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Access To Care: How Much Difference Does Medicaid Make?

Insurance coverage—public or private—is a potent policy tool to reduce financial barriers to health care.

by Marc L. Berk and Claudia L. Schur

PROLOGUE: The recent passage of the State Children’s Health Insurance Program (CHIP) prompted a number of states to pass new laws aimed at reducing the number of uninsured children. Still, many states persist in playing political football with the issue of children’s health insurance. For example, in April of this year, the Virginia General Assembly passed a bill that would provide insurance to 83,000 uninsured children of low-income, working Virginians. However, the bill was passed only after a rancorous debate on the issue that included a veto by Governor James Gilmore, who had opposed expansions to the state’s Medicaid program. Whatever the governor’s ideological misgivings concerning Medicaid, recent evidence, such as that presented in this paper by Marc Berk and Claudia Schur, suggests that that oft-maligned program serves not only as a necessary bulwark against high-cost medicine, but also as a gateway to regular and timely access to routine and preventive care.

Few have been more active than these authors in the debates surrounding Medicaid and access to care. Since the early 1980s their work on these issues has appeared regularly in a number of health policy and research journals. Berk is director of the Project HOPE Center for Health Affairs (CHA), where he has been since 1988. He holds a doctorate in sociology from New York University. Schur, who earned a doctorate in economics from the University of Maryland, is deputy director of CHA. Prior to joining CHA, both authors were with the National Center for Health Services Research (now the Agency for Health Care Policy and Research): Berk as a senior sociologist, Schur as an economist. Both played integral roles in the design and implementation of the 1987 National Medical Expenditure Survey.
ABSTRACT: Using the 1994 Robert Wood Johnson Foundation National Access to Care Survey, we examine the likelihood of having a usual source of care, inability to obtain needed care, and number of physician visits for persons with private insurance, Medicaid coverage, and no insurance. Inability to obtain services is surprisingly consistent: For each service, Medicaid enrollees were about half as likely as uninsured persons and about twice as likely as privately insured persons were to report difficulty. For other access measures, access for those on Medicaid more closely resembles that of the privately insured than that of the uninsured.

Recent public debate and legislative action on welfare reform, immigration policy, and children’s health insurance may have important consequences for the Medicaid program. These initiatives are likely to limit the program’s role for some groups while expanding it for others. At the same time, the attention generated has raised the role of entitlements to a new level in the American consciousness. With annual combined federal/state expenditures of approximately $160 billion in fiscal year 1996 and a recipient population of approximately thirty-six million persons, Medicaid remains a target for budget-cutting efforts and other initiatives aimed at reducing the role of the federal government.¹

There is ample evidence that the Medicaid program has been effective in reducing income-related differentials in access to care.² In particular, these studies found that poor persons enrolled in Medicaid were more likely than poor persons with no public or private coverage were to have a usual source of care, a higher number of annual ambulatory physician visits, and a higher rate of hospitalization. Findings such as these provide strong evidence that Medicaid has increased access to care for the covered population.

With the increasing policy focus on the uninsured population, much empirical research of the past decade has concentrated on differences in use of services between the insured and uninsured, sometimes aggregating Medicaid enrollees with the privately insured and sometimes leaving them out of the analysis altogether.³ Although this may be appropriate for many sorts of analyses, it should not obscure the importance of Medicaid as a source of health care financing for low-income Americans.⁴

In this paper we present data from the 1994 Robert Wood Johnson Foundation (RWJF) National Access to Care Survey to explore the role of Medicaid in providing access to care among insurance and sociodemographic groups and to assess the potential need for government intervention in maintaining the safety net.

Data and methods. The 1994 RWJF National Access to Care Survey represents a unique public/private partnership. Under this agreement the Project HOPE Center for Health Affairs (CHA) was
responsible for the design and analysis of the survey, while the National Center for Health Statistics (NCHS) received support to assist with the design and to oversee the data collection efforts by the U.S. Bureau of the Census. The survey was fielded in the spring and summer of 1994 as a follow-up component to the 1993 National Health Interview Survey (NHIS). The 1993 NHIS was used to identify specific types of respondents for follow-up interviewing as part of one of three independent survey components: (1) a national probability sample; (2) a sample of persons who reported access barriers or who met other specific criteria suggesting low access to care; and (3) a sample of persons with one of two specific chronic conditions for which well-accepted standards of care exist.

