

### **Assessing the Gains from Medicaid Coverage: Evidence for the Nation and 13 States**

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The Medicaid program, which provides health insurance to some of the nation's more vulnerable citizens, is a major budget commitment for federal and state governments. In 2004, spending on Medicaid totaled \$293 billion, of which \$170 billion was the federal share and \$120 billion the state share (Borger et al. 2006). Program costs are projected to reach \$320 billion (federal and state) in 2006 (Borger et al. 2006). Concern with the cost of Medicaid unquestionably has become a central issue in the debate on the program's future. Cost concerns also have driven many of the latest Medicaid policy and programmatic changes, which are fundamentally reshaping this important public health program.

The recently enacted Deficit Reduction Act of 2005, for example, includes a series of Medicaid cost-savings provisions, such as allowing states to raise co-payments and charge premiums on certain program beneficiaries. Further, under the new law, states can end Medicaid coverage for people who fail to pay premiums and providers can deny services for program beneficiaries who do not make the required co-payments. The new provisions also permit states to scale back Medicaid benefits for selected groups.

States themselves also have brought about major changes to Medicaid, largely through the Section 1115 waiver process.<sup>1</sup> Between 2001 and 2005, more than half of states secured a new demonstration waiver or amended an existing demonstration waiver. In these demonstration programs, states have, among other things, reduced or eliminated Medicaid benefits, capped program spending and enrollment, and imposed premiums and other costs on beneficiaries.

The consequences of these recent policy actions are potentially far-reaching, affecting not only the individual Medicaid beneficiary but also the nation's health care safety net and the number of uninsured Americans. With increased cost-sharing, for example, one likely fallout is beneficiaries will delay seeking needed care, potentially leading to worse health outcomes (IOM 2002a, 2002b, 2003; Hadley 2003, 2005). Another is that when faced with higher cost-sharing, some beneficiaries will drop Medicaid coverage and fewer people will apply for coverage under the program, causing a decline in enrollment (Artiga and O'Malley 2005). Since most Medicaid beneficiaries have no other potential sources of health insurance coverage (Long and Graves 2006), the number of uninsured will likely increase. Given the health status of Medicaid beneficiaries, the medical needs of these individuals are not going to disappear. They will seek care from the health care safety net, putting additional strain on an already strapped system (Hadley et al. 2005).

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<sup>1</sup> Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services broad authority to waive sections of the Medicaid statute to allow states to test substantially new ideas through pilot projects or demonstrations.

To assess Medicaid's importance in improving access to care, in this brief we compare health care access of Medicaid beneficiaries to that of the low-income uninsured population. We focus on low-income parents, the group most likely to be affected by the many recent Medicaid changes. We compare the two groups for the nation as a whole, as well as for selected states. While previous research has documented the significant role Medicaid plays in providing access at the national level (see, for example, Almeida, Dubay and Ko 2001; Dubay and Kenney 2001; and Long, Coughlin, and King 2005), only very limited work has examined how the program performs at the state level (Coughlin, Long, and Shen 2005).

To conduct the analysis, we rely on the National Survey of America's Families (NSAF). Two important features of the NSAF, a nationally representative survey, are that it oversampled the low-income population and it has large, representative samples in 13 states. The NSAF thus provides a relatively large sample of Medicaid beneficiaries as well as the overall low-income population for both the nation and the 13 study states. Although not a random sample, the 13 NSAF states accounted for about half the country's population and 55 percent of the total national Medicaid population in 2002. The states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin) represent a varied group of Medicaid programs; they differ in the share of their poor populations they cover, the benefits they provide, and how much they spend on Medicaid, among other things. For example, in Minnesota, working parents are eligible for Medicaid coverage with family income up to 275 percent of the federal poverty level (FPL), whereas in Alabama they are only eligible with family income below 19 percent of FPL (KFF 2006a). Similarly, spending per Medicaid beneficiary in fiscal year 2002 ranged from \$2,472 in California to more than twice that, \$5,516, in New Jersey (KFF 2006b).

The brief is organized as follows. We begin with a description of our data sources and methods. Then we present the study findings, which are followed by a discussion of the results and their policy implications.

