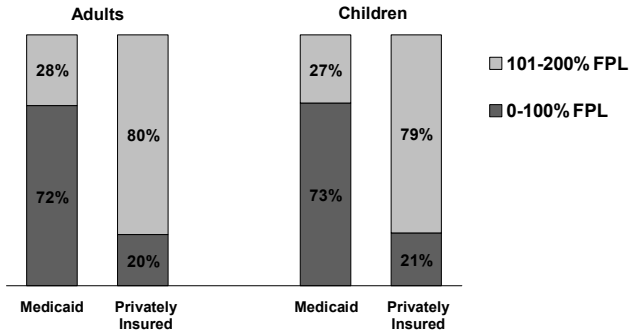
Income. The Medicaid population is much poorer than the low-income privately insured population.[3] The analysis by Hadley and Holahan indicates that the average family income for adults with Medicaid was only $18,614 – 56% of the average family income for low-income adults with private insurance. Similarly, average family income for children with Medicaid was 58% of average family income for low-income children with private coverage.

The much lower average income of the Medicaid population reflects the extremely high concentration of poverty among Medicaid enrollees. Among low-income adults, over 70 percent of those with Medicaid had incomes below the poverty level, compared with only 20 percent of the privately insured (Figure 1). Likewise, 73% of Medicaid children came from families below poverty, compared with only 21% of privately insured children.

Figure 1

Income Distribution of Low-Income Adults and Children

Medicaid and Privately Insured, 1996-1999



Note: All differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level, which was $28,256 for a family of 3 in 2001. "Adults" defined as age 19-64. "Children" defined as age 0-18.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

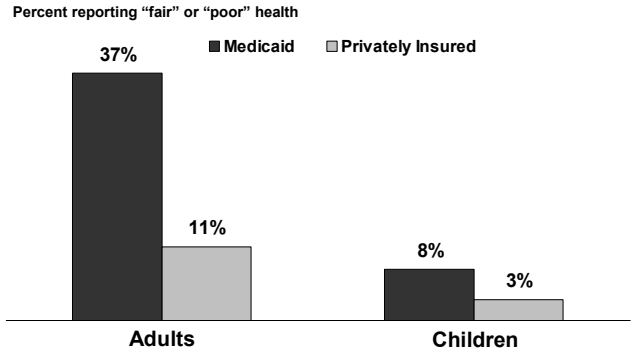
Health. Health status is markedly worse among both adults and children in Medicaid than among their privately insured counterparts. Among adults, the disparity is dramatic. In particular, over one-third of adults with Medicaid report that they are in fair or poor health, compared with only 11 percent of the privately insured. Nearly 60 percent of low-income adults with private coverage reported that they were in excellent or very good health, compared with only 34 percent with Medicaid (Figure 2, Table 1)[4]. The health status differentials for children are similar, though not as dramatic.

[3] "Low-income" is defined as income below 200% of the Federal Poverty Level (FPL).
[4] Tables 1 and 2 appear at the end of the brief.

Figure 2

Self-Reported Health Status among Low-Income Adults and Children

Medicaid and Privately Insured, 1996-1999



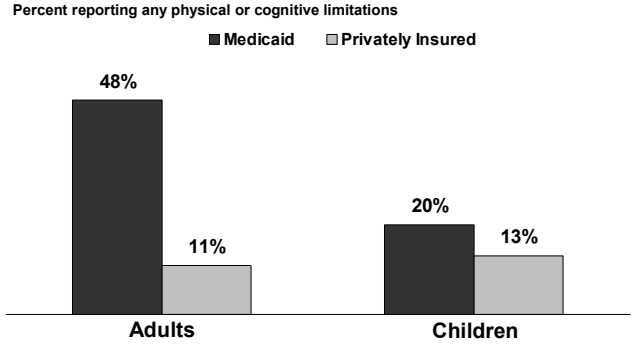
Note: All differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Children" defined as age 0-18.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Disability is also much more prevalent in Medicaid. Nearly half of adults with Medicaid report physical or cognitive limitations – a proportion over four times greater than among low-income adults with private insurance (Figure 3, Table 1). Among children, the disability rate is 20 percent in Medicaid, but 13 percent among the privately insured.

