Access to Care for Low-Income Women: The Impact of Medicaid

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ACCESS TO CARE FOR LOW-INCOME WOMEN: THE IMPACT OF MEDICAID

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Abstract: This study was undertaken to assess how low-income women with Medicaid, private insurance, or no insurance vary with regard to personal characteristics, health status, and health utilization. Data are from a telephone interview survey of a representative cross-sectional sample of 5,200 low-income women in Minnesota, Oregon, Tennessee, Florida, and Texas. On the whole, low-income women were found to experience considerable barriers to care; however, uninsured low-income women have significantly more trouble obtaining care, receive fewer recommended services, and are more dissatisfied with the care they receive than their insured counterparts. Women on Medicaid had access to care that was comparable with their low-income privately insured counterparts, but in general had significantly lower satisfaction with their providers and their plans. Future federal and state efforts should focus on expanding efforts to improve the scope and reach of health care coverage to low-income women through public or private means.

Key words: Women, access, Medicaid, insurance, uninsured, poverty, prevention, satisfaction.

Low-income women face numerous challenges in obtaining access to health care services. Economic disadvantage, limited educational achievement, discriminatory practices, and health problems all combine to affect their health care needs and use of health care services. For low-income women, health care coverage, whether through private insurance or Medicaid, makes a critical difference in whether and how they received their care.

Yet, many changes taking place in public and private sectors appear to be eroding coverage for this group. Despite increased workforce participation in the past decade, the proportion of women without insurance continues to rise.[1,2] On the Medicaid front, after years of expansion, particularly for low-

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income pregnant women and children, there are signs that Medicaid coverage may be falling.[3] This appears to be, in part, attributable to the decoupling of Medicaid and cash assistance, a stipulation in the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA). There is evidence that the rapid decrease in the number of persons receiving cash assistance through Temporary Assistance to Needy Families (TANF) has been accompanied by reductions in Medicaid enrollment.

These reductions in health care coverage are particularly significant for women because they are more likely to use health care services than men.[4] This is largely because of reproductive health care needs during their childbearing years and high prevalence of chronic health problems in their mature years. Women also have higher out-of-pocket health expenditures and spend a larger proportion of their income on health care than men.[5,6] For low-income women, these affordability problems are intensified. The lack of adequate financial resources translates to difficulties in the basic logistics of obtaining care. These include arranging and paying for child care and transportation to and from appointments, as well as taking time away from work, sometimes without pay.

In this article, we use the Kaiser/Commonwealth Five-State Low-Income Survey to examine the role of health care coverage for low-income women. We explore how women with Medicaid, private insurance, or no insurance vary with regard to personal and household characteristics, health status, and health care utilization. We show the problems with access and satisfaction with care faced by low-income, uninsured women and document the importance of Medicaid coverage in improving access to care for low-income women.

Methods

The study design and survey instrument were developed by researchers at The Henry J. Kaiser Family Foundation, The Commonwealth Fund, and Louis Harris and Associates, Inc. The Kaiser/Commonwealth Five-State Low-Income Survey includes a cross-sectional sample of adults 18 to 64 years of age with incomes at or below 250 percent of the federal poverty level, about $30,000 for a family of three in 1996. Approximately 2,000 adults were interviewed in each of the following states: Florida, Minnesota, Oregon, Tennessee, and Texas.

The survey collects basic demographic statistics and information on health status, health care coverage, access to and satisfaction with care, and health care utilization. A total of 10,013 telephone interviews were conducted in Minnesota, Oregon, and Tennessee between August 25, 1995 and October 27, 1995; and in Florida and Texas between January 12, 1996 and March 11, 1996. The chi-square analysis is restricted to the 5,200 women 18 to 64 years of age included in the survey.

The data were weighted based on an average of the March 1994 and March 1995 Current Population Surveys to reflect the known age, gender, race, education, number of adults in the household, and urbanicity for the low-income popuation within each of the states. Since the survey does not sample adults in households without telephones, our results are likely to understate the rates of having no insurance and poverty for the women in these states. The average response rate for the five states was 54 percent. The states were selected as part of the study because they represent a wide variety of models of state Medicaid programs—from those that have expanded coverage as in Tennessee, Oregon, and Minnesota, to those that maintain rather restrictive eligibility criteria and traditional programs, such as Florida and Texas. They also exemplify a broad range of Medicaid and private delivery systems including states with different managed care practices and policies, and those with fee-for-service dominated private and public insurance programs.

