ISSUE BRIEF
JUNE 2015

The COMMONWEALTH FUND

Does Medicaid Make a Difference?

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014

David Blumenthal, Petra W. Rasmussen, Sara R. Collins, and Michelle M. Doty

Abstract As millions of Americans gain Medicaid coverage under the Affordable Care Act, attention has focused on the access to care, quality of care, and financial protection that coverage provides. This analysis uses the Commonwealth Fund Biennial Health Insurance Survey, 2014, to explore these questions by comparing the experiences of working-age adults with private insurance who were insured all year, Medicaid beneficiaries with a full year of coverage, and those who were uninsured for some time during the year. The survey findings suggest that Medicaid coverage provides access to care that in most aspects is comparable to private insurance. Adults with Medicaid coverage reported better care experiences on most measures than those who had been uninsured during the year. Medicaid beneficiaries also seem better protected from the cost of illness than do uninsured adults, as well as those with private coverage.

For more information about this brief, please contact:

Sara R. Collins, Ph.D.
Vice President, Health Care Coverage and Access
The Commonwealth Fund
src@cmwf.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1825
Vol. 19

BACKGROUND

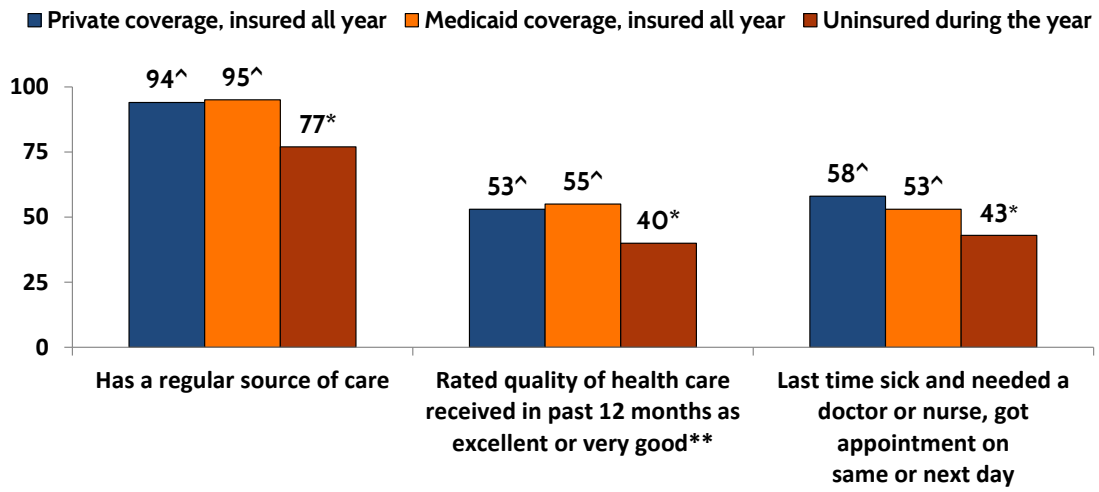
The rapid expansion of Medicaid enrollment since the enactment of the Affordable Care Act has focused attention on the access to care, quality of care, and financial protection afforded by Medicaid coverage.[1] To explore these questions, we analyzed data from the Commonwealth Fund Biennial Health Insurance Survey, 2014, which surveyed a nationally representative sample of Americans about their health care experiences from July to December 2014. This brief compares the experiences of adults ages 19 to 64 who have been insured continuously for the previous 12 months and who either had private insurance (through an employer or the individual market) or Medicaid at the time of the survey. We also examine experiences of adults who have been uninsured for some time during the past 12 months, regardless of their current coverage status. Because the three groups differ on a number of demographic characteristics, findings were adjusted for age, gender, race/ethnicity, income, and health status (Table 1).

MEDICAID ENROLLEES REPORT BETTER CARE EXPERIENCES THAN UNINSURED AND SIMILAR EXPERIENCES TO PRIVATELY INSURED

The survey asked respondents about their access to preventive health services, perceived quality of care, the responsiveness of their providers, and whether their care was coordinated among providers. Medicaid enrollees were as likely as those with

private insurance, and significantly more likely than uninsured adults, to report having a regular source of care (Exhibit 1).[2] Medicaid enrollees rated the quality of their care as highly as privately insured adults, and significantly better than uninsured adults. When they were last sick and needed an appointment with a doctor or nurse, Medicaid enrollees were significantly more likely than those who were uninsured during the year to say they had been seen by a doctor or nurse the same or the next day, and nearly as likely as privately insured adults.[3] The same pattern held for reports about how often medical staff were familiar with patients' medical history and coordinated their care with other doctors; those with Medicaid reported better experiences than those who had lacked coverage during the year and statistically equivalent experiences to privately insured patients (Exhibit 2).

