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Medicaid Outcomes: better than being uninsured and comparable to private coverage?

Summary

It is common practice in discussions of important policy questions to bring dueling analysts with competing analyses and claims regarding the paucity of the opposing side's evidence. Medicaid expansion is no exception. However, in the case of Medicaid, there is a long history of general success and satisfaction with the program. That is not to suggest that the Medicaid program does not have flaws and cannot be improved, but in the main, the program can be credited with improved access to care, lower unmet health care needs, better health outcomes, and better quality of life for people with low incomes.

In light of that history, it would seem that there should be no debate regarding the advantages of Medicaid expansion. However, critics of Medicaid expansion have selectively taken the work of credible scholars with seemingly sound analyses to make the counter intuitive claim that the Medicaid system is so broken that it is better to be uninsured than to have Medicaid coverage. The basis of this claim can be reduced to poor research design, partial reporting of research findings, and ignoring acknowledged limitations of the studies being cited. In particular, these results are based on comparisons across groups that are not comparable.

Correctly establishing peer groups is a vital first step in obtaining valid comparisons. In this note we demonstrate how lack of attention to the history – medical as well as economic – of the individual whose health outcomes are being compared as well as when the insurance coverage was obtained play an important role in determining outcomes and therefore, the relative benefits of Medicaid expansion. Some of common sources of error include failing to account for:

- length of time that a person has had Medicaid
- stage of diagnosis at time of Medicaid coverage
- mental health status
- type of Medicaid plan (fee-for-service or managed care)
- auxiliary support systems around the patient and situational differences, including access to other sources of care, resources, family support, housing, and transportation.

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In addition, lack of attention to differences in Medicaid implementation across states, which varies significantly, can make Medicaid seem to be an inferior option. Non medical factors such as quality of life and peace of mind, greater job mobility are considerations that favor Medicaid coverage over being uninsured or even having other forms of coverage available to people close to the Federal Poverty Level.

We conclude that when properly comparing people on Medicaid to people with other sources of health coverage, the general and inevitable conclusion is that having Medicaid coverage is better than being uninsured, including: better access to care, lower rates of unmet health needs; reduced financial burden, less stress; improved mental health status, and even reduced rates of death. Medicaid coverage can also be comparable to private coverage on many, though not all, measures. We further find that Ohio's Medicaid program performs better than that in most states and has results on some measures that are similar to or better than private pay in Ohio and better than the national private pay and the national state Medicaid average.

Medicaid Outcomes: better than being uninsured and comparable to private coverage?

One argument raised against Medicaid expansion is that Medicaid is such a broken system that it is better to be uninsured than on Medicaid.[i] This argument does not stand up to a broader review of the research that compares people on Medicaid to people who are uninsured. Medicaid also fares better compared to private insurance than critics of Medicaid expansion contend, sometimes having worse outcomes but other times having similar or even better outcomes.

Limitations with existing research

Several key Medicaid specific factors should be included in studies comparing people with Medicaid to those with other sources of coverage. These factors help account for differences in the outcomes that are attributed to Medicaid. Failure to account for these factors can undermine conclusions about the effectiveness of Medicaid. These factors include:

The length of time that a person has had Medicaid

The length of time that people have Medicaid coverage varies more widely than for people who have private coverage. Many Medicaid recipients have inconsistent Medicaid coverage. According to research by Benjamin Sommers, 29 percent of the always eligible adults no longer had Medicaid coverage within one year while 45 percent of the not always eligible adult category no longer had their Medicaid coverage within one year.[ii] Of those who no longer had Medicaid coverage, 33.5 percent had acquired other insurance within six months, while, 17.1 percent had reenrolled on Medicaid and the other 48.4 percent remained uninsured. The reasons for losing Medicaid coverage varied, including not completing reenrollment requirements and no longer meeting the categorical requirements of parental status, income, assets, or health condition.

