

Still no differences in the length or scope of primary and ambulatory care for Medicaid and commercial patients

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Abstract

Many seek to improve the quality of primary care in the United States, particularly for Medicaid patients. This paper revisits the question of whether Medicaid patients receive less primary care, such as the length or scope of services per visit, than commercial patients. Analyses of 2016–2019 National Ambulatory Medical Care Survey data, the most recent available, find there were no significant differences in the average length of ambulatory care visits, or of primary care visits in particular, between Medicaid and commercial care, nor differences in the scope, based on the number of diagnostic and treatment services, health education topics covered, or the number of medications prescribed in the visit. Only small differences were found for uninsured patients. The duration and scope of ambulatory and primary care visits were primarily related to the characteristics of patients, visits, and the physicians' practices. To improve primary and ambulatory care for disadvantaged patients, it may be more important to focus on increasing access to care by reducing insurance and cost-related barriers and on broad-based efforts to improve quality.

Key words: Medicaid; commercial insurance; ambulatory care; primary care; length of visit; content of visit.

Introduction

In 2021, a National Academy of Sciences, Engineering, and Medicine report recommended strategies to improve primary care services in the United States.¹ There has been special interest in improving primary care in Medicaid, which serves low-income patients who are at greater risk of poor health because of their disadvantaged and often marginalized status.^{2,3}

Medicaid payment rates for physicians are typically lower than payments from commercial insurance or Medicare⁴ and many physician practices do not accept new Medicaid patients.⁵ This leads to concerns that Medicaid patients might receive lower quality care than commercially insured patients. Some have speculated that higher use of emergency departments by Medicaid patients might be due to lower quality of primary care in Medicaid than with commercial insurance.⁶ Ding and Glied⁷ found that, although Medicaid patients were as likely to receive guideline-based care as non-Medicaid patients, they were often concentrated in a small number of office-based practices, which were less likely to use electronic medical records, which could deter the use of more advanced services.

The current study revisits and updates a 2013 paper that examined data from the 2006–2010 National Ambulatory Medical Care Surveys (NAMCS).⁸ That analysis determined there were no significant differences in the average length of a primary care visit for Medicaid, commercial, uninsured, or community health center patients, and there were scant differences in the scope of diagnostic, treatment, or health education services provided. The length and content of a typical primary

care visit were essentially equivalent for safety net and non-safety net patients, even for the uninsured.

The current paper revisits the topic using data from the 2016–2019 period, the most recent data available. Since 2010, the health environment has changed greatly: the Affordable Care Act was implemented and Medicaid eligibility expanded in most states. There were some concerns that Medicaid expansions could exacerbate a shortage of primary care providers, limiting access.⁹ One study found that primary care access improved in expansion states despite shortages, but suggested that providers might have coped with the influx of new patients by shortening visits.¹⁰

Other important changes since 2010 include the continued expansion of managed care, increased use of electronic medical records, the advent of value-based payment systems, and consolidation of physician practices into larger health systems. The 2016–2019 data used in this paper predate the COVID-19 pandemic; more recent data are not available.

The length of an ambulatory care visit may be particularly important since time is ultimately the most valuable medical care resource. The length of a visit is an important measure of care quality and is associated with patient satisfaction.^{11,12}

This paper focuses on insurance-related differences in the length and content of ambulatory care visits, particularly primary care, in the 2016–2019 period, as measured by the average time spent with the physician per visit and the reported number of diagnostic and treatment services, health education topics, and new medications prescribed. In addition to examining differences by source of coverage, we examined

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differences related to patient, visit, or provider characteristics, including differences for primary care and specialty status.

