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Medicaid Beneficiaries And Health Reform
by Robert J. Blendon, Karen Donelan, Craig Hill, Ann Scheck, Woody Carter, Dennis Beatrice, and Drew Altman

Abstract: Some health reform proposals include reductions in Medicaid benefits in favor of a more basic health plan that would cover a broader range of Americans, including the uninsured. This study provides data on the implications of such proposals. With current Medicaid coverage, the study finds that one in five adults experienced serious problems getting and paying for health care in the past year. In addition, a substantial number of Medicaid beneficiaries now have trouble paying for the basic necessities of life; the well-being of these beneficiaries (between one-quarter and one-half of all beneficiaries) would be placed in jeopardy by proposed cuts in coverage levels and benefits. Medicaid beneficiaries report worse health status and greater disability level than the general public, suggesting that proposals to link Medicaid coverage with ability to work should be pursued with caution.

Medicaid spending increased by 30 percent in 1992, reaching $120 billion. The 1992 increase followed an increase of 27 percent in 1991. Sometime in the next three years, spending on Medicaid is actually expected to surpass spending on Medicare—an astonishing development for a program originally designed to cover a small number of single parents on welfare. Not surprisingly, many proposals have been put forward in this context to reduce the rate of increase in Medicaid spending. These range from proposals to cap federal Medicaid spending to proposals (and actions) at the state level to cut eligibility and benefits.

Many health reformers would reduce Medicaid benefits by establishing a new public program to replace Medicaid with a much less comprehensive benefit package for the poor than the current program provides. Proponents of this approach believe that in a period of restrained resources it is more equitable to have a more “stripped-down” health plan providing coverage for all uninsured individuals than to have a more comprehensive plan such as our current Medicaid program, which now insures only half of those living below the poverty level. These discussions and suggestions about

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capping Medicaid or cutting eligibility and benefits occur in the absence of some critical information—specifically, the extent to which today’s Medicaid program meets the basic needs of the population it serves and the implications of cutting the program further.

This DataWatch seeks to fill this void in public discussion by focusing on the realities that face both Medicaid beneficiaries, with their current levels of coverage, and the uninsured. To accomplish this, we present data from a recently completed national household survey of the health, economic, and social problems facing Americans. Specifically, we examine how these problems differ today for people covered by Medicaid, those who are uninsured, and all Americans. We look at these issues along three dimensions: (1) the ability of each group to obtain the basic necessities of life; (2) problems obtaining the health services each group perceives it needs; and (3) the presence of ill health and disability among each of the groups. Our analysis focuses on the results of this survey only as they relate to the population under age sixty-five, which includes 87 percent of today’s Medicaid beneficiaries and virtually all of the uninsured population.

The Medicaid Program Today

Twenty-eight years ago President Johnson signed the Medicare and Medicaid programs into law. At that time, nobody imagined that by 1991 Medicaid would grow to pay for much of the health care provided to one in ten Americans, including three million elderly persons, four million disabled persons, and twenty million low-income adults and children, or that it would cost almost $120 billion annually in government funds to do so.

The public does not clearly understand who actually receives help under Medicaid. The Medicaid program is in effect three distinct health care programs, each with a different beneficiary group and different proportional uses of funds. The percentage of total spending devoted to each of these efforts varies greatly from state to state, because state officials may exercise considerable discretion about which of these three programs to encourage. The three groups are as follows. (1) Low-income elderly people represent 13 percent of Medicaid beneficiaries, but their use of services accounts for 32 percent of all Medicaid expenditures. This aspect of the program provides primarily long-term care. Most of these senior citizens were not poor when they retired, but their incomes have been eroded by inflation, loss of spousal income, or other factors. As they age, one-fifth of the elderly find themselves alone in nursing homes, forced to look to Medicaid for support that is not provided by Medicare. (2) The severely mentally retarded, the blind, and the physically disabled represent 15 percent of Medicaid beneficiaries and generate 36 percent of all Medicaid expenditures.
provides medical care and nursing home services for persons with severe, permanent disabilities and higher-than-average needs for medical care. This group includes an increasing number of people with acquired immunodeficiency syndrome (AIDS). (3) Low-income children from single-parent families and their parents comprise 72 percent of beneficiaries; their care represents only 32 percent of all Medicaid expenditures. This group accounted for nearly half of new Medicaid enrollees during 1988-1991.