This intermittent coverage matters. It can undermine the ability to use Medicaid coverage effectively, especially around primary, preventive, and chronic care management. According to research by Siran Koroukian on Ohio Medicaid data, the effectiveness of Medicaid as an insurance plan increases by the length of time a person has Medicaid coverage.[iii] She found that women on Medicaid with less than one year of coverage had a mammography screening rate of 8 percent compared to 73 percent for women with seven or more years of Medicaid coverage. She also found that the likelihood of women on Medicaid having a mammography screening increased by 50 percent for each year of Medicaid enrollment.

Therefore, varying length of time on Medicaid should be taken into account when comparing outcomes for people on Medicaid to outcomes for people with other sources of coverage. It is best to compare people with

similar lengths of coverage to get a more accurate picture of outcome differences between sources of coverage.

The stage of diagnosis at the time a person obtained Medicaid

Because there are multiple avenues to obtain Medicaid coverage not everyone enters Medicaid with the same health status. Some individuals qualify based on income and being the custodial parent for a low income child. Some qualify because they are 65 and have low income and few resources. Some qualify because of a health, even such as becoming pregnant. Most others qualify only after they become sick enough to meet the requirements for ABD Medicaid and have a low enough income and limited resources.

The variability in paths to eligibility results in the Medicaid program consisting of people who enter Medicaid at different stages of disease. Failure to account for this intra-group diversity can overstate the difference in outcomes between Medicaid and other sources of coverage, since outcomes for those who illness began before they were on Medicaid should be attributed to their prior coverage status.

Additional research by Koroukian demonstrates the importance of this distinction. She found significant differences in stage of cancer diagnosis by time on the Medicaid program[iv]. While the overall percent of Ohio Medicaid women diagnosed with a late stage cancer was 9.6%, that rate was:

- 6.2% for women who had been on Medicaid for 3 months or more (pre-diagnosis group).
- 18.4% for women diagnosed with cancer within the period of two months before or after enrolling on Medicaid (peri-diagnosis group) and
- 12.6% for women who enrolled three or more months after being diagnosed with cancer (post-diagnosis group)

These findings show that an analysis that aggregates the Medicaid population will overstate the negative outcomes associated with Medicaid. For example, Koroukian found that the odds of being diagnosed with late-stage breast cancer were 2.5 times higher for all women on Medicaid than the non-Medicaid group. But, it was only 1.6 times greater when looking only at the women who had been on Medicaid for at least three months before being diagnosed with breast cancer (the pre-diagnosis group of women). For cervical cancer the odds of being diagnosed with late stage cancer fell from 2 times for the entire Medicaid group of women to 1.2 times for the pre-diagnosis group compared to the non-Medicaid group

Koroukian and colleagues found a similar difference in five year survival rates for cancer based on length of time on Medicaid at time of diagnosis of cancer.[v] They found the five year survival odds were much worse when looking at all Medicaid women for the eight cancers they studied (2.43 times) versus the odds for women in the pre-diagnosis group (1.58 times) compared to the non-Medicaid group.

The mental health status of people on Medicaid

People on Medicaid have a higher likelihood of having a significant mental health condition than other populations, especially people with private insurance.[vi] For example, according to data from the Medical Expenditure Panel Survey (MEPS), 87 percent of persons living in the community with schizophrenia are covered by Medicaid or Medicare versus 15 percent covered by private insurance. Research indicates that people with mental health issues face higher prevalence of chronic conditions, excess mortality of two to three times the general population, which translate to a 13-30 year shortened life expectancy, and greater problems accessing and getting effective health care, including primary care.[vii]

The presence of mental illness itself can create challenges in accessing care or in adhering to treatment recommendations. For instance, Koroukian found that women on Ohio Medicaid with mental illness were 32 percent less likely to undergo at least one screening mammography compared to Ohio Medicaid covered women without a mental illness.[viii]

Therefore, studies that compare outcomes for Medicaid and non-Medicaid populations that are unable to control for differences in mental health between the study populations could well misstate the difference in outcomes due to source of health care coverage.

