

ISSUE BRIEF

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Medicaid: Obamacare Pushed More Americans into a Low-Quality Care System

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Attempts to change the Medicaid program have been widely and inaccurately characterized as a way for conservatives to deny care to people. However, the reality is that Medicaid fails to provide timely access to care and in many cases provides lower quality care. Yet, Obamacare's architects claimed success for having expanded Medicaid's sub-par services to more people, further exacerbating these problems.

The current Senate health reform bill¹ takes steps in the right direction by recognizing that health care "coverage" is not the same as health care and that simply pouring more taxpayer money into a failing, open-ended system is not the best way to help those in need. The bill rightly creates a pathway to transition to a more focused program that centers on the needs of the most vulnerable recipients—the disabled, elderly, children, and pregnant women in poverty—and gives people additional private options.

Increased Medicaid enrollment will not achieve increased access to high-quality health care for the following reasons. Medicaid:

- Fails to ensure health care access,
- Provides inadequate physician reimbursement rates,

- Hinders continuity of care,
- Fosters of a culture of bureaucracy,
- Furthers reliance on emergency departments, and
- Provides inferior quality care.

Medicaid Coverage Fails to Ensure Health Care Access

Medicaid's low physician reimbursement rates and administrative hassles make it difficult, if not impossible, for many physicians to incorporate Medicaid patients into their practices. Moreover, the Medicaid population disproportionately resides in medically underserved communities with serious shortages of primary care providers. These factors result in low participation rates, which in turn lead to reduced access to care for Medicaid beneficiaries.

Proponents of Medicaid expansion and even recent survey data² suggest that most doctors participate in the program, but objective data challenge that claim.

- The Centers for Disease Control and Prevention's National Center for Health Statistics show that the percentage of physicians accepting new Medicaid patients was 68.9 percent and the percentage for only primary care physicians dipped to 66.8 percent. Meanwhile, 84.7 percent accepted new privately insured patients and 83.7 percent accepted new Medicare patients.³

This paper, in its entirety, can be found at <http://report.heritage.org/ib4733>

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- Self-reported data from a voluntary survey of California physicians show physician participation in Medi-Cal (the state's Medicaid program) declined from 69 percent in 2013 to 63 percent in 2015.⁴

Medicaid's Low Physician Reimbursement Rates Undermine Access to Quality Care

Quality care means getting the right treatment for the right condition at the right time, which depends on access to a doctor. Physicians are less likely to accept Medicaid patients in their practice because Medicaid payment rates for medical services are set at artificially low levels—in some cases even below the cost of providing the services. As a general rule, Medicaid reimbursement rates are substantially lower than the fixed Medicare payments and substantially lower than the rates paid by privately insured patients.

Reimbursement rates vary across states and, not surprisingly, state reimbursement rates are directly correlated to physician participation rates. New Jersey, which reimburses physicians for services under Medicaid at only 45 percent of what it reimburses for Medicare, is also at the bottom in terms of access to care.⁵

This trend also holds true in specialty care. A 2016 study in *The Journal of the American College of Surgeons* found wide variations in payment across states, with many state Medicaid programs paying far less

than Medicare and private insurance for common, essential surgical procedures, raising concern that this may act as a disincentive for surgeons to care for Medicaid patients, especially in states with very low reimbursement rates.⁶

A 2017 analysis in *Health Affairs* found that, even when Medicaid patients get appointments, they experience significantly longer wait times in the doctor's office before being seen.⁷ The wait times were longer in states that had lower reimbursement rates.

Obamacare's anemic attempt to address the low physician reimbursement rates in Medicaid was a failure. The Medicaid primary care payment increase expired on December 31, 2014.⁸ The provision required that all state Medicaid programs increase payment for certain primary care services to Medicare payment levels during calendar years 2013 and 2014.