Exhibit 1. Continuously insured adults with private coverage or Medicaid rated the quality of their health care as excellent or very good at higher rates than did adults who were uninsured during the year.



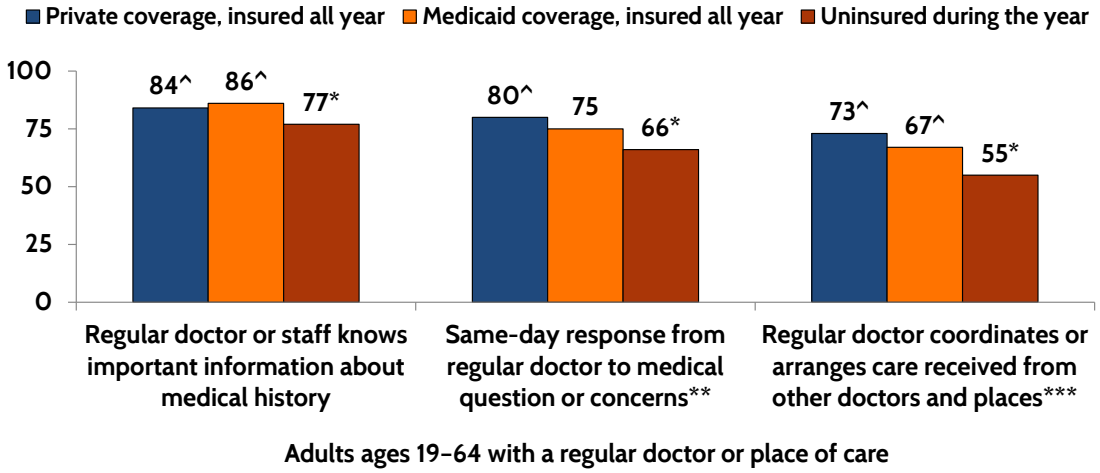
* Difference is statistically significant from those with private coverage who were insured all year (p≤0.05).
^ Difference is statistically significant from those who were uninsured during the year (p≤0.05). Percentages were adjusted for age, race, sex, health status, and income.
** Excludes those who had not received health care in past 12 months.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2014.

ADULTS WITH MEDICAID AND PRIVATE INSURANCE RECEIVE RECOMMENDED PREVENTIVE CARE AT SIMILAR RATES

Survey respondents were asked whether they had received preventive and cancer screening services—blood pressure and cholesterol checks, and flu shots—in the recommended time frame (Exhibit 3). Compared with those who had been uninsured during the year, continuously insured adults with Medicaid coverage were significantly more likely to report having received these services. Those with private coverage reported getting care at slightly higher rates than those with Medicaid, but the differences were not statistically significant.

Exhibit 2. Adults with private coverage or with Medicaid who were insured all year reported that their doctor always or often knows their medical history at higher rates than did those who were uninsured during the year.

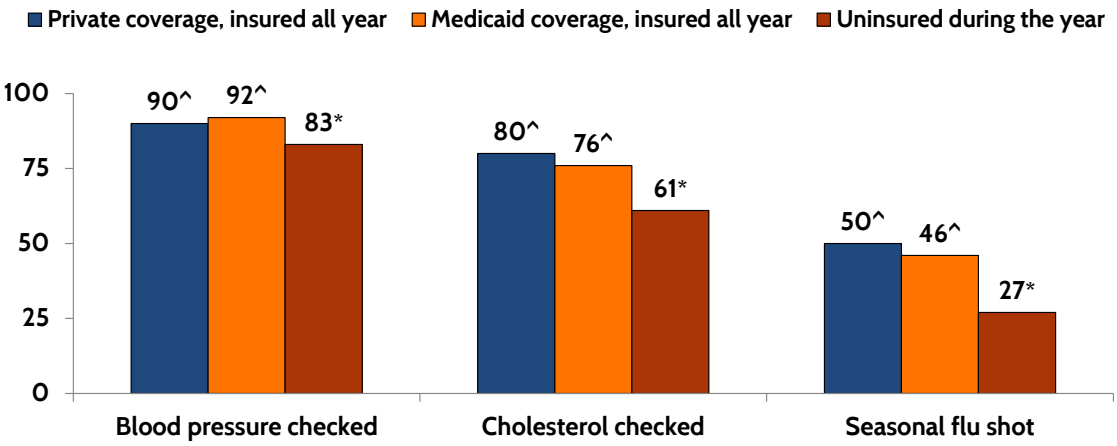
Percent of adults ages 19–64 who responded "always" or "often"



* Difference is statistically significant from those with private coverage who were insured all year (p≤0.05).
^ Difference is statistically significant from those who were uninsured during the year (p≤0.05). Percentages were adjusted for age, race, sex, health status, and income.
** Excludes those who never tried to contact regular doctor by telephone.
*** Excludes those who never saw other doctors or went to another place for care.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2014.