Methods

The study is based on pooled data for nonelderly patients from the 2016, 2018, and 2019 NAMCS, administered by the Centers for Disease Control and Prevention (CDC). The NAMCS identifies nationally representative samples of office-based, nonfederal physicians and data are either abstracted from medical records reviewed in the offices or abstracted from electronic medical records submitted to CDC.¹³ The NAMCS includes data about the length and content of each sampled visit, as well as related information about the physician's practice. We excluded data from those 65 and older because of the higher medical needs of elderly patients, almost all of whom are covered by Medicare. The sample of physicians across the 3 years was 2056, but the subsample for this study will be somewhat smaller because we excluded elderly patients.

The unit of analysis is an ambulatory medical visit. The sample includes data abstracted from 20 078 visits: 8164 from primary care providers, 6486 from surgical specialists, and 5428 from medical specialists. All analyses are adjusted by NAMCS's visit-based sample weights and survey design parameters.

These analyses particularly focus on care provided by primary care providers. For this study, primary care is based on the specialty of the physician as categorized by CDC,¹⁴ not the nature of specific medical care services; most physicians conduct evaluation and management services as well as treatment services. Primary care practices include family medicine, general internal medicine, pediatrics, obstetrics/gynecology, geriatrics, and related specialties. Surgical specialties include general and specialized surgery, orthopedic surgery, and surgical oncology, while medical specialties include cardiology, psychiatry, endocrinology, medical oncology, emergency medicine, and others.

On a weighted basis, 57.6% of visits were to primary care physicians, 18.1% to surgical specialists, and 24.4% to medical specialists. More than half of the visits (55.8%) were to physicians in group practices, 35.8% to solo physicians, and 8.4% to other practice types (eg, practices owned by a health maintenance organization [HMO] or hospital system).

Key outcomes include the following: the length of the ambulatory visit (in minutes) that a patient spent with the physician,

not including waiting time or time spent with non-clinicians; number of diagnostic and treatment services (eg, vital signs, hemoglobin A1c [glycated hemoglobin] test, X-ray, psychotherapy, wound care); number of health education topics (eg, tobacco cessation, diabetes, nutrition, exercise, family planning, etc); and number of new medications, not including prior medications reported in the record.

A key aspect is a comparison by the expected payer for the visit: commercial, Medicaid (or Children's Health Insurance Program [CHIP] or another state program), Medicare, other insurance (eg, worker's compensation, veterans), and uninsured/self-pay/charity. The expected payer is the source that the provider bills for service, although the actual payer may differ if the insurer rejects the claim.

Multivariate analyses control for other characteristics of the patient, visit, or provider practice. Patient and visit characteristics include the following: the major reason for the visit (new problem, chronic problem [routine], chronic problem [flare up], presurgery, postsurgery, and preventive), whether the patient is a new or existing patient for the provider, the total number of chronic conditions noted in the patient's record, the primary diagnosis category (based on the International Classification of Diseases, Tenth Revision [ICD-10], code), and the patient's age, gender (as recorded), and race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic or non-Hispanic other). Provider practice characteristics include primary care versus surgical specialty versus medical specialty and whether the practice is a solo, group, or other practice. To account for changes that may have occurred between 2016 and 2018, whether due to broad practice changes or changes in NAMCS survey methods, the survey year is also included as a covariate.

Most of the multivariate analyses in this paper use ordinary least-squares regression methods. In light of the findings from Ding and Glied,⁷ the [Supplementary Appendix](#) presents auxiliary analyses about factors affecting the availability of electronic medical records in ambulatory care. This study was exempt from human subjects review because it relied on de-identified public secondary data.

Results

Length of ambulatory visits

Table 1 presents weighted tabulations of the number and average length (in minutes) of ambulatory care visits, classified by the expected payer and provider type for nonelderly patients.

Table 1. Weighted number and average length of ambulatory care visits for those under 65 years, 2016–2019.