Figure 3

Physical and Cognitive Limitations among Low-Income Adults and Children

Medicaid and Privately Insured, 1996-1999



Note: All differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Children" defined as age 0-18.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Health Status Explains Medicaid's Higher Per Capita Spending

Driven largely by health status, per capita expenditures for adults with Medicaid were higher than the corresponding amounts for low-income adults with private coverage. However, when health status differences were adjusted by

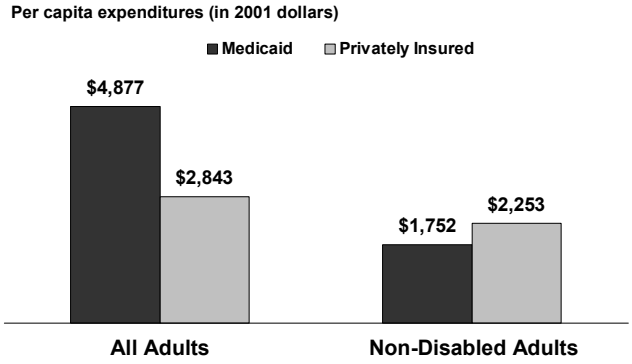
excluding disabled adults[5] from the analytic sample, per capita expenditures were significantly lower for Medicaid adults than for the privately insured. This result suggests that the higher per capita spending associated with Medicaid adults was due to the much poorer health of the Medicaid population.

When all sample adults were included in the analysis, per capita spending was $4,877 for those with Medicaid, compared with $2,843 for the privately insured. When only non-disabled adults were included, spending per Medicaid adult dropped by nearly two-thirds, to $1,752 – about 78 percent of the corresponding private insurance level of $2,253 (Figure 4, Table 2).

Figure 4

Per Capita Expenditures for Low-Income Adults

Medicaid and Privately Insured, All vs. Non-Disabled, 1996-1999



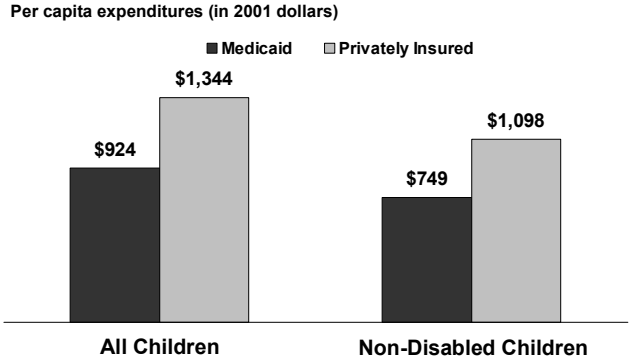
Note: All differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Non-disabled" defined as those not reporting any limitations.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Among children, per capita expenditures were significantly lower ($p<.10$) for those with Medicaid than for those with private coverage – even when children with disabilities, who are more prevalent in the Medicaid population, were included in the analysis (Figure 5, Table 2).

Figure 5

Per Capita Expenditures for Low-Income Children

Medicaid and Privately Insured, All vs. Non-Disabled, 1996-1999



Note: All differences are statistically significant at the 10% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Children" defined as age 0-18. "Non-disabled" defined as those not reporting any limitations.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

[5] For purposes of this analysis, "disabled" individuals are defined as those reporting any physical or cognitive limitation (see Table 1).