These data are the most recent available from an access survey that does not rely exclusively on telephone interviewing. This has important implications for findings because reliance on telephone interviewing may impart bias in two ways. First, previous studies have suggested that telephone surveys may underrepresent vulnerable populations, which results in misleadingly low estimates of access problems. This is because persons in low-income, minority, or other vulnerable groups who are more likely to have access problems are also less likely to have telephones and thus may be excluded disproportionately from being respondents in a telephone survey. However, the more serious problem comes from systematic nonresponse bias because of the low response rates that are achieved with random-digit dial surveys. Often people respond to surveys because an issue is important to them. In the case of access surveys, a low response rate is likely to overrepresent persons with access problems and thereby present an inaccurate picture of actual access to care.

The results reported here are from the first study component of the access survey. The general probability sample is based on interviews conducted with 3,480 persons, with a response rate of 76 percent. This is a cumulative response rate that takes into account both nonresponse to the 1993 NHIS and nonresponse to the follow-up access survey. All estimates are weighted to be representative of the civilian noninstitutionalized population in 1994. Since we are interested in examining the effect of insurance coverage on access, and the vast majority of the elderly population is insured, data reported here are limited to the population under age sixty-five.

All respondents were asked about their insurance coverage at the time of the interview. Using this type of insurance measure (a point-in-time indicator) with access measures reported for the previous twelve-month period may impart some bias to our findings. For example, some persons who reported having insurance at the time of the interview may not have been covered earlier in the year,
whereas others who reported being uninsured may previously have held coverage. It has been shown, however, that the likely effect of the incongruent time periods will be an underestimate of the difference in use of services between the insured and uninsured.

As do other researchers using national data sets, we aggregate Medicaid enrollees, despite the variations in program implementation across states, because of important similarities in the provision of financing for health care services.

We present estimates on three access indicators: having a usual source of care, inability to obtain a particular type of health care service during the year prior to the interview, and the mean number of ambulatory physician visits in the prior year. Cross-tabular estimates are presented for each of these indicators by type of insurance coverage while controlling for health status. For the data reported here, subgroups vary substantially by health status: Of those on Medicaid, 21 percent reported that they are in fair or poor health, compared with 6 percent of the privately insured and 12 percent of the uninsured. Although self-reported health status is a somewhat crude indicator of need, the literature shows support for use of this measure when only household-reported data are available.

**Findings**

**Having a usual source of care.** For those in good to excellent health, uninsured persons were much less likely than those with either public or private coverage were to report having a usual source of care (Exhibit 1). Uninsured persons in fair or poor health were less likely than Medicaid enrollees in fair or poor health were to have a usual source of care; the difference between the privately insured and uninsured in fair or poor health is not statistically significant. Health status appears to have no independent effect on having a usual source of care once insurance status is controlled for, with no significant differences within insurance categories.

**Ability to obtain care.** As did earlier RWJF access surveys, the 1994 National Access to Care Survey asked respondents whether or not they were able to obtain medical care or surgical services they believed they needed. However, the 1994 survey also included specific questions about dental care, prescription drugs, eyeglasses, and mental health care or counseling. A variable then was constructed to indicate whether or not the respondent had an unmet need for any of these services. Estimates of the percentage of persons unable to obtain care have been previously published. In this analysis we reexamine those estimates, focusing specifically on the differences in ability to obtain care by insurance coverage.

More than 34 percent of the uninsured were unable to obtain one
or more of the health care services they believed they needed during the previous year, compared with 22 percent of Medicaid enrollees and 13 percent of persons with private insurance. We found similar variation in inability to obtain medical/surgical care, dental care, prescription drugs, and eyeglasses, by insurance status (Exhibit 2). For each of the specific services about which information was collected, the uninsured were almost four times as likely as the privately insured were to report an unmet need. The largest disparity was for prescription drugs.