Measures

Health insurance. Women reporting current coverage from any source were counted as insured. Because a person may have more than one source of coverage, a hierarchical variable was created giving priority to Medicaid, then employment-based coverage, followed by privately purchased coverage, and lastly to Medicare. Women were divided into the following three insurance groups for this study: uninsured, Medicaid, and private/other coverage. This last group consists primarily of those with employment-based coverage (85 percent), but also includes women with privately purchased coverage (11 percent), and a small percentage with Medicare or other sources (4 percent).

Health status. Respondents' health status was measured in the following two ways: (1) perceived health status (excellent, good, fair, poor), and (2) whether the respondent had a serious illness, injury, or disability that required a lot of medical care in the past 12 months. In addition, household health status was measured using an indicator of whether anyone in the household had a serious illness, injury, or disability requiring considerable medical attention in the past 12 months.

Access-to-care indicators. Several access-to-care measures were used. Whether respondents had a regular provider was measured by the question, "Do you have a particular doctor or other health professional you usually go to when you are sick or want medical advice, or not?" Whether respondents had a usual source of care and the type of usual source were measured by the question, "Where do you usually go to get medical care?" Postponement of needed care was measured with the question, "In the past 12 months, have you ever put off or postponed seeking health care which you felt you needed, or not?" Information on the problems of getting needed care was obtained by

the question, "In the past 12 months, was there a time when you needed medical care but did not get it, or not?"

Health care use. Use of health care was measured by the absence or presence of a health care visit during the past year, including a physician visit, an obstetric visit, or a family planning visit. Health care use was also measured by the receipt of a Pap test during the past year, a clinical breast examination, or a mammogram (limited to women aged 50 to 64 years).

Satisfaction with care. Satisfaction with care was measured using a four-point scale (excellent, good, fair, or poor). Fair or poor ratings are reported in this article.

Analysis

The bivariate chi-square analysis compares women with Medicaid, those with private/other coverage, and those with no coverage, examining access to care, health care use, and satisfaction with care. To account for design effects due to the sampling approach, the SUDAAN software program was used to compute the standard errors. Sampling tolerances at the 95 percent confidence interval were used to evaluate statistically significant differences between proportions.

Results

Patterns of coverage. Medicaid is an important source of coverage for low-income women in the survey states, with one-quarter (24 percent) of women with incomes at or lower than 250 percent of poverty receiving this benefit (Table 1). An additional 54 percent have private or other coverage. An average of 22 percent of low-income women in the five states are uninsured, although the percentage varies across the states. Uninsured rates are lower in those states with broader Medicaid eligibility standards (Minnesota, Tennessee, and Oregon) that were operating Section 1115 waivers that allowed them to extend coverage to other low-income people who would not be eligible traditionally for Medicaid, and highest in the states where Medicaid eligibility policy is more restrictive (Florida and Texas).

Duration of coverage. Although 78 percent of respondents in the states were insured at the time of the survey, many have faced gaps in coverage. Among those with Medicaid, nearly one-third (31 percent) were without coverage at some time during the past two years. For women with private or other coverage, 19 percent experienced a lapse of coverage during the previous two years. Overall, 24 percent of low-income women in the survey states reported some period without coverage during the past two years. Twenty-four percent were uninsured for part of this period, and 16 percent were

TABLE 1
TYPE OF COVERAGE AND DURATION OF COVERAGE OF LOW-INCOME WOMEN BY STATE AND HEALTH INSURANCE STATUS, FLORIDA, MINNESOTA, OREGON, TENNESSEE, AND TEXAS, 1995-1996

	PERCENTAGE DISTRIBUTION (SE)			
	TOTAL (n = 5,242)	*MEDICAID (n = 1,269)*	*UNINSURED (n = 1,135)*	*PRIVATE/OTHER (n = 2,838)*
Insurance coverage	100	24 (<1)	22 (<1)	54 (<1)
Florida (*n* = 1,060)	100	16 (1)	30 (1)	54 (2)
Minnesota (*n* = 1,043)	100	25 (2)	12 (2)	63 (2)
Oregon (*n* = 1,003)	100	23 (2)	20 (2)	57 (2)
Tennessee (*n* = 1,084)	100	42 (2)	10 (1)	48 (2)
Texas (*n* = 1,053)	100	15 (1)	35 (2)	50 (2)
Health insurance duration				
Sporadic coverage during past two years	24	31 (2)	27 (2)	19 (1)
Without coverage during past two years	16	NA	73	NA

Source: 1997 Kaiser/Commonwealth Five-State Low-Income Surveys, 1995-1996.

uninsured for the full two years. Among uninsured women, 73 percent have been without coverage for at least two years.

