



## Access to Care for Non-elderly Adults

Medicaid and the State Children’s Health Insurance Program (CHIP) pay for approximately 16 percent of the nation’s health care (MACPAC 2012, MACStats Table 16). A key question for these programs—as well as for Medicare, private insurance, and other payers—is whether or not this spending produces the desired outcomes. One dimension for evaluating a health payer’s success is whether or not enrollees experience timely access to appropriate health care services.

As described in the Commission’s previous work (MACPAC 2011a), measuring access requires taking into account individuals’ unique characteristics, assessing the availability of a range of different health care providers, and examining how the combination of these factors affects utilization of health care. To capture all of these elements and to present a more complete picture, multiple measures and sources of data are necessary. Furthermore, some data sources are better suited to assessing access over the long term, while others may be helpful in identifying more immediate access issues.

Surveys of Medicaid and CHIP enrollees can provide useful data for measuring aspects of access from the enrollee perspective. Section B presents findings on access to care for adults age 19 to 64, based on individuals’ responses to questions in two national surveys, and will serve as a baseline set of measures for MACPAC’s future analyses assessing trends and changes in access. These results compare non-elderly adults enrolled in Medicaid to similarly situated adults who were uninsured or had employer-sponsored insurance (ESI).

Prior research has shown that enrollees’ characteristics can affect health care access and use. Because Medicaid enrollees differ significantly from adults with ESI and the uninsured, the comparisons in this Section attempt to control for their differing health, demographic, and socioeconomic characteristics using standard statistical methods. By controlling for these factors, this analysis attempts to isolate the effect of health insurance on access to care. However, it is not possible to perfectly control for every

potential factor that could affect individuals' access to care. Access differences that remain between Medicaid and those with ESI or no coverage may still not be entirely attributable to their health insurance status.

This analysis examines the population of adult Medicaid enrollees overall. Certain subpopulations of Medicaid enrollees—for example, individuals of a particular race or ethnicity or those in a particular geographic location—may report different levels of access and utilization. The analyses in Section B are not intended to evaluate how certain Medicaid subpopulations differ from each other (however some of these findings are included in Tables 3A-5C of this Report's MACStats). Instead, the findings in Section B provide a broad, national snapshot of how access to care for all non-elderly adults enrolled in Medicaid differs from access to care for similarly situated adults who have ESI or no insurance. Updating this particular analysis in the future may signal how access is changing nationally for Medicaid enrollees.

In its March 2012 Report to the Congress, the Commission published an analysis of children's access to and utilization of care, based on national household survey data. The analysis in this Section, focusing on non-elderly adults, uses the same sources of data and analytic approach as those used in the March 2012 report. These findings build on the Commission's prior work and provide a national-level picture of access for non-elderly adults enrolled in Medicaid, based generally on individuals' own responses to survey questions.

The key points include:

**Controlling for individuals' health and other characteristics gives a more accurate snapshot of differences due to health insurance status.**

As shown in previous Commission analyses, adults with Medicaid are, on average, in poorer health and are more likely to report barriers to access

than adults with ESI. This analysis compares adults enrolled in Medicaid to adults who were uninsured or covered by ESI, accounting for differences in their health, demographic, and socioeconomic characteristics. By controlling for the effects of these characteristics, to the extent that the data allow, any remaining differences in access may be due to being enrolled in Medicaid and not to these other factors. The term “similarly situated adults” is used when groups are compared after controlling for these characteristics.

**Medicaid enrollees experience better access than the uninsured.** For almost every measure of access to health care, non-elderly adults enrolled in Medicaid have substantially better access to care than similarly situated uninsured adults, based on adults' survey responses. Compared to uninsured adults, adults enrolled in Medicaid reported they were:

- ▶ more likely to have a usual source of care (USC);
- ▶ more likely to have had a visit to a general doctor in the past year;
- ▶ more likely to have had a specialist visit in the past year; and
- ▶ less likely to have delayed medical care in the past year.

**Medicaid enrollees' access is comparable to or better than that of enrollees with ESI on some measures, but worse on others.** Comparisons between adults with Medicaid and similarly situated adults with ESI yield a complex picture. Their health care access and use are comparable for many of the survey measures, such as having a USC and having a visit in an outpatient setting. On other measures, the results were more mixed. For example, adults with Medicaid report delaying care at rates similar to those among adults with ESI; however, they differed significantly as to *why* they delayed care. While ESI does not necessarily

represent ideal levels of access, it may be the coverage most likely to represent the “general population” to which Medicaid is supposed to provide comparable access (§1902(a)(30)(A) of the Social Security Act).

The next portion of this Section briefly describes the sources of data and methodology used,<sup>1</sup> followed by the specific findings on non-elderly adults’ access to care. These findings, as in the March 2012 chapter on children’s access, are structured based on the three main elements of the Commission’s access framework (Figure 1a-1):

- ▶ enrollees and their unique characteristics;
- ▶ provider availability; and
- ▶ health care utilization.

## Methodology Overview

The findings presented in this Section are based on information reported in two national household surveys—the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS). These are surveys of the civilian, non-institutionalized population; the results exclude individuals residing in nursing homes, assisted-living quarters, and other dormitory-like residences. In this analysis, the term “adults” refers to civilian, non-institutionalized adults age 19 to 64. More detailed descriptions can be found in the Annex to this Section as well as in MACPAC Contractor Report No. 2, upon which these findings are based (Long et al. 2012).

MACPAC analyses of data continue to demonstrate that individuals enrolled in Medicaid or CHIP are substantially different from other populations across numerous characteristics. This is illustrated in Tables 3A–5C of this Report’s MACStats. In this Section, Table b-1 as well as Figures b-1 and b-2 also show, for the adults and characteristics analyzed, the numerous ways in

which adults enrolled in Medicaid differ from uninsured adults and adults with ESI. When compared to those with ESI or no insurance, adults with Medicaid are more likely to report being in fair or poor health and to have any of several chronic conditions (e.g., asthma, diabetes, emphysema, hypertension).

### Health, demographic, and socioeconomic characteristics included in the analysis.

As shown in Table b-1, Medicaid<sup>2</sup>, ESI<sup>3</sup>, and uninsured adults differ in their health, demographic, and socioeconomic status. Therefore, the characteristics controlled for in the analysis are:

- ▶ health-related characteristics, such as age, gender, health status, pregnancy, presence of certain chronic conditions (e.g., asthma, diabetes, hypertension), and disability;
- ▶ additional demographic characteristics, such as race and ethnicity; and
- ▶ socioeconomic characteristics, such as income and education.

The full list of characteristics controlled for in this analysis is shown in Table 2 of the MACPAC Contractor Report’s technical appendix (Long et al. 2012). The MACPAC Contractor Report focuses on the unadjusted numbers—that is, where the access-related numbers for adults enrolled in ESI and uninsured adults are not adjusted to control for how these populations differ from Medicaid enrollees.