To this diverse group of beneficiaries, Medicaid covers a broader range of services than many private health insurance policies now cover. Covered services often include out-of-hospital drugs, mental health care, substance abuse treatment, family planning, home care, dental care, eyeglasses, and physician and hospital care without substantial copayments or deductibles.

As previously noted, Medicaid expenditures have risen precipitously in recent years. The Kaiser Commission on the Future of Medicaid attributes these cost increases to three key factors: increase in number of beneficiaries, general medical care inflation, and increased outlays per beneficiary. Each of these factors contributes equally to the sharp rise in outlays. Contrary to general perceptions, increased costs resulting from higher Medicaid enrollment have not been principally a result of federal requirements to add more low-income mothers and children to the program. Rather, they are the result of the addition of substantial numbers of elderly, disabled, human immunodeficiency virus (HIV)-infected, and unemployed adults as new beneficiaries. These groups tend to incur higher per patient costs than people in young families incur.

Data And Methods

In 1992 The Henry J. Kaiser Family Foundation commissioned the development of a household survey by the Harvard School of Public Health and the National Opinion Research Center (NORC) at the University of Chicago to look at a range of health and social welfare problems, with special attention to public-sector programs for low-income Americans. This first paper drawn from those data focuses on the survey results as they relate to Medicaid beneficiaries and compares their circumstances to those of the uninsured, a group known to face serious problems with access to care, and to the general population as a whole.

The survey was conducted by NORC during the period February-June 1992. Sampling for the study was done using NORC’s 1980 full-probability national sampling frame. Each household in the country was given an equal probability of inclusion in the sample. Selection procedures were used within the household to give each adult household member (age eighteen and over) an equal probability of being interviewed. NORC conducted
interviews in both English and Spanish. The sample design also included provisions for an oversampling of households defined for purposes of the study as low income—1991 annual incomes of $20,000 or less. A total of 4,660 households were screened for income eligibility; only households at or below the income ceiling were retained. An additional 1,623 households were contacted for inclusion as a cross-section.

In all, interviews were completed with 1,897 households, including 1,337 low-income households. The response rate for the survey was 67 percent. The majority of interviews (1,497) were conducted in person; the remainder were completed by telephone. In addition, a short interview was conducted with an adult proxy speaking for a randomly selected child (age seventeen and under) in 635 households.

Weights were applied to the sample cases to correctly reflect probabilities of selection and to compensate for differing rates of response across subgroups. First, weights were assigned to respondents that reflected the probability of selection for the respondent as well as the use of the oversample for low income. Second, a multidimensional raking (or balancing) procedure was applied to make the sample conform to known marginal distributions for age, sex, race, and income.

### Results

**Basic necessities.** A substantial proportion of Medicaid beneficiaries today have difficulty affording many of the basic necessities of life and, despite their insurance coverage, express serious concerns about their ability to pay their medical bills now and in the future. When compared with the population of all nonelderly Americans, Medicaid beneficiaries are much more likely to report problems meeting the basic needs of life, even with assistance from Medicaid and other public-sector programs. As shown in Exhibit 1, between one in five and one in two Medicaid beneficiaries said they had problems in the past year affording food, clothing, shelter, and even medical bills. The uninsured reported a similar level of difficulty in these areas; 40 percent reported problems with medical bills. The proportion of Medicaid beneficiaries reporting problems would almost certainly be higher if 67 percent did not also receive help from the federal food stamp program; almost 50 percent, from Aid to Families with Dependent Children (AFDC); 32 percent, from the Women, Infants, and Children (WIC) nutritional program; and 5 percent, from Medicare (primarily the disabled). Finding adequate and affordable child care is also a problem for this population; compared with all nonelderly Americans and the uninsured, Medicaid beneficiaries were almost three times more likely to report having this problem in the past year.
The data show that future economic hardship worries many people covered by Medicaid. When asked about their ability to meet their basic needs in the coming year, 30 percent said they had serious concerns about their ability to pay for food, 22 percent to pay the rent or mortgage, and 29 percent to cover medical bills, compared with 8 percent, 15 percent, and 10 percent of the general nonelderly American population, respectively. Similarly, our study finds that not only does the uninsured group have problems paying for medical care, but a significant subgroup currently lacks the means to pay for other necessities.