The payment increase was intended to address the need to maintain provider networks for those currently enrolled in Medicaid in light of the Obamacare-mandated expansion of Medicaid eligibility (later made optional by the U.S. Supreme Court), which was expected to cover millions of additional enrollees. This increase in payment rates was fully federally funded. Despite \$7.1 billion in taxpayer money spent on increased payments for services, nothing indicates that the payment increase had any effect on recruiting Medicaid primary care providers.⁹

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2. Michael L. Barnett and Benjamin D. Sommers, "A National Survey of Medicaid Beneficiaries' Expenses and Satisfaction With Health Care," *JAMA Internal Medicine*, July 10, 2017, <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643347> (accessed July 10, 2017).
3. Most recent figures are from 2013. Esther Hing, Sandra L. Decker, and Eric Jamoom, "Acceptance of New Patients with Public and Private Insurance by Office-based Physicians: United States, 2013," U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Data Brief* No. 195, March 2015, <https://www.cdc.gov/nchs/data/databriefs/db195.pdf> (accessed July 10, 2017).
4. California Health Care Foundation, "Physicians Participating in Public Insurance Programs," 2015, [http://www.chcf.org/aca-411/explore-the-data#chart%2Caccesstocare%2Csystemlevelaccess%2Cpubprogpact%2CPunchcard%20\(Physiciantype%7CPayer\)%2C2015](http://www.chcf.org/aca-411/explore-the-data#chart%2Caccesstocare%2Csystemlevelaccess%2Cpubprogpact%2CPunchcard%20(Physiciantype%7CPayer)%2C2015) (accessed July 10, 2017).
5. Kaiser Family Foundation, "Medicaid-to-Medicare Fee Index," 2014, <http://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedDistributions=all-services--primary-care&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed July 10, 2017), and Hing, Decker, and Jamoom, "Acceptance of New Patients With Public and Private Insurance by Office-based Physicians."
6. Charles Mabry, Lori A. Gurién, Samuel Smith, and Steven Mehl, "Are Surgeons Being Paid Fairly by Medicaid? A National Comparison of Typical Payments for General Surgeons," *Journal of the American College of Surgeons*, Vol. 222, No. 4 (April 2016), [http://www.journalacs.org/article/S1072-7515\(16\)00028-4/pdf](http://www.journalacs.org/article/S1072-7515(16)00028-4/pdf) (accessed July 10, 2017).
7. Tamar Oostrom, Liran Einav, and Amy Finkelstein, "Outpatient Office Wait Times and Quality of Care for Medicaid Patients," *Health Affairs*, Vol. 36, No. 5, (2017), https://healthaffairs.espsstores.com/Articles/HA/May_2017/2016.1478.pdf (accessed July 10, 2017).
8. Affordable Care Act, Public Law 111-148, as amended.
9. Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," March 2015, <https://www.macpac.gov/wp-content/uploads/2015/03/March-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf> (accessed July 10, 2017)

Medicaid and 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.¹⁰ 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.¹¹ Furthermore, under Obamacare, changes in income and family circumstances are likely to produce frequent transitions in eligibility for Medicaid and health insurance Marketplace coverage for low-income and middle-income adults.

A 2014 *Health Affairs* study estimated that more than 40 percent of adults likely to enroll in Medicaid or subsidized Marketplace coverage would experience a change in eligibility within twelve months, exacerbating gaps in coverage and disruptions in the continuity of care.¹²

Medicaid and a Culture of Bureaucracy

Substantial administrative burdens are another reason that provider participation rates are so low in Medicaid. These burdens include reimbursement delays; rejection of claims for seemingly capricious reasons; pre-authorization requirements for many services; and complex rules and regulations for claim filing procedure.

Of these, reimbursement delays within the program are especially problematic. Like reimbursement rates, reimbursement wait times vary widely across states: Kansas has an average of 37 days, while Pennsylvania’s is 115 days. In every state, however, the average wait time for Medicaid reimbursement is appreciably longer than the average wait time for payment from private insurers.¹³

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 the factors of reimbursement rates and wait times contribute to low physician participation in Medicaid and that fixing one without addressing the other is unlikely to close the access gap.¹⁴

Medicaid and Emergency Department Reliance

A clear example that Medicaid coverage does not equal access to health care is the continued reliance on the emergency department (ED) by Medicaid enrollees.