The goal of controlling for these factors is to determine how access varies for adults with Medicaid, ESI, and no health insurance who are similarly situated in terms of certain health, demographic, and socioeconomic characteristics. Box b-1 provides examples of peer-reviewed research using similar statistical approaches. For any of these analyses, there may be other relevant characteristics that could not be controlled for

**TABLE b-1. Selected Health, Demographic, and Socioeconomic Characteristics of Adults (19–64) by Insurance Status, 2009 (Unadjusted)**

Measure	Medicaid	ESI	Uninsured
<b>Health-related characteristics</b>			
Female	68.1%	51.1%*	42.7%*
Pregnant in the last 12 months	11.8	2.7*	1.1*
<b>Self-reported health status</b>			
Very good/excellent	45.1	71.2*	55.5*
Good	28.6	22.9*	31.4
Fair/poor	26.4	5.9*	13.1*
<b>Disability</b>			
Limited in any way	46.3	26.9*	27.5*
Work limitation	29.0	4.8*	8.1*
Functional limitation	42.1	25.8*	25.3*
<b>Chronic conditions</b>			
Asthma	19.5	12.4*	12.2*
Diabetes	13.2	6.2*	4.8*
Heart disease or condition	11.3	7.7*	5.7*
Hypertension	29.1	22.8*	16.1*
<b>Mental health status</b>			
Depressed or anxious feelings most or all of the time	26.4	8.1*	18.0*
Feelings interfered with life a lot in the past 30 days	8.9	2.1*	4.6*
<b>Demographic and socioeconomic characteristics</b>			
Parent of dependent child	54.6	40.9*	36.8*
Home owned, not rented	34.5	76.8*	44.1*
<b>Race/ethnicity</b>			
White, non-Hispanic	44.6	74.5*	47.2
Black, non-Hispanic	24.8	10.0*	13.6*
Hispanic	23.9	9.6*	34.3*
Other non-white, non-Hispanic	6.7	5.9	5.0
<b>Marital status</b>			
Married	42.6	72.1*	53.2*
Widowed, separated, or divorced	20.1	10.7*	15.6*
Never married	37.3	17.2*	31.2*
<b>Highest level of education</b>			
Less than high school	32.1	5.1*	29.3
High school diploma/GED	32.1	22.9*	34.8
Some college	26.3	34.2*	27.1
College or graduate degree	9.5	37.8*	8.8

**TABLE b-1, Continued**

Measure	Medicaid	ESI	Uninsured
<b>Employment</b>			
Not working	60.9	17.1*	35.9*
Working full-time	24.3	73.6*	48.3*
Working part-time	14.8	9.3*	15.8
<b>Income as a percent of the federal poverty level (FPL)</b>			
Less than 50% FPL	26.0	2.3*	15.2*
50% to 99% FPL	29.8	2.6*	18.0*
100% to 149% FPL	17.6	4.0*	18.9
150% to 199% FPL	9.4	5.4*	15.2*
200% to 249% FPL	5.1	6.8*	11.2*
250% to 299% FPL	3.1	7.6*	6.8*
300% to 399% FPL	3.0	15.7*	7.5*
400% to 499% FPL	2.6	14.4*	3.4
500% FPL or more	3.3	41.3*	3.9
<b>Sample size</b>	<b>1,828</b>	<b>11,671</b>	<b>3,565</b>

**Notes:** Unadjusted, descriptive statistics for all of the regression variables are shown in Table 2 of the MACPAC Contractor Report's technical appendix (Long et al. 2012). ESI is employer-sponsored insurance. The federal poverty level (FPL) is measured using the 2009 U.S. Department of Health and Human Services' poverty guidelines. GED is General Education Development test.

\*Significantly different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

given the available data (e.g., additional chronic conditions, severity of chronic conditions).

It is not possible to perfectly capture every potential factor that could affect individuals' access to care. While the results in this Section are adjusted for differences in individuals' health, demographic, and socioeconomic characteristics, they do not adjust for other factors such as the availability of transportation to health care providers or for whether or not individuals live in medically underserved areas. To the extent that these challenges are more common among Medicaid enrollees, and not addressed by other characteristics included in the analysis, they may affect the results.

It is worth noting that, regardless of whether the unadjusted or regression-adjusted numbers are used, adults with Medicaid report better access to care than do uninsured adults. The regression adjustments tend to lower the magnitude of the differences; part of the lower use of health care by uninsured adults relates to the fact that they are in better health, on average, than adults with Medicaid.

The regression controls tend to have a smaller impact on the differences between Medicaid enrollees and adults with ESI because the two sets of controls used in the analysis tend to move in opposite directions. For example, controlling for health characteristics tends to increase the likelihood of adults with ESI using health

### **BOX b-1. Selected Studies Comparing Adults' Access in Medicaid to Those with Private or No Insurance, Controlling for Enrollee Characteristics**

Following are examples from the peer-reviewed research literature that evaluate adults' access to care in Medicaid, compared to the uninsured or those with private insurance. The results are based on the standard research approach of using regressions to control for differences in the underlying populations' characteristics.

**Impact of Insurance Status on Access to Care and Out-of-Pocket Costs for U.S. Individuals with Epilepsy (Halpern et al. 2011).** Using MEPS data from 2002–2007, the authors reported that “[w]ith sociodemographic characteristics controlled for, uninsured individuals had significantly fewer outpatient visits, fewer visits with neurologists, and greater antiepileptic drug costs than did those with private insurance. Individuals with Medicaid coverage had similar medical resource utilization rates but lower out-of-pocket costs compared with privately insured individuals.”

**Medical and Dental Care Utilization and Expenditures under Medicaid and Private Health Insurance (Ku 2009).** Using MEPS data from 2005, the author reported that “[a]fter adjustment for health status and other factors, Medicaid adults and children had greater use of prescription drugs than the privately insured, but there were no significant differences in prescription expenditures. Adults on Medicaid had lower utilization of office-based medical and dental care and much lower expenditures than the privately insured. Contrary to stereotypes, there were no significant differences between Medicaid adults and children and the privately insured in emergency, outpatient, or inpatient hospital use, and the former had significantly lower expenditures.”

**Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States (Coughlin et al. 2005).** Using 1999 and 2002 data from the National Survey of America's Families, the authors controlled for demographic, social, and health characteristics and found “simple [unadjusted] differences in access to care between Medicaid and the low-income privately insured to be significant across all six measures examined.... After accounting for individual and area differences, we found few access disparities between Medicaid beneficiaries and the low-income privately insured for the country as a whole.”

**Reconsidering the Effect of Medicaid on Health Care Services Use (Marquis and Long 1996).** Using data from the 1987 National Medical Expenditure Survey and the Survey of Income and Program Participation for 1984–1988, the authors reported comparisons “based on multivariate models of health care use that control for demographic and economic characteristics and for health status.... AFDC [Aid to Families with Dependent Children] Medicaid beneficiaries use considerably more ambulatory care and inpatient care than they would if they remained uninsured. Use among the AFDC Medicaid population is about the same as use among otherwise similar, privately insured persons.”

care, while controlling for demographic and socioeconomic characteristics often decreases their utilization. Thus, the unadjusted and adjusted comparisons between enrollees with Medicaid and ESI can look fairly similar.

**Adults with part-year health insurance coverage excluded from analysis.** The survey measures in this analysis focus on individuals' access to and use of health care over the past year. In order to compare access to care for Medicaid adults to adults with ESI and the uninsured, the

## **BOX b-2. Household Surveys as a Source of Data on Access**

Different types of data—for example, household surveys (as used in this Chapter), provider surveys, and administrative data—provide unique insights on an issue and have both strengths and weaknesses as sources of information. For a complete assessment of access to care, the information provided from any single source, such as household survey data, should be considered in the context of findings from other data sources as well.

### **Strengths of household survey data:**

- ▶ Information is obtained on numerous relevant characteristics that are generally not available from other sources, such as self-reported health status, income, race, and educational attainment.
- ▶ For each of these characteristics, a great amount of detail can be obtained, such as the specific sources and amounts of individuals' income.
- ▶ Individuals provide their own perspectives on the questions to which they are responding, such as whether care was delayed due to costs.
- ▶ National surveys use consistent methods within a given survey, potentially allowing for direct comparisons across states (sample size permitting).
- ▶ Surveys can be structured to explore certain specific issues in depth, such as access to care.

### **Weaknesses of household survey data:**

- ▶ Surveys rely on information as reported by respondents, which may not be accurate.
- ▶ Respondents may feel pressure to provide certain socially acceptable answers (e.g., indicating they had a mammogram even if they did not).
- ▶ Responses are based on subjective perceptions that might not align with objective criteria (e.g., individuals may not be aware that they need a particular type of care and may thus underreport “unmet health care needs”).
- ▶ Such weaknesses may vary systematically according to individuals' source of health insurance, potentially biasing the comparisons between adults on Medicaid and those with ESI or no insurance.
- ▶ Survey data can only answer questions asked in the surveys, which can lack the detail and accuracy available from administrative data on particular issues such as health care spending.

analysis focuses on the subset of adults who were insured or uninsured for the entire year. This ensures that reports about access to care for insured adults, for example, do not actually include parts of the year when they did not have coverage. Similarly, it ensures that reports about access to care for uninsured adults do not include periods when they did have coverage.<sup>4</sup> The movement of individuals in and out of coverage and across sources of coverage has been widely recognized as

an important policy issue and will be explored in future MACPAC analyses.