The risk of being uninsured for at least two consecutive years is highest among women in fair or poor health and among those with incomes below poverty. Among uninsured women, 79 percent of those in fair or poor health have been uninsured for at least two years compared with 69 percent of those in excellent or good health (data not shown). Poor uninsured women are also more likely to have been uninsured for two years, with 76 percent reporting no coverage for at least two years, compared with 69 percent of women with incomes higher than the federal poverty level. Both lapses in coverage and lack of coverage translate to gaps in, and lack of stability of, coverage for this population.

Demographic factors and health status. The characteristics of the women in the three insurance groups differ considerably on most social and economic measures (Table 2). Medicaid eligibility policy for women is largely determined by low income and having small children in the household or pregnancy and, until recently, was automatically linked to the receipt of cash assistance through the receipt of Aid to Families with Dependent Children (AFDC). In the survey states, women on Medicaid are younger, more socially and economically disadvantaged, and in family situations with fewer options to generate resources than those with private/other coverage, and to a lesser

TABLE 2
DEMOGRAPHIC, HOUSEHOLD, AND HEALTH STATUS OF LOW-INCOME WOMEN BY HEALTH INSURANCE STATUS, FLORIDA, MINNESOTA, OREGON, TENNESSEE, AND TEXAS, 1995-1996

	TOTAL PERCENTAGE	*MEDICAID PERCENTAGE (SE)*	*UNINSURED PERCENTAGE (SE)*	*PRIVATE/OTHER PERCENTAGE (SE)*
Demographics				
Younger than 30 years of age	33	42 (2)	33 (2)***	29 (1)***
Nonwhite	31	38 (2)	40 (2)	25 (1)**
Less than high school education	19	28 (1)	30 (2)	10 (1)***
Not working	42	63 (2)	48 (2)***	29 (1)***
Receiving AFDC	8	26 (1)	3 (1)***	2 (<1)***
Household information				
Family incomes below poverty	43	72 (2)	55 (2)***	26 (1)***
Single, widowed, divorced, or separated	39	53 (2)	37 (2)***	34 (1)***
Children in household	64	74 (1)	63 (2)***	59 (1)***
Health status				
Self-reported fair or poor health	27	37 (2)	33 (2)*	20 (1)***
Serious health problem in past year	18	29 (2)	14 (1)***	15 (1)***
Family member in fair or poor health	21	23 (2)	20 (1)	20 (1)

Source: 1997 Kaiser/Commonwealth Five-State Low-Income Surveys, 1995-1996.
Note: AFDC = Aid to Families with Dependent Children.
*Different than Medicaid at $p < .05$. **Different than Medicaid at $p < .01$. ***Different than Medicaid at $p < .001$.

extent, uninsured women. Because of the historical link between Medicaid and cash assistance, it is not surprising that women on Medicaid are also more likely to receive income from public benefits, such as AFDC, and less likely to be in the labor market. Whereas 63 percent of women receiving Medicaid reported that they did not work, 48 percent of uninsured women and 29 percent of women with private/other coverage are not in the labor market. They are also the most economically disadvantaged. Nearly three-fourths (72 percent) have family incomes below the poverty level, in contrast to one-fourth (26 percent) of women with private/other coverage. Uninsured women fall

in-between, with approximately one-half (55 percent) living in poverty. Many of the uninsured may have incomes that are very low, but still too high to qualify for Medicaid.

Medicaid recipients are also more likely to be single, widowed, divorced, or separated, which limits opportunities for private insurance coverage as a dependent and also results in reduced overall resources entering the family. A further difference among the insurance groups is the proportion with children in the household, with the highest rate seen for women on Medicaid, of whom nearly three-fourths (74 percent) have children in the household. A similarity of note is the educational status of women on Medicaid and those without insurance. Both groups are three times more likely to lack a high school education than are women with private/other coverage.