Measure	No. of observations	Weighted no. of visits	Minutes with physician	
			Weighted mean	SE
Expected source of payment				
Commercial insurance	13 042	398.4 mil.	22.17	0.31
Medicare	1053	31.2 mil.	21.18	0.74
Medicaid/CHIP/other state	3228	109.1 mil.	21.82	0.70
Worker's compensation/other	482	22.3 mil.	28.81	4.26
Uninsured/self-pay/charity	1100	37.2 mil.	25.58	1.32
Provider type				
Primary care	8164	361.9 mil.	20.79	0.34
Surgical specialist	6486	113.6 mil.	22.73	0.70
Medical specialist	5428	153.2 mil.	26.37	1.16

Abbreviations: CHIP, Children's Health Insurance Program; mil., million.
Source: Pooled 2016, 2018, and 2019 National Ambulatory Medical Care Surveys data.

Table 2. Multivariate factors associated with the length of the ambulatory care visit (in minutes) for those under 65 years, 2016–2019.

	Model 1: all provider types (n = 18 195)		Model 2: primary care only (n = 7511)	
	Coeff.	SE	Coeff.	SE
Expected payment source (ref = commercial)				
Medicare	−1.99	0.68**	−1.18	0.82
Medicaid/CHIP/other state	−0.03	0.54	0.01	0.61
Worker's compensation/other	3.91	2.82	−1.85	1.44
Uninsured/self-pay/charity	1.05	1.24	−1.78	1.09
Characteristics of patient or visit				
Existing patient (vs new)	−2.26	0.68***	−1.20	0.89
Major reason for visit (ref = preventive)				
New problem	0.68	0.63	−0.40	0.76
Chronic problem (routine)	1.61	0.94	−0.48	0.85
Chronic problem (flare-up)	3.11	1.01**	3.53	1.28**
Presurgery	9.23	2.22***	6.03	2.56*
Postsurgery	−1.35	0.84	−2.74	1.43
Total no. of chronic conditions	0.01	0.23	0.10	0.15
Race/ethnicity (ref = White)				
Black	−0.35	0.57	−1.18	0.71
Hispanic	1.60	0.62**	1.52	0.74*
Other	0.91	0.74	0.48	0.76
Age category (ref = <15 y)				
15–24 y	0.44	0.70	1.27	0.77
25–44 y	0.59	0.75	1.69	0.74*
45–64 y	1.31	0.76	2.46	0.79**
Characteristics of provider				
Provider type (ref = primary care)				
Surgical specialist	0.61	0.75	N/A	
Medical specialist	4.10	0.95***	N/A	
Practice type (ref = other type)				
Solo	2.10	1.00*	1.53	1.03
Group	−0.08	0.88	−0.16	0.84

Abbreviations: CHIP, Children's Health Insurance Program; Coeff., coefficient; N/A, Not Applicable; NAMCS, National Ambulatory Medical Care Surveys; ref, reference.

Source: 2016–2019 NAMCS data. Models also control for patient gender, metropolitan/non-metropolitan status, category of the primary diagnosis, and survey year.

* $P < .05$, ** $P < .01$, *** $P < .001$; otherwise not significant.

In total, there were 598.2 million ambulatory care visits per year, of which two-thirds (66.7%) were for commercial insurance, 18.2% Medicaid, 6.2% uninsured, 5.2% Medicare, and 3.7% worker's compensation. For Medicaid, commercial, and Medicare patients, an average visit with a physician lasted 21–22 minutes; the average length was slightly longer for other/worker's compensation and uninsured/self-pay/charity visits. The average visit with a primary care provider was 21 minutes, 22 minutes for surgical specialists, and 26 minutes for medical specialists. Differences are more rigorously examined in multivariate analyses that control for patient, visit, and practice characteristics.

Table 2 presents results from multivariate regression models of factors associated with the length of the visit. Model 1 examines all ambulatory care visits pooled together, including primary care providers and medical and surgical specialists, while model 2 is solely for visits to primary care providers. In model 1, the pooled model, there were no significant differences in the average visit length associated with Medicaid, commercial, or uninsured status, after controlling for patient, visit, and practice characteristics. However, the length of an ambulatory visit was approximately 2 minutes shorter for nonelderly Medicare patients in the pooled model. Visits to medical specialists were approximately 4 minutes longer than for primary care providers, but there were no significant differences for surgical specialists.