**Access to certain services excluded from analysis.** The findings in this Section do not include results for certain specific services such as dental care. Dental services are delivered by a unique set of providers and are often financed differently than other types of care. MACPAC plans to produce focused analyses on dental care

and other services in the context of Medicaid and CHIP in the future.

## Enrollees and Their Unique Characteristics

Medicaid and CHIP enrollees differ from the general population in terms of their health, demographic, and socioeconomic characteristics. These differences can influence whether, how, and where adults with Medicaid obtain health care services. The findings on access to care presented in this analysis take into account the unique characteristics of enrollees with Medicaid and how they differ from adults with ESI or no insurance.

**Health characteristics.** Compared to those with ESI or no insurance, adults with Medicaid are more likely to report being pregnant, having a number of chronic conditions (e.g., asthma, diabetes, emphysema, hypertension),<sup>5</sup> facing limitations in their ability to work, and being in fair or poor health (Figure b-1).<sup>6</sup> These results reflect the fact that two of the major Medicaid eligibility pathways for non-elderly adults are for persons with disabilities and for pregnant women. The Commission's March 2012 Report to the Congress focused on Medicaid-enrolled persons with disabilities, whose access to and use of care will be assessed by MACPAC on an ongoing basis (MACPAC 2012).<sup>7</sup> In addition, the Commission has work under way pertaining to pregnant women and their coverage, access, and outcomes in Medicaid.

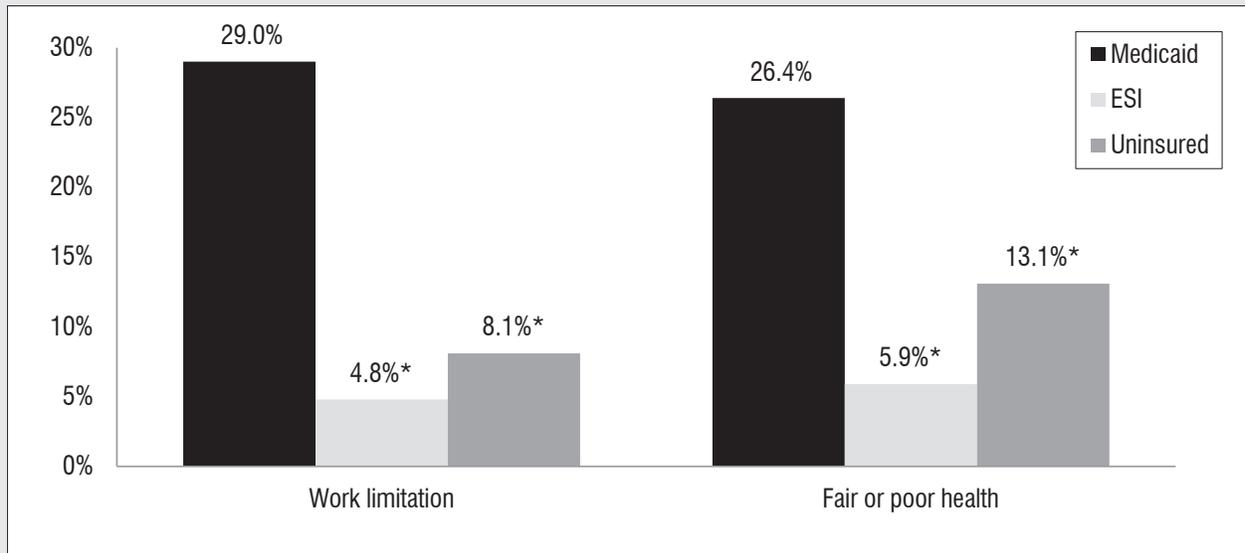
Because adults with Medicaid tend to be in poorer health than individuals with ESI or no insurance, these individuals would be expected to use more health care services. As a result, adults with Medicaid could show higher utilization of health care services, not necessarily because Medicaid provides greater access, but simply because adults with Medicaid are sicker. The findings in

this Section attempt to control for health-related characteristics that make adults without insurance and with ESI differ from adults with Medicaid. Again, these controls ensure that the access and utilization differences that remain are more likely to be attributable to the source of coverage rather than individuals' characteristics.<sup>8</sup>

**Demographic and socioeconomic characteristics.** Adults with Medicaid also differ from other adults in terms of their demographic and socioeconomic characteristics. For example, adults with Medicaid are more likely to have income below the federal poverty level and to be parents of dependent children, compared to adults with ESI and uninsured adults (Figure b-2). This is expected, because having low income is a general prerequisite for Medicaid eligibility and because low-income parents of dependent children comprise another major Medicaid eligibility pathway for non-elderly adults.

As a result of these demographic and socioeconomic differences, adults with Medicaid could show different levels of health care utilization and access to care, not because of their source of coverage, but because of their underlying demographic and socioeconomic characteristics. For example, because adults with Medicaid are significantly more likely to report living below the poverty line than adults with ESI or with no insurance, this analysis attempts to control for income in order to account for differences in levels of access due to income status. Unless noted otherwise, the findings described in the remainder of this Section are based on controlling for health, demographic, and socioeconomic characteristics that make adults with ESI and no insurance differ from adults with Medicaid.<sup>9</sup>

**FIGURE b-1. Personal Health Characteristics of Adults (19–64) by Insurance Status, 2009 (Unadjusted)**

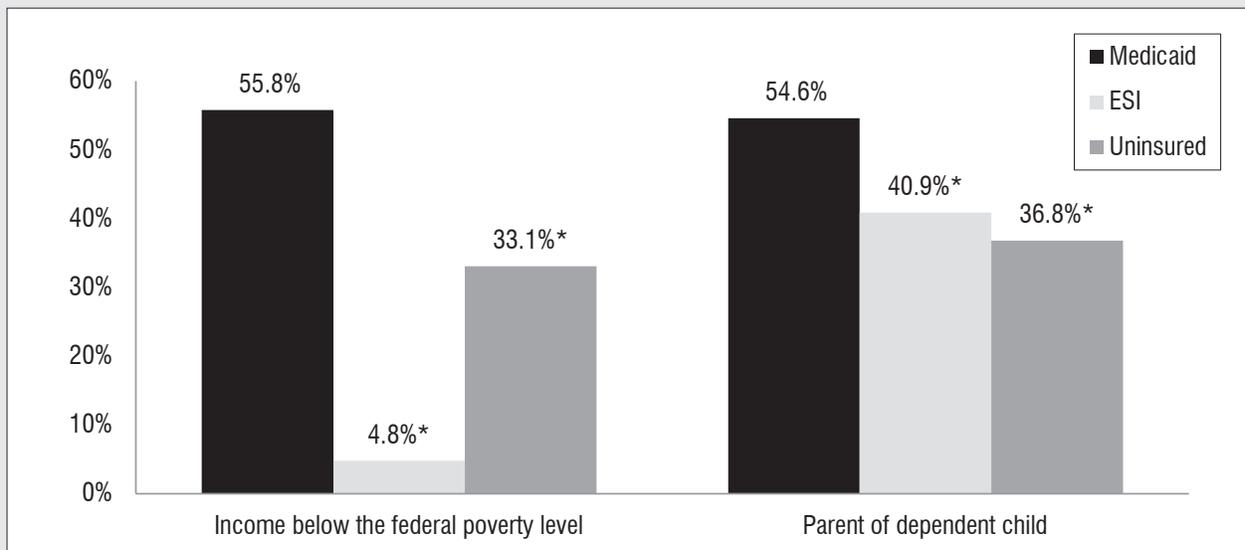


**Notes:** ESI is employer-sponsored insurance. Work limitation is based on whether individuals report that a physical, mental, or emotional problem limits the kind or amount of work they can do. To show how Medicaid adults differ from adults with ESI or no coverage, these numbers are *not* adjusted as elsewhere for the groups' differing health, demographic, or socioeconomic characteristics.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

**FIGURE b-2. Demographic and Socioeconomic Characteristics of Adults (19–64) by Insurance Status, 2009 (Unadjusted)**



**Notes:** ESI is employer-sponsored insurance. Income is measured at the health insurance unit. The federal poverty level is measured using the 2009 U.S. Department of Health and Human Services' poverty guidelines. To show how Medicaid adults differ from adults with ESI or no coverage, these numbers are *not* adjusted as elsewhere for the groups' differing health, demographic, or socioeconomic characteristics.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

## Provider Availability

Availability focuses on whether health care providers are accessible to Medicaid and CHIP enrollees. There are two key factors that influence the availability of providers in a given area:

- ▶ provider supply—for example, the ratio of providers to the population; and
- ▶ provider participation—for example, the proportion of providers in an area that accepts Medicaid and CHIP.

