Medicaid and Managed Care: Implications for Low-income Women

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This commentary reviews Medicaid's role for low-income women and examines the implications of Medicaid managed care on the delivery of health services to this vulnerable population. Today 40% of the Medicaid population, mostly poor women and their children, is enrolled in managed care. Medicaid agencies are hoping man- aged care will control spending and address longstanding problems with access to care. Low-income women have a number of characteristics that make them doubly vulnerable to access to care and place them at high risk for health problems. Furthermore, many beneficiaries have historically experienced nonfinancial barriers to care under fee-for-service Medicaid. While many look to managed care to overcome these obstacles, the evidence suggests that it does not offer a great improvement over fee-for-service in terms of improved access or reduced long-term costs for low-income women. For Medicaid managed care to realize its potential, it must assure that financing is adequate, resources for monitoring and oversight are sufficient, and systems and benefits are responsive to the complex and diverse health care needs of low-income women.

Medicaid makes access to health care possible for millions of women. The program, however, is changing rapidly as millions of beneficiaries, mostly poor women and their children are being enrolled in managed care. Because of Medicaid's importance to low-income women, understanding the opportunities and challenges involved in making man- aged care meet their needs is critical.

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Medicaid was at the center of a fierce policy debate in the last Congress. At its core was a proposal to convert the Medicaid program to a block grant, potentially eliminating the entitlement to health care coverage for millions of low-income people. Although no federal legislation restructuring Medicaid was passed, the newly enacted welfare law and reforms occurring at the state level- mostly mandatory managed care-are having a direct impact on Medicaid and the women it serves. This commentary reviews Medicaid's role for low-income women and examines the implications of the shift to Medicaid managed care for the delivery of health services to this vulnerable population.

Medicaid's Importance to Women

The importance of health coverage in improving access to health care services is well documented.[1] Since its inception, Medicaid has been critical in reducing disparities in access to care. Today, low-income women with Medicaid coverage are as or more likely than low-income privately insured women to have a usual source of care, a physician visit in the past year, and timely preventive care.[2]

In 1993, Medicaid covered about 12% of nonelderly women and more than half of poor women (Kaiser Commission on the Future of Medicaid, unpublished data, 1995). Women under 65 typically obtain Medicaid coverage through links to Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI), or because they are low income and pregnant. The new welfare law, however, severs the automatic link between AFDC and Medicaid and has serious repercussions for Medicaid eligibility.[3] at state discretion, a separate application process may be required for Medicaid, potentially depressing participation rates. Moreover, women who are ineligible for cash assistance because of time limits and other restrictions included in the new law may no longer have a pathway to Medicaid. They are likely to join the ranks of the millions of low-income single or childless women who are uninsured because they do not fit into any of Medicaid's "categories," lack the financial means to purchase insurance on their own, and do not receive it through their employers.

Medicaid plays a significant role in financing maternity care, paying for an estimated 40% of all births in this country.[4] However, Medicaid coverage ceases 60 days postpartum. Unless a new mother qualifies for welfare assistance, she is no longer eligible for Medicaid- although her infant will be.

Medicaid is also a vital source of health coverage for disabled women who qualify for SSI. These women have severe and chronic illnesses that result in long-term disability, are mentally retarded, or dev- elopmentally disabled. Medicaid not only covers their acute care, but also includes such long-term benefits as personal care, habilitation services, and other assistance critical to promoting independent living, as well as institutional care.

Medicaid Managed Care

Virtually every state looks to managed care with the hope it will control spending and address longstanding problems with access to care. This is evident in the extent to which Medicaid managed care enrollment has soared in the past decade, rising from 1.2 million beneficiaries in 1985 to 13.3 million in 1996-40% of Medicaid enrollment. [5, 6] Most managed care efforts have targeted low-income women and their children, with elderly and disabled populations enrolled to a much lesser extent. About two-thirds of enrollees are in capitated HMOs or prepaid health plans, where the plan assumes either full or partial financial risk for providing medical care. The other third are enrolled in primary care case management (PCCM) arrangements that rely on a gatekeeper, usually a primary care physician reimbursed on a discounted fee-for-service basis.[5]

Despite intense efforts to expand Medicaid managed care penetration, the evidence of its ability to both increase access and save money is inconclusive. Theoretically, the potential exists for managed care to provide more coordinated and comprehensive care and to reduce inappropriate emergency and unnecessary health care use, thus reducing costs. Most of the research on Medicaid managed care conducted to date, however, does not demonstrate increased access or significantly reduced spending growth over the long term.[7] This is because most Medicaid managed care efforts have targeted low-income families, who account for about one-quarter of Medicaid expenditures. Without addressing the cost of acute and long- term care for the disabled and elderly who account for the remainder, it is unlikely that states can make significant reductions in future Medicaid spending.

Just as many believe managed care holds numerous potential benefits, others cite its many risks. These include experiences with fraudulent or discriminatory enrollment practices, disruptions of patient-doctor relationships, financial incentives to undertreat, limits on access to specialty care, many plans lack of experience caring for the poor, and questionable state capacity to monitor quality of care. These concerns are particularly serious in view of the vulnerable nature of the Medicaid population.