In model 2, for primary care provider visits only, there were no significant insurance-related differences in the length of primary care visits, even Medicare visits, after controlling for other factors.

Characteristics of patients and visits were generally the dominant factors influencing visit length. In the pooled provider model, visits were 2 minutes shorter for established compared with new patients, approximately 3 minutes longer for visits related to flare-ups of chronic conditions, and 9 minutes longer for presurgery visits. Interestingly, visits for Hispanic patients averaged approximately 1.5 minutes longer than for non-Hispanic White patients. Visits to solo practitioners were approximately 2 minutes longer than those in other practice settings.

When the model was confined to visits to primary care providers, visits were significantly longer when they were related to flare-ups of chronic conditions and presurgery care. The length of visits remained longer for Hispanic patients and visit length increased as patients grew older. A primary care visit by a 45–64-year-old patient averaged 2.5 minutes longer than one by a child under 15 years.

The scope of ambulatory and primary care visits

Table 3 presents weighted means for the number of diagnostic and treatment services, health education topics, and new

Table 3. Average number of services, health education topics, or new medications mentioned per ambulatory visit, in those under 65 years: 2016–2019.

	No. of diagnostic/ treatment services		No. of health education topics		No. of new medications	
	Mean	SE	Mean	SE	Mean	SE
Expected source of payment						
Commercial insurance	5.37	0.13	0.42	0.03	0.68	0.03
Medicare	5.39	0.28	0.56	0.09	0.50	0.06
Medicaid/CHIP/other state	5.87	0.36	0.47	0.05	0.76	0.06
Worker's compensation/other	4.08	0.18	0.37	0.05	0.55	0.14
Uninsured/self-pay/charity	3.50	0.32	0.32	0.09	0.78	0.25
Provider type						
Primary care	6.19	0.16	0.58	0.04	0.78	0.04
Surgical specialist	3.63	0.17	0.12	0.03	0.58	0.10
Medical specialist	4.46	0.36	0.30	0.04	0.54	0.05

Abbreviation: CHIP, Children's Health Insurance Program.

Source: Pooled 2016, 2018, and 2019 National Ambulatory Medical Care Survey data.

Table 4. Multivariate factors associated with the number of services, health education topics, or new medications mentioned per primary care visit for those under 65 years, 2016–2019 (not including surgical or medical specialists).

	No. of diagnostic/ treatment services		No. of health education topics		No. of new medications	
	Coeff.	SE	Coeff.	SE	Coeff.	SE
Expected payment source (ref = commercial)						
Medicare	−0.74	0.40	0.14	0.16	−0.13	0.07
Medicaid/CHIP/other state	0.10	0.32	−0.07	0.06	−0.04	0.06
Worker's Comp/other	−0.99	0.56	0.01	0.12	0.30	0.29
Uninsured/self-pay/charity	−0.47	0.34	0.33	0.14*	−0.20	0.08*
Characteristics of patient or visit						
Existing patient (vs new)	−0.33	0.25	0.16	0.06**	0.05	0.07
Major reason for visit (ref = preventive)						
New problem	−1.10	0.28***	−0.31	0.07***	0.16	0.06**
Chronic problem (routine)	−1.09	0.34***	−0.08	0.11	−0.06	0.06
Chronic problem (flare-up)	1.11	0.86	−0.03	0.11	0.15	0.09
Presurgery	0.60	0.83	−0.30	0.24	−0.27	0.18
Postsurgery	−2.73	0.26***	−0.56	0.10***	−0.16	0.09
Total no. of chronic conditions	0.34	0.07***	0.12	0.02***	0.03	0.01
Race/ethnicity (ref = White)						
Black	0.20	0.25	−0.05	0.08	0.03	0.06
Hispanic	0.50	0.25*	0.05	0.08	0.11	0.08
Other	0.30	0.41	−0.01	0.08	0.19	0.10
Age category (ref = <15 y)						
15–24 y	0.41	0.30	−0.25	0.09**	−0.22	0.08**
25–44 y	0.65	0.35	−0.35	0.11**	−0.37	0.08***
45–64 y	1.32	0.41***	−0.37	0.12**	−0.30	0.09***
Characteristics of provider						
Practice type (ref = other types)						
Solo	−2.11	0.69**	−0.03	0.13	−0.12	0.11
Group	−1.50	0.72	−0.02	0.12	−0.10	0.10