Whether the people on Medicaid were served through the fee-for-service system or by Medicaid managed care plans

Medicaid programs vary over time and across states on whether people are served through the fee-for-service system or through Medicaid managed care plans, typically private sector plans. This distinction can matter for several reasons, including:

- that states enter into more explicit contracts with managed care plans than with individual providers
- managed care plans pay some providers more than what they get paid for under fee-for-service, especially around primary care
- managed care plans provide care coordination and other member service programs for people they cover

For this reason, some studies choose to examine the fee-for-service Medicaid patients separately from the Medicaid managed care patients. One such study was cited by Avik Roy in his article entitled Medicaid Mess. This study counted the Medicaid managed care population in the private insurance study group versus the Medicaid study group.[ix] Thus, this study's findings on Medicaid outcomes only apply to patients served under fee-for-service Medicaid. For states with significant Medicaid managed care penetration, such as Ohio, therefore this study's results do not apply.

How similar the Medicaid and non-Medicaid study groups are on demographic and other situational factors

People with Medicaid coverage typically differ in multiple ways from people with private insurance and those who are uninsured. For example, in her study comparing five year survival outcomes for Medicaid and non-Medicaid women with cancer Koroukian identified the following differences between the two study populations with the Medicaid group of women having more individuals who were:

- Younger
- African American
- Not married
- Of lower income, with 41.9% of the non-Medicaid group residing in the two lowest income quartiles of census tracts compared to 81% in the prediagnosis group and 71.2% in the peri/post diagnosis group
- Residing in census tracts with lower education attainment; and
- Residing in Appalachia and other disadvantaged areas versus suburban counties where a higher proportion of the non-Medicaid group lived

But there are other factors that these studies do not even discuss controlling for, factors that are even harder to manage in the datasets they are using. These differences include:

- ❒ The resources to pay for needed services not covered under Medicaid source compared to other population groups
- ❒ Family support capacity of people on Medicaid compared to other population groups
- ❒ The housing situation of the people on Medicaid compared to other population groups
- ❒ The transportation resources of people on Medicaid compared to other population groups
- ❒ Mental health status of people on Medicaid compared to other population groups

The studies cited by the critics and those cited in this review seek to control for as many of these variables as possible and acknowledge their methodological limitations. Their challenge is that the datasets used in observational studies lack the ability to control for many of these factors and the studies by the critics of Medicaid expansion did not even acknowledge many of these challenges.

These methodological limitations can affect the ability to make broad claims about outcomes differences between diverse sources of coverage. As Koroukian and her coauthors noted in their study looking at survival differences for different cancer types between Medicaid and non-Medicaid populations, "First, it is possible that Medicaid beneficiaries are initiating treatment late, and/or receiving inadequate treatment. Our data sources in this study preclude us from determining whether treatment-related factors are associated with the differences in survival outcomes between Medicaid and non-Medicaid patients. Second, poor survival associated with Medicaid may be a reflection of the patients' high level of vulnerability, as adults enrolled in the Medicaid program are likely to be disabled, presenting with psychiatric and/or physical comorbidities. Furthermore, although financial barriers may be somewhat reduced with their enrollment in the Medicaid program, these patients encounter various barriers (eg, transportation, poor psychosocial support) that may hinder receipt of adequate treatment and follow-up care."[x]

Austin Frakt and his co-authors underscore these methodological challenges for observational studies that seek to compare outcomes between people on Medicaid and those with other sources of coverage.[xi] They state: "It's far more likely that such results [meaning that outcomes are worse for people on Medicaid] are driven by selection bias. Medicaid enrollees (including dual-eligible recipients of both Medicaid and Medicare) tend to be sicker than uninsured patients and to have lower socioeconomic status, poorer nutrition, and fewer community and family resources. Medical and social service providers may also help the sickest or neediest patients to enroll in Medicaid — a more direct cause of selection bias. Few of these potential confounders can be completely addressed using commonly available clinical or population data."

What do studies report about Medicaid outcomes?

