Backgrounder

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How Washington Pushes Americans into Low-Quality Health Care

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Because Washington insists, more Americans will likely find themselves with low-quality health care. President Barack Obama favors an expansion of Medicaid, a welfare program, as well as the State Children's Health Insurance Program (SCHIP), as a key component of his health care reform agenda.[1] Aside from the President's proposal,[2] Senate Finance Committee Chairman Max Baucus (D–MT) is also committed to a Medicaid expansion.[3]

With the recent enactment of additional Medicaid funding in the American Recovery and Reinvestment Act of 2009, popularly known as the "stimulus bill," as well as the rapid enactment of the SCHIP reauthorization, the President and Congress have already made a substantial down payment on major expansion of public programs; and because of the "crowd out" of private insurance that routinely follows such expansion, millions of Americans, regardless of their personal preferences, will find themselves in these programs, whether they want to be in them or not.[4] Beyond that, President Obama and congressional leaders favor the creation of a new government-run health plan to compete with private health plans in a national health insurance exchange, which would also result in an accelerated crowd out of private health insurance coverage.[5]

Less Quality for More People

While increasing access to high-quality health care should be a central goal of health care reform, Washington's insistence on increasing enrollment in Medicaid will not achieve it. There are several reasons:

Talking Points

- President Barack Obama favors an expansion of government health insurance programs, such as welfare programs like Medicaid and the State Children's Health Insurance Program (SCHIP), as a key component of his health care reform agenda.
- Because of the "crowd out" of private insurance that routinely follows such expansion, millions of Americans, regardless of their personal preferences, will find themselves in these programs—willingly or unwillingly.
- Federal and state policymakers need to get serious and address not only the problem of the uninsured, but also how to extend access of quality health care to all Americans.
- Washington policymakers, largely responsible for some of the most serious problems in the health care sector, should recognize that their schemes for "coverage" are not the same as providing quality health care.
- Serious health care reform should include efforts to move individuals out of, not into, Medicaid.

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- **Poor Access to Care.** Because of low physician reimbursement rates and administrative hassles within the program, many physicians find it difficult or impossible to incorporate Medicaid patients into their practices. The resulting low physician participation leads to reduced access to care for Medicaid beneficiaries.
- **Poor Performance.** In addition to the access problems, there is a clear record of substandard performance, especially in the areas of cancer and cardiac care. Medicaid patients commonly receive a significantly lower quality of care than patients covered by private health insurance. In Washington, these persistent quality deficiencies are routinely overlooked in discussions of the Medicaid Program.[6]

Along with providing only nominal "health insurance coverage," expanding Medicaid would have other adverse yet unavoidable consequences. For example, a substantial number of Americans now covered in private health plans would be transitioned to Medicaid simply because it is nominally less expensive.[7] Indeed, according to the Lewin Group, a nationally prominent econometrics firm that models health care reform proposals, Medicaid on average pays only 56 percent of the price of medical services delivered by physicians in the private sector.[8]

If Medicare, which pays roughly 81 percent of private physicians' rates, is to be touted as a cost-cutting model for a new public plan to compete with private-sector health plans, then, logically, Medicaid should be ideal. Of course, the reality is very different. So, rather than extending Medicaid's flaws to a larger portion of the population, policymakers should focus on providing disadvantaged individuals with "premium support," transforming current government spending into a direct contribution that would enable them to buy into the insurance plan of their choice.[9]

How Medicaid Undermines Access to Quality Care

Quality means getting the right treatment for the right condition at the right time. In the final analysis, it depends on access to a doctor. Compared to people with private health coverage, Medicaid enrollees have limited access to physicians. In 2004 and 2005, only 52 percent of physicians reported