Studies have shown that physicians and other health care providers are disproportionately located in areas where incomes are high and health care is financed predominantly by private insurance; they are less willing to locate in the more rural or low-income areas where many Medicaid enrollees reside (Ricketts and Randolph 2008, Brasure et al. 1999, Fossett and Perloff 1999). Research has also found that communities with high proportions of black and Hispanic residents were much more likely than others to have a shortage of physicians, regardless of the average income in the community (Komaromy et al. 1996). Although overall provider supply may not be affected by federal or state Medicaid policies, providers' willingness to participate in these programs may be affected by a number of factors under states' control, including payment rates and administrative burden for providers.

Because the data used here are from interviews of users of care, rather than providers, they do not directly measure the extent to which providers are available to Medicaid enrollees. Other sources of data such as provider surveys can produce more information on access as measured by provider availability and are being used in analyses that MACPAC is currently conducting. However, there are several measures available in household survey data that indirectly measure whether providers are available to the individuals being surveyed. For

example, whether an enrollee reports having a USC may be the result of multiple influences, but one important factor is whether the enrollee is able to find a provider to serve as a USC.

**The vast majority of adults with Medicaid have a USC.** A USC is defined as the place where a person typically goes when sick or in need of health-related advice. For the analyses in this Section, the emergency department is not considered a USC. Nearly 90 percent of adults with Medicaid (88.1 percent) and similarly situated adults with ESI (86.9 percent) were reported to have had a USC, compared to 45.7 percent of similarly situated uninsured adults (Figure b-3).

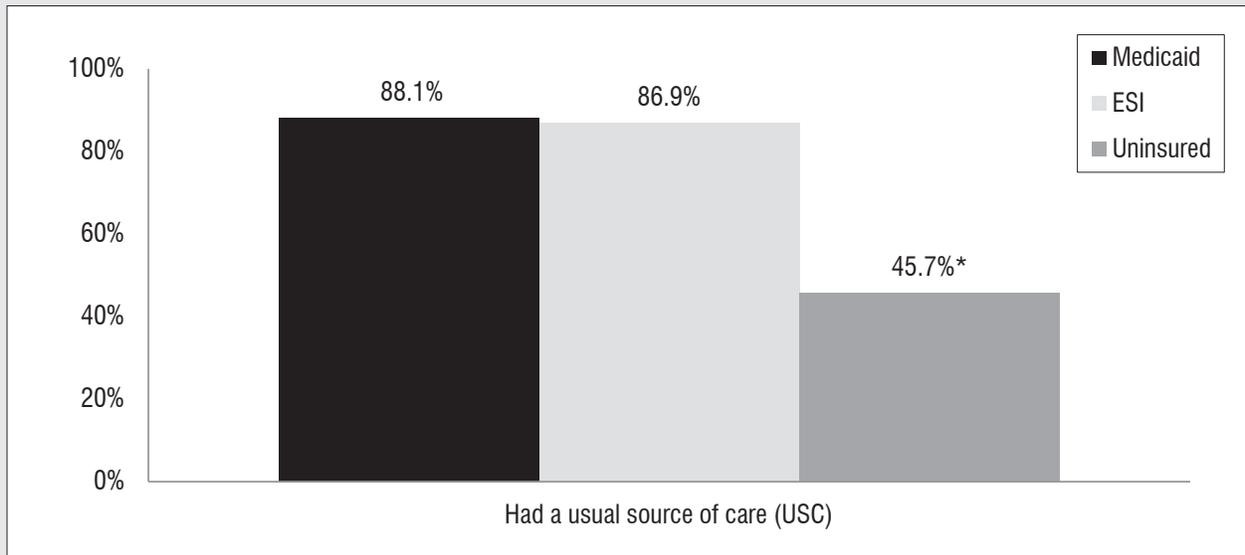
### Adults with Medicaid differ in their USC.

Among adults with a USC, most have a doctor's office as their USC, regardless of whether they are enrolled in Medicaid or ESI. Previous research has found that Medicaid enrollees disproportionately rely on providers at community health centers for primary care services (Hing and Uddin 2008). This is consistent with the findings in Figure b-4, which show that, even after accounting for differences in the health, demographic, and socioeconomic status of adults with a USC, adults with Medicaid are more likely to have a clinic or health center as their USC, compared to adults with ESI.<sup>10</sup> Uninsured adults with a USC are even more likely than adults with Medicaid to rely on clinics and health centers as their USC.

**Reasons for delaying needed medical care vary with insurance status.** After accounting for differing enrollee characteristics, adults with Medicaid and those with ESI reported similar rates of delayed medical care (Table b-2).

As previously mentioned, the findings in this Section rely on comparisons of adults with Medicaid to similarly situated adults with ESI by controlling for a variety of characteristics that might influence access to care. When comparing

**FIGURE b-3. Usual Source of Care among Similarly Situated Adults (19–64) by Insurance Status, 2009**

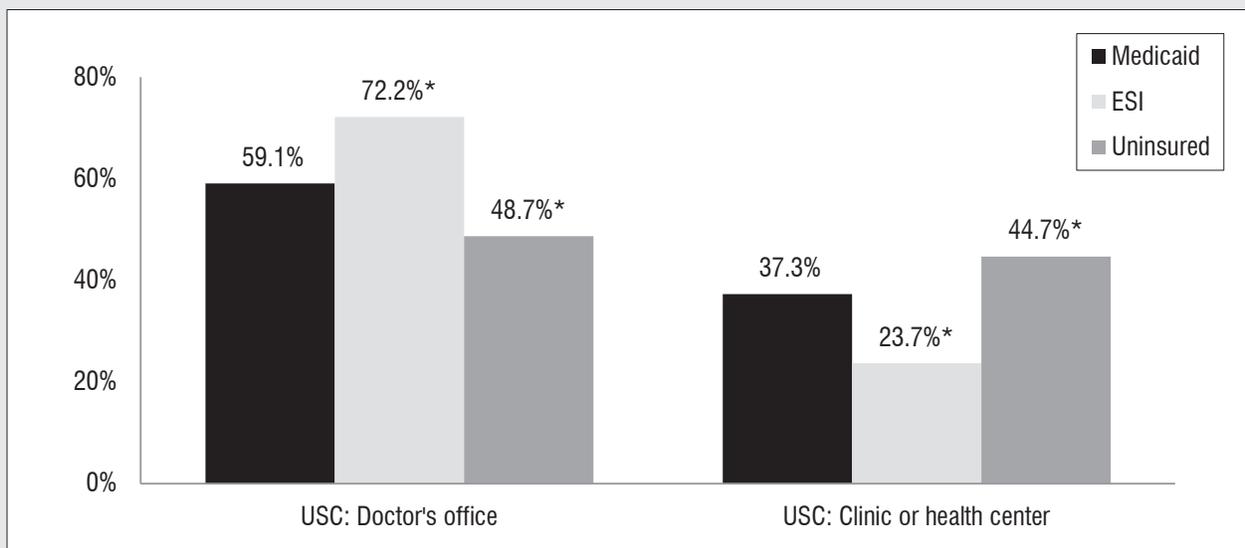


**Notes:** ESI is employer-sponsored insurance. Usual source of care (USC) is defined as the place that the person usually goes to when sick or in need of health-related advice; the emergency department is not considered a USC. The means reported for adults with ESI coverage and for uninsured adults are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the adults with Medicaid.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

