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Research Paper

Examining access to care for younger vs. older dual-eligible adults living in the community

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Abstract

Background: Recent state dual-eligible (Medicare and Medicaid) payment reform demonstrations have included groups of both working-age and older adults, but relatively little is known about how access to care varies between these two populations.

Objectives/hypothesis: To examine access to a usual source of care for younger and older dual-eligible adults, to analyze whether timely access to several types of care differed in these two populations, and to understand some of the underlying reasons for delayed care among younger and older dual-eligibles.

Methods: Using observations pooled across calendar years 2003–2012 of the Medical Expenditure Panel Survey, this study conducted descriptive and multivariate analyses to examine access to care measures.

Results: Younger dual-eligible adults were more likely to encounter problems with accessing medical care, dental care, and prescription medications than older dual-eligible adults. Both groups of dual-eligible adults reported that a lack of affordability, gaps in existing insurance coverage, and difficulty in getting to a provider's office were the most common reasons for delayed access to care.

Conclusions: A lack of affordability for medical care, dental care, and prescription medications suggests that high co-payments and cost sharing for some services may be deterring access to needed care. Younger dual-eligibles were more likely to encounter service coverage gaps than older dual-eligibles. States should monitor Medicare-Medicaid plans to confirm they have adequate provider networks. © 2015 Elsevier Inc. All rights reserved.

Keywords: Dual-eligible; Access to care; Disability

About 10 million Americans are dually eligible for public health insurance from both the Medicare and Medicaid programs.[1] Most dual-eligible adults have multiple chronic conditions and face a complex array of needs that require different providers of health care services and long-term supports.[2] Dual-eligible adults historically have incurred a disproportionately large share of health care spending in the United States, accounting for 39 percent of Medicaid spending,[3] and 31 percent of total Medicare spending.[4] It is essential for this population to receive timely and coordinated care in order to manage their health conditions and live in the community.

State policymakers concerned with Medicaid spending growth have increasingly focused attention on dual-eligible populations. However, since Medicare is a federal program while Medicaid is separately administered in each state, incentives to coordinate services across both programs have been limited to date.[5] Since 2011, the Centers for Medicare and Medicaid Services (CMS) has encouraged states to develop integrated care models and payment reforms that seek to improve quality of care and service coordination for dual-eligible beneficiaries.[6] More than 10 states had received approval as of 2015 to implement payment demonstrations for dual-eligible populations and are in the process of evaluating whether such reforms have any effects on access to care, quality, and cost.[7,8]

A majority of approved state dual-eligible payment demonstrations include both younger, working-age adults (between 18 and 64 years old) and older adults (65 years or more). Some states view dual-eligible adults as a single category of sick, low-income individuals.[9] However, younger and older dual-eligible adults may have different service needs and barriers in accessing care. Specifically, prior work has shown that younger dual-eligible adults have fewer chronic conditions than older dual-eligibles.[2]

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However, they are more likely to report problems with obtaining health care and be dissatisfied with the quality of the care they receive.[10] All working-age dual-eligible adults have a disability and qualified for Medicare following a 2 year waiting period as a Social Security Disability Insurance (SSDI) beneficiary. In addition, they became eligible for Medicaid coverage by meeting the low income and asset tests which vary by state and are defined in state and federal regulations.

Compared to those without disabilities, adults with disabilities face many structural and environmental barriers, including finding readily available transportation to medical appointments, communicating with providers and office staff, and connecting with providers who understand disability issues.[11] Prior studies have found strong evidence that adults with disabilities are significantly more likely to encounter delays in timely access to health care services compared to adults without a disability.[12–15] Among young adults with disabilities, persons with cognitive, physical, or vision impairments are especially likely to experience barriers to health care.[16–19] Although the prevalence of disability varies for younger and older dual-eligibles, few studies have examined whether access to care is more challenging for younger versus older dual-eligible adults while accounting for disability.

The purpose of the study was threefold: to examine access to a usual source of care for younger and older dual-eligible adults, to analyze whether timely access to several types of care differed for these two populations, and to understand some of the underlying reasons for delayed care among younger and older dual-eligibles. Using data from a nationally representative survey of non-institutionalized adults, we conducted multivariate analyses to address three research questions: (1) does the likelihood of having a usual source of care vary for younger and older dual-eligibles?, (2) is delayed access to care more likely to occur for younger or older dual-eligibles?, and (3) what are the most prevalent reasons for delayed access to needed care?

Methods

Data source

The Medical Expenditure Panel Survey (MEPS) is a nationally representative survey of non-institutionalized adults in the United States. Sponsored by the Agency for Healthcare Research and Quality (AHRQ), the MEPS has been fielded each year since 1996 and uses a multistage probability design to collect responses through in-house, in-person interviews.[20] The MEPS participant panels had an average response rate of 90% across rounds. The MEPS data included information on the health insurance coverage of respondents and access to needed care. As a result, the MEPS has been used to examine relationships between health insurance and access to care in prior studies.[12,18] Detailed information on MEPS is available at http://meps.ahrq.gov/mepsweb/.

Analytic approach

Our overarching approach was to include all community-dwelling adults with disabilities who participated in the MEPS between calendar years 2003–2012 and were covered by both Medicare and Medicaid. We then evaluated their likelihood of reporting a usual source of care and investigated their likelihood and self-reported reasons for problems accessing medical care, dental care, and prescription medications.

Sample definition

One panel of the MEPS is surveyed five times over a two-year period. The MEPS measures an individual's health insurance coverage on a monthly and per-round basis. To obtain a sufficiently large sample size of dual-eligible adults in the United States, we combined observations from Panels 8–16 representing calendar years 2003–2012. For this study, dual eligibility status was determined based on the individual's report of both Medicare and Medicaid coverage at their first, second, and third interviews. 2264 individuals were dually eligible by this definition.

We restricted our sample to adult respondents who participated in all five rounds of MEPS data collection. However, 200 dual-eligible adults did not meet this criterion. This restriction was needed to exclude individuals who were out-of-scope because they had died or entered an institutional setting after the first round of the survey. Individuals with missing data values were also excluded from analysis: 358 adults were excluded from the sample because they did not have complete information. After excluding the 558 adults from the original sample of 2264 individuals, we obtained a final analytic sample of 1706 dual-eligibles with complete information across all five rounds. Younger dual-eligible adults were categorized as 18–64 years, while older dual-eligibles were 65–85 years. Analyses of dental care excluded individuals who lost all their permanent teeth.

Measures

Dependent variables

We used four measures to examine access to needed care for dual-eligible adults. The first variable looked at whether the individual had a usual source of care (yes/no). A usual source of care is defined in the MEPS questionnaire as the "medical professional, doctor's office, clinic, health center, or other place where a person usually goes if they are sick or in need of advice about his or her health." A follow-up question asked for the particular location for the individual's usual source of care. Responses of emergency department were recoded as having no usual source of care. The

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