1. For a description and discussion of the Obama health care agenda, see Robert E. Moffit and Nina Owcharenko, "The Obama Health Plan: More Power to Washington," Heritage Foundation *Backgrounder* No. 2197, October 15, 2008, at *http://www.heritage.org/Research/HealthCare/bg2197.cfm*.
2. "Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All," Obama for America, at *http://www.barackobama.com/pdf/issues/Health careFullPlan.pdf* (April 15, 2009).
3. Senator Max Baucus, "Call to Action: Health Care Reform 2009," Senate Finance Committee, November 12, 2008, at *http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf* (April 15, 2009).
4. For the taxpayers, the effect of this process is absurd: It is akin to spending two dollars for every one dollar of additional coverage. For a discussion of the crowd-out phenomenon, see Paul L. Winfree and Greg D'Angelo, "SCHIP and 'Crowd-Out': The High Cost of Expanding Eligibility," Heritage Foundation *WebMemo* No. 1627, September 19, 2007, at *http://www.heritage.org/Research/HealthCare/wm1627.cfm*.
5. Robert E. Moffit, "How a Public Health Plan Will Erode Private Care," Heritage Foundation *Backgrounder* No. 2224, December 22, 2008, at *http://www.heritage.org/Research/HealthCare/bg2224.cfm*.
6. For a previous discussion of quality problems in Medicaid, see John S. O'Shea, "SCHIP Will Not Improve Quality of Kids' Health Care," Heritage Foundation *WebMemo* No. 1687, November 2, 2007, at *http://www.heritage.org/Research/HealthCare/wm1687.cfm*.
7. Paul L. Winfree and Greg D'Angelo, "The New SCHIP Bill: The Senate Must Protect Private Coverage," Heritage Foundation *WebMemo* No. 2246, January 26, 2009, at *http://www.heritage.org/Research/HealthcCare/wm2246.cfm*.
8. See Lewin Group, Presentation to the Republican Staff of the Senate Finance Committee, December 5, 2008.
9. Indeed, state officials, within existing federal laws, can undertake such a reform today. For a description of how state officials can create a "premium support" system for Medicaid, see Dennis G. Smith, "State Health Reform: Converting Medicaid Dollars into Premium Assistance," Heritage Foundation *Backgrounder* No. 2169, September 16, 2008, at *http://www.heritage.org/Research/HealthCare/bg2169.cfm*.

accepting all new Medicaid patients and 21 percent reported that they were not accepting any new Medicaid patients.[10] During that same time period, 72 percent of U.S. physicians accepted all new privately insured patients; only 4 percent did not accept any new privately insured patients.

As noted, a major reason that many physicians limit the number of Medicaid patients they treat is that Medicaid reimburses physicians at a substantially lower rate than other payers. Medicaid payments may even fail to cover the costs of providing services. In 2003, national Medicaid reimbursement rates were only 69 percent of Medicare rates; for primary care services specifically, the rates were even lower (only 62 percent of Medicare).[11] Since Medicare reimbursement rates are generally lower than those of private insurance companies, when Medicaid reimbursement is compared with private coverage, the gap is even larger.

Reimbursement rates vary across states and, not surprisingly, state reimbursement rates are directly correlated to physician participation rates. New Jersey, a state with the lowest reimbursement rates in the nation (56 percent of the national Medicaid average and only 35 percent of Medicare),[12] is also at the bottom in terms of access to care, especially primary care for its Medicaid beneficiaries.[13]

Bureaucracy. Another reason that provider participation rates are so low is that physicians in the Medicaid program are burdened with substantial administrative hassles. Red-tape burdens include payment delays, rejection of claims for seemingly capricious reasons, pre-authorization requirements for many services, and complex rules and regulations for how claims are to be filed. Reimbursement delays within the program are especially problematic. Like reimbursement rates, reimbursement wait times vary widely across states: from an average of 37 days in Kansas to 115 days in Pennsylvania. In every state, however, the average wait time for Medicaid reimbursement is appreciably longer than the average wait time for payment from private insurers.