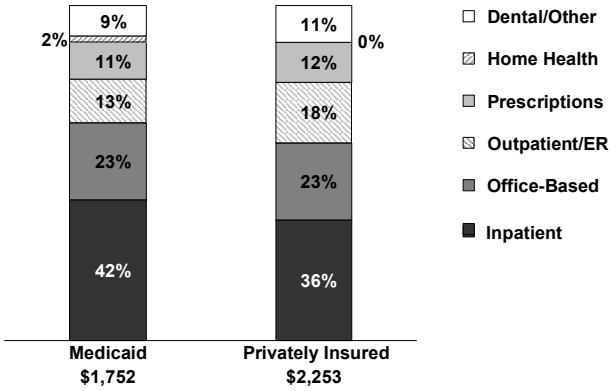
Benefits Often Cited as "Overly Generous" Account for Small Share of Medicaid Spending and a Larger Share of Private Insurance Spending

Dental and other services that states are not required by federal law to provide under Medicaid were found to account for less than ten percent of per capita spending for non-disabled adults in Medicaid. In fact, per capita spending for these services was higher for the privately insured than it was for the non-disabled in Medicaid (Figure 6).

Figure 6

Distribution of Per Capita Spending by Service for Low-Income, Non-Disabled Adults

Medicaid and Privately Insured, 1996-1999



Note: "Low income" defined as income below 200% of the Federal Poverty Level. Adults defined as age 19-64. "Non-disabled" defined as those not reporting any limitations. Totals in 2001 dollars.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Medicaid Protects against the High Out-of-Pocket Spending Faced by the Low-Income Privately Insured

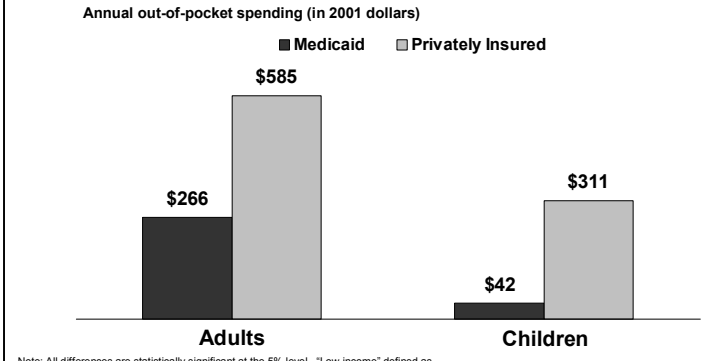
Low-income people with private insurance incur much higher out-of-pocket costs than do those covered by Medicaid. Presumably, the higher out-of-pocket costs they bear are attributable to cost-sharing charges and spending for non-covered benefits.

Privately insured adults below 200% FPL had out-of-pocket costs more than twice those of Medicaid adults, $585 versus $266 (Figure 7, Table 2). When disabled adults were excluded from the sample to increase comparability

Figure 7

Out-of-Pocket Spending by Low-Income Adults and Children

Medicaid and Privately Insured, 1996-1999



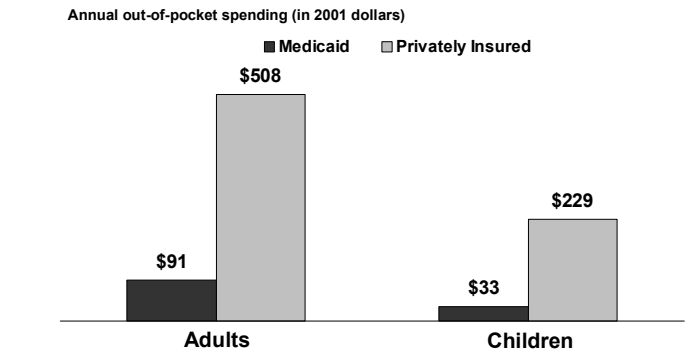
Note: All differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Children" defined as age 0-18.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

between the Medicaid and privately insured groups with respect to health status, the out-of-pocket gap widened to nearly a six-fold difference – $508 for the privately insured versus $91 for those in Medicaid (Figure 8). In the case of children, the privately insured spent roughly seven times more than those with Medicaid – whether children with disabilities were included or not. The limits on cost-sharing in Medicaid appear to protect its beneficiaries from large out-of-pocket obligations.