Taking these factors into account, is it possible to say whether Medicaid makes a difference compared to people who are uninsured or even people who have private coverage? It is. Research shows that similarly situated people who are able to use Medicaid as a regular health insurance plan versus a high risk, episodic source of care have outcomes BETTER than the uninsured and often comparable to those with private insurance on some measures. Differences with private health coverage are further diminished for individuals who participate in Medicaid managed care plans. The family resources, mental health, housing, and transportation differences among the population groups likely account for much of the remaining differences.

Access to care and unmet needs

According to a November 2012 Government Accountability Organization (GAO) report that compared people with

full year Medicaid coverage to people with full year private coverage, full year uninsured, partial year Medicaid, or being uninsured "less than 4 percent of beneficiaries who had Medicaid coverage for a full year reported difficulty in obtaining medical care, which was similar to individuals with full-year private insurance." [xii] It did find that people on Medicaid had significantly lower rates of unmet needs than people who were uninsured and no statistically significant difference in unmet needs from those with private insurance, except for dental care (see Table 1)

Table 1
Comparison of people with full year private, Medicaid, and uninsured on unmet needs (GAO 2012)

	Private*	Medicaid**	Uninsured
Unmet medical care service need	3.0%	3.7%	10.4%
Unmet prescription drug need	2.4%	2.7%	5.6%
Unmet dental care need	3.7%	5.4%	12.3%

*** difference between Medicaid and private is statistically significant ONLY for dental care**

**** difference between Medicaid and uninsured is statistically significant for each category**

Research using Ohio specific data confirms that it is better to be on Medicaid than to be uninsured, especially for those having Medicaid for one full year. As with the GAO analysis, these studies also found that having Medicaid can be similar to having private sector coverage on some, though not all, variables. For example, one study using 2008 Ohio Family Health Survey data, found for 19-64 year old adults who were on Medicaid, private insurance or uninsured for a full year that those who were uninsured always fared worse than those on either ABD Medicaid or Healthy Start/Healthy Families Medicaid (see Table 2).[xiii] The results also showed that adults on Healthy Family/Healthy Start Medicaid and ABD Medicaid had similar results to private insurance on some measures, such as receiving high quality care, while those on Healthy Families/Healthy Start Medicaid had less difficulty in obtaining needed care than those with private insurance. Adults with private insurance did report better access to specialists than those with Medicaid coverage.

Table 2
Comparison of adults with full year coverage by Medicaid type, private insurance, or being uninsured
(2008 OFHS data)

	Healthy Start/ Healthy Families Medicaid	ABD Medicaid	Private Insurance	Uninsured
Reporting receiving high quality care	42.2%	40.3%	43.7%	27.5%
Reporting not obtaining needed care	9.0%	19.0%	14.0%	36.0%
Reporting problems accessing a specialist	28.2%	40.7%	17.6%	52.3%

A second study using the 2008 Ohio Family Health Survey, which compared parents with full year Medicaid coverage to full year uninsured, found it better to be on Medicaid than to be uninsured[xiv] as shown in Table 3. This analysis found that parents who were uninsured for a full year had much higher rates of unmet need, delay in seeking care, and not getting needed care than parents with full year Medicaid coverage by between twenty-four and forty percentage points.

Table 3
Comparison of parents with full year Medicaid to full year uninsured (OFHS 2008 data)

	Medicaid	Uninsured
unmet dental need	19%	46%
unmet prescription drug need	9%	33%
unmet other need	10%	37%
delay in seeking care	14%	54%
did not get needed care	9%	35%

Another analysis used the 2010 Ohio Family Health Survey to compare childless adults (the expansion population) to Medicaid covered parents. It found much greater unmet need and less appropriate health care utilization by those who were uninsured[xv] versus those with Medicaid, as shown in Table 4.