A 2014 examination of the Oregon Health Insurance Experiment, which expanded Medicaid through random-lottery selection of potential

10. Kathryn Klein, Sherry Glied, and Danielle Ferry, “Entrances and Exits: Health Insurance Churning, 1998–2000,” *The Commonwealth Fund, Issue Brief*, September 2005; http://www.commonwealthfund.org/-/media/files/publications/issue-brief/2005/sep/entrances-and-exits--health-insurance-churning--1998-2000/klein_855_entrancesexits_ib-pdf.pdf (accessed July 10, 2017)
11. Scott Gottlieb, “What Medicaid Tells Us About Government Health Care,” *The Wall Street Journal*, January 8, 2009, <http://online.wsj.com/article/SB123137487987962873.html#printMode> (accessed July 10, 2017)
12. Benjamin Sommers, John Graves, Katherine Swartz, and Sara Rosenbaum, “Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact,” *Health Affairs*, Vol. 33, No. 4 (2014), <http://content.healthaffairs.org/content/33/4/700.full.pdf> (accessed July 10, 2017).
13. Peter J. Cunningham and Ann S. O’Malley, “Do Reimbursement Delays Discourage Medicaid Participation by Physicians?” *Health Affairs*, Vol. 28, No. 1 (November 18, 2008), <http://content.healthaffairs.org/content/28/1/w17.abstract> (accessed July 10, 2017).
14. See the following: 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 Journal*, Vol. 110, No. 2 (August 2002), <http://pediatrics.aappublications.org/content/110/2/239> (accessed July 10, 2017); Joel Cohen and Peter Cunningham, “Medicaid Physician Fee Levels and Children’s Access to Care,” *Health Affairs*, Vol. 14, No. 1 (Spring 1995), <http://content.healthaffairs.org/content/14/1/255.abstract> (accessed July 10, 2017); Peter 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), <https://www.ncbi.nlm.nih.gov/pubmed/18307478> (accessed July 10, 2017); and Janet Perloff, Phillip Kletke, and James Fossett, “Which Physicians Limit Their Medicaid Participation, and Why,” *Health Services Research*, Vol. 30, No. 1 (April 1995), <https://www.ncbi.nlm.nih.gov/pubmed/7721586> (accessed July 10, 2017).

enrollees beginning in 2008, found that expanded Medicaid coverage produced no detectable changes in physical health, employment rates, or earnings, and also increased emergency department (ED) visits by 40 percent in the first 15 months, including increases in visits for conditions that may be most readily treatable in primary care settings.¹⁵

A follow-up study in 2016 found that the increased use of the ED in Medicaid persisted for at least two years and therefore was not due simply to “pent-up demand” that would dissipate over time. Medicaid enrollees’ ED use in California surged by an even more dramatic 75 percent in the two years following the massive eligibility expansion authorized by Obamacare, according to data from the California Office of Statewide Health Planning and Development.¹⁶

Nationwide statistics from the Centers for Disease Control and Prevention (CDC) also show no reduction in the traditionally high rates of ED use for non-urgent reasons among adults with Medicaid during and immediately following the Affordable Care Act implementation, suggesting that increasing “coverage” by adding more people to the Medicaid roles may not be the best solution in terms of improving access to primary care.¹⁷

Medicaid’s Poor Quality Care Problem

If Medicaid patients overcome these other barriers to access, evidence suggests that the care they receive in the doctor’s office may be inferior to the care received by privately insured patients.

Discussions of the Medicaid program routinely overlook these persistent quality deficiencies. For example, a 2015 study in *Health Affairs* found that after patient and provider characteristics were controlled for, Medicaid-insured visits were less likely than privately insured visits to include several preventive services, including clinical breast exams and Pap tests.¹⁸

Previous studies regarding cardiac and cancer patients have revealed extensive shortcomings in the quality of care delivered through Medicaid. For example, 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.¹⁹

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 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, even after controlling for other factors, such as site and stage of the cancer and the gender of the patients.²⁰