## **Data Sources**

### *National Survey of America's Families*

Our primary data source is the 1999 and 2002 rounds of the NSAF, which collected economic, health and social characteristics on over 100,000 children and nonelderly adults in each survey year (Kenney, Scheuren, and Wang 1999). Combining telephone surveys with in-person interviews, the NSAF oversampled families with incomes below 200 percent of FPL and families in the 13 study states, which were selected to provide information on a large proportion of the nation's population while also providing a collection of states that differ in terms of geography, fiscal capacity, population needs, and traditions of providing government services. The overall survey response rate for adults was 59.4 percent in 1999 and 51.9 percent in 2002.

Responses to the interviews were weighted to adjust for the oversampling of low-income families, nonresponse, and undercoverage. Because of the complex design of the NSAF, we relied on jackknife methods to obtain accurate variance estimates. To increase sample size for the analysis, we pooled data from the 1999 and 2002 rounds of NSAF. By doing this, our

estimates represent average effects across the 1999 to 2002 time period, rather than the specific survey year.

We limited our study sample to parents age 19 to 64. In addition, we restricted the sample to individuals who reported having the same insurance coverage (Medicaid or no insurance) for the entire year preceding the survey to ensure that we focused on health care experiences or services received while in that insurance state. For the Medicaid analysis sample, this yielded a national sample of 3,373 Medicaid beneficiaries; state samples ranged from 131 beneficiaries in Texas to 458 in Massachusetts. For the uninsured analysis sample, we further limited the sample to individuals with household income below 200 percent of FPL. This yielded a national sample totaling 6,379 individuals, with state samples ranging from 344 in Massachusetts to 792 in Wisconsin.<sup>2</sup>

### *Other Data Sources*

Beyond NSAF, we used data from the Area Resource File for county-level health care market characteristics, such as the number of hospital beds in county per 1,000 people and number of dentists in the county per 1,000 people. We proxy local health care costs with county Medicare payment information (the adjusted average per capita cost, or AAPCC) from the Centers for Medicare and Medicaid Services web site. The percentage of hospital beds in public hospitals was constructed from American Hospital Association data.

## **Methods**

To separate the effects of insurance status from the effects of differences in the characteristics of the individuals with different types of insurance coverage within and across the states, we estimated multivariate models for this analysis.<sup>3</sup> Specifically, we modeled health care access and service use as a function of an individual's predisposition to use health care services, factors that enable or impede use, and the need for health care (Anderson and Aday 1978). Predisposing factors included demographic and social characteristics (e.g., age, gender, race/ethnicity, education, and marital status). Enabling and impeding characteristics included individual and family resources (e.g., income and home ownership), and community health care resources (e.g., supply of health care providers). Finally, an individual's need for services was measured by self-reported health status, whether the person reported a work limitation, and (for women) whether they reported being pregnant in the past year.

Using this framework we examined access to care for Medicaid beneficiaries and their uninsured counterparts at the national level and for each of the study states. We looked at six measures—three realized access measures and three potential measures—that assessed access to ambulatory care. Note that doctor care is a mandatory benefit under the Medicaid program, while dental care and prescription drugs are optional benefits that states can choose to cover. All the measures describe the individual's health care experiences in the year before the survey. The measures are whether the respondent reported having

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<sup>2</sup> The larger sample size in Wisconsin reflects a special supplemental oversample of that state in 1999.

<sup>3</sup> For simplicity, we present the regression-adjusted estimates of the differences between Medicaid parents and uninsured parents. The unadjusted estimates are very similar.

- at least one doctor visit;
- at least one dental care visit;
- a clinical breast exam (CBE) and a PAP smear (women only);
- an unmet need for medical care or surgery;
- an unmet need for prescription drugs; and
- an unmet need for dental care.

We use regression analysis to compare access differences between the Medicaid population and uninsured individuals for the nation and for each of the 13 states, controlling for other factors. Specifically, we use the coefficient estimates obtained from the model to predict the values of the outcome measure by first assuming that everyone in the sample is a Medicaid enrollee, and then assuming everyone is uninsured. The difference between those two standardized predictions is our measure of the Medicaid–uninsured access gap for the nation as a whole or, for the state-specific analyses, in that state. To facilitate the comparisons across outcomes, populations, and states, we estimate linear probability models.