Given our focus on the safety net, it is important to note here the
levels of unmet need for persons covered by Medicaid. Reported levels of inability to obtain needed services are again consistent: For each of the services asked about, Medicaid enrollees were about half as likely as the uninsured and about twice as likely as the privately insured were to report having difficulty in obtaining care.

The inability to obtain care is correlated across services; this is not surprising, since, for example, one cannot get a prescription without first visiting a physician. However, the correlation is more modest than one might expect; the population with unmet need varied for each of the services. Of those unable to obtain medical or surgical care, approximately 40 percent reported unmet need for another service. The overlap of the population with unmet need for different services also is related to insurance coverage. For those with at least one reported unmet need, just over half of the uninsured had unmet need for more than one type of service, compared with fewer than one-quarter of persons with private insurance.

Because persons are more likely to seek care when in ill health, it is not surprising that those Americans in fair or poor health were much more likely than other Americans to experience barriers to care (Exhibit 3). Differences in unmet need between persons on Medicaid and those with private coverage were not significant within each health status group. The uninsured were most vulnerable, regardless of health status.

■ Ambulatory physician visits. The pattern of ambulatory phy-

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**EXHIBIT 3**

Percentage Of Nonsenior Persons Unable To Obtain Care, By Insurance Status, 1994

<table>
<thead>
<tr>
<th>Health status</th>
<th>Private</th>
<th>Medicaid</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good/excellent</td>
<td>11.9</td>
<td>16.5</td>
<td>31.4</td>
</tr>
<tr>
<td>Fair/poor</td>
<td>27.5</td>
<td>39.7</td>
<td>57.9</td>
</tr>
</tbody>
</table>

**SOURCE:** Project HOPE tabulations from the 1994 Robert Wood Johnson Foundation National Access to Care Survey.

**NOTE:** Estimates include reported inability to obtain at least one of the following services: medical/surgical care, dental care, prescription drugs, eyeglasses, and mental health care.
Physician visits appears to be heavily influenced by health status, and the effect of insurance differed somewhat across health status groups (Exhibit 4). The mean number of visits for persons in fair or poor health was more than twice that for those in good to excellent health (9.7 visits annually compared with 4.3, numbers not shown). At the same time, insurance status—at least for those in fair or poor health—continued to have a substantial impact on use. For those reporting to be in fair or poor health, the privately insured as well as those covered by Medicaid had approximately nine visits per year, compared with five visits per year for the uninsured.

Results of multivariate analyses. Findings from the multivariate analyses confirm the importance of insurance coverage in improving access to care, although there are variations across indicators and health states.\(^{13}\)

Compared with uninsured persons in good or excellent health, persons with private insurance or Medicaid—regardless of health status—were two to four times as likely to have a regular place to obtain medical care. For the uninsured, health status did not have a significant effect on the likelihood of having a usual source of care.

In terms of inability to obtain care, for those in good or excellent health, Medicaid and private insurance appear to be comparable in terms of preventing access problems; both the privately insured and those enrolled in the Medicaid program were much less likely than the uninsured were to report being unable to obtain the care they thought they needed. However, Medicaid enrollees in fair or poor health were about twice as likely as the privately insured in similar health were to report inability to obtain care. Again, the uninsured

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**EXHIBIT 4**

Mean Number Of Physician Visits For Nonelderly Persons, By Insurance Status, 1994

<table>
<thead>
<tr>
<th>Number</th>
<th>Good/excellent health status</th>
<th>Fair/poor health status</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Private</td>
<td>Medicaid</td>
</tr>
<tr>
<td>5</td>
<td>3.3</td>
<td>6.9</td>
</tr>
<tr>
<td>6</td>
<td>5.5</td>
<td>8.6</td>
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<tr>
<td>4</td>
<td>2.8</td>
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<tr>
<td>2</td>
<td></td>
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<tr>
<td>0</td>
<td></td>
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</tbody>
</table>

**SOURCE:** Project HOPE tabulations from the 1994 Robert Wood Johnson Foundation National Access to Care Survey.
were most likely of all groups to report access problems, with the uninsured in fair or poor health more than three times as likely as the healthier uninsured were to report unmet need.