**FIGURE b-4. Type of Usual Source of Care (USC) among Similarly Situated Adults (19–64) with a USC by Insurance Status, 2009**



**Notes:** ESI is employer-sponsored insurance. Usual source of care (USC) is defined as the place that the person usually goes to when sick or in need of health-related advice; the emergency department is not considered a USC. See Figure b-3 for overall rates of adults having a USC. Doctor's office includes an HMO. Clinic or health center does not include hospital outpatient departments. The means reported for adults with ESI coverage and for uninsured adults are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the adults with Medicaid.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

the two groups without controlling for their differing characteristics, adults with ESI were less likely to have delayed care (16.4 percent, as shown in Table 6 of the MACPAC Contractor Report’s technical appendix) than adults with Medicaid (24.2 percent)—a difference of 7.8 percentage points. When controlling only for the populations’ differing health characteristics, the difference between the two groups reverses; if adults with ESI had as many health needs as adults with Medicaid, 25.6 percent would have delayed care, a higher number (but a statistically insignificant difference) than the 24.2 percent for Medicaid-enrolled adults. In this particular case, also controlling for demographic and socioeconomic characteristics does not change the result; there is still no significant difference in reported delayed medical care between adults with Medicaid and similarly situated adults with ESI. This may indicate that delaying needed medical care reflects challenges faced by adults with more serious, chronic health conditions, regardless of their health insurance status.

**Adults with Medicaid are less likely than adults with ESI or the uninsured to report delaying medical care because of worries about out-of-pocket costs.** When asked why care was delayed, adults with Medicaid reported lower levels of delaying medical care because of worries about out-of-pocket costs compared to similarly situated adults with ESI and uninsured adults (Table b-2). This is most likely related to the requirement that adults generally face little or no cost sharing in Medicaid (MACPAC 2012, MACStats Table 13). However, worries about cost were more commonly cited for Medicaid-enrolled adults than for children (1.6 percent, MACPAC 2012), since children enrolled in Medicaid are generally exempt from any cost-sharing (42 CFR 447.53(b)(1)).

**Adults with Medicaid report challenges with office waiting times and transportation.** For adults with Medicaid and with ESI, similar rates were reported for delaying medical care because of difficulty in obtaining an appointment soon

**TABLE b-2. Delayed Medical Care among Similarly Situated Adults (19–64) by Insurance Status, 2009**

	Medicaid	ESI	Uninsured
<b>Delayed medical care (any reason below)</b>	<b>24.2%</b>	<b>25.6%</b>	<b>47.3%*</b>
Because once at the site, wait too long to see the doctor	9.8	7.3*	8.5
Because could not get an appointment soon enough	9.6	7.9	7.1*
Because of out-of-pocket costs	8.3	13.6*	38.7*
Because did not have transportation	8.2	5.1*	5.5*
Because could not get through on the phone	5.4	4.7	4.4
Because could not go when open (office hours)	4.7	4.5	4.3

**Notes:** ESI is employer-sponsored insurance. The means reported for adults with ESI coverage and for uninsured adults are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the adults with Medicaid.

\* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

enough, getting through on the phone, or going during office hours (Table b-2). Adults enrolled in Medicaid were more likely to have delayed care because the wait for the doctor in the office was too long or because they did not have transportation.

**Timeliness and ease of obtaining health care are reported to be comparable by adults with Medicaid and similarly situated adults with ESI, but uninsured adults report worse results.** For the following four measures, there were no significant differences between adults with Medicaid and similarly situated adults with ESI; however, the uninsured reported significantly worse results:

- ▶ **Timeliness of needed health care.** Among adults who had a condition that needed health care right away, 77.6 percent of these adults with Medicaid were reported to have received care as soon as it was needed, compared to 83.6 percent of similarly situated adults with ESI and 65.4 percent of uninsured adults.
- ▶ **Appointments for routine care.** Among adults who had appointments for routine care, an appointment was reported to be available as soon as was needed for 80.1 percent of these adults with Medicaid, compared to 77.6 percent of similarly situated adults with ESI and 69.8 percent of uninsured adults.
- ▶ **Ease of obtaining care and tests.** Among adults who needed care, tests, or treatments, it was reported to be easy for 82.2 percent of these adults with Medicaid to get such care, compared to 85.1 percent of similarly situated adults with ESI and 65.6 percent of uninsured adults.
- ▶ **Ease of obtaining specialty care.** Among adults who needed to see a specialist, it was reported to be easy for 69.2 percent of adults with Medicaid to see the necessary specialist, compared to 75.7 percent of similarly situated

adults with ESI and 56.6 percent of uninsured adults.

For these four measures (and many others), adults were more likely to report issues compared to the results reported for children (MACPAC 2012), regardless of health insurance status.

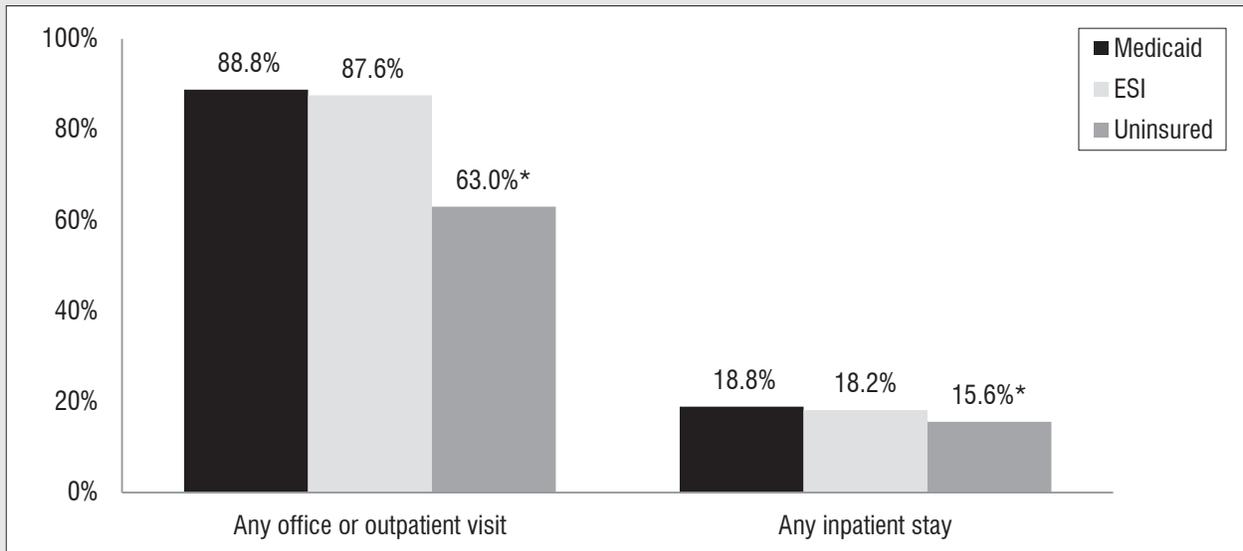
## Utilization of Health Care Services

By itself, insurance coverage does not guarantee the receipt of necessary or appropriate services. Thus utilization, the third component of the Commission's framework on access, assesses enrollees' use of services and how they perceive their experiences with obtaining care and interacting with their providers. Utilization is "realized access," or how services are actually used by individuals. Findings on utilization of care by adults enrolled in Medicaid, compared to similarly situated adults with ESI and with no coverage, are shown below.