Figure 8

Out-of-Pocket Spending by Low-Income Non-Disabled Adults and Children

Medicaid and Privately Insured, 1996-1999



Note: All differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Children" defined as age 0-18. "Non-disabled" defined as those not reporting any limitations.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

The higher out-of-pocket health care costs incurred under private coverage would be difficult for the sicker and poorer Medicaid enrollees to afford if they were enrolled in private plans unless states provided comprehensive "wrap around" or supplemental protection to cover these costs.

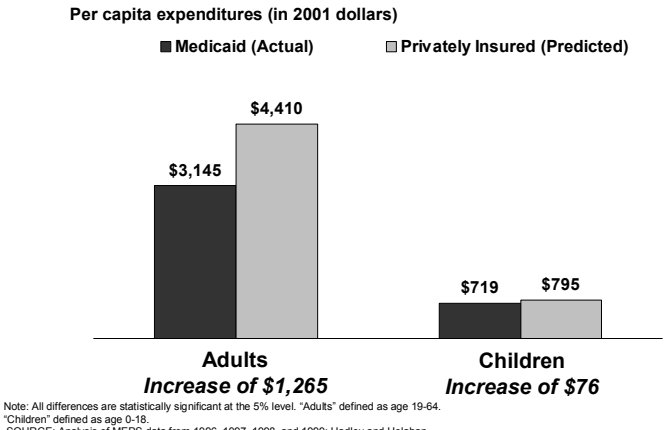
Simulation Results: Estimates of Spending per Person under Medicaid and Private Insurance

If the average person enrolled in Medicaid were shifted to private insurance, simulation models indicate that per capita spending would increase by $1,265 for an adult and by $76 for a child (Figure 9).[6]

[6] See Hadley and Holahan, 2004, for more details on the simulation models used.

Figure 9

Predicted Spending for Low-Income Medicaid Adults and Children if Given Private Insurance

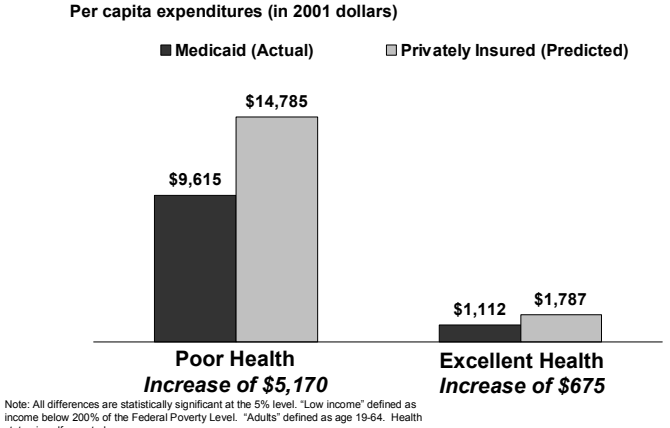


Note: All differences are statistically significant at the 5% level. "Adults" defined as age 19-64. "Children" defined as age 0-18.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Per capita spending for an adult Medicaid beneficiary in poor health would rise from $9,615 to $14,785 if the person were insured privately and received services consistent with private utilization levels and private provider payment rates. For an adult in excellent health, a shift from Medicaid to private coverage would increase per capita spending by $675 (Figure 10). The results for children are generally similar, but less dramatic because the spending per person is so much lower.

Figure 10

Predicted Spending for Low-Income Medicaid Adults if Given Private Insurance, by Health Status



Note: All differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. Health status is self-reported.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Medicaid's low per capita spending levels are due, in part, to lower provider payment rates under Medicaid than in private insurance. Inadequate payment rates have affected some providers' willingness to participate in the Medicaid program and have impeded access to care. But, as discussed below, this research indicates that utilization of basic services among Medicaid beneficiaries

is generally the same as or higher than the utilization of these services by the low-income privately insured.

