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Challenges & Opportunities in Women's Health Care Coverage, Access, and Delivery in Medicaid

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Nearly 70 percent of women enrolled in the Medicaid program are of reproductive ages -15 – 49 (World Health Organization, n.d.), which suggests that Medicaid plays a critical role in the health of low-income, reproductive-age women. Although previous research has examined access and coverage within payer types, there is little research that compares access and coverage across four types of coverage status (i.e., commercial insurance, the Marketplace, Medicaid, and uninsured). This report highlights findings from our data analysis that expands on existing scientific literature on access and coverage to care and women's perceptions of their experiences interacting with the health care system. In addition, the report provides a critical lens on how women across the four types of coverage status may differ, with a specific focus on women enrolled in the Medicaid program. A number of interesting findings emerged from the data. For example, women enrolled in the Medicaid program often had similar access to health care services as women enrolled in commercial insurance programs. Despite experiencing certain barriers to accessing services, the majority of women in the Medicaid program reported that they are satisfied with the program. Finally, based on the findings from the data analysis, we outline critical policy, research, and clinical opportunities to improve access and coverage for women.

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.

Medicaid's Role in Women's Health

Medicaid provides health care coverage to more than 25 million low-income women in the U.S. (KFF Fact Sheet, 2017). Approximately half of all births are covered by Medicaid; ranging from 20 percent to 69 percent, depending on the state (Markus et al., 2013). Medicaid covers 75 percent of all publicly funded family planning services, with approximately 67 percent of adult women enrolled in Medicaid in their reproductive years, 19 to 49 (KFF Fact Sheet, 2017). Medicaid covers 53 percent of all long-term care services for women and 35 percent of services for nonelderly women with disabilities (Guttmacher, 2018; KFF Fact Sheet, 2017). The Medicaid program provides access to essential preventive, primary, specialty, and long-term care services for women. Medicaid is important for the health and well-being of women in the nation. This issue brief highlights key

findings from a nationally representative sample of women ages 19-44 about their health care experiences with access and coverage in Medicaid, the Marketplace, commercial insurance, and being uninsured.

Health Care Coverage, Access, and Delivery for Women

A national, cross-sectional self-report public opinion poll by PerryUndem Research & Communication was administered online at the end of 2016, which targeted a nationally representative sample of reproductive-age women. The survey captured information about women's access and coverage to preventive, primary, and specialty care, along with their experiences interacting with the health care delivery system. The survey intentionally sought diverse perspectives from women who were uninsured or who received coverage through the Marketplace, Medicaid, or commercial insurance.

Health Care Coverage

For women who reported coverage through Medicaid, 46 percent identified as white, 23 percent black, 26 percent Hispanic, and 5 percent other. Medicaid was the most frequent payer type for black women (23%), with Hispanic women reporting no insurance coverage most frequently (47%). The majority of women enrolled in Medicaid had a high school degree (37%) or some college (35%), whereas the majority of women in the Marketplace or with commercial insurance had either some college or a college degree (Marketplace 40% some, 28% degree; commercial 33% some, 44% degree, respectively). Across all payer types, the majority of women reported that they were the primary decisionmaker in their family/household (uninsured 85%, Medicaid 90%, Marketplace 90%, and commercial 84%, respectively). The majority of women who were uninsured or in the Marketplace or had commercial insurance reported that they were working. In contrast, the majority of women enrolled in Medicaid (53%) indicated that they were not currently working. Finally, of women who reported that they had Medicaid coverage, 18 percent lived in the Northeast, 21 percent lived in the Northeast, 26 percent in the Midwest, and 35 percent in the West.

Health Care Access & Gaps

Across all types of coverage, women indicated that they needed similar common types of health care services. The most commonly needed services were Pap tests, well-woman visits, dental care, and routine physicals (Table 1). However, women enrolled in Medicaid had some distinctly different health care needs compared to other types of coverage. For example, they were the only group to indicate that mental health care was one of their top–ten, most-needed types of health care services.

Table 1. Most Frequent Types of Health Care Needed, Stratified by Payer Type, 2016.