Exhibit 3. Adults with Medicaid coverage who were insured all year reported getting recommended preventive care services at higher rates than did those who were uninsured during the year.

Percent of adults ages 19–64



Note: Blood pressure checked in past two years (in past year if has hypertension or high blood pressure); cholesterol checked in past five years (in past year if has hypertension, heart disease, or high cholesterol); seasonal flu shot in past 12 months.
* Difference is statistically significant from those with private coverage who were insured all year (p≤0.05).
^ Difference is statistically significant from those who were uninsured during the year (p≤0.05). Percentages were adjusted for age, race, sex, health status, and income.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2014.

MEDICAID ENROLLEES HAD FEWER COST-RELATED ACCESS PROBLEMS AND FEWER PROBLEMS PAYING MEDICAL BILLS THAN DID PRIVATELY INSURED AND UNINSURED ADULTS

The survey also asked respondents whether they had cost-related problems accessing care or problems paying medical bills. On most measures, adults with Medicaid coverage reported fewer problems than uninsured or privately insured adults. Adults with Medicaid coverage were significantly less likely than either privately insured or uninsured individuals to report difficulty paying medical bills, being contacted by a collection agency about unpaid bills, having to change their way of life to pay medical bills, or paying off medical bills over time (Exhibit 4). Those with Medicaid were also significantly less likely to report skipping services because of the cost of care compared with adults who had spent a time uninsured (Exhibit 5). In some cases, differences in cost-related problems getting needed care between adults with Medicaid coverage and those with private insurance were statistically significant. For example, privately insured adults reported skipping a recommended medical treatment, test, or follow-up visit because of cost at twice the rates reported by adults with Medicaid (18% vs. 7%). Notably, though Medicaid coverage is widely believed to afford poor access to specialists (because Medicaid's provider payment rates tend to be lower than private plan reimbursement), Medicaid enrollees were less likely than privately insured adults to report that cost was a reason not to pursue specialty care (5% vs. 11%).

LIMITATIONS OF THIS STUDY

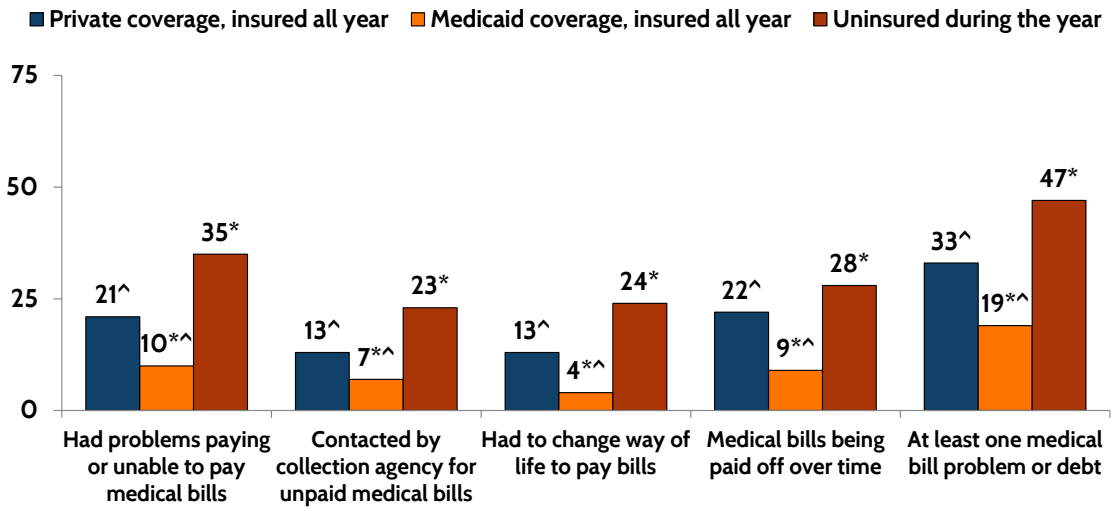
Our findings have certain limitations. They do not shed light on whether Medicaid or private insurance improves health outcomes for adults, or whether one type of insurance is more effective in this regard than the other. The analysis also focuses on adults with Medicaid or private insurance who had continuous coverage during the year prior to our survey. Medicaid and privately insured adults who lose eligibility during a given year may have somewhat different experiences from those described here. Still, comparing the experiences of those with continuous coverage, while controlling for demographic characteristics and health status, enables us to isolate the effects of insurance on health care quality and access.