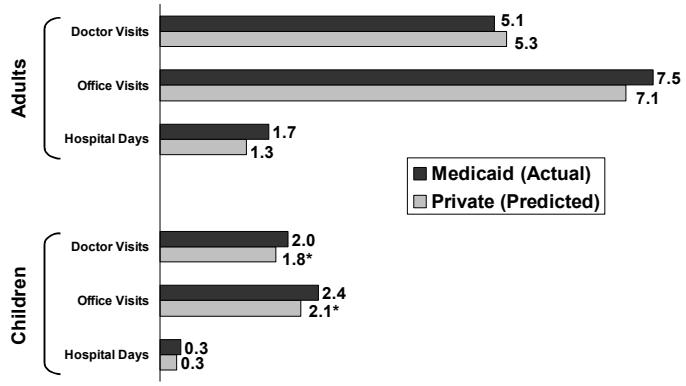
Utilization of Services

When controlling for income, health and other characteristics, adults in Medicaid appear no more or less likely than those with private coverage to have a medical expense (i.e., use a service). Among the adults who did have an expense, total spending was significantly lower for those with Medicaid than for the privately insured, largely reflecting Medicaid's lower provider payment rates. Unlike adults, children with Medicaid were found to be more likely than their privately insured peers to use a service. However, among children with any expense, total expenditures were also lower for those covered by Medicaid.

Using simulation techniques, the predicted utilization of Medicaid adults shifted to private insurance is not significantly different from their actual utilization under Medicaid (Figure 11). However, the findings for children are different – children in Medicaid have more doctor and office visits under Medicaid than they would be expected to have if their utilization followed private insurance patterns (Figure 11). This may reflect Medicaid's emphasis on well-child care, and the deterrent effect on utilization of the much higher cost-sharing requirements of many private plans.

Figure 11

Predicted Impact on Utilization by Low-Income Adults and Children with Medicaid If Given Private Insurance



*Differences are statistically significant at the 5% level. "Low income" defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Children" defined as age 0-18.
SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

It should be noted that while utilization of broad categories of service was examined, possible differences in the detailed content of the care (e.g., specialist services, surgical procedures, diagnostic tests, etc.) between the Medicaid and privately insured low-income populations were not analyzed.

Discussion

When the poorer health status of Medicaid beneficiaries is taken into account, Medicaid provides coverage at a lower per capita cost than private insurance. The study findings highlight the distinctive profile of the Medicaid population, compared with other low-income people, and the special role that Medicaid plays as an insurer. Neither higher utilization in Medicaid nor the program's more comprehensive benefit structure are key factors driving Medicaid spending.

The results of this research suggest that using public funds to purchase private coverage would cost considerably more than building on Medicaid. However, any reform based on a broad expansion of Medicaid would need to address the low provider payment rates long associated with the program. Additionally, the prospect of much higher out-of-pocket costs for the Medicaid population if they were moved to private coverage could limit their access to needed care, particularly considering their poverty and extensive health care needs.

As policymakers evaluate Medicaid's performance as an insurer for low-income non-elderly adults and children, and private-market coverage as a potential alternative, these key study findings and implications warrant consideration:

- **The high per capita spending associated with non-elderly adults and children with Medicaid, as compared with the privately insured low-income population, is due to the much poorer health of those with Medicaid.** The Medicaid population differs significantly from the privately insured low-income population. Comparisons between the two groups need to account for their different income and health profiles. Medicaid plays a critical role in our health insurance system as the source of coverage for many of the sickest and poorest Americans, whom private insurance does not reach.

- **Out-of-pocket spending for the low-income privately insured is six to seven times greater than that faced by low-income Medicaid beneficiaries.** These much higher out-of-pocket costs would represent a heavier financial burden for the much sicker and mostly poor population in Medicaid. If Medicaid beneficiaries were moved into private coverage without the financial protection of "wrap around" or supplemental coverage, access to care could be diminished for those most in need.