Using the conceptual model outlined earlier, we included a number of control variables in our estimations. A list of the variables, and their means and standard deviations, for the two analytical groups (the Medicaid sample and the uninsured sample) is provided in the appendix table. As noted above, controls for individual characteristics included age, gender, race/ethnicity, education, marital status, income, and home ownership. For health status we used three control variables—self-reported health status, whether the person reported having a health condition that prevented them from working, and, for women, whether they were pregnant in the past year. Owing to limited sample sizes in some of the states (in particular, Colorado and Texas), we estimated a parsimonious model.

We also controlled for local health care market characteristics that may influence a low-income individual's access to care. These included the supply of providers in the county, the cost of health care in the county (as measured by county AAPCC rates), and place of residence (rural versus urban county). For the supply of providers, we used the number of physicians and the number of hospital beds in the model for each outcome, and added the number of dentists in the models of dental outcomes and the number of OB/GYNs in the model of women's preventive care. Finally, the model included a dummy variable for the 1999 survey year to account for any national changes in access that may have occurred from 1999 to 2002.

To account for the complex design of the NSAF, all the analyses reported were weighted and standard errors were estimated using jackknife replication methods. The explanatory power of the models varied across the six outcomes, with  $R^2$  ranging from 0.04 for receipt of preventive care to 0.18 for having a dental visit in the past year.

## Study Shortcomings

We acknowledge that our study has limitations. First, like all survey-based research, the findings are based on self-reported data and thus rely on the respondents' perceptions of their health status, access to care, and the like. To the extent that there are systematic differences in misreporting between Medicaid and uninsured respondents, our comparisons are biased. We have no reason to believe, however, that such differences exist, especially at the state level where comparisons are focused.

Another shortcoming is the limited sample sizes in some states, especially in Colorado and Texas, which have a total of 115 and 131 Medicaid respondents, respectively. Because of small sample sizes, we may erroneously conclude that there is no difference between Medicaid beneficiaries and the uninsured when in fact there is one.

Finally, we take insurance status as given. However, people are not randomly assigned an insurance status, rather they voluntarily choose a status. A variety of factors may affect that decision, and if some factors also directly affect individuals' health care access and use, then observed differences in access and use being on Medicaid and being uninsured may be due to unmeasured differences between individuals rather than insurance status. Because of these unmeasured differences, it is likely that we underestimate the gains from Medicaid coverage relative to being uninsured within the states.<sup>4</sup>

## Results

### *National Access Gap between Medicaid and the Uninsured*

Table 1 presents the regression-adjusted estimates of access to care for Medicaid and low-income uninsured parents derived from our multivariate analysis. The differences in access to care between the two groups are shown in the bottom panel of the table.

Corroborating previous research, we find that for the nation, Medicaid beneficiaries consistently had significantly better access to care than the uninsured on all measures tested, all else equal. For example, more than three-quarters of individuals insured by Medicaid said that they had had at least one doctor visit in the past year, which was 26 percentage points higher

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<sup>4</sup> Several studies have attempted to deal with insurance selection issues by estimating the impacts of public coverage using instrumental variables (IV) methods (for example, Currie and Gruber 1996; Glied et al. 1997, 1998/99; Kaestner 1999; Long et al. 2005; and Selden and Hudson forthcoming). In general, the studies using IV methods find that controlling for selection into insurance status has significant implications for estimates of the impacts of insurance coverage. When we controlled for insurance selection using IV methods with the national sample (not shown), we found that the benefits of having Medicaid coverage versus being uninsured were substantially larger than the estimates we got when we did not account for selection into insurance status. (For this part, we used an analytic framework similar to that of Long et al. 2005). For example, we found that the likelihood of having an outpatient visit over the prior year with Medicaid coverage relative to being uninsured increased from 26 percentage points to 39 percentage points after controlling for selection into insurance coverage. Unfortunately, when we attempted the IV method in the state-specific models, our estimates were imprecise and, consequently, seldom statistically significant. We did, however, find that the point estimates for the state-specific models were generally consistent with the pattern of estimates obtained from the IV models at the national level—the gains from Medicaid relative to uninsurance appear to be even greater than the simple regression model would suggest.

than that reported by the uninsured. Further, nearly 60 percent of persons with Medicaid coverage reported a visit to a dentist in the past year, about twice the rate of those without insurance. Female Medicaid beneficiaries also reported receiving more preventive care services (as measured by getting a clinical breast exam and a Pap smear) than their uninsured counterparts.

