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More Medicaid Means Less Quality Health Care

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In spite of Medicaid's growing pressure on state budgets, some governors and state lawmakers want to expand its coverage. They seek to increase eligibility for the program up the income scale and enroll larger numbers of uninsured working families. Aside from the daunting fiscal issues, as a clinical matter, this would be an ideologically driven mistake because Medicaid does not provide high-quality health care. And according to surveys, uninsured Americans would prefer private coverage to Medicaid. Nonetheless, many policymakers insist on pushing them into Medicaid. As editorialists of *The Washington Times* noted, "That's like forcing people into the medical equivalent of public housing."[1]

A much better option would be to mainstream low-income families into the private health insurance markets, enabling them to secure the kind of coverage that best meets their personal needs.

What the Data Show. Medicaid provides care to over 53 million low-income Americans, and total federal and state Medicaid expenditures will reach $349 billion in 2007. About 57 percent ($199 billion) of the program is federally funded, and 43 percent ($150 billion) is state funded. Medicaid accounts for 22 percent of all state spending. It is the largest expenditure in increasingly strained state budgets, exceeding spending education and other important state services.

Medicaid is burdened by quality issues, at a time when a broad spectrum of health policy analysts have emphasized the need to promote evidence-based medical practice and to secure value for payment for medical goods and services. Meanwhile, there is mounting evidence that Medicaid, as it is currently structured, is a bad value for beneficiaries as well as taxpayers. Not only does it fail to provide adequate access to primary care and preventive services, a recent study shows that Medicaid patients receive inferior care compared to patients with private insurance.

Poor Access. In spite of Medicaid's hefty price tag, Medicaid patients find it difficult to access the health care system. Medicaid payment rates are considerably lower than physician payment rates under private insurance or even Medicare, in which physician payment is a recurrent problem. This has deterred physician participation in Medicaid. According to a 2003 Medicare Payment Advisory Commission (MEDPAC) study, only 69.5 percent of physicians surveyed were willing to accept new Medicaid patients, substantially fewer than the number willing to accept new privately insured patients (99.3 percent), Medicare patients (95.9 percent), and even the uninsured (92.8 percent). This disparity holds for primary care physicians as well as medical and surgical specialists.[2]

More recent data from the Center for Studying Health System Change (HSC) show a continuation of this trend. About one-fifth of physicians (21 percent) reported accepting no new Medicaid patients in 2004–05, a rate *six times* higher than for Medicare

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patients and *five times* higher than for privately insured patients. Low physician participation in Medicaid has been shown to reduce enrollees' access to medical care.[3] The most important reasons given by physicians for not accepting Medicaid patients are inadequate or delayed reimbursement and the growing burden of Medicaid administration and paperwork.[4]

There is much evidence of Medicaid's inability to provide access to primary care services. The number of Medicaid beneficiaries who use emergency department services (ED) for non-urgent problems is a serious problem in many states. In 2004, the ED visit rate for Medicaid and SCHIP patients (80.3 visits per 100 persons) was higher than the rate for those in any other payer group, including those in Medicare (47.1 visits per 100 persons), without insurance (44.6 visits per 100 persons), and with private insurance (20.3 visits per 100 persons). In addition, a greater portion of ED visits by Medicaid/SCHIP patients in 2005 were classified as non-urgent or semi-urgent (35.7 percent) than visits by self-pay patients (23.7 percent), according to data from the National Ambulatory Medical Care Survey.[5]

Poor Quality. Once Medicaid beneficiaries gain access to the health care system, they receive inferior quality of care compared to patients with private insurance.

For example, patients with non-ST segment elevation acute coronary syndromes (NSTSE ACS), a form of heart attack, benefit significantly from innovative therapeutic approaches, including early invasive management strategies. These measures have now been incorporated into the guidelines of the American College of Cardiology and the American Heart Association. According to a study in the *Annals of Internal Medicine*, however, Medicaid patients with NSTSE ACS were less likely to receive evidence-based therapies and had worse outcomes (including increased mortality rates) than patients who had private insurance as the primary payer.[6] This study found that these differences in care and outcomes persisted *after adjusting for clinical characteristics* (associated illness), socioeconomic factors (education and income), and the type of center where patients received treatment. In other words, the most important predictor of treatment and outcome in the study was whether the patient had Medicaid or private insurance.

Moreover, the data also show that Medicaid beneficiaries face more difficulties scheduling adequate and timely follow-up care after initial treatment for an illness than those with private insurance.[7]

So despite the high costs of Medicaid, its enrollees face limited access to care, relatively poor quality of care, and inadequate follow-up care. There is no reason why policymakers, either at the federal or state level, should push even more families into Medicaid. They should instead devise better ways to help families get superior private coverage in a consumer-driven system that is far more responsive to patients' needs.