Table 4
Comparison of Medicaid covered parents and low income uninsured childless adults with similar incomes (OFHS 2010 data)

	Medicaid covered parents	Uninsured Childless Adults
unmet dental need	20.7%	43.8%
unmet vision need	17.3%	44.7%
unmet prescription drug need	17.8%	40.3%
unmet medical care need	14.0%	51.5%
lacking usual source of care	31.5%	49.9%
not seen physician in last 2 years	7.0%	34.5%

Mortality rates

Critics of Medicaid respond that there is no evidence that this increased access to care and lower unmet needs translates into better health outcomes, including lower rates of mortality. But, a 2012 study that compared differences in mortality in states that expanded Medicaid coverage to comparable states that did not expand Medicaid coverage challenges this claim.[xvi]

This research found:

- Medicaid expansions were associated with a significant reduction in adjusted all cause mortality (by 19.6 deaths per 100,000 adults, for a relative reduction of 6.1%; P = 0.001).
- Mortality reductions were greatest among older adults, nonwhites, and residents of poorer counties.

This report also found that these expansions

- increased Medicaid coverage (by 2.2 percentage points, for a relative increase of 24.7%; P = 0.01)
- decreased rates of being uninsured (by 3.2 percentage points, for a relative reduction of 14.7%; P<0.001)
- decreased rates of delayed care because of costs (by 2.9 percentage points, for a relative reduction of 21.3%; P = 0.002), and
- increased rates of self-reported health status of "excellent" or "very good" (by 2.2 percentage points, for a relative increase of 3.4%; P = 0.04).

Other research has found higher mortality for people who are uninsured compared to people who have health insurance. One of these studies concluded that the lack of coverage among the near-elderly is likely to account for an excess of 105,000 deaths between 2003 and 2010. Per the authors this rate of mortality places being uninsured as the third leading cause of death for the near elderly below only heart disease and cancer.[xvii]

Quality of care

While there have been identified differences in quality of care outcomes between private pay and Medicaid covered patients, a new May 2013 study sheds some interesting light on these differences.[xviii] This study compared the quality of hospital care between patients with Medicaid and private pay patients for three conditions: myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia. The study used data that all hospitals are required to report on processes of care to identify what percent of patients with these different funding sources were reported to have received all of the recommended care processes for their specific condition. It found wide variation across Medicaid programs, with smaller differences between Medicaid patients and private pay patients within a given state.

The study finds that Ohio Medicaid performed as well as Ohio private pay, better than the national average for private pay, and better than national average for Medicaid programs. According to this study's state level data (see Table 5):

- There were no difference in quality outcomes for Ohio Medicaid patients compared to Ohio private pay for CHF versus 2.9 percentage points at the national average
- There was no difference between Ohio Medicaid and Ohio private pay quality scores for pneumonia, compared to a 1.3 percentage point difference at the national level
- There was a one percentile difference for AMI quality scores compared to a 2.7 percentage point difference at the national level
- Ohio Medicaid's quality scores were higher than the national average for private pay by 6 percentage points for CHF and 4 percentile points for pneumonia, with no difference for AMI.
- Ohio Medicaid's quality scores exceeded the national average for state Medicaid programs for all three conditions by 3 percentage points for AMI, 9 for CHF, and 5 for pneumonia

Table 5
Comparison of Ohio Medicaid and Ohio Private Pay to each other and other states on 3 conditions (Weissman, 2013)

	AMI	CHF	pneumonia
Ohio Medicaid quality score	91%	82%	82%
Ohio private pay quality score	92%	82%	82%
Percentile point difference between Ohio Medicaid and Ohio private pay	1%	0%	0%
Ohio Medicaid rank	4th	tied 8th	tied 15th
US Medicaid average quality score	88%	73%	77%
US average private pay quality score	91%	76%	78%
Best Medicaid state quality score	97%	90%	90%
Worst Medicaid stat quality score	71%	36%	63%
Best private pay state quality score	97%	86%	89%
Worst private pay state quality score	81%	45%	67%
Percentile point difference between Ohio Medicaid and national private pay average	0%	6%	4%
Percentile point difference between Ohio Medicaid and national Medicaid average	3%	9%	5%
Percentile point difference between Ohio Medicaid and Ohio private pay average	1%	6%	4%

The authors offered the following conclusions:

- "We found that a substantial number of hospital patients failed to receive all appropriate services, but differences between Medicaid and privately insured patients tended to be small, on the order of 1–3 percentage points in magnitude, nationally. Private-Medicaid differences also tended to be small within most states."
- "Our finding of minimal differences between Medicaid and privately insured patients tends to support the value of public insurance."
- "Our study tends to support that view, as the quality scores for the two payers moved more or less in tandem, suggesting that quality of care is related to something other than payer source. There may be some non-Medicaid characteristics that vary by state and affect all patients, but these are yet to be identified."