In a recent study published in *Health Affairs*, researchers examined the effect of reimbursement wait times on physician participation in Medicaid.[14] Compared with physicians in states with relatively slow reimbursement times, physicians in the states with the fastest reimbursement times were more likely to accept some or all new Medicaid patients.

As expected, in the states where providers face low reimbursement *and* long wait times, the number of physicians who accept Medicaid patients was particularly low. However, in states with high reimbursement rates but long wait times, physician participation was not significantly higher, suggesting that raising reimbursement rates without addressing wait times will not improve access. Other studies of various physician groups, such as pediatricians, have corroborated the findings that these two factors contribute to low physician participation in Medicaid and that fixing one without addressing the other is not likely to close the access gap.[15]

10. Peter Cunningham and Jessica May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health System Change *Tracking Report* No. 16, August 2006, at *http://www.hschange.com/CONTENT/866/866.pdf* (April 15, 2009).
11. Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols, "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation," *Health Affairs,* June 23, 2004, at *http://content.healthaffairs.org/cgi/content/short/hlthaff.w4.374* (April 15, 2008).
12. *Ibid*.
13. Steve Berman, Judith Dolins, Suk-fong Tang, and Beth Yudkowsky, "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics*, Vol. 110, No. 2 (August 2002), pp. 239–248.
14. Peter J. Cunningham and Ann S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation By Physicians?" *Health Affairs*, November 18, 2008, pp. W 17–W 28, at *http://content.healthaffairs.org/cgi/content/full/28/1/w17* (April 15, 2009).
15. Berman, Dolins, Tang, and Yudkowsky, "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients"; Joel W. Cohen and Peter J. Cunningham, "Medicaid Physician Fee Levels and Children's Access to Care," *Health Affairs*, Vol. 14, No. 1 (Spring 1995), pp. 255–262; Peter J. Cunningham and Jack Hadley, "Effects of Changes in Income and Practice Circumstances on Physicians' Decisions to Treat Charity and Medicaid Patients," *The Milbank Quarterly,* Vol. 86, No. 1 (March 2008), pp. 91–123; Janet D. Perloff, Phillip Kletke, and James W. Fossett, "Which Physicians Limit Their Medicaid Participation, and Why," *Health Services Research*, Vol. 30, No. 1 (April 1995), pp. 7–26.

Discontinuity of Care. "Churning" in Medicaid—people cycling on and off the program—also hinders access. Churning makes it difficult to maintain continuity of care and contributes to the total number of uninsured. From 1998 to 2003, 30 percent of Medicaid enrollees had at least one uninsured spell, compared to only 12 percent of individuals with private coverage.[16] Medicaid enrollees, many of whom have lower educational levels and face language barriers, are required to complete complicated paperwork to enter or remain in the program.[17] Documentation requirements and administrative confusion cause many eligible children and families to lose their coverage at renewal time.

Why Medicaid Provides Low-Quality Health Care

Although quality deficiencies in the Medicaid program cannot be completely disentangled from the difficulties that enrollees face in accessing care, it does appear that the medical services delivered through Medicaid are of lower quality than those delivered through private insurance, even for enrollees with access to a physician. As an indirect attempt to measure disparities in the quality of services, a study of Medicaid in urban settings showed that the physicians treating Medicaid patients were less likely to be board-certified than those serving the privately insured.[18]

The track record of previous Medicaid-expansion efforts gives a good indication of the types of care to which new enrollees gain access. During the 1980s and 1990s, Congress expanded Medicaid eligibility for pregnant women. Although a stated goal of this congressional expansion was to get poor patients into mainstream private practices, researchers found that all observed increases in access occurred in public settings, such as public clinics and hospitals,[19] which have been shown to offer a lower quality of care.[20] Because of institutional goals or government mandates, physicians in these settings may have limited control over the extent of their services to Medicaid patients—they may be required to serve all Medicaid patients who come to them.[21]