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15. Sarah Taubman, Heidi Allen, Bill Wright, Katherine Baicker, and Amy Finkelstein, “Medicaid Increases Emergency-Department Use: Evidence from Oregon’s Health Insurance Experiment,” *Science*, Vol. 343, No. 6168 (January 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3955206/> (accessed July 10, 2017).
 16. Rich Daly, “ED Use Surges Among California Medicaid Enrollees,” *Healthcare Business News*, May 5, 2016, <https://www.hfma.org/Content.aspx?id=48018> (accessed July 10, 2017).
 17. Renee M. Gindi, Lindsey I. Black, and Robin A. Cohen, “Reasons for Emergency Room Use Among U.S. Adults Aged 18–64: National Health Interview Survey, 2013 and 2014,” U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *National Health Statistics Reports* No. 90, February 18, 2016, <https://www.cdc.gov/nchs/data/nhsr/nhsr090.pdf> (accessed July 10, 2017).
 18. Stacey McMorro, Sharon Long, and Ariel Fogel, “Primary Care Providers Ordered Fewer Preventive Services for Women with Medicaid than for Women with Private Coverage,” *Health Affairs*, Vol. 34, No. 6 (June 2015), <http://content.healthaffairs.org/content/34/6/1001.full.pdf+html> (accessed July 10, 2017).
 19. Anwar Zacharias, Thomas Schwann, Christopher Riordan, Samuel Durham, Aamir Shah, and Robert 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 2005), <http://www.sciencedirect.com/science/article/pii/S0735109705017717?via%3Dihub> (accessed July 10, 2017).
 20. Cathy Bradley, Joseph Gardiner, Charles Given, and Carlee Roberts, “Cancer, Medicaid Enrollment, and Survival Disparities,” *Cancer*, Vol. 103, No. 8 (March 2005), <http://onlinelibrary.wiley.com/doi/10.1002/cncr.20954/abstract;jsessionid=3EE1BC250E81650DF5363A6B60E55BFB.f03t03> (accessed July 10, 2017).
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More recently, a report in the *Journal of Pediatric Health Care* also found that privately insured patients had higher rates of medication adherence than Medicaid patients. Moreover, “patients with Medicaid plans also had 20 percent more inpatient hospitalizations, 48 percent increased odds of emergency department visits and 42 percent fewer outpatient visits compared with those who had a private plan.”²¹

Expand Access to Quality Care: Medicaid Premium Support

The Medicaid payment policies in the Senate and House bills both offer the states federal payment alternatives: a per-capita payment system for different Medicaid populations or a state block grant with enhanced managerial flexibility for state officials. Both bills put Medicaid on a more predictable budgetary path, and replace automatic federal spending for Medicaid as an open-ended entitlement—an approach long recommended by many health policy analysts.²² These steps could encourage the highest and best use of federal Medicaid funds for the affected Medicaid populations.

To secure better access to care, Congress should consider the creation of a Medicaid premium support program for the able-bodied Medicaid population. Congress should fund assistance to Medicaid patients through a direct defined contribution payment system (a “premium support” program) for these beneficiaries to enroll in private health plans. The Senate bill takes a step in this direction by providing lower-income individuals access to tax credits to purchase private insurance, rather than put them into Medicaid.

Such a policy would mainstream Medicaid beneficiaries into the same competitive private health insurance coverage that is available to their fellow citizens. This would mean that they would have access to the same doctors and networks of medical professionals that most Americans enjoy through the private sector. Unlike at present, then, when many Medicaid beneficiaries cannot find a doctor to care for them, these individuals could secure superior medical care, especially primary care.²³

Conclusion

The Medicaid status quo is not effectively serving the health care needs of the disabled, elderly, children, and pregnant women in poverty. Policymakers should ignore hyperbolic political rhetoric claiming that conscientious reforms to secure and improve the safety net for Medicaid’s core populations and to provide better options for coverage and care to others will result in a situation in which “thousands will die.”²⁴ Obamacare expanded the poorly performing Medicaid and claimed success for doing so. These new recipients can fare better under a new system that broadens their access to quality care. A Medicaid premium support program can accomplish that worthy end.

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 22. “The Medicaid program is growing significantly in both enrollment and cost. Congress should separate Medicaid enrollees into three distinct categories—able-bodied, disabled and elderly—and should finance each category independently but within an aggregate federal spending cap. This change would put Medicaid spending on a more predictable fiscal path and allow for different policy and financing arrangements for these different sets of enrollees to better meet their different needs.” The Heritage Foundation, *Blueprint for Reform: A Comprehensive Policy Agenda for a New Administration in 2017*, Mandate for Leadership Series (2016), p. 55, http://thf_media.s3.amazonaws.com/2016/BlueprintforReform.pdf.
 23. “Federal Medicaid assistance to able-bodied individuals should be converted to a direct contribution to facilitate participation in the private marketplace, and federal assistance to the states for the disabled and elderly should be limited to ensure fiscal control.” The Heritage Foundation, *Blueprint for Balance: A Federal Budget for 2017*, The Mandate for Leadership Series (2016), pp. 8–9.
 24. Josh Delk, “Sanders: ‘Thousands Will Die’ Under GOP Health Bill,” *The Hill*, June 23, 2017, <http://thehill.com/blogs/blog-briefing-room/news/339234-sanders-thousands-will-die-under-gop-health-bill> (accessed July 10, 2017).
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