Access disparities between those with Medicaid and those without insurance are also evident in levels of reported unmet health care needs. Thirteen percent of the uninsured said they did not get needed care for medical care or surgery, more than double the rate reported by persons with Medicaid coverage. Similarly, unmet need for prescription drugs among the uninsured was twice the rate reported by individuals with Medicaid.

### *State-Level Access Gaps between Medicaid Beneficiaries and the Uninsured*

The story that health insurance matters for low-income parents also held true in the majority of the 13 states studied. For 11 of the 13 states (Colorado and Texas are the exceptions), access for Medicaid beneficiaries was significantly better than that of the uninsured on at least four of the six measures examined; in two states (Alabama and Massachusetts), Medicaid beneficiaries were better off on all measures.

For Colorado and Texas, Medicaid beneficiaries' access to care was better than the uninsured population on a more limited set of measures. In Colorado, for example, Medicaid beneficiaries were significantly more likely to report having had a doctor visit and a dental visit, as well as reporting less unmet need for medical care than their uninsured counterparts, but did not have better access to care on the other three measures. In Texas, we find that Medicaid beneficiaries' access to care was not statistically different from that of the uninsured on any measures except having had a doctor visit in the past year. However, the lack of statistical significance may reflect the small samples of Medicaid beneficiaries in these states rather than a real lack of access differences between the two populations.

As for the nation as a whole, the gains under Medicaid in the states were often quite large. For example, the share of Medicaid beneficiaries with a doctor visit was 24 to 37 percentage points higher than that of the uninsured in every state except Mississippi (figure 1). Consistent with that finding, unmet need for medical care or surgery was lower for Medicaid beneficiaries than for the uninsured in all the states, although the difference was not significantly different from zero in Texas (figure 2). While there was not a large gain in doctor visits under Medicaid in Mississippi, it is noteworthy that unmet need for medical care or surgery in that state was much lower among Medicaid parents than the uninsured (3 versus 13 percent), suggesting that, even though the frequency of doctor visit is roughly the same, Medicaid beneficiaries are receiving more comprehensive care than the uninsured.

While on balance parents with Medicaid coverage have much better access than those without insurance, in certain areas the program does not consistently improve access to care in every state studied—most prominently, in access to dental care. Across the 13 states, only between 40 and 73 percent of Medicaid beneficiaries reported a visit to a dentist over the prior year, and 10 to 24 percent reported unmet need for dental care. In 8 of the 13 states, reported levels of unmet for dental care by Medicaid beneficiaries were not statistically different from

those reported by the uninsured. Access to dental care services has been a long-standing problem in Medicaid, stemming in part from the limited participation in the program by dentists (GAO 2000b). Beneficiaries' access to dental care is also hampered by the limited dental coverage generally provided by state Medicaid programs. Dental coverage, an optional service in Medicaid, is not offered altogether in some states, whereas other states cover only a very narrow scope of dental services.<sup>5</sup> In 2000, 18 states (including Alabama, Mississippi, and Texas) did not provide any dental coverage or limited coverage to emergency treatment only (GAO 2000a).

Another area where Medicaid beneficiaries' access appears problematic in at least some states was getting needed prescription drugs—unmet need for prescription drugs was at 12 percent in Colorado and Texas. In 4 of 13 states, beneficiaries' unmet need for prescriptions drugs was not statistically different from that of the uninsured. While all states cover drugs, the vast majority require beneficiary cost-sharing, and many impose a monthly limit on the number of prescriptions that can be filled, which can pose a barrier to getting needed drugs (Bruen 2002).

Finally, access to preventive care by those with Medicaid looks to be a problem in some of the states, with, at most, only half of women on Medicaid reporting getting a clinical breast exam and a Pap smear in the past year. For female beneficiaries in Colorado, Mississippi, Texas, and Washington, receipt of a clinical breast exam and a Pap smear was not significantly better than for their uninsured counterparts.