In an important study published in *Pediatrics,* researchers examined the effect of expansions in the Medicaid program on low-income children from 1989 to 1995. Although the expansions produced some reductions in non-insurance rates, poor children did not experience significant changes in either their level of health-service use or their health status during the period of the expansions, regardless of race or ethnicity.[22]

Mainlining HMOs. Transitioning beneficiaries into health maintenance organizations (HMOs), an increasing trend in recent years, has also not solved the quality problems in the Medicaid program. While enrollment in private HMOs overall has declined in recent years, the number of Medicaid beneficiaries enrolled in HMOs has dramatically increased. Transitioning care to HMOs represents efforts at cost reduction by Medicaid programs and does not reflect an

16. Kathryn Klein, Sherry Glied, and Danielle Ferry, "Entrances and Exits: Health Insurance Churning, 1998–2000," The Commonwealth Fund, September 2005, at *http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2005/Sep/Entrances-and-Exits--Health-Insurance-Churning--1998-2000.aspx* (April 15, 2008).
17. Scott Gottlieb, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*, January 8, 2009, at *http://online.wsj.com/article/SB123137487987962873.html#printMode* (April 15, 2009).
18. Janet D. Perloff, Phillip R. Kletke, James W. Fossett, and Steven Banks, "Medicaid Participation Among Urban Primary Care Physicians," *Medical Care,* Vol. 35, No. 2 (February 1997), pp. 142–157.
19. Laurence C. Baker and Anne Beeson Royalty, "Medicaid Policy, Physician Behavior, and Health Care for the Low-Income Population," *The Journal of Human Resources*, Vol. 35, No. 3 (Summer 2000), pp. 480–502.
20. Leo S. Morales, Douglas Staiger, Jeffrey Horbar, Joseph Carpenter, Michael Kenny, Jeffrey Geppert, and Jeannette Rogowski, "Mortality Among Very Low-Birthweight Infants in Hospitals Serving Minority Populations," *American Journal of Public Health*, Vol. 95, No. 12 (December 2005), pp. 2206–2212.
21. Baker and Royalty, "Medicaid Policy, Physician Behavior, and Health Care for the Low-Income Population."
22. Andrew D. Racine, Robert Kaestner, Theodore J. Joyce, and Gregory J. Colman, "Differential Impact of Recent Medicaid Expansions by Race and Ethnicity," *Pediatrics*, Vol. 108, No. 5 (November 2001), pp. 1135–1142.

exercise of personal choice on the part of beneficiaries. Currently, the proportion of Medicaid beneficiaries in managed care is more than 60 percent.[23] An analysis in the *Journal of the American Medical Association* found that Medicaid managed-care enrollees received significantly lower levels of care than private managed-care enrollees on all but one of 11 important quality measures included in the study.[24]

How Medicaid Fails Cancer and Cardiac Patients

For a number of reasons, the overall health status of Medicaid enrollees is, in general, worse than the health status of individuals with private insurance.[25] This difference in health status makes a direct comparison of the quality of medical care in the Medicaid program to the quality of care in private insurance difficult. However, many studies that have compared quality of care between Medicaid and private insurance have shown an independently lower quality of care and worse clinical outcomes in Medicaid after controlling for potential confounding factors. The literature for cardiac and cancer patients in particular reveals extensive shortcomings in the quality of care delivered through Medicaid.

Cardiac Care. In another important study, published in the *American Journal of Public Health,* researchers found that Medicaid patients who suffered a heart attack were significantly less likely than patients with other forms of insurance to receive a number of important clinical interventions including cardiac catheterization, percutaneous transluminal coronary angioplasty, and revascularization procedures.[26] These differences were observed after adjusting for age, race, sex, household income, patient history (including history of hypertension, diabetes, cardiac surgery, and other comorbidities), heart attack type and location, admitting hospital characteristics, and other factors. The authors of the study strongly suggested that the financial disincentives of caring for Medicaid patients contributed to the gap in the quality of treatment. Other studies have found a similar disparity in the use of invasive procedures between cardiac patients in Medicaid and those with other types of insurance.[27]

Further evidence of inferior cardiac care within Medicaid can be found in research on the management of patients with non-ST-segment elevation acute coronary syndrome, a common type of heart attack, for which there are evidence-based guidelines for diagnosis and management.[28] In a study published in the *Annals of Internal Medicine*, the researchers found that Medicaid patients received fewer evidence-based therapies than patients with private insurance coverage. The authors controlled for differences in clinical characteristics, hospital characteristics (including the proportion of Medicaid patients at each hospital), sex, and other factors.