Both insurance coverage and health status were strongly associated with use of physician visits as well. Among those in good or excellent health, both Medicaid enrollees and the privately insured had more visits than the uninsured had (approximately 60 percent and 36 percent more, respectively). Persons in fair or poor health with either Medicaid or private insurance used the most services—about 70 percent more visits annually than the uninsured in fair or poor health used.

Race had a statistically significant effect on access for two of the three indicators. Nonwhites were almost 70 percent more likely than whites were to be unable to obtain medical care and had 10 percent more physician visits but had similar chances of having a usual source of care. The comparison between females and males is probably affected by unmeasured health status differences as well as by differences in health care behavior. Although women were twice as likely as men were to have a usual source of care and had one-third more physician visits, they were still 50 percent more likely than men were to have unmet need for medical care.

The nonpoor were about 40 percent more likely than the poor were to have a usual source of care, but poverty status had no statistically significant effect on either unmet need or the use of ambulatory visits. Although there were few age-related differences in access among the adult population, children were much more likely than adults were to have a regular place to obtain care. Children under age six were almost six times as likely as adults ages forty-five to sixty-four were to have a usual source of care, and children age six and older were twice as likely as these adults were to have a regular place to obtain care.

**Discussion**

Our findings show that although the vast majority of Americans are able to obtain adequate access to health care, there is substantial variation across population subgroups, particularly as defined by type of insurance coverage. Large and consistent differences among insurance groups are observed in ability to obtain a number of different health care services, the number of physician visits, and the likelihood of having a regular source of care. These differences between the insured and uninsured persist, regardless of whether the insurance is privately or publicly financed.

Our findings are consistent with a number of previous studies and indicate the potency of health insurance coverage as a policy
lever in reducing financial barriers to care. In particular, the data presented suggest that Medicaid is critical in mitigating many of the deprivations in access of poor persons who are eligible for public insurance. Once insurance status is controlled for, the poor are no more likely than the nonpoor are to be unable to obtain health care services, and they have about the same number of physician visits.

- **Assessing use of services.** With the changes occurring in the health care delivery system, interpreting differences in use of services across population subgroups must be done with caution. Managed care organizations have used a variety of mechanisms to try to decrease inappropriate or unnecessary care as well as to substitute less expensive primary care for specialty care. This may be reflected in either lower or higher use rates for some services. In fact, for the privately insured, previous research using the access survey showed that those in health maintenance organizations (HMOs) use more physician visits than do those in traditional fee-for-service (FFS) settings. Poor persons are not exempt from this, either—particularly those who are covered by Medicaid, which increasingly is turning to managed care. It is not clear whether physicians’ incentives to provide less or more appropriate care for insured patients affect physicians’ treatment of the uninsured, which would exacerbate the problem of interpreting use levels.

Nonetheless, the fact that use of physician services among persons without health insurance is lower than it is for persons covered by either Medicaid or private insurance is of concern. Although it is sometimes argued that some of the uninsured are relatively healthy, our data demonstrate lower levels of use among uninsured persons, regardless of health status.

- **Medicaid’s effectiveness.** Our analysis suggests that an evaluation of the effectiveness of the Medicaid program varies depending upon the access indicators used. An examination of reports of inability to obtain various health care services reveals that although Medicaid improves access, for those with more serious health problems, it goes only halfway toward providing the same level of care that private insurance provides. For other indicators of access, such as having a usual source of care or number of physician visits, access to care for those on Medicaid closely resembles that of the privately insured. These seeming inconsistencies across indicators may, in fact, be related to the level of health care need. Although we have attempted to control for variation in health status, it is interesting to note that persons covered by Medicaid have the same access to a usual source of care as the privately insured have and the same average number of physician visits, but still are twice as likely to report inability to get services.
These findings suggest that Congress as well as state policymakers should be sensitive to the implications of changing a public insurance program that, while costly, has generally served vulnerable citizens well. We are entering a period when both the White House and Congress are interested in welfare reform and experiments that could dramatically affect not only Medicaid eligibility but also—because of the decoupling of welfare and Medicaid applications—the likelihood that persons who are eligible for Medicaid will enroll in Medicaid. As states begin to respond to the recent federal welfare reform legislation, we need to carefully monitor shrinkage in the safety net. Congress must approach both the welfare and health care reform debates with a keen eye toward their implications for vulnerable populations’ ability to obtain access to health care services.