Value-Based Reform. Given the high cost and poor quality of the services provided by Medicaid, state lawmakers should refrain from expanding it to address the growing number of Americans without health insurance. Instead, state and federal pol-

1. "Bush's Better Health Care Policy," *The Washington Times*, January 24, 2007, p. A-18.
2. MEDPAC, "Access to Care in the Medicare Program," *Data Book*, June 2004, p. 42.
3. Peter J. Cunningham and Len M. Nichols, "The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective," *Medical Care Research and Review*, Vol. 62, No. 6, December 2005.
4. Peter J. Cunningham and Jessica H. May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health Systems Change, *Tracking Report* 16, August 2006.
5. L.F. McCaig and E.W. Nawar "National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary," Centers for Disease Control, *Advance Data*, June 2006, at *www.cdc.gov/nchs/data/ad/ad372.pdf*.
6. James E. Calvin, Matthew T. Roe, Anita Y. Chen, et al, "Insurance Coverage and Care of Patients with Non-ST Segment Elevation Acute Coronary Syndrome," *Annals of Internal Medicine,* (Nov. 21, 2006) 145 (10): 739-748
7. Lindsey Tanner, "Study Says Uninsured Lack Follow-Up Care," Associated Press, September 13, 2005, at *www.washingtonpost.com/wp-dyn/content/article/2005/09/13/AR2005091301221_2.html*.

icymakers should move rapidly to a new system that gives patients powerful economic incentives to get the best care for the dollars spent. These incentives should be accompanied by personal ownership of heath insurance policies and the provision of solid consumer information on quality and performance of doctors, hospitals, and other medical professionals.

Such a new system would enhance the doctor–patient relationship and would be driven by patients' personal decisions and doctors' professional decisions in an environment of transparency in cost and quality of care. Specifically, policymakers at the federal and state level should:

- **Restructure health care financing to assist low-income Americans in purchasing coverage.** Government heavily subsidizes health care, especially for low-income Americans. The large federal and state expenditures in the Medicaid program need to be restructured in a way that addresses the basic purpose of the program—providing quality health care coverage for low-income and medically needy individuals. The current approach is "system-based," defining in advance the specific services and goods that are or are not to be covered, and government subsidies are directed toward institutions rather than individuals and families. A better approach would be one that is "patient–centered." The financing should be a defined contribution to an individual or family eligible for government assistance.
- **Increase flexibility through creative federalism.** The health care needs of low-income populations vary considerably from state to state, and this is inadequately addressed by Medicaid. Congress needs to allow states enough flexibility to tailor programs to meet their particular needs without having to go through burdensome federal waiver process. Medicaid should be incorporated into a broader approach to state health care experimentation, in which federal assistance is available for states to try new and different approaches to health care financing. The federal government would oversee the performance of the states in using federal funds to expand coverage, increase quality, and improve patient outcomes. [8]
- **Promote individual responsibility and realign economic incentives for the purchase of value-based health care.** In order to promote personal responsibility for health care, federal lawmakers and state officials should establish incentives for low-income patients to secure value for the health care dollars provided for their care. At the federal level, Congress could enact an advanceable and refundable individual health care tax credit for low-income individuals and families to help them secure affordable private health insurance. This policy is embodied, for example, in the Tax Equity and Affordability Act of 2006 sponsored by Senators Mel Martinez (R–FL) and Tom Coburn (R–OK).[9] State lawmakers could use existing state funds, plus existing federal subsidies intended to offset the costs of the uninsured, to establish a "premium support" system for low-income persons to get the coverage they need.

  The aim of these policies would be to transfer decision making from government to individuals and families, who can best determine the type of insurance coverage most appropriate to their personal needs. Meanwhile, state and federal officials could also promote initiatives to secure transparency in the price and quality of health care. Private insurance, based on the empirical evidence, works better than public programs in terms of reducing the number of patients who use the emergency room for nonurgent medical problems. With ample consumer information, it will work even better.

8. This general approach is embodied in the Health Care Partnership Act (H.R. 5864) sponsored by Representatives Tammy Baldwin (D–WI) and Tom Price (R–GA). For a discussion of this approach, see Stuart M. Butler, Ph.D., and Nina Owcharenko, "The Baldwin-Price Health Bill: Bipartisan Encouragement for State Action on The Uninsured," Heritage Foundation *WebMemo* No. 1190, August 7, 2006, at *www.heritage.org/research/healthcare/wm1190.cfm*.
9. For a discussion of this legislation, see Nina Owcharenko, "The Tax Equity and Affordability Act: A Solution for the Uninsured," Heritage Foundation *Backgrounder* No. 1963, August 30, 2006, at *www.heritage.org/research/healtcare/bg1963.cfm*.

Conclusion. An expansion of Medicaid is the wrong policy for the uninsured and for the taxpayers. Medicaid is expensive and rapidly becoming unsupportable in many states, while the quality of care it delivers is often substandard. Medicaid patients are more likely to face difficulties accessing care, often receive inferior treatment, and are more likely to receive inadequate follow up care than those with private health plans.

Congress needs to restructure the way tax dollars are used to finance health care for low-income individuals, and states need to develop innovative programs appropriate to their needs and allow patients to enroll in the health plans of their choice. Personal ownership of health insurance, and personal control over the flow of dollars in the health care system, will enhance personal responsibility and create powerful economic incentives for patients to demand and receive better value for health care dollars. This is an opportunity currently unavailable to patients enrolled in the Medicaid program.

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