**Adults with Medicaid are as likely to report an office or outpatient visit in the past year as similarly situated adults with ESI and more likely than uninsured adults.** As shown in Figure b-5, the likelihood of having any visit in the past year in an office or outpatient setting was comparable for adults with Medicaid and similarly situated adults with ESI. Adults with Medicaid reported significantly more use of ambulatory care than similarly situated uninsured adults across a variety of measures.<sup>11</sup>

**Adults with Medicaid are as likely to report an inpatient stay in the past year as similarly situated adults with ESI and more likely than uninsured adults.** As shown in Figure b-5, the likelihood of having an inpatient hospital stay in the past year was comparable for adults with Medicaid and similarly situated adults with ESI.

**FIGURE b-5. Any Ambulatory and Inpatient Care in the Past 12 Months among Similarly Situated Adults (19–64) by Insurance Status, 2009**

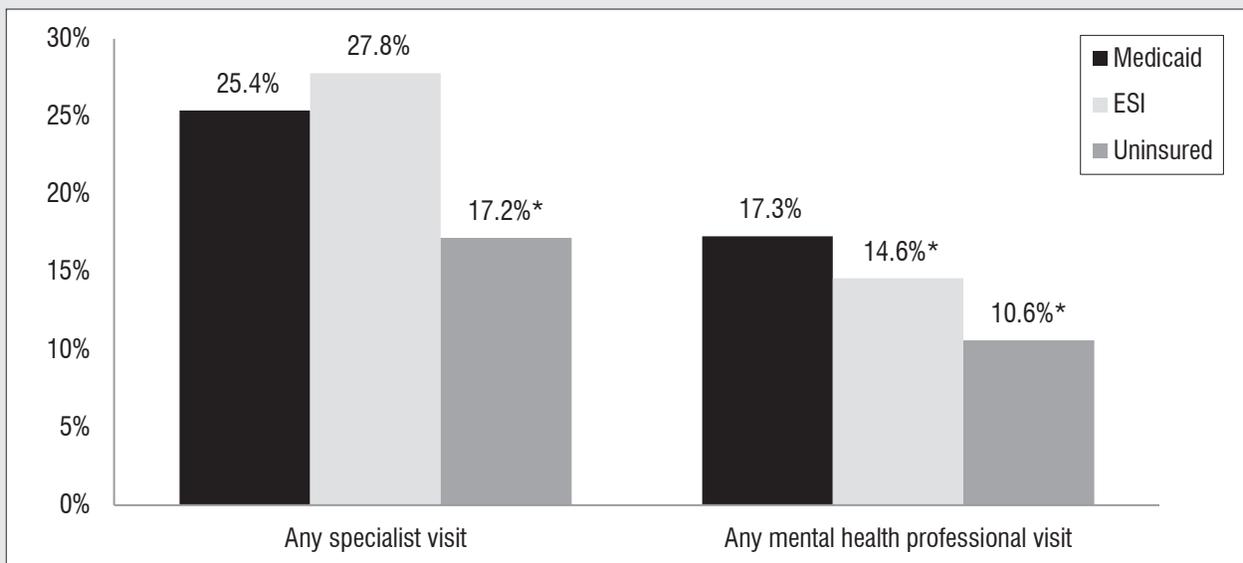


**Notes:** ESI is employer-sponsored insurance. The means reported for adults with ESI coverage and for uninsured adults are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the adults with Medicaid.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

**FIGURE b-6. Any Specialist Visit in the Past 12 Months among Similarly Situated Adults (19–64) by Insurance Status, 2009**



**Notes:** ESI is employer-sponsored insurance. Specialists include medical doctors who specialize in a particular medical disease or problem (excluding OB/GYNs, psychiatrists, and ophthalmologists). The means reported for adults with ESI coverage and for uninsured adults are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the adults with Medicaid.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

Adults with Medicaid were significantly more likely to have reported an inpatient stay compared to similarly situated uninsured adults.

**Adults with Medicaid and similarly situated adults with ESI receive mammograms and flu vaccines at comparable rates, but uninsured adults receive this preventive care less often.**

Adults with Medicaid reported receiving flu vaccines at rates similar to adults covered by ESI (29.9 percent vs. 33.7 percent) and higher than uninsured adults (20.8 percent). This was also the case with respect to mammograms for females 30 and older (35.8 percent Medicaid, 38.8 percent ESI, 19.2 percent uninsured).

**Likelihood of a specialist visit in the past year is comparable among adults with Medicaid and similarly situated adults with ESI, but not for uninsured adults.**

As shown in Figure b-6, the likelihood of having a visit to a specialist in the past year was comparable for adults with Medicaid and similarly situated adults with ESI. Adults with Medicaid were significantly more likely to have reported a specialist visit than similarly situated uninsured adults.<sup>12</sup>

However, adults with Medicaid were significantly more likely to have reported a visit to a mental health professional than similarly situated adults with ESI (and with no coverage).<sup>13</sup> This may be related to less generous coverage of mental health benefits in ESI, particularly for small employers, compared to Medicaid.

Whether individuals had a specialist visit in the past year provides another example of the effect of controlling for differing enrollee characteristics. When comparing adults with Medicaid to adults with ESI *without* controlling for their differing characteristics, adults with ESI are as likely to have had a specialist visit (26.5 percent, as shown in Table 6 of the MACPAC Contractor Report's technical appendix) as adults with Medicaid

(25.4 percent). When controlling *only* for the populations' differing health characteristics, adults with ESI are *more* likely to have had a specialist visit (33.9 percent); if adults with ESI had as many health needs as adults with Medicaid, they would be much more likely to have visited a specialist. However, after controlling for demographic and socioeconomic characteristics, in addition to differing health characteristics, the significant differences disappear with respect to a specialist visit, as shown in Figure b-6. This may indicate that accessing specialty care is a challenge for low-income adults, regardless of their health insurance status.

This measure does not assess the extent to which specialty care was needed, nor whether adults received all necessary specialty care. For example, if individuals enrolled in Medicaid and ESI were equally as likely to have visited a cardiologist, the results cannot be interpreted to indicate whether or not individuals with Medicaid or ESI were more likely to have received a needed procedure, such as a stent. Rather, it is a simple measure of whether a visit to a specialist was reported by the individual. This sole measure cannot be used to indicate whether or not adults with Medicaid face challenges in obtaining access to needed specialty care, but must also be placed in the context of information from other sources, such as provider surveys and claims data. For example, although the results were specific to children, the Government Accountability Office recently conducted a survey in which physicians were more than three times as likely to report difficulty with referrals to specialty care for Medicaid/CHIP children (84 percent) compared to privately insured children (26 percent). For both Medicaid/CHIP and private insurance, physicians reported particular problems for children needing specialty referrals for mental health, dermatology, and neurology (GAO 2011a).

**Regardless of patients' source of health insurance, health care providers were reported to listen carefully and spend enough time with their patients.**

The vast majority of adults who had at least one visit to a health care provider's office or clinic in the past 12 months reported positive interactions with the provider. For similarly situated adults in all three insurance groups, most indicated that the provider usually or always listened carefully, explained things in a way that was easy to understand, showed respect, and spent enough time with them (Figure b-7). Interestingly, these numbers were all lower for adults, compared to the results reported by parents for their children (MACPAC 2012).

As previously noted, these measures are based on the perceptions of respondents who obtained care. The surveys do not identify, for example, the amount of time the provider actually spent with the respondent, only whether respondents considered it to be "enough." Respondents may have different expectations for how much time is "enough" that vary with their type of insurance or other characteristics, which could affect their responses and these results.

**Adults with Medicaid have the highest rates of emergency department (ED) visits.** Although ED care is necessary for some conditions, utilizing EDs for non-emergent care is generally more costly and provides fewer opportunities for follow up than if the underlying condition were treated by a primary care provider (GAO 2011b). A high rate of ED use may indicate that individuals are not receiving care in the optimal setting.