Differences emerged in health status measures as well. Overall, the Medicaid group reports being in the worst health even though they are younger. Nearly 4 out of 10 (37 percent) women receiving Medicaid report being in fair or poor health, a rate slightly higher than for women who are uninsured (33 percent). Both of these groups report poorer health than women with private/other coverage (20 percent). The Medicaid population is twice as likely (29 percent) to have had a serious illness or injury in the past 12 months that required a lot of medical care than low-income, privately insured (15 percent) and uninsured women (14 percent). Similarities are seen among the groups in the percent reporting a household member with a serious illness or injury during the past year, with approximately 2 out of 10 reporting this. Very often, these are the very women who are the primary caretakers for sick children, parents, or spouses.

Access to health care. The survey found that uninsured, low-income women face the most serious barriers to care. Half lack a regular provider (50 percent), compared with 26 percent of women receiving Medicaid and 26 percent of those with private/other coverage (Table 3). Uninsured women are three to four times more likely to lack a regular source of care (20 percent) than either those on Medicaid (6 percent) or those with private coverage (4 percent). Women with Medicaid coverage, even though they have more sporadic coverage, have a similar connection to the health care system as do women with private coverage. Of note is that low-income women overall are more likely to report having a usual source of care than a regular provider, perhaps indicating that they are more likely to get their care from institutional providers where they may see a different physician at each visit.

Another indicator of access is the ability to get care when indicated. Postponing care was common among low-income women across all insurance categories, but most prominent among the uninsured, with 42 percent reporting a delay. However, coverage alone does not prevent delays in seeking care. Just less than one-third (32 percent) of women with Medicaid coverage delayed care, a rate slightly higher than that for women with private/other coverage (28 percent). The inability to receive care when needed was less

TABLE 3
ACCESS TO CARE AND USE OF HEALTH CARE SERVICES FOR LOW-INCOME WOMEN BY HEALTH INSURANCE STATUS, FLORIDA, MINNESOTA, OREGON, TENNESSEE, AND TEXAS, 1995-1996

	TOTAL PERCENTAGE	*MEDICAID PERCENTAGE (SE)*	*UNINSURED PERCENTAGE (SE)*	*PRIVATE/OTHER PERCENTAGE (SE)*
Access				
No regular provider	31	26 (1)	50 (2)***	26 (1)
No regular source of care[a]	8	6 (1)	20 (1)***	4 (<1)
Postponed needed care	32	32 (2)	42 (2)***	28 (1)*
Did not receive needed care	14	15 (1)	26 (2)***	8 (1)*
Use of health care services				
No doctor visit past year	18	9 (1)	32 (2)***	16 (1)***
No Pap test past year	43	38 (2)	57 (2)***	39 (1)
No clinical breast examination past year	51	51 (2)	65 (2)***	46 (1)*
No mammogram past year (ages 50 to 64 years)	54	53 (3)	73 (3)***	47 (2)
At least one obstetric visit (ages 18 to 29 years)	29	39 (3)	22 (3)**	26 (3)**
At least one family planning visit (ages 18 to 29 years)	23	33 (3)	22 (3)**	18 (2)***
Using public health/ family planning clinic (ages 18 to 29 years)	58	55 (5)	81 (5)***	47 (6)

Source: 1997 Kaiser/Commonwealth Five-State Low-Income Surveys, 1995-1996.
[a] Includes those reporting emergency department as regular provider.
*Different than Medicaid at $p < .05$. **Different than Medicaid at $p < .01$. ***Different than Medicaid at $p < .001$.

frequently reported than postponing care, but did affect 26 percent of uninsured women. Insured women also reported not receiving needed care but to a lesser extent, with 15 percent of women on Medicaid and 8 percent of those with private/other coverage reporting that they were unable to get care they felt they needed during the past year.

Use of health services. Uninsured women are two to three times more likely than either women on Medicaid or women with private/other coverage to have been without a physician visit during the past year. Only 9 percent of

women on Medicaid had no physician visit in the past year, considerably lower than their privately insured (16 percent) and uninsured (32 percent) counterparts. These differences hold when comparisons are made among those in fair or poor health, with the uninsured the least likely to have had a visit, and those on Medicaid the most.