## **Discussion**

A major goal of the Medicaid program is to assure access to care for low-income individuals. Our study confirms the importance of Medicaid coverage in providing that access. It also adds to the existing body of research on the program's effectiveness by showing that Medicaid is not only significant for the nation but also across a wide range of states, from Alabama to Mississippi to New York, that vary with respect to their Medicaid programs and the composition of their low-income populations.

The findings also document the considerable access problems encountered by uninsured Americans. Only half reported having a visit to the doctor in the past year, less than two-fifths had seen a dentist, and less than a third of the women reported receiving preventive care in the form of a clinical breast exam and a Pap smear. The level of dental visits and preventive care received by the uninsured is well below the national access goals as set out in the federal government's Healthy People 2010 goals (HHS 2000). Reflecting their low use of services, a sizable share of the uninsured reported not getting needed health care. More than 1 in 10 reported unmet need for medical care and prescription drugs, and more than 2 in 10 reported not getting needed dental care. Although not examined here, other studies have shown that the barriers to timely and needed care experienced by the uninsured have important and real health care consequences (IOM 2002a, 2002b, 2003; Hadley 2003; Hadley et al. 2005).

Although Medicaid provides critical health care access to America's poor and disabled, study results illustrate that it is not perfect, and, like most health insurance (public or private), the

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<sup>5</sup> Details on state Medicaid benefits are provided at [www.kff.org/medicaid/benefits/index.jsp?CFID=2561528&CFTOKEN=77461178](http://www.kff.org/medicaid/benefits/index.jsp?CFID=2561528&CFTOKEN=77461178).

program has its strengths as well as its weaknesses. Results suggest two particular problem areas—providing needed dental care and prescription drugs. As discussed, dental care and prescription drugs are optional benefits under Medicaid, and as such states often impose cost-sharing on beneficiaries or offer a narrow scope of coverage for these services. That some beneficiaries reported problems getting dental care and drugs suggest that decisionmakers should be particularly sensitive to the consequences of reducing coverage and increasing cost-sharing, especially since it is these exact types of policy changes that are actively being debated in Washington and in state capitals across the country.

Medicaid is often criticized as being a costly and inefficient program. In recent years, however, much of the increase in Medicaid costs can be attributed to rising enrollment levels due to the economic downturn that occurred in the early 2000s and to declining rates of employer-sponsored insurance (Holahan and Ghosh 2004). Moreover, Medicaid has been shown more efficient at delivering care than private coverage, especially for persons in fair or poor health (Hadley and Holahan 2003/04). Nevertheless, Medicaid's large and growing budget poses serious issues for state lawmakers who are often faced with making difficult choices between raising taxes or cutting state spending for Medicaid and other budget sectors such as K–12 and higher education. As federal and state policymakers contemplate the future of Medicaid, they should be mindful that, despite all its flaws, the program provides essential health care coverage to the sickest and most disadvantaged members of our society, many of whom would be uninsured without the program.