CONCLUSION

The results from the Commonwealth Fund Biennial Health Insurance Survey, 2014, suggest that people with Medicaid coverage have better access to health care services, including proven preventive care, and fewer medically related financial burdens compared with those who lack insurance. Our findings also suggest that, compared to those with private coverage, Medicaid enrollees have nearly equivalent levels of access to care on many important dimensions. Medicaid coverage also appears to offer better financial protection than private insurance against the cost of illness. This last observation may reflect the steady increase in recent years in many private plans' deductibles and copayments.

Exhibit 4. Continuously insured adults with Medicaid coverage reported medical bill problems or having medical debt at lower rates than did those with private coverage and adults who were uninsured during the year.

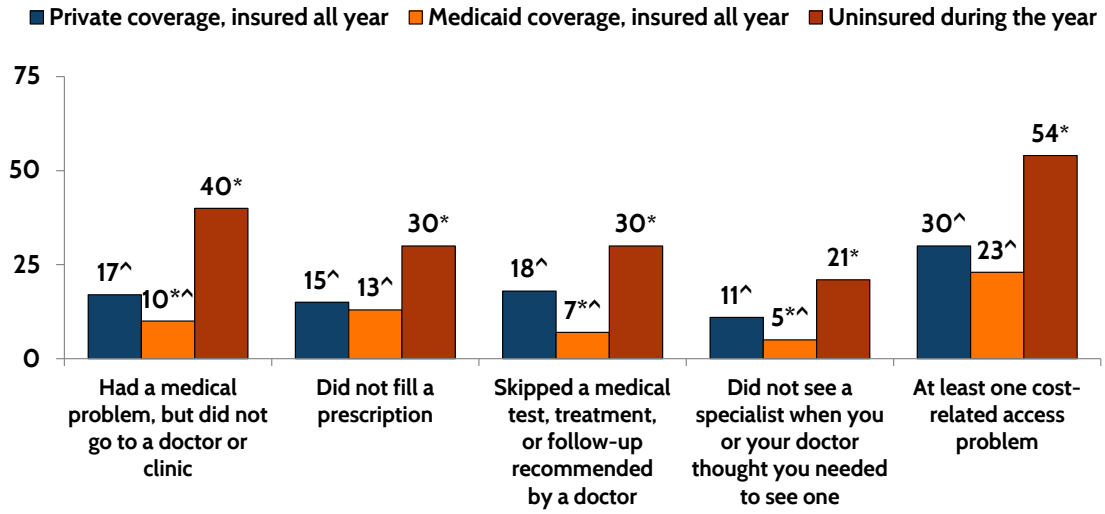
Percent of adults ages 19–64



* Difference is statistically significant from those with private coverage who were insured all year (p≤0.05).
^ Difference is statistically significant from those who were uninsured during the year (p≤0.05). Percentages were adjusted for age, race, sex, health status, and income.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2014.

Exhibit 5. Continuously insured adults with Medicaid coverage reported cost-related problems getting care at lower rates than did adults uninsured during the year.

Percent adults ages 19–64



* Difference is statistically significant from those with private coverage who were insured all year (p≤0.05).
^ Difference is statistically significant from those who were uninsured during the year (p≤0.05). Percentages were adjusted for age, race, sex, health status, and income.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2014.

NOTES

[1] As of March 2015, 12.2 million additional people had enrolled in Medicaid or the Children's Health Insurance Program since October 2013; http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/2015-march-enrollment-report.pdf.

[2] All reported differences are statistically significant at the $p \leq 0.05$ level or better, unless otherwise noted.

[3] Difference between privately insured and those with Medicaid coverage is not statistically significant.

Table 1. Demographics

	Total (ages 19–64)	Insured all year		Uninsured during the year**
		Private coverage*	Medicaid coverage	
Total (millions)	182.8	99.6	13.0	51.8
Percent distribution	100%	55%	7%	28%
Unweighted n	4,251	2,269	327	1,219
Age				
19–34	34	29	45	44
35–49	31	31	33	32
50–64	35	40	23	24
Race/Ethnicity				
Non-Hispanic White	61	70	41	46
Black	13	9	25	15
Latino	17	10	23	31
Asian/Pacific Islander	4	5	4	4
Other/Mixed	4	3	5	4
Poverty status				
Below 133% poverty	30	11	67	50
133%–249% poverty	18	14	27	22
250%–399% poverty	19	25	5	16
400% poverty or more	25	41	2	5
Below 200% poverty	44	21	89	68
200% poverty or more	48	70	11	24
Length of time insured by current coverage				
Less than 1 year	21	12	13	–
1 year or more	78	87	86	–
Health status				
Fair/Poor health status, or any chronic condition or disability^	51	47	60	51
No health problem	49	53	40	49
Adult work status				
Full-time	52	69	17	40
Part-time	13	12	18	16
Not currently employed	35	19	64	43
Employer size^^				
1–19 employees	26	19	44	41
20–49 employees	8	7	11	13
50–99 employees	9	8	13	12
100 or more employees	54	65	32	30