	Types of Insurance Coverage			
Rank (1 = Most Frequent)	**Uninsured**	**Medicaid**	**Exchange**	**Commercial**
1	Pap tests	Pap tests	Well-woman visit	Pap tests
2	Dental care	Dental care	Routine physical	Well-woman visit
3	Well-woman visit	Routine physical	Pap tests	Dental care
4	Routine physical	Well-woman visit	Vision/eye care	Routine physical
5	Birth control	Vision/eye care	Dental care	Vision/eye care
6	Vision/eye care	Birth control	Birth control	Birth control
7	Breast exams	Care for a chronic condition	Breast exams	Immunizations
8	Prenatal care	Mental health care	Immunizations	Breast exams
9	Other	Immunizations	Mammogram	Prenatal care
10	Care for a chronic condition	Prenatal care	Care for a chronic condition	Care for a chronic condition

Source: Institute for Medicaid Innovation. (2018). Women's Access & Coverage to Care by Payer Type: Health Care Delivery and Access Survey (2016) Analysis. Washington, D.C.

However, discrepancies were noted in the health care services that women reported they needed and whether they were received. Identifying a need for a specific service did not necessary translate into receiving that service, which indicates that there were barriers to care (Table 2). For example, 34 percent of women enrolled in Medicaid who self-reported needing a well-woman visit did not receive one during the past two years of coverage. Similarly, 23 percent of women who needed a Pap test did not receive one. In addition, women enrolled in Medicaid frequently reporting needing but not receiving dental (39%) or vision (31%) care.

Table 2. Health Care Services Women Did Not Receive, Stratified by Payer Type, 2016.

Health Care Service Needed	Type of Insurance Coverage			
	Uninsured	Medicaid	Marketplace	Commercial
	Did not receive care (%)	Did not receive care (%)	Did not receive care (%)	Did not receive care (%)
Dental care	47.3	39.4	41.7	45.6
Well-woman visit	39.3	34.3	46.4	29.2
Routine physical	32.2	32.5	45.5	30.4
Vision care	25.3	30.7	30.6	22.7
Pap test	38.3	22.8	31.3	19.8
Breast exam	19.9	18.5	16.3	15.2
Care for chronic condition	7.9	12.7	9.5	4.7
Immunizations	13.6	11.3	16.4	13.6
Help choosing birth control method	16.2	6.9	7.2	5.7
Birth control	17.9	6.7	18.6	11.7
How to plan and prepare body for pregnancy	4.8	6.1	1.2	3.9
Mammogram	13.9	5.7	5.9	6.2
Prenatal care	3.1	4.5	2.6	2.4

Source: Institute for Medicaid Innovation. (2018). *Women's Access & Coverage to Care by Payer Type: Health Care Delivery and Access Survey (2016) Analysis.* Washington, D.C.

Gaps in Well-Woman Visit

The well-woman visit is considered one of the most fundamentally essential health care needs for the well-being of all women. The annual visit provides life-saving screenings, evaluation and counseling, and immunizations based on age and risk factors (USPSTF, 2017 & ACOG, 2016). As highlighted in Table 2, a substantial portion of women across payer types did not receive a well-woman visit in the past two years. Almost half (46%) of women in the Marketplace reported that they did not have a well-woman visit in the past two years, followed by uninsured women (39%) and women covered by Medicaid (34%). Less than 30% of women with commercial insurance did not receive a well-woman visit in the past two years.

The significant gaps between needed and received care, especially the well-woman visit, across all types of health care coverage require a deeper look into barriers that women experience.

Barriers to Care and the Role of Health System Structures

Women face multiple barriers to obtaining necessary care, which can be exacerbated by co-morbidities, social determinants of health, and other identities (e.g., identifying as a person of color, low-income, sexual minority identity, gender minority identity).

Women enrolled in Medicaid and those with commercial insurance reported the same most common reasons for not accessing a women's health provider, including lack of time to find a provider and being too busy to get this kind of care (Table 3). In addition, other common reasons cited for not having a women's health care provider were (1) having another health care provider who provides this care or (2) not being sexually active at the present time, or (3) not needing women's health care. These reasons may indicate a need to better inform women as consumers of health care about the importance of well-woman visits.

Table 3. Reasons for Not Obtaining Women's Health Care Services, by Payer Type, 2016.