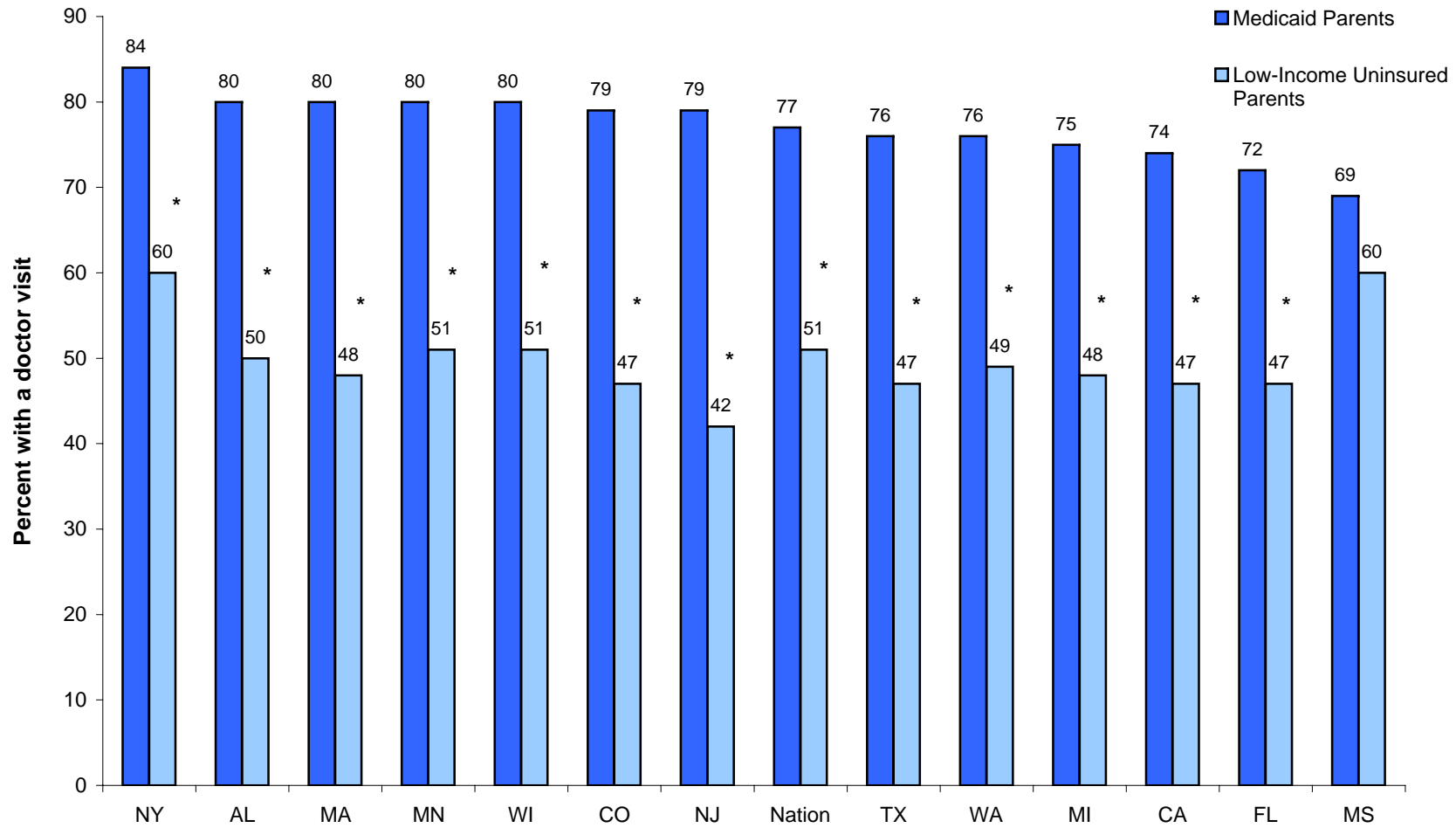
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**Figure 1: Regression-Adjusted Differences in Doctor Visits Per Year for Medicaid Beneficiaries and Low-Income Uninsured Parents, for the Nation and Selected States**