23. Centers for Medicare and Medicaid Services, "Medicaid Managed Care: Overview," at *http://www.cms.hhs.gov/MedicaidManagCare* (April 15, 2009).
24. Bruce E. Landon, Eric C. Schneider, Sharon-Lise T. Normand, Sarah Hudson Scholle, L. Gregory Pawlson, and Arnold M. Epstein, "Quality of Care in Medicaid Managed Care and Commercial Health Plans," *JAMA*, Vol. 298, No. 14 (October 10, 2007), pp. 1674–1681.
25. *Medicaid: A Primer*, The Henry J. Kaiser Family Foundation, 2009, at *http://www.kff.org/medicaid/upload/7334-03.pdf* (April 15, 2009).
26. Edward F. Philibin, Peter A. McCullough, Thomas G. DiSalvo, G. William Dec, Paul L. Jenkins, and W. Douglas Weaver, "Underuse of Invasive Procedures Among Medicaid Patients With Acute Myocardial Infarction," *American Journal of Public Health*, Vol. 91, No. 7 (July 2001), pp. 1082–1088.
27. Jan Blustein, Raymond R. Arons, and Steven Shea, "Sequential Events Contributing to Variations in Cardiac Revascularization Rates," *Medical Care*, Vol. 33, No. 8 (August 1995), pp. 864–880; John G. Canto, William J. Rogers, William J. French, Joel M. Gore, Nisha C. Chandra, and Hal V. Barron, "Payer Status and the Utilization of Hospital Resources in Acute Myocardial Infarction," *Archives of Internal Medicine*, Vol. 160 (March 27, 2000), pp. 817–823; Mark Sada, William French, David Carlisle, Nisha Chandra, Joel Gore, and William Rogers, "Influence of Payor on Use of Invasive Cardiac Procedures and Patient Outcome After Myocardial Infarction in the United States," *Journal of the American College of Cardiology*, Vol. 31, No. 7 (June 1998), pp. 1474–1480; Salpy V. Pamboukian, Ellen Funkhouser, Ian Child, Jeroan J. Allison, Norman W. Weissman, and Catarina I. Kiefe, "Disparities By Insurance Status in Quality of Care for Elderly Patients with Unstable Angina," *Ethnicity & Disease*, Vol. 16 (Autumn 2006), pp. 779–807.

The study also found that Medicaid patients were less likely to be cared for by cardiologists and had worse risk-adjusted, in-hospital outcomes. Pointedly, the authors suggested that "restructuring the Medicaid infrastructure and financing may be needed to promote better quality of care."

Looking at the deficiencies in cardiac care in Medicaid from a different viewpoint, other researchers, whose study was published in the *American Journal of Medicine,* analyzed whether non-medical factors, including insurance status, influenced the probability of a patient with a heart attack being transferred to another hospital.[29] Since only a small percentage of hospitals nationwide have the capability to perform the full range of cardiovascular diagnostic and therapeutic procedures, a reduced likelihood of transfer suggests a reduced access to necessary cardiovascular services. After adjusting for differences in hospital characteristics, age, sex, race, cardiac history, delay in arriving at the hospital, heart attack location, and other clinical variables, researchers found that heart attack patients covered by Medicaid were significantly less likely than those with private insurance to be transferred to another hospital after admission. This disparity was especially apparent for patients admitted to hospitals without full therapeutic capabilities, suggesting that the reduced likelihood of transfer left Medicaid patients less likely to receive necessary interventions. The finding of a reduced hospital-transfer rate for Medicaid cardiac care patients is supported by data from other studies.[30]