Children’s coverage. Recent expansions and contractions within the Medicaid system have affected population subgroups differentially. Accordingly, our efforts to protect children have met with some success, with contractions in children’s eligibility for Medicaid in the early 1980s partially rectified through the series of expansions in the latter part of the decade. Even more recent efforts to improve coverage also have focused primarily on children. In our analyses, children fared equally or better than nonelderly adults did with respect to each of the three access indicators used. Children were more likely than adults were to have a usual source of care and more visits to the physician and were less likely to be unable to obtain care when needed. Yet low-income adults (with the exception of pregnant women) have seen no such expansions of coverage.

There are those who must seek care without the aid of the safety net. Our findings show that, even as Medicaid expansions increase the numbers of persons eligible for the program, those who are not eligible for coverage continue to face barriers to care, with a potential risk for poorer long-term health outcomes. Almost three-fifths of the uninsured in fair or poor health were unable to obtain at least one health care service they felt they needed—about 50 percent more than the proportion of persons on Medicaid and more than twice the percentage of the privately insured with comparable health status. To have their desired effect, continued efforts to increase access to health care services must focus on those groups with the most serious access problems and target scarce resources accordingly.
The authors acknowledge the generous support of the Robert Wood Johnson Foundation and, in particular, the assistance of James Knickman, Robert Hughes, and Joel Cantor. They extend their thanks to many persons at the National Center for Health Statistics, including Jennifer Madans, Jacob Feldman, the late P. Ellen Parsons, and the late Steven Botman, who were essential in overseeing data collection and preparation and in providing insight on many of the findings. The programming assistance of Michael Cheng, Elizabeth Dorosh, and L. Clark Paramore is gratefully acknowledged. The authors also thank Debbie Standifer Francis and Janis Berman for help with preparation of the exhibits and the manuscript.

NOTES


8. Respondents with both private insurance and Medicaid were classified as having private coverage. Persons who reported private coverage but who had listed a “single-purpose” plan (for example, vision or dread disease) on the earlier NHIS interview were not included in the private category. After assignment of insurance status, unweighted sample sizes by insurance category were as follows: 2,239 persons with private insurance, 282 with Medicaid or other
public coverage (not including Medicare or military coverage), and 415 persons who were uninsured. Those with Medicare or military coverage (forty-one and fifty-five observations, respectively) were excluded from the analysis.


10. Standard errors were computed with SUDAAN, which uses the Taylor series linearization method to account for the complex survey design. Tests of statistical significance were used to assess whether differences in population estimates exist at specified levels of confidence. Only differences significant at the .05 level are discussed in the text.

To control for other confounding factors that influence access to health care, regression analyses were conducted as well. For the two dichotomous dependent variables, we used the SUDAAN procedure LOGISTIC to fit logistic regression models to binary data, estimating odds ratios and confidence levels for the parameters. For the physician visits equation, we used a negative binomial model based on a Poisson distribution. See J. Hausman, B. Hall, and Z. Griliches, "Econometric Models for Count Data with an Application to the Patents-R&D Relationship," Econometrica 52, no. 4 (1984): 909–938; and W.H. Green, Econometric Analysis (New York: Macmillan, 1990). The Poisson regression model, in contrast to a linear model, allows us to improve on the estimation by accounting for the characteristics found in the distribution of visits; specifically, we observe a large number of zeros, a large number of small values, and a variable that is discrete in nature. Although this model better reflects the observed distribution of visits, the estimation program does not allow for appropriate estimation of standard errors given the complex survey design. Because standard errors are understated, we apply a stricter test when interpreting results, considering as significant only those coefficients that are different from zero at a 99 percent confidence interval.


13. Full regression results can be obtained from the authors at Project HOPE Center for Health Affairs, Suite 600, 7500 Old Georgetown Road, Bethesda, Maryland 20814.