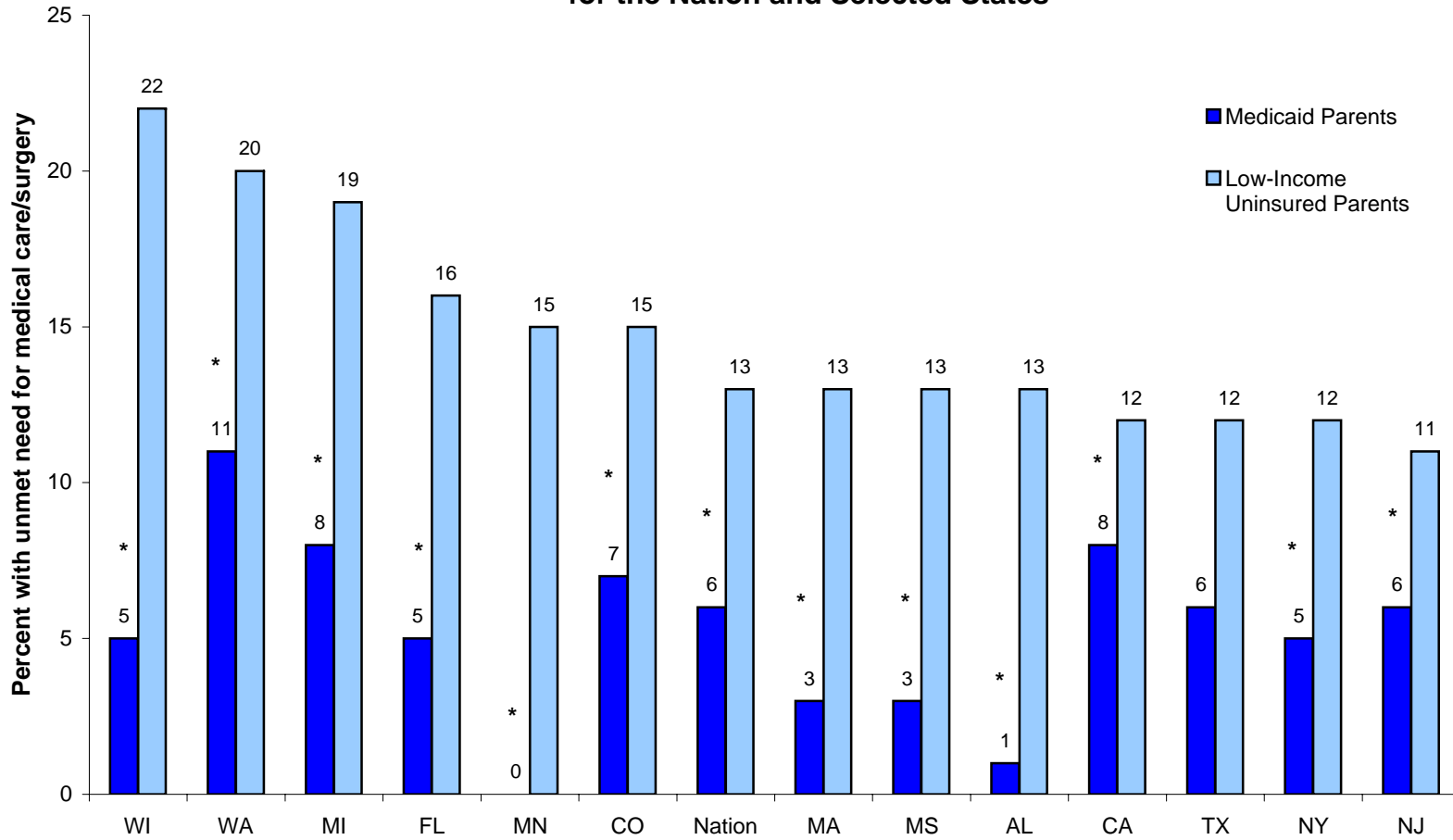


Source: 1999 and 2002 rounds of National Survey of America's Families

Notes: These are regression-adjusted estimates based on the multivariate model described in the text.

\*Difference between Medicaid parents and low-income uninsured parents significant at the 5% level.

**Figure 2: Regression-Adjusted Differences in Unmet Need for Medical Care/Surgery for Medicaid Beneficiaries and Low-Income Uninsured Parents, for the Nation and Selected States**



Source: 1999 and 2002 rounds of National Survey of America's Families

Notes: These are regression-adjusted estimates based on the multivariate model described in the text.

\*Difference between Medicaid parents and low-income uninsured parents significant at the 5% level.

**Table 1: Regression-Adjusted Differences in Access and Use for Medicaid Beneficiaries and Low-Income Uninsured Parents, for the Nation and Selected States**