Finally, a study published in the *Journal of the American College of Cardiology* examined outcomes from coronary artery bypass surgery and found that Medicaid status was independently associated with a worse 12-year mortality than for patients with other types of insurance. In fact, Medicaid enrollees had a 54 percent greater 12-year risk-adjusted mortality than patients enrolled in other types of insurance plans.[31] Insufficient access to physician follow-up services and cardiac rehabilitation within Medicaid was thought likely to be a contributing factor in this disparity, according to the authors. Several other studies have found similar increased risk-adjusted mortality among cardiac patients enrolled in Medicaid when compared to privately insured patients.[32]

Cancer Care. Controlled studies of cancer patients have also found differences in quality of care and clinical outcomes between Medicaid patients and patients with private coverage. According to a recent study in the journal *Cancer,* researchers found that Medicaid patients who were diagnosed with breast, colorectal, or lung cancer had a two-to-three-times greater risk of dying from their disease than patients with other types of insurance. This disparity in outcomes was apparent whether the patients were enrolled in Medicaid before or after their diagnosis of cancer and held up even after controlling for other factors, such as site and stage of the cancer and the gender of the patients.[33]

In another study of cancer patients published in the *New England Journal of Medicine* researchers

28. James E. Calvin, Matthew T. Roe, Anita Y. Chen, Rajendra H. Mehta, Gerard X. Brogan, Jr., Elizabeth R. DeLong, Dan J. Fintel, Brian Gibler, E. Magnus Ohman, Sidney C. Smith, Jr., and Eric D. Peterson, "Insurance Coverage and Care of Patients with Non-ST-Segment Elevation Acute Coronary Syndromes," *Annals of Internal Medicine*, Vol. 145, No. 10 (November 21, 2006), pp. 739–748.
29. Jerry H. Gurwitz, Robert J. Goldberg, Judith A. Malmgren, Hal V. Barron, Alan J. Tiefenbrunn, Paul D. F. Frederick, and Joel M. Gore, "Hospital Transfer of Patients with Acute Myocardial Infarction: The Effects of Age, Race, and Insurance Type," *The American Journal of Medicine*, Vol. 112 (May 2002), pp. 528–534.
30. Blustein, Arons, and Shea, "Sequential Events Contributing to Variations in Cardiac Revascularization Rates."
31. Anoar Zacharias, Thomas A. Schwann, Christopher J. Riordan, Samuel J. Durham, Aamir Shah, and Robert H. Habib, "Operative and Late Coronary Artery Bypass Grafting Outcomes in Matched African-American Versus Caucasian Patients Evidence of a Late Survival-Medicaid Association," *Journal of the American College of Cardiology*, Vol. 46, No. 8 (October 18, 2005), pp. 1526–1535.
32. Blustein, Arons, and Shea, "Sequential Events Contributing to Variations in Cardiac Revascularization Rates"; Canto, Rogers, French, Gore, Chandra, and Barron, "Payer Status and the Utilization of Hospital Resources in Acute Myocardial Infarction"; and Sada, French, Carlisle, Chandra, Gore, and Rogers, "Influence of Payor on Use of Invasive Cardiac Procedures and Patient Outcome After Myocardial Infarction in the United States."

compared stage-specific breast cancer survival between women with private insurance, no insurance, and Medicaid. Controls were included for age, race, marital status, household income, co-existing diagnoses, and disease stage. The study found that, compared to patients with private insurance, the adjusted risk of death in the first 54 to 89 months following diagnosis was significantly worse for uninsured patients, with Medicaid patients faring only marginally better than the uninsured. According to the authors, the comparable outcomes of uninsured patients and patients covered by Medicaid suggest that Medicaid coverage alone—without efforts to enhance primary care and screening—may be insufficient to improve outcomes for poor women with breast cancer.[34] Although this study is somewhat older, the conclusions remain valid and the quality problems in the Medicaid program have persisted.

