



# The effect of Medicaid physician fees on take-up of public health insurance among children in poverty

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## ABSTRACT

I investigate how changes in fees paid to Medicaid physicians affect take-up among children in low-income families. The existing literature suggests that the low level of Medicaid fee payments to physicians reduces their willingness to see Medicaid patients, thus creating an access-to-care problem for these patients. For the identical service, current Medicaid reimbursement rates are only about 65 percent of those covered by Medicare. Increasing the relative payments of Medicaid would increase its perceived value, as it would provide better access to health care for Medicaid beneficiaries. Using variation in the timing of the changes in Medicaid payment across states, I find that increasing Medicaid generosity is associated with both an increase in take-up and a reduction in uninsured rate. These results provide a partial answer to the puzzling question of why many low-income children who are eligible for Medicaid remain uninsured.

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## 1. Introduction

Medicaid was created in 1965 to provide virtually free public health insurance to low-income individuals in the United States. Although most children below the poverty line are eligible for public insurance through several federally mandated programs, the uninsured rate in this group has remained high, at almost double that of children above the poverty line.<sup>1</sup> This puzzling phenomenon of ‘eligible but not enrolled’ under means-tested social insurance and transfer programs has motivated a good deal of research in identifying factors that affect take-up. The previous literature has proposed several explanations for individuals not participating in public programs even when they are eligible for benefits. Although the monetary costs of enrolling in Medicaid are almost zero as Medicaid entails virtually no out-of-pocket costs, individuals may face nonmonetary costs when they enroll in the public program, including the stigma attached to public insurance and administrative hassles (Remler et al., 2001). There are also informational barriers,

particularly if potential enrollees have not used public programs before (Aizer, 2007; Kenney and Haley, 2001).

In this paper, I offer a new perspective on the take-up of Medicaid. The previous literature on the determinants of Medicaid take-up has largely focused on the cost of enrolling in public programs. This current study departs from the previous literature by focusing on how the value of Medicaid affects take-up. In particular, I examine the relationship between take-up and patient access to care, using the Medicaid-to-Medicare fee index as a proxy for access to care provided by Medicaid. Historically, Medicaid reimbursement levels for physicians are low. As a result, physicians are not incentivized to treat Medicaid patients, and this creates access-to-care problems for this group. In fact, 20 percent of pediatricians in the United States do not see Medicaid patients at all, and 40 percent limit the number of Medicaid patients in their practice (Currie and Fahr, 2005). All else being equal, increasing the Medicaid payment to physicians would lead to a higher participation rate among physicians. Past studies have both theoretically posited and empirically tested this positive relationship between Medicaid payment and physician participation (McGuire and Pauly, 1991; Perloff et al., 1995; Decker, 2007).

One valid conjecture then is how increased physician participation, which is induced from an increase in Medicaid reimbursement, affects the decision faced by potential Medicaid beneficiaries. If the potential beneficiaries weigh the cost against the benefit of enrolling in Medicaid and decide to take-up only

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<sup>1</sup> For example, the uninsured rate among poor children was 16 percent, while the uninsured rate of children above the poverty line was 9 percent, according to March Current Population Survey data for year 2007.

when the benefit exceeds the cost, then the increase in access to care would encourage higher enrollment rates among the Medicaid-eligible. This paper is the first to explore the relationship between patients' access to care and take-up.

I focus on the effect of access to care on the health insurance status among poor children, since this is the population that is both most likely to suffer from access problems and most vulnerable to financial and health shocks. The effect of improved access to care on take-up among poor children is identified by exploiting within-state variation over time in the Medicaid-to-Medicare primary fee index. I find that increasing the Medicaid fee payments from 65 percent to 100 percent of the Medicare level increases the take-up rate among poor children by 4.8 percentage points and decreases the uninsured rate by 6.2 percentage points, thus reducing the uninsured rate in this group by almost 30 percent. Therefore, improving access to care through increased physician reimbursements can be an effective way to provide health insurance coverage to uninsured low-income children.

The paper proceeds as follows. Section 2 lays out the potential mechanisms by which the increase in Medicaid provider payment improves access to care and eventually leads to an increase in take-up. Section 3 describes the measure for access to care and the main dataset. In Section 4, I specify estimation strategies. Section 5 reports results for baseline specification and the specifications that control for various time-varying state policies. Section 6 addresses potential identification issues by reporting results for robustness checks and placebo tests. Section 7 concludes by discussing the policy implications of the findings in this paper.

## 2. Conceptual background

In this section, I discuss the possible mechanisms through which changes in the Medicaid fee would affect the incentives that physicians perceive and, in turn, influence take-up behavior among potential Medicaid beneficiaries.