	Types of Insurance Coverage			
Frequency (1 = most common)	**Uninsured**	**Medicaid**	**Exchange**	**Commercial**
1	Cost	Not sexually active	Lack of time to find an OB/GYN	Lack of time to find an OB/GYN
2	No insurance	Another provider handles this care	Another provider handles this care	Don't need this care
3	Don't need this care	Lack of time to find an OB/GYN	Not sexually active	Not sexually active
4	Lack of time to find an OB/GYN	Don't need this care	Too busy	Another provider handles this care
5	Not sexually active	Too busy	Cost	Do not like this type of care
6	Do not like this type of care	Do not like this type of care	Unable to find OBGYN that takes insurance	Too busy

Source: Institute for Medicaid Innovation. (2018). *Women's Access & Coverage to Care by Payer Type: Health Care Delivery and Access Survey (2016) Analysis.* Washington, D.C.

Barriers to Care: Time

Across all types of insurance coverage, women identified "time" as a reason for not obtaining women's health care services. Women enrolled in Medicaid specifically noted that there was a lack of time to find an OBGYN and/or that they were too busy. Indeed, time is a barrier that continues to prevent women from receiving needed care. Women in Medicaid oftentimes are employed in positions that do not allow time during work hours to call to find a provider/make an appointment or take time off from work. A recent survey by the Kaiser Family Foundation also found similar results. One in four women, ages 18-64, reported that they did not obtain care that

they needed because they did not have time; either because they couldn't find time to go to the doctor or they couldn't take time off work (Kaiser Family Foundation, 2018).

Barriers to Care: Cost

For women enrolled in Medicaid, cost was not identified as a significant reason for or barrier to not receiving needed care (Table 3). Medicaid coverage, by and large, has eliminated financial barriers and is successfully supporting the health care needs of women. However, cost was identified as the most common reason that women enrolled in Medicaid did not obtain needed dental and vision care or routine physicals (Table 4). Oftentimes, dental and vision care are either carved-out or not provided as part of the physical health coverage of the state Medicaid program, which creates a health system that places the financial burden on women and their families. For women who were uninsured or in the Marketplace, delaying a needed well-woman visit because of cost was identified as a barrier.

Table 4. Health Care Services Delayed Because of Cost, Stratified by Payer Type, 2016.

	Types of Insurance Coverage			
Frequency (1 = Most Common)	**Uninsured**	**Medicaid**	**Exchange**	**Commercial**
1	Dental care	Dental care	Dental care	Dental care
2	Routine physical	Vision care	Vision care	Vision care
3	Well-woman visit	Routine physical	Well-woman visit	Filling a prescription

Source: Institute for Medicaid Innovation. (2018). *Women's Access & Coverage to Care by Payer Type: Health Care Delivery and Access Survey (2016) Analysis.* Washington, D.C.

Out-of-pocket, deductible costs were a barrier for more than half of women enrolled in Medicaid (55%) for dental and vision care, over twice the rate of those with commercial insurance. Deductible cost was also associated with delaying health care services. For example, a substantial portion of women enrolled in Medicaid indicated that they had delayed needed dental and vision care in the past two years because of the cost of their deductible. The majority of women enrolled in Medicaid indicated that they had a deductible of less than $1,000, generally lower than other payer types, but that it was a financial hardship.

Barriers to Care: Churn

One of the most significant barriers to continuous care for low-income women is churn. Churn is a pattern of disruption in insurance coverage and can refer to gains or losses of coverage. Pregnant women are especially vulnerable before and after childbirth (Daw, Hatfield, Swartz, & Sommers, 2017). Since most states have higher eligibility limits for pregnant women than for other nonelderly and childless women, many women first become eligible for Medicaid during their pregnancy (Molina & Pace, 2017).

In addition, changes in employment and income during this time period can also affect insurance coverage status (Daw et al., 2017). Women who receive Medicaid coverage only during pregnancy would lose their benefits 60 days postpartum (Molina & Pace, 2017). It has been found that women who experience churn are more likely to delay care, use fewer preventive care services, and have a more negative perceived quality of care (Daw et al., 2017). Changing health insurance coverage alone has been associated with a 37 percent decrease in the likelihood of having a usual source of care and a 65 percent increased likelihood of delaying care (Daw et al., 2017). Of pregnant women with Medicaid or CHIP coverage during the month of delivery, 73 percent experienced a change in health insurance status in the prior nine months, and 65 percent were uninsured in at least one month after delivery (Daw et al., 2017).