Abbreviations: CHIP, Children's Health Insurance Program; Coeff., coefficient; NAMCS, National Ambulatory Medical Care Surveys; ref, reference Source: 2016–2019 NAMCS data. Models also control for patient gender, metropolitan/non-metropolitan status, category of the primary diagnosis, and survey year.

* $P < .05$, ** $P < .01$, *** $P < .001$; otherwise not significant.

medications reported in the medical record. Out of the 28 possible diagnostic and treatment services, the average number for Medicaid, commercial, and Medicare patients ranged between 5 and 6 services provided in a visit; averages were slightly lower for other/worker's compensation and uninsured/self-pay/charity visits, at approximately 4 services. Primary care providers averaged 6 services per visit, while surgical and medical specialists averaged approximately 4.

The average number of health education topics mentioned in the record averaged from 0.3 to 0.6 per visit, depending

on the expected payor. Primary care providers tended to cover more education topics (0.6 per visit) than surgical specialists (0.1 per visit) or medical specialists (0.3).

The average number of new medications ranged from 0.5 to 0.8 per visit. That is, a new medication is prescribed about every 1 or 2 visits. The total number of medications mentioned in the record was higher, averaging 2.6 (data not shown), including medications that patients were already taking.

These counts are based on reporting in the medical records and abstraction into NAMCS forms. The actual number of

diagnostic or treatment services or health education topics delivered might differ, depending on how thoroughly they were noted in the record or whether there were appropriate categories in the NAMCS abstraction tool. The number of medications is probably more accurate because of the importance of recording and issuing prescriptions.

Table 4 presents factors associated with differences in the number of diagnostic or treatment services, health education topics, or new medications per visit, among visits to primary care providers. (A version that pools primary care, surgical, and medical specialty data is shown in the [Supplementary Appendix](#).) There were few significant differences related to the source of payment, although the uninsured received slightly fewer new medications (−0.2) but more health education topics (+0.3) than the commercially insured.

The content of services delivered during a primary care visit was primarily influenced by patient and visit characteristics. Those with chronic conditions received more diagnostic, treatment, and health education services but not more new medications. Patients presenting with new problems received more new medications but fewer diagnostic, treatment, and health education services. Routine chronic condition visits and post-surgery visits had fewer diagnostic and treatment services. Existing patients received more health education.

Hispanic patients and those aged 45–64 years received more diagnostic and treatment services, although increasing age was associated with fewer health education topics and fewer new medications per visit. Solo practitioners provided fewer diagnostic and treatment services than those in other practice types. Gender (male vs female) was not significantly associated with the length or scope of visits in any of the analyses conducted, nor did metropolitan/non-metropolitan status. Other analyses (data not shown) also included the effect of the proportion that a practice's revenue came from managed care; these generally did not find that reliance on managed-care revenue significantly affected the length or content of primary care visits.

Analyses that included surgical and medical specialists are shown in the [Supplementary Appendix](#) and reveal that surgical and medical specialists provide fewer diagnostic and treatment services and less health education than primary care providers.