**Illness and disability.** As a group, Medicaid beneficiaries have higher rates of illness and disability than other Americans and thus are more dependent on their health insurance coverage. By several different measures, Medicaid beneficiaries were more likely to report disability and fair or poor health status than were nonelderly Americans (Exhibit 2). Overall, in the past year 29 percent of persons covered by Medicaid reported problems with general health, compared with only 11 percent of other nonelderly Americans. Medicaid beneficiaries were twice as likely as the general population to note problems performing daily activities because of their ill health or the presence of a disability. Furthermore, 23 percent of Medicaid beneficiaries, compared with 9 percent of all Americans, reported that at the time the survey was conducted, a disability, handicap, or chronic illness...
kept them from participating fully in work, school, housework, or other daily activities.

When asked to rate their overall health status, almost one-third (32 percent) of Medicaid beneficiaries (under age sixty-five) rated their health as fair or poor, compared with 13 percent of all nonelderly Americans. Similarly, 14 percent of Medicaid beneficiaries reported having an emotional or mental condition, compared with 8 percent in the general nonelderly population. The uninsured report a similar degree of health problems, which suggests that as a group they are closer in health status to the Medicaid population than to the general population.

Children. Children on Medicaid are more likely than the general population of children their age to be in ill health but report similar levels of access to preventive health services (Exhibit 3). These data were provided by adult proxy respondents in each household surveyed. Twenty-two percent of children on Medicaid reportedly had problems in the past year with their general health, and 10 percent had an emotional or mental condition. In addition, 15 percent of Medicaid-beneficiary children were noted to have problems getting their school work done, compared with 9 percent of all children. Child Medicaid beneficiaries were also more likely than all children to be in fair or poor health. They were slightly more likely than uninsured children or all American children to have been screened for lead toxicity, although fully 78 percent of all American children age six and under had not been screened in the past year.

In general, children on Medicaid were substantially more likely than other children to have parents or guardians who were supposed to receive
child support payments. However, of those adults owed payments, those with child Medicaid beneficiaries were just as likely as all adults with children to report serious problems receiving that financial support.

**Employment and education.** In addition to their more severe financial and health problems, the Medicaid population faces more problems finding jobs and obtaining employment training or education than do other Americans, although very few said they had actually turned down an offered job because the health benefits were not as good as their Medicaid coverage. Almost half of Medicaid beneficiaries surveyed reported problems finding a job in the past year, compared with only 17 percent of all nonelderly Americans (Exhibit 4). Furthermore, 21 percent of Medicaid beneficiaries noted problems with inadequate job training, and 23 percent had problems obtaining additional education, compared with less than half those proportions in the general nonelderly population. It is often anecdotally reported that many Medicaid beneficiaries do not take available jobs for fear of losing Medicaid coverage. Surprisingly, this study finds only 6 percent of Medicaid beneficiaries (under age sixty-five) reporting that they did not take a job in the past year because it did not provide health insurance that was as good as Medicaid coverage.

**Access to services.** Medicaid coverage is not a secure guarantee of access to health care services. Although it provides access to care in some
Job And Training Problems Of Nonelderly Medicaid Beneficiaries And The Uninsured

<table>
<thead>
<tr>
<th>Problem</th>
<th>Nonelderly Medicaid beneficiaries (ages 18-64)</th>
<th>Uninsured Americans</th>
<th>Nonelderly Americans (ages 18-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate job training</td>
<td>21.4%</td>
<td>25.4%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Finding a job</td>
<td>44.5%</td>
<td>36.6%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Obtaining additional education</td>
<td>23.3%</td>
<td>18.6%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

Percent who did not take a job in the past year because it did not provide health insurance as good as Medicaid coverage 6.2


Approximately one in six nonelderly Medicaid beneficiaries reported having a range of difficulties. Getting care once they had obtained the coverage. Exhibit 5 compares the experiences of elderly persons covered by Medicare with those of nonelderly persons on Medicaid (this series of questions was asked only of public-sector program beneficiaries, not of the general population or the uninsured). Eighteen percent of the nonelderly Medicaid group reported problems with physicians or hospitals refusing to accept coverage, compared with only 3 percent of elderly Medicare beneficiaries. Similarly, 13 percent of Medicaid beneficiaries noted that doctors or hospitals treated them differently from other patients, compared with 3 percent of Medicare beneficiaries. These perceptions may reflect the fact that Medicare reimburses doctors and hospitals at higher rates than does Medicaid and may reflect the impact of other nonfinancial barriers to care such as language or race. Cutbacks in program benefits were perceived by some beneficiaries of both public programs, however; 15 percent of the Medicaid population and only 7 percent of persons with Medicare coverage noted such changes.