Financial and stress burdens

Finally lacking health coverage creates economic burden, as well as health burdens. Critics of Medicaid ignore these additional burdens. Per data from the 2010 Ohio Family Health Survey, Ohio's uninsured with incomes below 200% of poverty reported the following experiences[xix]:

- Over 63% having difficulty paying their medical bills (624,028 Ohioans)
- Almost 48% having difficulty paying for other necessities, such as food, rent, or heat, due to their medical bills (299,135 Ohioans)
- Over 65% using up most or all of their savings to pay for their medical bills (408,435 Ohioans)
- Over 11% having to declare bankruptcy due to their medical bills (71,464 Ohioans)

Research from a natural Medicaid experiment in Oregon affirms the non-financial benefits of Medicaid expansion. In 2008 Oregon expanded Medicaid through a lottery process where some people gained coverage while others who were similar in income and other factors did not get coverage. A research team is comparing the experience of these two similarly situated groups to understand what benefits, if any, having Medicaid coverage produces. The initial findings on financial security include[xx]:

- 40% reduction in probability that people who got Medicaid had to borrow money or skip payment on other bills due to medical expenses
- 25% decrease in probability of having unpaid medical bills that are sent to a collection agency

This research also found that obtaining Medicaid coverage produced meaningful mental health and health status benefits, potentially due to the reduction in financial stress, including:

- 25% increase in people reporting their health status as good, very good, or excellent vs fair or poor
- 25% less likely to screen for depression
- 30% more likely to report being happy or very happy vs. not too happy

In addition this research found that those who obtained Medicaid coverage increased the probability of using health care services, including:

- 35% increase in use of outpatient care
- 15% increase in use of prescription medications
- 30% increase in hospital admissions
- No statistically significant change in emergency room utilization
- 70% more likely to report having a regular source of care
- 60% increase in mammograms and 20% increase in cholesterol monitoring

These researchers issued a follow up report released in May 2013[xxi]. Contrary to broad misrepresentations of the finding, this research actually shows that having Medicaid versus being uninsured generated statistically significant positive effects. The authors conclude that "We found that insurance led to increased access to and utilization of health care, substantial improvements in mental health, and reductions in financial strain, but we did not observe reductions in measured blood-pressure, cholesterol, or glycated hemoglobin levels." Specifically, their analysis found that for people who obtained Medicaid coverage compared to those who did not there was:

- A positive, but not statistically significant improvement in measured blood-pressure, cholesterol, or glycated hemoglobin levels. The improvements may not have measured as statistically significant because of the small sample size of individuals with these conditions.[xxii] Specifically the points estimates show that people on Medicaid had the following gains:
  - Decrease in the percentage of people with elevated blood pressure from 16.3% to 15%. (p=0.65).
  - Decrease in the percent of people with diabetes with a high A1C from 5.1% off Medicaid to 4.2% (p=0.61).
  - Decrease in the percent of people with high total cholesterol from 14.1% to 11.7% (p=0.45).
- An increase in the number of people identified as having diabetes and started on treatment for their diabetes, while no increase diagnosis for high blood pressure or high cholesterol levels
- A statistically significant 9.2 percentage point decrease in the rate of depression, which was accompanied by a 1.95 percentage point increase in the average score on the mental health components of a health-related quality of life measure
- A statistically significant 7.8 percentage point increase in the proportion of people reporting health was the same or better as compared to the prior year
- A 23.8 percent point increase in perceived access to care, including improvements in real access to care such as:
  - A greater than 50 percent increase in the probability of having a reporting a consistent place to get care and receive preventive screenings, with no increase in the use of the ER
  - An increase in preventive screenings, including a 14.6% increase in cholesterol screening
- A reduction in financial strain from medical costs, including:
  - A 50 percent reduction in the probability of having to borrow money or having to skip paying other bills because of medical expenses
  - The virtual elimination of individuals experiencing an episode of catastrophic expenditures (defined as out-of-pocket expenses exceeding 30 percent of income)