- **Medicaid's comprehensive coverage of dental care and other optional services accounts for less than 10 percent of per capita spending for individuals with Medicaid; per capita spending for these services is higher for individuals with private coverage.**

- **Lower per capita spending in Medicaid (adjusted for differences in health status) reflects, in part, Medicaid's lower provider payment rates, raising concerns about access to care in the program.** Although this study indicates that expected utilization of basic services by Medicaid beneficiaries is comparable to what would be expected for the privately insured, further analysis is needed to examine whether less access to medical specialists, advanced diagnostic and therapeutic procedures, and high cost drugs contribute to Medicaid's lower costs.

- **Moving those who are now on Medicaid into private coverage could significantly increase health care spending and might not improve access if cost-sharing proved to be a barrier.** Better access to specialty care or better quality of care through market-based coverage would need to be balanced against budget concerns, and against the risk that higher cost-sharing might diminish access to care and increase financial hardship for very low-income people.

This brief was prepared by Julia Paradise and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured and is based on research conducted for the Commission by Jack Hadley and John Holahan of the Urban Institute. For more details on this research see Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry*, Vol. 40, No. 4, Winter 2003/2004.

Table 1
Health Status and Health Conditions of Low-Income Adults and Children by Source of Coverage (2001)

	Medicaid	Private	
Adults			
Self-Reported Health Status (%)			
Excellent	13.8	27.7	*
Very Good	19.9	30.8	*
Good	29.1	30.2	
Fair	21.3	8.8	*
Poor	16.0	2.5	*
Limitations (%)			
Fair or Poor Mental Health	25.6	4.3	*
ADL/IADL Screener	11.3	1.2	*
Used Assistive Devices	6.9	1.3	*
Difficulty Lifting, Walking, or with Steps	15.6	3.1	*
Social or Cognitive Limitations	21.4	3.7	*
Work/Housework/School Limitations	9.0	2.8	*
Unable to Perform Activity	17.8	2.5	*
Deceased or Institutionalized	2.4	0.5	*
Any Limitations	48.0	10.8	*
Children			
Self-Reported Health Status (%)			
Excellent	40.4	49.4	*
Very Good	27.5	31.3	
Good	24.4	16.2	*
Fair	6.4	2.5	*
Poor	1.3	0.6	*
Limitations (%)			
Fair or Poor Mental Health	5.2	2.2	*
ADL Screener	1.4	0.5	*
IADL Screener	10.6	8.6	*
Limited in Any Activity (age<5)	1.1	0.3	
Special Group (age<5)	2.4	1.5	
Deceased or Institutionalized	0.4	0.1	
Any Limitations	20.4	12.6	*

* significantly different from Medicaid at the 5% level.

SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Table 2
Per Capita Expenditures for Low-Income Americans by Source of Coverage (2001)

	All		Non-Disabled	
	Medicaid	**Private**	**Medicaid**	**Private**
Adults				
Total Expenditures	$4,877	$2,843 *	$1,752	$2,253 *
Private	$2	$2,051 *	$0	$1,617 *
Medicaid	$4,003	$17 *	$1,540	$8 *
Out-of-Pocket	$266	$585 *	$91	$508 *
Other	$607	$190 *	$120	$120
Children				
Total Expenditures	$924	$1,344 **	$749	$1,098 **
Private	$0	$1,004 *	$0	$853 *
Medicaid	$801	$10 *	$645	$4 *
Out-of-Pocket	$42	$311 *	$33	$229 *
Other	$81	$19 *	$71	$13 *

* significantly different from Medicaid at the 5% level.

** significantly different from Medicaid at the 10% level.

Note: "Other" includes Medicare, VA, Champus, other Federal, other state and local, workers' compensation, other public, other private, and other sources.

SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

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