Discussion

The length and general content of primary care visits (and ambulatory care visits more broadly) are not significantly associated with the type of insurance that a patient has but are primarily affected by the patient's characteristics, reasons for the visit, and practice-related factors. After controlling for those factors, the length and scope of care that Medicaid patients receive in a medical appointment are essentially the same as the care received by commercial patients. Even uninsured patients received similar care to insured patients in a visit, although the uninsured received slightly fewer new medications and more health education during a primary care visit.

While insurance status did not substantially alter the length or content of a primary care visit, insurance status and the level of cost-sharing can affect a patient's ability to access ambulatory care. For example, it is well known that uninsured patients have poorer access to care.¹⁵ While Medicaid beneficiaries have greater access than the uninsured and Medicaid

expansions have improved access to care, Medicaid beneficiaries often have problems getting timely care.¹⁶ On the other hand, deductibles and higher cost-sharing can deter care for those with commercial insurance or Medicare.¹⁷ But this study indicates that, when patients are able to access ambulatory care, the duration and scope of care appear to be similar regardless of the type of coverage they have.

This study has a number of limitations. It is based on the accuracy of information in the medical records and the NAMCS data abstraction; errors or omissions may occur. The study uses very broad measures of the content of care provided in ambulatory visits and did not measure quality of care comprehensively. It did not, for example, examine whether a patient was appropriately screened for diabetes or whether diabetic patients received appropriate medications or education. Errors in the expected source of payment are possible. For example, private Medicaid managed-care organizations could be recorded as commercial insurers or those whose commercial insurance has high deductibles might be considered uninsured/self-pay.

The study used broad groupings of categories of providers. As of 2019, the NAMCS data no longer list detailed physician specialties and merely categorize providers as primary care, surgical, or medical specialists. Differences in patients' insurance may affect access to care, such as whether they have assigned primary care providers and can only see specialists after referrals.

These results are similar to the earlier 2013 study, which used 2006–2010 data.⁸ Regrettably, unlike the earlier study, this analysis did not include community health centers, a key part of the nation's health care safety net, because 2016–2019 NACMS data sampled from community health centers have not yet been released (although they appear to have been collected; private communication with the CDC). The earlier study found that the length and content of primary care received at community health centers did not differ from care in other care settings. Other research continues to show that health centers provide high-quality, cost-effective care.^{18,19} Ding and Glied⁷ also found no relation between the use of medical management, counseling, or screening service and the share of practices seeing Medicaid patients, although they did find differences in the use of electronic medical records. This issue is examined in the [Supplementary Appendix](#).

Overall, patient, visit, and practice characteristics are more important in shaping the length and scope of primary care visits than the type of insurance coverage. Older patients and those whose chronic conditions flared up tended to have longer primary care visits. Patients who had more chronic conditions received more diagnostic, treatment, and health education services but had similar visit lengths and numbers of new medications. Presurgery visits were longer but did not differ significantly in services rendered. Postsurgery visits had fewer diagnostic and treatment services and less health education.

Significant differences were not detected in the average length or scope of ambulatory care for White compared with Black patients, which is important given concerns about racial health equity. But Hispanic patients had significantly longer visits and received more diagnostic and treatment services than non-Hispanic White patients. This is somewhat surprising since Latinos often have greater barriers to health care access.²⁰ More time or testing may be needed to compensate for

Hispanic patients who are more likely to have limited English proficiency, which also impedes access and overall utilization of care.²¹ Unfortunately, although using professional interpreters can improve the quality of care, fewer than half of physicians reported using interpreters when caring for limited-English-proficient patients.²²

While this study found that some factors are associated with differences in medical visit length, the differences are usually small, just 1 to a few minutes per visit. An important reason for the lack of difference is that the typical modern medical appointment system relies on scheduling visits in 15-to-30-minute blocks, although new patients often get longer appointments. Physicians, particularly primary care physicians, have limited flexibility to alter the length of a visit. Taking more time with 1 patient can delay appointments for all the following appointments, so it can be more expedient to schedule a follow-up visit or make a referral to another physician for further care.