Notes: The total includes some adults who were not looked at in the study, including those who were insured all year but had Medicare or did not name their coverage but said they were insured.

* Privately insured adults include those with employer-provided insurance, marketplace coverage, or a private plan they purchased outside of the marketplace.

** Combines those who were "Insured at the time of the survey but uninsured in the past 12 months" and those who were "Uninsured at the time of the survey."

^ At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

^^ Base: Full- and part-time employed adults ages 19–64.

Source: The Commonwealth Fund Biennial Health Insurance Survey, 2014.

Methodology

The Commonwealth Fund Biennial Health Insurance Survey, 2014, was conducted by Princeton Survey Research Associates International from July 22 to December 14, 2014. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 6,027 adults ages 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial samples was used to reach people. In all, 3,002 interviews were conducted with respondents on landline telephones and 3,025 interviews were conducted on cellular phones, including 1,799 with respondents who live in households with no landline telephone access.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. This report limits the analysis to respondents ages 19 to 64 (n=4,251). Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2013 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 182.8 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 15.8 percent response rate and the cellular phone component achieved a 13.6 percent response rate.

The analysis groups respondents by insurance status and includes adults insured all year with private coverage (n=2,269), those insured all year with Medicaid (n=327), and those who were uninsured when surveyed or at some point during the past year (n=1,219). Because part of the observed differences by insurance status may also be the result of differences in age, gender, income, race/ethnicity, and health status, logistic regressions were estimated to explore the extent to which access and quality of care differences by insurance status are a function of these additional underlying factors. The adjusted percentages presented in this brief take into account the underlying differences in health status and demographics between those insured by private insurance, Medicaid, and uninsured populations.

About the Authors

David Blumenthal, M.D., M.P.P., is president of The Commonwealth Fund. Dr. Blumenthal is formerly the Samuel O. Thier Professor of Medicine at Harvard Medical School and Chief Health Information and Innovation Officer at Partners Healthcare System in Boston. From 2009 to 2011, he served as the National Coordinator for Health Information Technology. Previously, Dr. Blumenthal was a practicing primary care physician, director of the Institute for Health Policy, and professor of medicine and health policy at Massachusetts General Hospital/Partners Healthcare System and Harvard Medical School. He is the author of more than 250 books and scholarly publications. He is a member of the Institute of Medicine and serves on the editorial boards of the *New England Journal of Medicine* and the *Journal of Delivery Science and Innovation.* He is the founding chairman of AcademyHealth, and a trustee of the University of Pennsylvania Health System. Dr. Blumenthal received his undergraduate, medical, and public policy degrees from Harvard University and completed his residency in internal medicine at Massachusetts General Hospital.

Petra W. Rasmussen, M.P.H., is former senior research associate for the Fund's Health Care Coverage and Access program. In this role, Ms. Rasmussen was responsible for contributing to survey questionnaire development, analyzing survey results through statistical analysis, and writing survey issue briefs and articles. In addition, she was involved in tracking and researching emerging policy issues regarding health reform and the comprehensiveness and affordability of health insurance coverage and access to care in the United States. Ms. Rasmussen holds an M.P.H. in health policy and management from Columbia University's Mailman School of Public Health.

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

Michelle McEvoy Doty, Ph.D., is vice president of survey research and evaluation for The Commonwealth Fund. She has authored numerous publications on cross-national comparisons of health system performance, access to quality health care among vulnerable populations, and the extent to which lack of health insurance contributes to inequities in quality of care. Dr. Doty holds an M.P.H. and a Ph.D. in public health from the University of California, Los Angeles.

Acknowledgments

The authors thank Eric Schneider, Munira Gunja, Chris Hollander, Martha Hostetter, Paul Frame, Jen Wilson, Sarah Berk, and David Squires of The Commonwealth Fund for helpful comments and editorial support and design.

Editorial support was provided by Martha Hostetter.

The
COMMONWEALTH
FUND

www.commonwealthfund.org