Outcomes	Nation	AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI
<b>Medicaid Parents</b>														
Doctor visit in last year	77	80	74	79	72	80	75	80	69	79	84	76	76	80
Dental visit	59	48	64	49	40	65	49	73	55	67	70	46	55	63
Received CBE and Pap smear (women)	46	41	41	37	37	51	46	47	39	44	50	35	42	50
Unmet need for medical care/surgery	6	1	8	7	5	3	8	<1	3	6	5	6	11	5
Unmet need for prescription drugs	5	4	5	12	12	3	7	4	4	4	3	4	8	2
Unmet need for dental care	17	13	21	24	16	12	18	15	10	15	16	18	23	17
Sample size	3,373	182	355	115	170	458	227	255	209	289	355	131	290	337
<b>Low-Income Uninsured Parents</b>														
Doctor visit in last year	51	50	47	47	47	48	48	51	60	42	60	47	49	51
Dental visit	37	36	35	32	30	37	36	32	41	39	47	40	38	48
Received CBE and Pap smear (women)	30	26	30	34	25	28	25	23	35	27	28	33	35	25
Unmet need for medical care/surgery	13	13	12	15	16	13	19	15	13	11	12	12	20	22
Unmet need for prescription drugs	11	13	9	11	10	13	14	5	15	12	12	10	14	11
Unmet need for dental care	22	23	21	23	26	27	30	22	27	21	17	21	27	26
Sample size	6,379	545	449	476	445	344	520	474	551	440	447	481	415	792
<b>Difference between Medicaid Parents and Low-Income Uninsured Parents</b>														
Doctor visit in last year	26 *	30 *	27 *	32 *	25 *	32 *	27 *	29 *	9	37 *	24 *	29 *	27 *	29 *
Dental visit	22 *	12 *	29 *	17 *	10 *	28 *	13 *	41 *	14 *	28 *	23 *	6	17 *	15 *
Received CBE and Pap smear (women)	16 *	15 *	11 *	3	12 *	23 *	21 *	24 *	4	17 *	22 *	2	7	25 *
Unmet need for medical care/surgery	-7 *	-12 *	-4 *	-8 *	-11 *	-10 *	-11 *	-14 *	-10 *	-5 *	-7 *	-6	-9 *	-17 *
Unmet need for prescription drugs	-6 *	-9 *	-4 *	1	2	-10 *	-7	-1	-11 *	-8 *	-9 *	-6	-6 *	-9 *
Unmet need for dental care	-5 *	-10 *	0	1	-10 *	-15 *	-12 *	-7	-17 *	-6	-1	-3	-4	-9

Sources: 1999 and 2002 rounds of National Survey of America's Families.

Notes: These are regression-adjusted estimates based on the multivariate model described in the text. The explanatory power of the models varied across the six outcomes, with R2 ranging from .18 and .13 for a doctor or dental visit in the past year, respectively, to .04 to .06 for receipt of preventive care and unmet need.

\* Difference between Medicaid parents and low-income uninsured parents is significant at the 5% level.

**Appendix Table: Characteristics of the National Sample**

<b>Explanatory Variables</b>	<b>Medicaid Parents</b>		<b>Low-Income Uninsured Parents</b>	
	<b>Mean</b>	<b>SE</b>	<b>Mean</b>	<b>SE</b>
Male	0.25	0.015	0.44	0.011
Age (years)	35.61	0.331	34.73	0.226
Black, non-Hispanic	0.32	0.012	0.13	0.010
Hispanic	0.23	0.012	0.49	0.013
Not a citizen	0.10	0.009	0.40	0.013
High school graduate	0.51	0.015	0.46	0.011
College graduate	0.04	0.005	0.05	0.005
Married	0.31	0.012	0.55	0.011
Widowed, divorced, or separated	0.29	0.012	0.16	0.007
Number of children	2.29	0.048	2.19	0.025
Reports fair or poor health	0.39	0.015	0.25	0.011
Reports work limitation	0.43	0.016	0.10	0.007
Pregnant	0.09	0.007	0.03	0.004
Owns home	0.29	0.013	0.42	0.010
Has a car	0.63	0.013	0.76	0.009
Lives in urban county	0.79	0.012	0.79	0.009
County AAPCC relative to median for all counties	1.24	0.007	1.23	0.006
Number of doctors in the county per 1,000 population	2.62	0.046	2.30	0.042
Number of hospital beds in the county per 1,000 population	3.29	0.053	3.08	0.055
Number of OB/GYNs in the county per 1,000 population	0.12	0.002	0.11	0.001
Number of dentists in the county per 1,000 population	0.46	0.005	0.43	0.004
Survey year is 1999	0.49	0.016	0.50	0.011
Sample size	3,373		6,379	

Sources: 1999 and 2002 rounds of National Survey of America's Families.

Note: Number of OB/GYNs in the county is included only in the CBE/Pap smear equation; number of dentists in the county is included only in the dental visit and unmet need for dental care equations.