Receipt of clinical preventive services is generally felt to be a good indicator of overall access. Low-income women overall show serious gaps in receipt of Pap tests, clinical breast examinations, and mammography screenings. These gaps are highest for uninsured women. Nearly 6 out of 10 (57 percent) uninsured, low-income women report that they have not received a Pap test during the past year. In contrast, approximately 4 out of 10 insured women were not screened in the past year, with rates similar for those on Medicaid and with private/other coverage. Clinical breast examination rates also show differences by insurance status, with 65 percent uninsured women reporting no screening compared with those with private/other coverage (46 percent) or Medicaid (51 percent).

A similar pattern is seen for mammography screening among women aged 50 to 64 years. Nearly three-fourths of uninsured women did not receive a mammogram during the past year, compared with approximately one-half of women with Medicaid (53 percent) and those with private/other coverage (47 percent; no statistically significant difference).

Reproductive health care is an important component of access for women. Nearly 3 out of 10 low-income women aged 18 to 29 years had at least one obstetric visit in the past year. Rates are highest for women on Medicaid (37 percent), reflecting Medicaid's expanded coverage of pregnant women, who otherwise might be ineligible for Medicaid, and the fact that many of the women eligible through AFDC are in their peak childbearing years. It is possible that many of the uninsured women in the sample would become eligible for Medicaid if they were to become pregnant. Women on Medicaid are also more likely to have had a family planning visit, with 33 percent aged 18 to 29 years reporting this, compared with 22 percent of uninsured women and 18 percent of privately/other insured women. There are also differences by insurance status in the location in which low-income women get their reproductive care. Despite the fact that all of the groups had a great reliance on publicly funded family planning providers and public health clinics, 81 percent of uninsured women who had at least one family planning visit said they went to one of these publicly supported providers for their contraceptive care compared with about one-half of Medicaid (55 percent) and privately insured women (47 percent).

Satisfaction with care. Low-income women were dissatisfied with several aspects of the care they received. Uninsured women were the least satisfied with their care and were most likely to rate as fair or poor indicators of initial entry (i.e., time it takes to get appointments, location of provider), care once an appointment is made (i.e., wait in the doctor's office), and aspects of the

TABLE 4
SATISFACTION WITH USE OF HEALTH SERVICES REPORTED BY LOW-INCOME WOMEN BY HEALTH INSURANCE STATUS, FLORIDA, MINNESOTA, OREGON, TENNESSEE, AND TEXAS, 1995-1996

	TOTAL PERCENTAGE	*MEDICAID PERCENTAGE (SE)*	*UNINSURED PERCENTAGE (SE)*	*PRIVATE/OTHER PERCENTAGE (SE)*
Percent rating fair/ poor care during past 12 months				
Time to get appointments	25	27 (2)	34 (2)**	20 (1)***
Doctor's location	13	14 (<1)	20 (1)**	10 (1)**
Time wait at doctor's office	36	37 (2)	46(2)***	32 (1)**
Whether doctor cares about you	19	21 (1)	24 (2)	16 (1)**
Time doctor spends with you	20	20 (1)	27 (2)**	18 (1)
Doctor listening to you carefully	16	16 (2)	21 (2)	13 (1)
Doctor making sure you understand information	14	18 (3)	17 (2)	11 (1)**
Percentage rating health plan or insurance as fair or poor with regard to[a]				
Choice of doctors	19	24 (1)	—	17 (1)***
Availability of advice by phone	27	28 (2)	—	27 (1)
Amount of paperwork filing claims	25	26 (2)	—	24 (1)
Reasonableness of fees out of pocket	37	32 (2)	—	39 (1)***
Quality of health care services used	14	16 (1)	—	14 (1)
Ease of changing doctors	24	31 (2)	—	21 (1)***

Source: Kaiser/Commonwealth Five-State Low-Income Surveys, 1995-1996.
[a] Percentage of those with Medicaid or other insurance.
**Different than Medicaid at $p < .01$. ***Different than Medicaid at $p < .001$.

patient/physician relationship (i.e., whether doctor cares about you, time doctor spends with you, and doctor listens carefully). Although women on Medicaid were generally more satisfied with their care than the uninsured, they were less satisfied than were women with private/other coverage. One

area of concern identified by women across insurance groups was the time it takes to get an appointment. One-third of uninsured women rated this aspect of their care as fair or poor, as did 27 percent of women on Medicaid and 20 percent of women with private/other coverage (Table 4). Time spent waiting in the doctor's office was another area of dissatisfaction identified by one-third or more of women in each insurance group, and nearly one-half of uninsured women.