A substantial number of office-based primary care physicians place a limit on the size of their Medicaid practices or do not see Medicaid recipients at all (Held and Holahan, 1985; Perloff et al., 1997). The main reason for this low level of physician participation in Medicaid appears to be the low Medicaid payments to doctors. According to a survey of fellows of the American Academy of Pediatrics, 58 percent of the pediatricians reported that the low fee was a key reason for limiting participation in Medicaid, and 53.3 percent of the pediatricians reported that Medicaid payments did not cover overheads (Yudkowsky et al., 2000).<sup>2</sup>

As a result, Medicaid patients in general have greater problems in terms of accessing health care in a number of dimensions compared to other types of insurance. For instance, they have a harder time getting a referral to a specialist; 40 percent of Medicaid patients reported a problem with getting a referral to a specialist, while only 18 percent of Medicare patients and 21 percent of patients with private insurance reported experiencing such a problem. The fraction of Medicaid patients whose usual place of care is a doctor's office (as opposed to hospital outpatient clinic, other clinic/health center and hospital emergency room) is considerably lower (51 percent) than Medicare (63 percent) or private patients (74 percent). They also wait longer on average in a doctor's office

or clinic (35 min) relative to the patients with private insurance (23 min) or Medicare (26 min).<sup>3</sup>

In order to see how the change in Medicaid fees affects access to care, I first consider a simple case of a single payer (insurance) system where physician services are reimbursed by fee-for-service. There is an excess of demand in the Medicaid health care market as Medicaid patients face almost no out-of-pocket costs once insured, while marginal costs of providing care to Medicaid patients are not zero. This unmet excess demand for health care—the access problem—is likely to be more severe since the Medicaid reimbursement is low. Thus, if the Medicaid fee increases, it would improve access to health care since total supply of health services would increase.

An increase in the Medicaid fee has several confounding effects on the supply of health care when there are multiple insurance payers. The current health insurance market in the United States can be characterized by physicians' facing multiple payers such as private insurance, Medicaid and the State Children's Health Insurance Program (SCHIP), private insurance, Medicare and other types of public insurance (i.e. Indian health service or military health care TRICARE). Theoretically, an exogenous increase in Medicaid fee would lead to both substitution and income effects. The substitution effect would occur as an increase in Medicaid fee would make marginal Medicaid patients more attractive relative to the marginal private patients. At the same time, a higher fee would make physicians richer so they would respond by decreasing the supply of care (income effects). McGuire and Pauly (1991) illustrate that the income effect is likely to dominate the substitution effect when insurance payers who cover a large volume of patients change the fee. The substitution effect dominates when insurance payers who cover a small volume of patients change the fee. Since Medicaid patients constitute a small share of total patients, the substitution effect dominates for those physicians whose practice-share of Medicaid patients is small. Thus, the increase in Medicaid fee would predict the increase in the quantity of care supplied to Medicaid patients.

Increases in the quantity of care can take several forms. First, physicians can spend more time with Medicaid patients (intensive margin). They may also accept more Medicaid patients, or the probability of seeing Medicaid patients at all may increase (extensive margin). Since greater physician participation means more choices for patients, it would make Medicaid a more attractive option to both existing and potential beneficiaries. Findings from earlier studies suggest that physician participation in the Medicaid program does in fact respond to Medicaid fee changes. In empirical analysis controlling for state fixed effects, Decker (2007) finds that higher Medicaid-to-Medicare fee ratios increase both the fraction of Medicaid patients seen by physicians and the number of private physicians who see Medicaid patients. Zuckerman et al. (2004) also document that in 1998 and 2003 physicians in states with the lowest Medicaid fees were less willing to accept new Medicaid patients.

The increase in provider participation would indirectly improve other aspects of health care as well, such as having usual care occur in office-based settings and decreasing the travel costs involved in obtaining health care. With a lack of office-based physicians' participation, many Medicaid recipients are treated in freestanding clinics or hospital outpatient departments (Cohen, 1989; Long et al., 1986). Studies find that an increase in Medicaid payment shifts the usual place of care from clinics to private physicians' sites, which is more desirable for the continuity of care and to receive

<sup>2</sup> Others, such as paperwork concerns (40.5 percent), unpredictable payments (39.6 percent), and payment delays (34.3 percent) are also the reasons for limiting participation in Medicaid. Only 11.4 percent reported Medicaid payments cover overheads, and 35.4 percent did not know whether Medicaid payments cover overheads.

<sup>3</sup> Calculated using Community Tracking Study Household Survey (2003) data.

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