The findings from the survey found that more than 70 percent of women enrolled in the Medicaid program reported having consistent health care coverage over the past two years, and 76 percent were confident that they would retain coverage into the future. The majority of women with coverage through the Marketplace (66%) and commercial insurance (90%) also reported high rates of consistent coverage. However, more than 30 percent of women in the Marketplace were not confident that they would retain coverage in the future. Over the past two years, 13 percent of women enrolled in Medicaid, 63 percent in the Marketplace, and 26 percent with commercial insurance reported changing health plans for their health care coverage. The high rates of churn among women in the Marketplace may explain their lower rates of confidence in having continuous coverage in the future. Finally, only 22 percent of women enrolled in Medicaid reported that they had to change their health care provider because of changes in their health insurance coverage. In contrast, 39 percent of women in the Marketplace reported changing their provider.

Barriers to Care: Social Determinants of Health

The World Health Organization defines social determinants of health (SDOH) as "the conditions in which people are born, grow, live, work and age" (World Health Organization, n.d.). This constellation of environmental, political, socioeconomic, environmental, and behavioral factors contributes to 60 percent of preventable mortality (Braveman & Gottlieb, 2014; McGinnis, Williams-Russo, & Knickman, 2002). The complex relationships between the social determinants and health result in inequities in care and outcomes (Daniel, Bornstein, & Kane, 2018; Goldstein & Holmes, n.d.; Orgera & Artiga, 2016) with greater burden of major disease, disability, and mortality (Braveman & Egerter, 2013). Although social determinates affect all individuals to varying degrees, low-income individuals, as well as those of certain racial and ethnic groups, are disproportionally affected (Braveman & Egerter, 2013).

Despite research indicating that women enrolled in Medicaid oftentimes have a need for resources and support that address multiple social determinants of health, a low number of women reported receiving information on resources from a primary care provider (24%) or women's health care provider (28%). An alarming number of women with no insurance coverage reported that they were rarely offered information by their provider during a health care visit on how to get their social needs met (Table 5).

Table 5. Receipt of Information on Social Determinants of Health, Stratified by Payer Type, 2016.

	Types of Insurance Coverage			
Received Information on SDOH	**Uninsured N (%)**	**Medicaid N (%)**	**Exchange N (%)**	**Commercial N (%)**
From primary care provider	**25.8**	24.4	9.0	11.5
From women's health care provider	26.4	**28.0**	8.6	13.3

Source: Institute for Medicaid Innovation. (2018). *Women's Access & Coverage to Care by Payer Type: Health Care Delivery and Access Survey (2016) Analysis.* Washington, D.C.

Satisfaction with Care

Satisfaction with health care services, such as interactions with providers, has been shown to influence critical health outcomes such as preventive adherence (Jerant, Fenton, Bertakis, & Franks, 2014). Recent research suggests that Medicaid enrollees are satisfied with the care they receive through the program. For example, a survey of Medicaid enrollees found that 46 percent scored their coverage as a nine out of 10, with similar rates of satisfaction in both expansion and non-expansion states (Barnett & Sommers, 2017). In the study, less than 8 percent of enrollees scored their Medicaid health care as less than a five out of 10, suggesting that the vast majority of Medicaid enrollees are satisfied with the Medicaid program.

Despite the significant gaps that were highlighted between needed services and care that was received, the majority of women enrolled in Medicaid indicated that they were very satisfied with their coverage through the program (Table 6). Women in Medicaid had higher rates of satisfaction than those in the Marketplace or commercial insurance, which highlights the success of Medicaid in delivering coverage for women.

Table 6. Satisfaction with Current Health Insurance, Stratified by Payer Type, 2016.

	Types of Insurance Coverage			
Satisfaction	**Uninsured (%)**	**Medicaid (%)**	**Marketplace (%)**	**Commercial (%)**
Not at all satisfied	N/A	1.3	11.8	1.7
Not too satisfied	N/A	7.1	18.3	9.6
Somewhat satisfied	N/A	40.6	47.3	45.5
Very satisfied	N/A	51.0	22.6	43.2

Source: Institute for Medicaid Innovation. (2018). *Women's Access & Coverage to Care by Payer Type: Health Care Delivery and Access Survey (2016) Analysis.* Washington, D.C.