The survey results show that adults with Medicaid are much more likely than similarly situated uninsured adults and adults with ESI to have had an ED visit and to have had multiple ED visits in the past 12 months (Figure b-8). The greater utilization of EDs among Medicaid enrollees is well documented in the research literature and

confirmed in this analysis. This may be due in part to their perceived long wait times in the office to see their providers (Table b-2) and the low Medicaid cost-sharing requirements for ED visits.

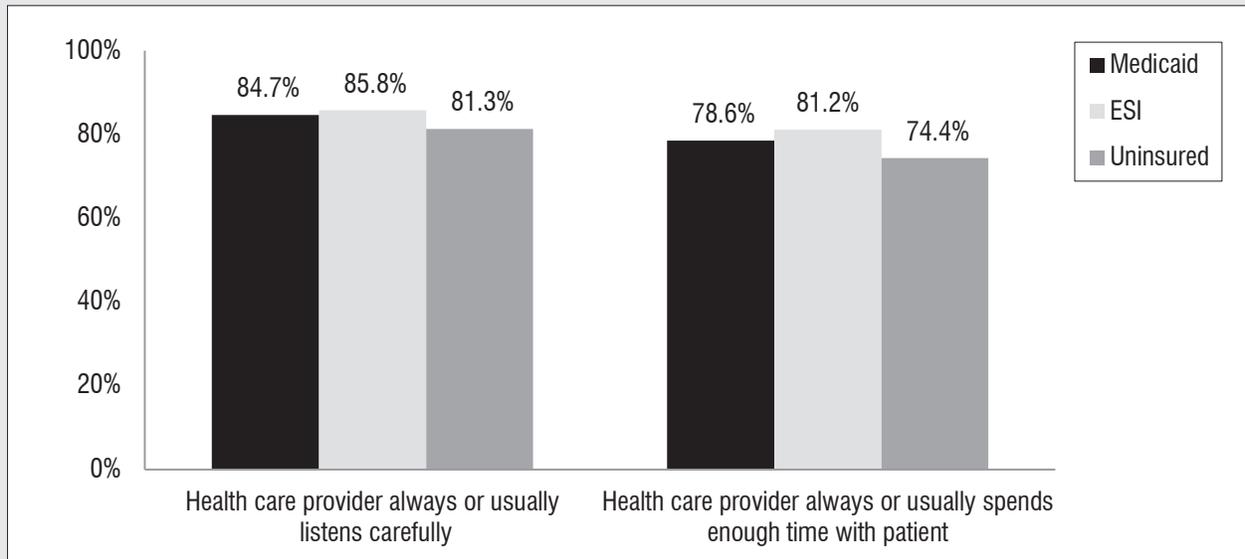
In addition, provisions related to the Emergency Medical Treatment and Active Labor Act (EMTALA) require that Medicare-participating hospitals maintain a list of specialists who are on call to the emergency department.<sup>14</sup> Thus, individuals may go to an ED if they feel it is their only viable option to obtain needed specialty care. While these findings indicate comparable reported levels of delayed care for adults with Medicaid and similarly situated adults with ESI (Table b-2), prior research has found that when individuals with Medicaid and with private insurance experience comparable barriers to care, it is more likely to increase ED utilization for Medicaid enrollees than for those with private coverage (Cheung et al. 2012). Research has also found a correlation between reductions in Medicaid physician fees and increased ED usage (Decker 2009).

More analysis is needed to understand what may be causing higher rates of ED use among Medicaid enrollees, whether or not such ED use is appropriate, and whether or not the higher rates are a reflection of problems with access to primary or specialty care. As part of its research agenda, MACPAC plans more in-depth analyses of Medicaid enrollees' ED usage.

## Looking Forward

Prior studies have shown that insurance coverage improves access to care compared to being uninsured, and the findings in this Section are consistent with that earlier research (IOM 2009, Hargraves and Hadley 2003). Other studies have examined the impact of Medicaid and CHIP relative to ESI or private insurance on access to care and had generally similar findings to those

**FIGURE b-7. Patient-centered Measures among Similarly Situated Adults (19–64) with a Health Professional Visit in the Past 12 Months by Insurance Status, 2008**

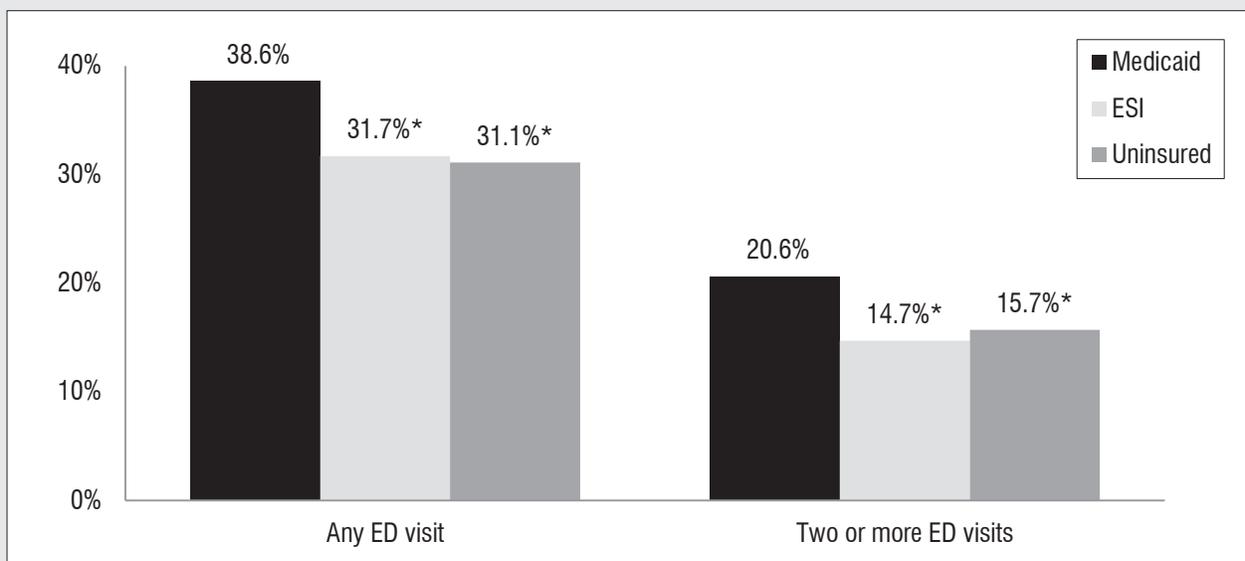


**Notes:** ESI is employer-sponsored insurance. Questions only asked of adults that had at least one doctor or health care professional visit in the past 12 months. The means reported for adults with ESI coverage and for uninsured adults are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the adults with Medicaid.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2008 Medical Expenditure Panel Survey (MEPS)

**FIGURE b-8. Emergency Department Visits among Similarly Situated Adults (19–64) by Insurance Status, 2009**



**Notes:** ESI is employer-sponsored insurance. The means reported for adults with ESI coverage and for uninsured adults are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the adults with Medicaid.

\* Statistically different from Medicaid at the (.05) level, two-tailed test.

**Source:** Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

shown here (Halpern et al. 2011, Ku 2009, Selden and Hudson 2006, Coughlin et al. 2005, Long et al. 2005, Dubay and Kenney 2001, Marquis and Long 1996).

Using its framework for examining access to care, the Commission will continue to explore access in Medicaid and CHIP. The Commission also plans to explore in greater depth particular issues pertaining to access, including oral health, geographic variation by state and by rural and urban status, individuals' shifts in and out of Medicaid, the relationship between payment policy and access, and trends over time.