Prior studies have shown that emergency room care for routine medical problems is more expensive and less efficacious for patients than primary care treatment. Nearly 21 percent of nonelderly Medicaid beneficiaries reported in this survey that in the past year they had to go to an emergency room because they did not have a regular doctor. Even with insurance coverage, Medicaid beneficiaries face barriers to needed health care services. Access problems are reported far more frequently by this group than by elderly respondents covered by Medicare.
### Exhibit 5
Serious Problems Using Medicaid And Medicare Benefits In The Past Year, As Reported By Beneficiaries

<table>
<thead>
<tr>
<th>Problem reported</th>
<th>Nonelderly Medicaid beneficiaries (ages 18-64)</th>
<th>Elderly Medicare beneficiaries (age 65 and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors or hospitals refusing to accept coverage</td>
<td>18.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Doctors or hospitals treating beneficiary differently from other patients</td>
<td>12.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Cutbacks or reductions in benefits</td>
<td>15.3</td>
<td>6.8</td>
</tr>
<tr>
<td>Having to go to emergency room for care because beneficiary did not have a regular doctor</td>
<td>20.5</td>
<td>-a</td>
</tr>
</tbody>
</table>

**Source:** Kaiser/Harvard/NORC survey of Americans of low income, 1992.

*Not asked of Medicare beneficiaries.*

room for care because they did not have a regular doctor. These data raise the question of whether the failure of some providers to treat Medicaid patients could be a factor in the use of emergency rooms. In this study 42 percent of beneficiaries who said a doctor or hospital had refused to accept their Medicaid coverage also said they had to use an emergency room in the past year because they did not have a regular doctor.

On a more positive note, nonelderly Medicaid beneficiaries were just as

### Exhibit 6
Access To Health Services Among Nonelderly Medicaid Beneficiaries And The Uninsured, 1992

<table>
<thead>
<tr>
<th>Percent who obtained preventive services</th>
<th>Nonelderly Medicaid beneficiaries (ages 18-64)</th>
<th>Uninsured Americans</th>
<th>Nonelderly Americans (ages 18 - 64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure check in the past year</td>
<td>81.7%</td>
<td>59.0%</td>
<td>78.1%</td>
</tr>
<tr>
<td>Breast examination in the past year (women)</td>
<td>57.8</td>
<td>32.8</td>
<td>60.5</td>
</tr>
<tr>
<td>Pap smear in the past year (women)</td>
<td>66.6</td>
<td>41.3</td>
<td>62.5</td>
</tr>
<tr>
<td>Prenatal care in the first trimester of pregnancy</td>
<td>81.4</td>
<td>71.6</td>
<td>89.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent who reported symptom in the past month who saw a doctor</th>
<th>Nonelderly Medicaid beneficiaries (ages 18-64)</th>
<th>Uninsured Americans</th>
<th>Nonelderly Americans (ages 18 - 64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss of more than 10 pounds when not dieting</td>
<td>33.8</td>
<td>8.9</td>
<td>22.6</td>
</tr>
<tr>
<td>Shortness of breath during light exercise or work</td>
<td>51.6</td>
<td>15.1</td>
<td>35.7</td>
</tr>
<tr>
<td>Chest pain while exercising</td>
<td>66.7</td>
<td>26.5</td>
<td>34.4</td>
</tr>
<tr>
<td>Loss of consciousness, fainting, passing out, or blacking out</td>
<td>42.3</td>
<td>24.6</td>
<td>38.0</td>
</tr>
<tr>
<td>Bleeding (not nosebleeds or menstrual periods) not caused by accident or injury</td>
<td>45.4</td>
<td>52.3</td>
<td>36.0</td>
</tr>
</tbody>
</table>

**Source:** Kaiser/Harvard/NORC survey of Americans of low income, 1992.
likely as the general population, and more likely than persons without health insurance, to report having had their blood pressure checked in the past year (Exhibit 6). Similarly, women on Medicaid were as likely as women in the general nonelderly population to have had breast examinations and Pap smears, although those who had a pregnancy in the past year were somewhat less likely than other pregnant women to have received prenatal care in their first trimester of pregnancy.

Using a list of symptoms validated in previous studies as important indicators of a need for medical care, respondents were asked to report whether they had experienced any one of five symptoms in the past month and whether they had seen or talked to a doctor about the symptom. Responses to these questions show that nonelderly Medicaid beneficiaries, as a group, were more likely than all nonelderly Americans and the uninsured to report having seen a physician if they noted experiencing these medical symptoms. These findings suggest the higher rates of poor health experienced by people on Medicaid and reinforce earlier findings showing that the uninsured put off seeking needed care in comparison with other groups. In this case Medicaid coverage is far better health protection than being uninsured.