Impact of Access, Coverage, and Health Systems for Women in Medicaid

Women enrolled in Medicaid had the same level of access, coverage, and satisfaction as women enrolled in commercial insurance, commonly considered the gold standard for health care coverage. These results suggest that the Medicaid program is successful in effectively ensuring that women have access and coverage to high-quality, affordable care. For example, women enrolled in Medicaid reported more frequent health care provider visits than those enrolled in the Marketplace or commercial insurance. Although it might suggest that women in Medicaid have higher health care needs, it also indicates that women covered by Medicaid are able to access and utilize health care services to meet their needs without health system barriers (e.g., prior authorization). It is not surprising then that women enrolled in the Medicaid program reported higher levels of satisfaction than did those in both the Marketplace and commercial insurance.

Looking Ahead: Implications for the Future

Health care is a central component of women's lives, affecting their ability to care for themselves and their families and participate in the workforce. Access to comprehensive, evidence-based care that is affordable and of high quality is essential for women to address their overall health care needs. Women's access to care is shaped by a wide range of factors, including federal and state health care policies.

Medicaid was not created as a program for women. However, it has created an important pathway for health insurance coverage and access to essential services for low-income women in the U.S. The Medicaid program has served as a critical safety net for women by providing coverage to a wide range of services, including access to essential preventive, primary, specialty, and long-term care services.

Findings from this survey indicate that Medicaid is an effective health care program and that, overall, women enrolled in this program reported levels of access, coverage, and satisfaction that address their health care needs. Changes in the Medicaid program to weaken the services covered and provided could potentially have a negative impact on the overall health and well-being of women, families, and communities.

As key stakeholders, such as policymakers, explore ways to address the health care needs of women and the role of Medicaid in achieving those goals, there are several clinical, research, and policy opportunities to consider.

Clinical Opportunities

Screen for and provide accurate information on SDOH resources.

As noted in the findings, women are not consistently being screened for or receiving SDOH information from both primary care and in women's health providers. The health care setting serves as an important potential point to ensure that women's social needs are being met.

Provide information on the importance of well-woman services and visits.

Women reported reasons such as not being sexually active for not obtaining women's health care. However, research suggests that reproductive-age women benefit from routine preventative care. There is a need to provide education on the importance of obtaining well-women's health care and address the individual reasons for not seeking care.

Research Opportunities

Investigate reasons and barriers that reproductive-age women do not obtain health care.

The findings from the survey found that not being sexually active and lack of time were two primary reasons reproductive-age women do not seek care; especially the well-woman visit. Understanding knowledge gaps in the importance of obtaining essential women's health care and the role of social determinants of health would enhance the development of initiatives and interventions to better provide care to women.

Explore how other demographic factors affect payer-related disparities.

Although this analysis focused on stratifying by four types of health care coverage, exploring differences by demographic factors, including race/ethnicity, age, geographic location, and Medicaid expansion vs. non-expansion states, would be valuable to further understand payer-related disparities.

Policy Opportunities

Maintain policies that support access and coverage for women's health.

As the data about the role of Medicaid from the survey highlight, access and coverage are critical and effective for women's health. Current policies and funding that support women's access to health care, such as Medicaid and Title X, are critical for maintaining access to care for reproductive-age women.

Implement policies that reduce churn and increase access.

Periods of time without insurance coverage, churn, and carve-outs of services (e.g., dental and vision care) have significant impacts on women's health. The survey findings highlighted that lack of insurance, churn, and carve-outs affected women's ability to receive needed services. Continuous coverage could be one solution to eliminate barriers to health care access and improve outcomes.

Identify policies to reduce or eliminate out-of-pocket costs for low-income women.

Cost was reported as the most common barrier for uninsured women to access care, with women enrolled in Medicaid noting that out-of-pocket costs was the primary reason for not receiving needed dental and vision care. Women in the Marketplace, presumably in high-deductible health plans, also cited cost as a significant barrier to accessing care.

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