More recently, cancer screening rates among older Medicaid recipients have been found to fall far short of national objectives. According to a 2008 study in the *Archives of Internal Medicine,* documentation that the primary care provider recommended colorectal, breast, or cervical cancer screening was found for only 52.7 percent, 60.4 percent, and 51.5 percent of eligible patients, respectively. Documentation that adequate screening procedures were actually carried out was found for only for 28.2 percent of patients for colorectal cancer testing, 31.7 percent for mammography testing within two years, and 31.6 percent for cervical cancer testing within three years. When medical record and claims data were combined, only approximately half of eligible patients had evidence of adequate screening.[35]

Conclusion

As jobs disappear and Americans lose their employment-based health care coverage, the number of uninsured will grow. For federal and state policymakers, the conventional answer is simply to enroll more and more Americans in Medicaid and SCHIP. Based on data from the Kaiser Commission on Medicaid and the Uninsured, Kaiser Foundation executive vice president Diane Rowland estimates that for every increase of 1 percentage point in the national unemployment rate, an additional 1 million Americans will receive Medicaid for their health care coverage and an additional 1.1 million will become uninsured.[36]

Federal and state policymakers need to get serious and address not only the problem of the uninsured, but also how to extend access to quality health care to all Americans. President Obama's proposal, like Senator Baucus's, would rely on a Medicaid expansion, as well as the creation of a new, as yet unspecified, "government-run health care plan" that would compete with private health plans. This policy prescription is both insufficient and counterproductive.

In order to achieve effective health reform, including access to quality care, it essential to go beyond the simple expansion of the *status quo*. Simply counting the number of people who will be nominally covered under poorly performing public programs is not the same as expanding access to quality health care. American taxpayers, who are footing increasingly larger bills for public health plans, deserve a candid discussion of Medicaid and how it performs, and what kind of value they are getting for their tax dollars. Meanwhile, Washington policymakers, who are largely responsible for some of the most serious problems in the health

33. Cathy J. Bradley, Joseph Gardiner, Charles W. Given, and Carlee Roberts, "Cancer, Medicaid Enrollment, and Survival Disparities," *Cancer*, Vol. 103, No. 8 (April 15, 2005), pp. 1712–1718.
34. John Z. Ayanian, Betsy A. Kohler, Toshi Abe, and Arnold M. Epstein, "The Relation between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer," *The New England Journal of Medicine*, Vol. 329, No. 5 (July 29, 1993), pp. 326–331.
35. C. Annette DuBard, Dorothee Schmid, Angie Yow, Anne B. Rogers, and William W. Lawrence, "Recommendation for and Receipt of Cancer Screenings Among Medicaid Recipients 50 Years and Older," *Archives of Internal Medicine*, Vol. 168, No. 18 (October 13, 2008), pp. 2014–2021.
36. Diane Rowland, "Health Care and Medicaid-Weathering the Recession," *The New England Journal of Medicine,* Vol. 360, No. 13 (March 26, 2009), pp. 1273–1276.

care sector of the economy, should at least recognize that their schemes for "coverage" are not the same thing as providing quality health care.

Needless to say, federal and state policymakers have given little attention to the poor access to care in Medicaid or to Medicaid's track record of providing substandard services. The evidence for these quality deficiencies persists even after controlling for possible confounding characteristics among the Medicaid population, such as income and underlying health status. Expanding Medicaid will not result in better access to high-quality health care—it will merely funnel more Americans into a flawed system. Serious health care reform should include efforts to move individuals out of, not into, Medicaid. This can be done by providing low-income Americans with the financial support they need to purchase their own health insurance. Personal control of the flow of dollars in a "patient-centered" health care system will encourage value-based decisions at the individual patient–doctor level and will drive demand for a high level of quality—which Medicaid has failed to provide.

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