In commenting on the results of this study, John Lumpkin, MD, MPH, the senior vice president and the director of Robert Wood Johnson's Health Care Group and former Director of the Illinois Department of Public Health stated? "The bottom line is that better health requires health insurance coverage, but it doesn't end there."[xxiii] Ongoing research confirms this conclusion, showing that Medicaid programs with chronic care management, including an emphasis on patient-centered medical homes, demonstrate improved health outcomes and financial savings. These Medicaid improvements are new coming after the time period for the data used for studies cited by the critics of Medicaid expansion.

The Patient-Centered Primary Care Collaborative's 2012 review of studies on patient-centered medical home includes examples of the benefits of these program improvement for Medicaid patients and providers, including[xxiv]:

- Between 2007 and 2009 increased provider participation from 20 to 76 percent in Colorado's CHIP program and an increase in well-care visits for children from 54 to 73 percent accompanied with a $215 lower per member per year cost for children
- A 27 percent reduction in hospital spending and 35 percent reduction in ER spending in the first year of a Medicaid PCMH program in Chemung County, New York

- A 21 percent increase in asthma staging and 112 percent increase in flu shots, along with 23 percent lower ER use and costs, 25 percent lower outpatient care costs, and 11 percent lower pharmacy costs between 2003 and 2010 because of North Carolina's Community Care of North Carolina initiative
- An 8 percent increase patients reporting "always getting treatment quickly" within one year of Oklahoma Medicaid PCMH initiative, which also showed a $29 decrease in per capita member costs

How do these findings square with claims from opponents of Medicaid expansion?

Given this discussion above, how do these findings square with the claims from opponents of Medicaid expansion on health outcomes. First, some of the studies cited by opponents of Medicaid expansion actually show that people on Medicaid do better than those who are uninsured even though those with private insurance fared better. For example:

- A Heritage Foundation report cites a study by Nakela Cook which found that community health center patients with fee-for-service Medicaid had a 2.83 times greater difficulty in accessing specialty medical services than patients with private insurance. The report failed to mention that those who were uninsured had a **109.88** times greater difficulty in accessing specialty medical services than those with private coverage, which is 38.8 times more difficult than for someone who had Medicaid coverage. The report also did not compare people with Medicaid managed care to private insurance.

Second, some of the studies by critics of Medicaid expansion or cited by these critics show people on Medicaid managed care doing similar or better than people with private coverage, such as:

- A 2011 report from the conservative Foundation for Government Accountability in Florida which assessed Florida Medicaid's five county Medicaid managed care pilot experience of enrollees found that their experience was similar or better than that of many commercial plans.[xxvi] According to the report "access to and satisfaction with specialists for Reform Pilot enrollees at or above national averages for Medicaid *and* commercial plans" (reports own use of italics)
- As stated earlier, a study in Avik Roy's "Medicaid Mess" article defined people with Medicaid managed care as being private pay, thus the results only focused on Medicaid fee-for-service patients

Third, the studies cited have methodological limitations discussed above that limit the ability to make the strong assertions on Medicaid that the critics of Medicaid expansion choose to make, including:

- The studies often can only apply to the context of the specific state Medicaid program
- The studies are unable to account for several critical features that likely differ between people with Medicaid, people who are uninsured, and people with private pay, features that may well cause some of the differences found in the report and which are outside of any of the sources of coverage
- The studies attribute to Medicaid outcomes that could well apply to the prior source of coverage especially for people who had the health care condition being studied at the time that their Medicaid coverage began
- Given the different ways that someone can obtain Medicaid coverage, the studies often do not properly compare patients with Medicaid to patients who have private pay

Fourth, the studies the critics cite do not focus at all on non-medical outcomes, outcomes that are an important reason that people obtain health care coverage. These outcomes include reductions in financial strain, financial stress, and overall mental well being.