Examination of satisfaction with a health care plan showed similarities between Medicaid recipients and those with private/other coverage in the areas of availability of phone consultation, amount of paperwork necessary to file claims, and the quality of care. Women on Medicaid were more dissatisfied than women with private/other coverage with the choice of doctors they had (24 vs. 17 percent, respectively), and the ease of changing doctors (31 vs. 21 percent, respectively). Of concern for both groups was the effect of out-of-pocket costs. As would be expected, a considerable share of low-income women with private/other coverage reported out-of-pocket costs as a concern because many private plans can have significant nominal cost-sharing requirements. A surprising finding was that nearly one-third of women on Medicaid reported out-of-pocket expenditures as a concern. Even nominal cost-sharing, permitted by Medicaid, may be problematic for women with such low incomes.

Discussion

The findings from this study document the critical role health care coverage—either Medicaid or private insurance—plays for low-income women in the five study states. Compared with their insured counterparts, the disadvantage faced by uninsured women is dramatic and consistent. Not only do they have more trouble obtaining care, but they also receive fewer recommended services, and are more dissatisfied with the care they get.

Another important finding is the significant contribution of Medicaid in reducing many of the disparities in accessing care. Medicaid covered one-quarter of low-income women in the survey. Despite serving a significantly more socioeconomically disadvantaged and sick population of women, by most measures of access and use, Medicaid coverage was associated with significantly improved access and satisfaction compared with no insurance, and was often on par with private insurance. It should be noted that the women in the different insurance groups did vary considerably from each other on a number of demographic indicators, and that these differences also could account for the range of health experiences reported by the women in the sample.

The state variations in coverage of women found in this survey are consistent with other research that has documented state-level disparities in insurance coverage for low-income people.[6] Medicaid eligibility criteria are largely state determined within broad federal guidelines. Unless women are poor

and disabled, they are only eligible for Medicaid assistance if they are low-income and pregnant or meet AFDC eligibility criteria—which are state determined. States with restrictive Medicaid eligibility policies, such as Texas and Florida, have a considerably higher rate of having no insurance among low-income women. In contrast, states that have expanded eligibility, such as Tennessee and Oregon, have a higher share of low-income women covered by Medicaid.

A key issue raised by this analysis is the duration of coverage for low-income women. For many with either Medicaid or private insurance, coverage is short-lived. Others have documented the transitory nature of Medicaid eligibility,[7,8] but it is also an issue of concern for low-income women generally. Nearly one-quarter of insured women were uninsured at some point in the past two years, and among the uninsured, three-fourths lacked coverage for the full two years. This is particularly worrisome in light of the health problems and characteristics of low-income women and their families. While low-income women with Medicaid coverage appeared to be the most vulnerable from a socioeconomic and health perspective, uninsured, low-income women also faced numerous challenges and in many ways were similar to women on Medicaid, but just not as impoverished.

The access barriers evident in this study underscore the importance of having coverage, be it Medicaid or private insurance. Across the board, uninsured, low-income women experienced significantly poorer access to care and had lower utilization of health care services than their low-income, insured counterparts. Many studies have documented the importance of insurance coverage in assuring access to care[9] and in receipt of preventive services.[10,11] Few studies have compared the performance of Medicaid with private insurance among low-income women.[12] This study finds that despite their health and economic disadvantage, women on Medicaid had generally similar health care use and access as those with private insurance. Low-income women on Medicaid were as likely as those with private coverage to have a regular provider and a usual source of care, as well as receive preventive services such as Pap smears and mammograms.

Given Medicaid beneficiaries' poorer health status, social and economic vulnerability compounded by long-standing problems with provider participation in Medicaid and heavy reliance on institutional providers, this finding is somewhat unexpected, but consistent with other research.[13] One would have anticipated that the Medicaid population would fare more poorly. A number of factors related to scope of coverage and out-of-pocket spending could explain the similarities between the Medicaid and private groups.