Medical specialists had longer visits (26 min) than primary care physicians (21 min), which is probably related to greater complexity or smaller patient caseloads. Some visits, such as those for new patients or presurgery visits, are longer, but these are the exceptions rather than the norms and those scheduling appointments often know that more time is required for a new patient or presurgery visit.

Conclusion

The key finding of this analysis is that average ambulatory care and primary care visits tend to be similar in length and scope regardless of the type of insurance that a patient has. Differences are primarily related to patient characteristics (eg, number of chronic conditions, age), visit type (eg, new or established patient, presurgery), or practice type (specialty, solo/group/other practice). Other than age, the demographic characteristic that mattered most was Hispanic ethnicity; Black-White differences were not observed.

These results for the 2016–2019 period are similar to those from a decade earlier.⁸ Changes like Medicaid expansions under the Affordable Care Act or other aspects of the changing health landscape did not materially alter the length or content of medical visits.

On the other hand, the average duration and scope of ambulatory care visits are not the same as access to care. Surveys indicate that physicians are most likely to accept privately insured patients, followed by Medicare, then Medicaid, and are less likely to serve uninsured patients.²³ In these data, 67% of visits were to commercial patients compared with 18% for Medicaid patients and 6.2% for uninsured patients (Table 1). Medicaid participation rates vary widely by state, however.²⁴ Although the duration and scope of visits are similar across insurance types, Medicaid and uninsured patients typically have fewer medical visits,²⁵ leading to less overall receipt of ambulatory medical care.

From the perspective of health equity, it is important and reassuring that there are no significant differences in duration and content ambulatory and primary care visits between Medicaid, commercially insured, and uninsured patients. The individual medical needs of patients are more important than the type of insurance they have. But these findings may be a little surprising since they seem contrary to the physicians' economic interests since Medicaid payments tend to be lower

than commercial or Medicare payments and uninsured patients only have self-payments.

Some potential reasons for the lack of differences include the following:

1. Many factors, only some of which are economic in nature, affect how physicians practice; professional and ethical norms are also important. The evidence about the influence of economic incentives on physician behavior remains mixed, particularly because incentives are often diffuse, differing across payers and insurance plans.²⁶ In many cases, physicians may not even be aware of patients' insurance status.
2. The US health care system has “relief valves” that serve uninsured and Medicaid patients, like community health centers, government clinics, and safety net hospitals. They effectively reduce economic pressures on other physician practices.
3. Other supply factors may also contribute. One analysis found an influx of new general internists to expansion states occurred after the Affordable Care Act was enacted, but non-expansion states had fewer new general internists, which could relieve some of the expected problems associated with Medicaid expansions.²⁷

While these analyses suggest that there are no (or minimal) insurance-related differences in the length or scope of ambulatory and primary care services, insurance-related differences still exist in patients' access to medical care. Efforts to bolster access to care for underserved populations, by strengthening Medicaid coverage, including the continuity of coverage, strengthening the scope of benefits, reducing cost-related barriers to care, and expanding the pool of safety net providers, may be more important in expanding the quality and benefits of ambulatory and primary care in the United States, and thereby lowering the need for more expensive emergency and inpatient care services.

These results are consistent with an earlier, more comprehensive study of the quality of ambulatory care. A landmark 2006 study found that the quality of care was similar across all insurance types (eg, Medicaid, private managed care, fee-for-service managed care, uninsured). Patients received an average of 54% to 57% of the services that were appropriate, based on their medical conditions, regardless of the kind of coverage they had.²⁸ The authors concluded that efforts to improve medical care needed to be broad-based, not just by the type of insurance. In addition to improving access for disadvantaged populations, the nation should consider efforts to improve the quality of primary care across all types of insurance coverage, such as those recommended by the National Academy of Sciences, Engineering, and Medicine.¹

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

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