Discussion

Our study presents four quite powerful findings relating to the current health reform debate. First, even with today’s broader levels of Medicaid coverage and welfare assistance, 28 percent of beneficiaries reported not having enough money last year to buy food, 31 percent to pay their rent or mortgage, and 29 percent to pay their heat and light bills. These percentages represent between three and five million adult Medicaid beneficiaries.

Second, Medicaid still leaves one in four beneficiaries (approximately three million adults) without enough money to pay this year’s or next year’s forecast medical bills. Uncovered services, payments, or other family members’ medical expenses remain a serious problem for this group.

Third, one in six beneficiaries (approximately two million adults) reported that a hospital or doctor would not treat them because the providers would not accept Medicaid. In addition, 13 percent (approximately 1.5 million adults) said they were treated differently from other patients. Lastly, one in five beneficiaries (approximately 2.3 million adults) reported that they had to seek care from an emergency room because they did not have a regular doctor.

Negative consequences of reduced spending. We recognize that with the nation’s attention directed to the need to cut the federal budget deficit and to hold down future state outlays, any study that points to the possible
negative consequences of reduced expenditures for a particular group may be seen as special pleading. Yet the implications of our results are clear and need to be fairly presented.

Today a subgroup of the Medicaid population, ranging somewhere from one-quarter to one-half of beneficiaries, would suffer considerable hardship if asked to absorb cutbacks in their current Medicaid coverage. This subgroup already reports not having enough money to pay for the basic necessities of life. One in four also report current difficulties with paying for noncovered medical bills. For this segment of the Medicaid population, America’s welfare safety net is not holding. Future cutbacks affecting this group will push even more of these individuals and families over the financial edge. To avoid this scenario, policymakers must pay careful attention to the presence of current personal resources and the level of health problems faced by individuals and families in carrying out any reductions in coverage levels or benefits. Our study finds a similar phenomenon with the uninsured. As with other earlier studies, we find that this group faces substantial barriers to obtaining needed medical care. But beyond this, one-fourth to one-third report not having enough money to obtain the basic necessities of life.

In another policy area, further reduction in Medicaid payment levels to hospitals and doctors as a budget-saving measure requires careful monitoring. Already one in six persons covered by Medicaid report being turned away by providers. In many communities this practice may be much more widespread, and further reductions could lead to even more refusals to treat Medicaid patients and to an increase in dumping patients on hospital emergency rooms for often costly and sometimes inappropriate treatment.

Likewise, our study suggests that caring for many Medicaid beneficiaries may cost providers more than it costs to treat other patients. Medicaid patients are more likely to be disabled, to have psychological or social problems, and to be lacking in some of the essential necessities of life required for medical treatment to be effective. In a reimbursement system that paid for the “social complexity” of caring for particular patients, many Medicaid beneficiaries would qualify for higher payments to providers, not a priori lower ones as exist under the current program. Moreover, our data suggest that current proposals to limit eligibility for public assistance to two years will have to be administered with great care. The plan now being discussed by President Clinton will have to distinguish able-bodied welfare beneficiaries who can go to work or school from those with serious disabilities or health problems. Our results suggest that the latter group will not be a small one.

**Policy implications.** The findings of this study point to two broad policy implications for health reform. First, for a subgroup of both the Medicaid
population and the uninsured there is a need to provide more comprehensive health benefits and services than most Americans require. This will be the case whether we scrap the Medicaid program and replace it or build on it as we cover the uninsured. The enriched set of benefits and possibly higher level of reimbursement will be required if we are to care adequately for low-income and special-needs populations in the future. Clearly this will drive up the cost of reform proposals and pose considerable administrative and political challenges in their implementation, but these policies are essential if the safety net is actually to be in place in the years ahead.

Second, while efficiencies and savings can be achieved in the current Medicaid program with reform efforts such as managed care, these savings are not likely to be great. The Medicaid program today enrolls beneficiaries with unusually difficult health and social problems and currently pays doctors and hospitals at much lower rates than paid by private insurance plans or Medicare. Future savings are likely to be modest; they likely will accrue from less use of emergency room care and a slower rate of general medical inflation if major systemwide health reform is enacted.

NOTES

2. Rowland et al., Medicaid at the Crossroads.
5. Ibid.
6. Ibid.