Implications for Low-income Women

From a health system standpoint, poor women face many challenges. Their economic disadvantage, race and ethnicity, family structure, and educational levels all affect their health needs. While Medicaid makes health care affordable, many beneficiaries have historically experienced nonfinancial barriers to care under fee-for-service Medicaid. These have included inadequate payment levels resulting in low physician participation, a scarcity of physicians in the impoverished communities where many Medicaid beneficiaries reside, and heavy reliance on fragmented care in hospitals that are often overcrowded and understaffed. If Medicaid managed care is to achieve its potential, consideration of both the historical, systemic barriers found under fee-for-service as well as the characteristics of the women served is vital.

An often cited advantage of managed care is its focus on prevention and health promotion. On the whole, however, research on Medicaid managed care has found that enrollees were just as or only slightly more likely to have received timely preventive services such as Pap smears and breast exams than those in traditional Medicaid.[7,8]

Reproductive health care is a critical issue for all women, but particularly for those on Medicaid. About half of adult women on Medicaid were eligible because they qualified for AFDC, and one-quarter because they were low income and pregnant.[9] These are women in their peak childbearing years and are at risk for unintended pregnancy, sexually transmitted diseases (STD), and acquired immune deficiency syndrome (AIDS). Many rely on traditional family planning providers for contraceptive and STD care. Medicaid pays for nearly half of all publicly supported contraceptive services; and publicly funded family planning clinics are currently the major providers of reproductive care for Medicaid beneficiaries.[10] Some states "carve out" family planning services from Medicaid managed care so that women can maintain their relationships with their family planning providers even if they are enrolled in a managed care plan. This is an especially important protection for teenagers, who may be less inclined to seek reproductive health care if they are required to use their family's provider or obtain gate- keeper approval to get care.

Because Medicaid is the leading financier of births in the nation, prenatal care is a key issue for Medicaid managed care. Although mainstream managed care plans have considerable experience providing maternity care to middle-class women, the social and economic hardships faced by the Medicaid population present a different set of challenges. For example, many poor women are single mothers and lack social support networks. They may rely solely on public transportation, live in substandard housing in dangerous neighborhoods, and lack access to telephones. To improve the adequacy of prenatal care and pregnancy outcomes for this high-risk group, Medicaid managed care plans need to be familiar with the risk factors and realities of the lives of the women they serve. An advantage of managed care has been that capitated payments can give plans flexibility to provide services that address needs that go beyond the medically necessary care covered under traditional Medicaid. A review of research evaluating Medicaid managed care prenatal services, however, has not found that it yields any better outcomes than fee-for-service.[7]

Besides reproductive health concerns, poor women generally experience a higher incidence of chronic conditions such as arthritis, hypertension, diabetes, or limitations in activities than higher income women. Furthermore, 20% of women on Medicaid qualify because they receive SSI,[9] and a recent study found that between 17% and 19% of women receiving AFDC have disabilities that may limit their ability to work or the scope of their work.[11] These high rates of disability and chronic illness highlight the importance of access to specialist care and experimental treatments and is an issue of growing importance as Medicaid managed care is broadened to include peoples with disabilities.

Given the financial and social difficulties faced by poor women, it is not surprising to find an association between lower socioeconomic status and mental health problems. Compared to those who are more affluent, low-income women are more likely to report anxiety or depression, suicidal thoughts, and dissatisfaction with their lives or have low self-esteem.[2] These difficulties compound their physical health problems and have broad implications for how health services should be structured. Primary care providers treating low-income women should be alert to possible behavioral health problems and are able to Make appropriate referrals. Plans and state agencies should take special precautions to assure that women obtain all of the benefits to which they are entitled, even if they are not included in the managed care contract.

On a daily basis, low-income women confront very difficult choices about necessities of life such as housing, food, child care, and clothing. And because more than half of poor women have children at home, they are faced with meeting the

the health needs of their children as well as their own.[2] Although they may view health care as important, obtaining care for themselves, particularly preventive services, may be understandably low on their list of priorities.

To assure that low-income women get the care they need, state Medicaid agencies, plans, and providers need to give them the education and guidance required to make informed decisions about selecting health plans and providers and obtaining specialist care, as well as understanding and following treatment alternatives and plans. Those serving these women will need to be particularly mindful of transportation and childcare needs, translation services, cultural sensitivity, and accessibility during evenings and weekends. This will be particularly important given recent efforts to increase workforce participation among the welfare population, particularly mothers, who may experience additional difficulties in getting care.

The increasing complexity of the health care system and the velocity with which it is changing are already having an impact on the delivery of care to poor women. For Medicaid managed care to realize its potential, it must assure that financing is adequate, resources for monitoring and oversight are sufficient, and systems and benefits are responsive to the complex and diverse health care needs of low-income women. In addition, significant effort and resources must be placed into educating women how to select and use managed care systems. State Medicaid agencies, plans, and providers all share a responsibility for assuring that managed care meets its potential in improving both access to care and health outcomes for low-income women.

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