Is Medicaid Real Insurance?

John Goodman **March 25, 2011**

As governors across the land struggle with fiscal pressures and pepper the federal government with requests to scale back Medicaid – many people are losing sight of the fact that health care reform (what some call ObamaCare) requires a huge expansion of Medicaid.

In fact, in just three years the nation is expected to start insuring about 32 million uninsured people. About half will enroll in Medicaid directly. If the Massachusetts experience is repeated, most of the remainder will be in heavily subsidized private plans that pay providers little more than Medicaid does.

That raises an important question: How good is Medicaid? Will the people who enroll in it or in private plans that function like Medicaid get more care, or better care, than they would have gotten without health reform? The answer to that question is not obvious. In fact it's probably fair to say that we are about to spend close to $1 trillion over the next 10 years insuring the uninsured and we really don't know what we expect to accomplish by spending all that money.

Here's a stab at an answer. The 32 million newly insured may not get more health care. They may even get less care – because of difficulties getting a doctor. And even if they do get more, odds are that low-income families as a group will get less care than if there had never been a health reform law in the first place. The reason: the same measure that insures 32 million new people also will force middle- and upper-middle-income families to have more generous coverage than they now have. As these more generously insured people attempt to acquire more medical services they will almost certainly outbid people paying Medicaid rates for doctor services and hospital beds. To make matters worse, the health reform law (following the Massachusetts precedent) did nothing to increase the supply side of the market to meet the increased demand.

Both anecdotal and scholarly reports from Massachusetts are consistent with this prediction. The wait to see a family doctor in Boston is now longer than in any other U.S. city. More people are going to emergency rooms for their care in the state than before its health reform became law. A Boston cab driver went through a list of twenty doctors (a list the state's Medicaid program gave her!) before she found a doctor who would see her. A preliminary report on the state as a whole found that nearly a quarter of adults who were in fair or poor health reported being unable to see a doctor because of cost during the implementation of the reforms. Further, state residents earning less than $25,000 per year were much less likely than higher earners to receive screening for cardiovascular disease and cancer.

That brings us back to the initial question: Is Medicaid real insurance? Or is there little practical difference between being on Medicaid and being uninsured? It would appear at the margin that there's not much difference.

Currently there are roughly 10 million people in the U.S. who are eligible for Medicaid and CHIP but have not bothered to enroll. That implies that for about one in every six eligibles, Medicaid insurance is not worth the effort it would take them to fill out the enrollment papers!

Consider the case of Dallas emergency rooms. At Parkland Memorial Hospital both uninsured and Medicaid patients enter the same emergency room door and see the same doctors. The hospital rooms are the same, the beds are the same and the care is the same. As a result, patients have no reason to fill out the lengthy forms and answer the intrusive questions that Medicaid enrollment so often requires. At Children's Medical Center, next door to Parkland, a similar exercise takes place. Medicaid, CHIP and uninsured children all enter the same emergency room door; they all see the same doctors and receive the same care.

Interestingly, at both institutions, paid staffers make a heroic effort to enroll people in public programs -- working patient by patient, family by family right there in the emergency room. Yet they apparently fail more than half the time! After patients are admitted, staffers go from room to room, continuing with this bureaucratic exercise. But even among those in hospital beds, the failure-to-enroll rate is significant.

Clearly, Medicaid enrollment is important to hospital administrators. It determines how they get paid. Enrollment may also be important to different sets of taxpayers. It means federal taxpayers pay more and Dallas County taxpayers pay less. But

aside from the administrative, accounting and financial issues, is there any social reason we should care?

Economics teaches that people reveal these preferences through their actions. If people act as though they are indifferent between being uninsured and being on Medicaid, we may infer -- based on this behavior -- they are equally well off in both states of the world from their own point of view.

Against this conclusion, there are two counter arguments worth considering. First, some claim that transactions costs (administrative difficulties) are the real reason why so many eligibles don't enroll. At Parkland and Children's Hospital those costs are close to zero, however. Second, there is the argument from paternalism: that people will be better off if we push them into Medicaid, whether they prefer it or not. But even on that score, the evidence is weak. A very comprehensive RAND study found that the type of insurance people have -- or whether they are insured at all -- does not affect the quality of care they receive. With respect to cancer care, it is unclear that Medicaid matters very much. Health blogger Avik Roy has written about other studies that find that Medicaid patients do no better and sometimes worse than the uninsured. Additional evidence is supplied by Scott Gottlieb **.** If you're trying to get a primary care appointment, it appears your chances are better if you say you are uninsured.

Health economist Austin Frakt takes issue with these studies, claiming that Medicaid and non-Medicaid populations are fundamentally different, even after adjustment for race, income and other socio-economic factors. That claim seems improbable, however, in light of the heavy ping-pong migration of people in and out of Medicaid eligibility. Frakt points to some studies finding that Medicaid makes a positive difference over being uninsured. But the results would probably have been just as good or better if we spent the money giving free care to vulnerable populations. Moreover, even with their Medicaid cards, enrollees turn to emergency rooms for their care twice as often as the privately insured and the uninsured.

Bottom line: after we get through 10 years of spending our $1 trillion under ObamaCare, there is no convincing reason to believe that the bottom half of the income distribution will have more care, better care, or better access to care than they have today.