Is Medicaid without issues?

Given the importance of continually improving the Medicaid program, it is necessary to acknowledge that there can be variation in outcomes between people on Medicaid and those not on Medicaid that program policy should seek to understand and address. But these differences do not always make for easy conclusions on what causes the variation or how to respond. For example, in Koroukian and colleagues' comparison of five year survival rates for eight types of cancer they found the survival rates were similar between Medicaid pre-diagnosis group and non-Medicaid Ohio women for Hodgkin's lymphoma, and melanoma and Medicaid women in the peri/post-diagnosis group and non-Medicaid women for colon cancer.[xxvii]

Some of the challenges to the Medicaid program identified by its critics and even its supporters, such as low provider payment rates, the extent of Medicaid managed care in different states, need for support for patient-centered medical homes, or need for support for chronic care management initiatives, are state Medicaid program design decisions. Programs in different states are at different stages of addressing many of these challenges. Some of these program changes would likely cost more money, such as increased provider payments, while others are likely budget neutral or budget saving.

Other challenges relate to socioeconomic factors that are outside of direct health care interactions. As Weissman notes "One possible explanation for the difference between hospital quality and ambulatory quality is that, as Medicaid patients are socioeconomically disadvantaged compared with private pay patients, they may face competing needs that make adhering to treatment recommendations more difficult in ambulatory settings." Many state Medicaid programs are looking to address these challenges through use of community health workers, participation in federal initiatives like Strong Start, and use of payment reforms that require providers to look at non-medical factors that affect treatment outcomes. But commercial insurance has no better tools for addressing these challenges and typically less need and experience dealing with these issues given the demographics of the commercially insured population.

But there is no research that shows putting people on Medicaid into commercial health plans with the Medicaid population having the same benefits and cost sharing requirements as commercial plan enrollees produces better outcomes for the Medicaid population.

Conclusion

The Medicaid program is not perfect. It can be better. But, the argument that Medicaid is such a broken system that it is better to be uninsured than to be on Medicaid is not supported by the evidence. As discussed above the evidence shows that:

- People on Medicaid overall have much better access to care and fewer unmet health needs that those who are uninsured;
- That Medicaid expansions can be tied to decreases in mortality compared to states that did not expand Medicaid;
- People getting Medicaid have significant improvements in financial stress and other stress, outcomes often ignored by critics of Medicaid expansion
- That people who are able to stay on Medicaid for a year or more have screening and access rates that are comparable, and sometimes superior, to people on private insurance
- Some people come on to Medicaid already with disease making it important to associate their health outcomes with their prior health coverage situation and not simply to Medicaid; and
- Studies in a given state may not translate to other states because of differences in state Medicaid programs, most notably the degree of managed care across states

The argument that Medicaid is a broken system is especially hard to argue for Ohio. Per the research cited in this analysis, Ohio specific data show:

- People with Ohio Medicaid have much better access to care and much lower unmet needs than the uninsured; they also report less financial burden and stress
- People with full year Ohio Medicaid coverage fare better than private insurance on some access to care measures and poorer on others
- Ohio Medicaid patients have comparable quality score to Ohio private pay patients for AMI, CHF, and pneumonia
- Ohio Medicaid patients had much higher quality scores than the national average for private pay patients and the national average for Medicaid patients for AMI, CHF, and pneumonia

For more information on this study, please go to glenn.osu.edu/policy

The John Glenn School of Public Affairs provides in-depth analysis on public policy issues and would like to talk with you about your research needs. Contact Cindy Holodnak, Associate Director of Outreach & Engagement, at 614-292-7731 or email her at holodnak.1@osu.edu.

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