## Endnotes

- 1 Additionally, more detailed information is presented in this Section's Annex and in MACPAC Contractor Report No. 2 (Long et al. 2012), which was the basis of the findings presented in this Section. The MACPAC Contractor Report is available at [www.macpac.gov/publications](http://www.macpac.gov/publications).
- 2 Although CHIP covers adults in a handful of states, the numbers are so small compared to Medicaid that the discussion in this Section uses "Medicaid" to refer to adults enrolled in Medicaid or CHIP.
- 3 In the NHIS analysis, ESI coverage is defined as coverage through an employer (including self-employed), union, or the military (TRICARE/CHAMPVA). In the MEPS analysis, ESI is defined as private group coverage through an employer or union, self-employed coverage, or the military (TRICARE/CHAMPVA).
- 4 The coverage categories used in this report are as follows for the NHIS: (1) full-year uninsured, (2) full-year insured with Medicaid at the time of the survey (and not with ESI or Medicare at the time of the survey), and (3) full-year insured with ESI at the time of the survey. While the full-year insurance variables are defined over a 12-month period, some of the adults in the ESI category may have had Medicaid or other types of coverage over the course of the year; likewise, some of those in the Medicaid category may have had ESI coverage over the course of the year. The coverage categories for the MEPS are: (1) full-year uninsured, (2) full-year Medicaid coverage, and (3) full-year ESI coverage.
- 5 The survey results on chronic conditions are based on whether individuals were ever told by a medical professional that they had the condition. Uninsured individuals may report lower prevalence of chronic conditions because they have undiagnosed health problems related to the fact that they do not see health care providers as regularly.
- 6 The survey results on work limitations are based on whether individuals report that a physical, mental, or emotional problem limits the kind or amount of work they can do.
- 7 Building on this work focused on Medicaid-only persons with disabilities, additional analyses were produced for this Section in order to compare Medicaid enrollees with and without a Supplemental Security Income (SSI). These results are described in the MACPAC Contractor Report (Long et al. 2012). Similar to the findings presented in March, the unadjusted results show that adults enrolled in Medicaid and SSI report poorer health status, more health conditions, and greater utilization of health care when compared to non-SSI Medicaid adults.
- 8 The MACPAC Contractor Report (Long et al. 2012) describes in detail the adjustments used, which are consistent with methods used by the Institute of Medicine in examining differences in access to care among different racial/ethnic population groups (IOM 2002).
- 9 The MACPAC Contractor Report (Long et al. 2012) also shows the findings without these adjustments.
- 10 "Clinic or health center" does not include hospital outpatient departments.
- 11 See Table 8 of the MACPAC Contractor Report's technical appendix for additional measures.
- 12 These results are based on individuals' response to the following: "During the past 12 months, have you seen or talked to any of the following health care providers about your own health? A medical doctor who specializes in a particular medical disease or problem (other than obstetrician/gynecologist [OB/GYN], psychiatrist, or ophthalmologist)." Additional analyses found that if OB/GYNs were included for specialist visits, the numbers in Figure b-6 for a specialist visit in the past 12 months would be 50.4 percent for Medicaid-enrolled adults, 51.6 percent for adults with ESI (not significantly different from Medicaid), and 35.2 percent of uninsured adults (significantly lower than Medicaid). Additional statistics are shown in Tables 6 and 8 of the MACPAC Contractor Report's technical appendix.
- 13 These results are based on individuals' responses to the following: "During the past 12 months, have you seen or talked to any of the following health care providers about your own health? A mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker."
- 14 §1866(a)(1)(I)(iii) of the Social Security Act (the Act), although the primary provisions of Emergency Medical Treatment and Active Labor Act are in §1867 of the Act.

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## Section B Annex

### Summary of Data Sources and Methods for the Analysis of Adults' Access to Care

This Annex gives a brief overview of the data sources and the analytic approach used to produce the statistical analysis presented in Section B regarding non-institutionalized civilian adults age 19 to 64. The data sources and analytic approach are nearly identical to those used for children in the Commission's March 2012 Report to the Congress (MACPAC 2012). More detailed information is presented in the MACPAC Contractor Report that was the basis of the findings presented here (Long et al. 2012).

### Sources of Data

The results presented in this Section are from publicly available data from two national household surveys that are administered annually by the federal government—the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS). The core survey responses were provided by a knowledgeable adult in the household. Although state-specific estimates may be available for some of the largest states, neither the NHIS nor the MEPS permits state-level estimates for all 50 states. Thus, these estimates do not provide information on state-level differences in access to care or on the factors that drive differences across states.

**NHIS.** The NHIS (2009) is the primary source of data used in this analysis because it provides great detail on individuals' health while also providing some of the most reliable estimates of individuals' sources of health insurance coverage (Plewes 2010). The NHIS is an annual face-to-face household survey of civilian non-institutionalized individuals and is designed to monitor the health of the U.S. population through the collection of information on a broad range of health topics. Administered by the National Center for Health Statistics within the Centers for Disease Control and Prevention, the NHIS consists of a nationally representative sample from approximately 35,000 households with about 87,500 people (CDC 2010). The NHIS is fielded continuously throughout the year, with data collected through an in-person household interview using computer-assisted personal interviewing technology. The NHIS employs a complex, multistage sample design and includes an oversample of minority populations, including African American, Hispanic, and Asian American respondents.

The NHIS Basic Module remains relatively constant over time and consists of the Family, Sample Adult, and Sample Child Core components. For the Family Core

component, information is collected for each member of the household. One sample child (if any children under age 18 are present) and one sample adult are randomly selected from each household to collect more detailed information for the Sample Child Core and the Sample Adult Core components. Responses to the Sample Adult Core questionnaire are generally provided by the selected adult; however, if the person cannot respond due to a physical or mental condition, a knowledgeable adult residing in the household may provide responses. The Sample Adult and Sample Child questionnaires differ on some items, but both collect basic information on health status and health care service use.

**MEPS.** The MEPS (specifically, its household component) is used in this Section to provide estimates not available from the NHIS. The sample frame for the MEPS is drawn from a subsample of households participating in the previous year's NHIS. Like the NHIS, the MEPS is a face-to-face household survey of civilian non-institutionalized individuals. Administered by the Agency for Healthcare Research and Quality, the MEPS consists of a nationally representative sample, with about 12,300 households and about 31,000 people in 2008 (AHRQ 2010). The full-year consolidated MEPS datafile for 2008 was used in this Section.

The MEPS collects data through an overlapping panel design. A new panel of sample households is selected each year, and data for each panel are collected for two calendar years. The two years of data for each panel are collected in five rounds of interviews that take place over a two-and-a-half-year period. A single household respondent reports information for the entire household through in-person household interviews using CAPI technology. The survey collects detailed information on health care use, expenditures, sources of payment, and health insurance coverage for all household members. The MEPS also

provides estimates of health status, demographic and socioeconomic characteristics, and access to health care.

## Analytic Approach

These findings were generated using a standard regression model that controls for factors in addition to health insurance status. In this case, the goal was to determine how reported measures of access to and use of health care differ based on adults' insurance coverage, controlling for numerous other characteristics using regression models. Those characteristics are:

- ▶ health-related characteristics, such as age, gender, health status, presence of certain chronic conditions (e.g., asthma, diabetes, hypertension), and disability;
- ▶ additional demographic characteristics, such as race and ethnicity; and
- ▶ socioeconomic characteristics, such as income, education, and citizenship.

Additional analyses in the MACPAC Contractor Report show unadjusted as well as regression-adjusted differences in access and use among adults with Medicaid, ESI, and no insurance coverage. Two multivariate regression model specifications were used to capture differences related to two types of factors. For the first set of models, based on Institute of Medicine recommendations (IOM 2002), the analyses controlled for differences in health status. For adults, these factors were age, gender, self-reported health and mental health status, chronic conditions, disability status, pregnancy, and body mass index. The second set of factors included additional variables that capture demographic and socioeconomic characteristics. The additional variables were race, ethnicity, citizenship, marital and parental status, educational attainment, employment, family income, homeownership, family size, and the health and

disability status of other family members. These are the results presented in this Section.

Even with these adjustments, the differences in access that persist may not necessarily be wholly attributable to insurance status. There may be other relevant variables that could not be controlled for in this analysis. For example, whether or not a person lived in a Metropolitan Statistical Area is not available on the publicly available NHIS data, even though it is collected through the survey. There may be additional unobserved factors related to health status, health-seeking behavior, and socioeconomic status that influence both insurance status and access to care.