While Medicaid provides comprehensive benefits for its beneficiaries with nominal cost sharing, little is known about the scope of coverage typically associated with commercial plans. An Alan Guttmacher Institute survey found that private insurance is often deficient in its coverage of reproductive health care[14]—priority services for low-income women in their childbearing years. For example, while virtually all health maintenance organizations

(HMOs) covered an annual gynecologic exam, about two-thirds of preferred provider organizations (PPO) and only half of indemnity plans covered annual exams. Similar rates are found for coverage of contraception and other reproductive services. This is worrisome in light of the high rates of obstetric and family planning visits for women in this survey. Limited coverage of reproductive services may explain, in part, the heavy reliance of all low-income women on public health centers and family planning clinics for contraceptive care. These providers play a key role in the delivery of reproductive services for all low-income women.

The extent of out-of-pocket spending associated with care also is another possible reason for the similarities between private and Medicaid coverage. Low-income women are considerably more likely to have out-of-pocket expenditures exceeding 10 percent of their income.[15] Cost sharing and other costs borne by privately insured women could limit their access. This is reflected in the finding that nearly 4 in 10 privately insured women reported dissatisfaction with out-of-pocket costs. Women on Medicaid have been largely shielded by these costs, given its comprehensive benefit package and nominal cost-sharing requirements. It is worth noting, however, that the Medicaid group also had problems with out-of pocket costs. For such an impoverished group, even nominal charges may cause difficulties. Women on Medicaid were more likely than women with private coverage to report that they postponed care or did not get care they thought they needed. Furthermore, even among these insured groups there was tremendous room for improvement—slightly less than one-third reported that they postponed needed care, more than one-third had not had a Pap test, and half had not had a mammogram in the past year. Clearly, coverage is necessary but not sufficient to ensure that women gain access to needed services.

Satisfaction with care was an area where Medicaid and private coverage showed the greatest divergence. While uninsured women were the most dissatisfied with the care received, women with private insurance were often less likely to give their provider or their insurance a fair or poor rating than women on Medicaid. This could be associated with the poorer health and higher use of services experienced by the Medicaid group. Others have found that persons with health problems are more likely to be dissatisfied with their care.[16] Another explanatory factor could relate to site of care. Because private physicians historically have been reluctant to participate in Medicaid, patients may have greater reliance on institutional providers, often resulting in greater dissatisfaction because they must travel far or wait long hours for appointments in overcrowded settings.

Conclusion

Despite the unambiguous findings of this study and of others on the association of insurance with improved access and satisfaction with care, the current climate does not appear to be receptive to expansions of health care

coverage for low-income women. Costs are growing in the private sector. Copayments and deductibles have been increasing,[17] as have average monthly premiums paid by employees, growing from $60 for family coverage in 1988 to $107 in 1993. These changes are likely to disproportionately and negatively affect the access to coverage and care for low-income women with private coverage.

On the Medicaid front, the news also is not good. Many low-income women do not meet Medicaid's restrictive income and categorical criteria or do so for only a short while. The new welfare law may further depress Medicaid coverage of women, now that cash assistance under AFDC and Medicaid is uncoupled; welfare diversion programs are created, time limits are established, and new immigrants are barred from receiving federal assistance. Early anecdotal evidence suggests that Medicaid enrollment among low-income adults is falling.

In recent years, large-scale national efforts to broaden coverage to uninsured adults under Medicaid have been largely abandoned. In their place is growing activity at the state level, mostly through the use of Section 1115 Research and Demonstration waivers, with the intent of using savings generated through the waivers to expand coverage.[18] However, many of the states intending to expand coverage found themselves hamstrung by budgetary constraints and thus did not broaden eligibility to the extent they had planned. Instead, they primarily used the waiver programs to mandate enrollment in Medicaid managed care arrangements.

In the wake of the failed national effort to achieve universal coverage, the new State Children Health Insurance Program (CHIP) is a commendable effort by Congress, the administration, and the states to reduce the number of uninsured children. Next, we should consider placing low-income women and men—in many cases the fathers and mothers of the very children targeted by CHIP—squarely on the national agenda if we are to continue our progress in insuring our most vulnerable populations.

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