

Insight on the Issues***Monitoring the Impact of Health Reform on Americans Ages 50–64:*****Access to Health Care Improved during Early ACA Marketplace Implementation**

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This *Insight on the Issues* is the latest in a series that looks at the experience of 50- to 64-year-olds during implementation of the Affordable Care Act (ACA).

New data from the Urban Institute and the AARP Public Policy Institute show improvements in key measures of access to health care for 50- to 64-year-olds over the first two open enrollment periods of the Affordable Care Act (ACA). Between December 2013 and March 2015, the share of 50- to 64-year-olds with a usual source of health care other than emergency rooms increased. Concurrently, the share who reported having a problem accessing health care decreased.

These measures of health care access improved most in states that chose to expand their Medicaid programs under the ACA. However, despite these early improvements, certain vulnerable populations remain more likely to experience difficulties accessing care.

HEALTH COVERAGE CORRELATED WITH IMPROVED ACCESS AND BETTER HEALTH OUTCOMES

Health insurance coverage is associated with improved access to and use of health care (Institute

of Medicine 2009; Artiga et al. 2015). Our previous paper in this series reported a 47 percent reduction in the uninsured rate among 50- to 64-year-olds between December 2013 and March 2015 (Skopec et al. 2015). Several measures of access to care improved alongside increases in coverage, as examined in this paper.

Access to health care and health insurance coverage are important to addressing health care needs and improving health outcomes among 50- to 64-year-olds. Prior research has shown that an estimated 64 percent of adults ages 50–64 suffer from a chronic condition (Collins, Doty, and Garber 2010). Uninsured adults with chronic conditions such as hypertension and diabetes are more likely to have their conditions underdiagnosed or poorly controlled and are more likely to suffer poor outcomes than those with insurance (Institute of Medicine 2009). Health coverage also increases the likelihood of having a usual source of care. One



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study found that adults with a usual source of care and health care provider were more likely to receive preventive care such as cancer screenings and flu shots (Blewett et al. 2008). Other studies found that adults without a usual source of care are less likely to receive treatment for hypertension or high cholesterol (Spatz et al. 2010) and are more likely to have poorly controlled diabetes (Ali et al. 2012).

RESULTS

Access to Care Improved for 50- to 64-Year-Olds

Between December 2013 and March 2015, over the first two ACA Marketplace open enrollment periods, key measures of access to health care improved. The share of 50- to 64-year-olds with a usual source of care other than emergency departments increased from 78.9 percent to 82.4 percent (figure 1). Over

the same period, the share of 50- to 64-year-olds reporting a problem accessing care dropped from 16.8 percent to 14.5 percent, and the share experiencing a delay in care due to difficulty getting an appointment dropped from 11.7 percent to 9.4 percent (figure 2). These improvements were concentrated in states that chose to expand eligibility for their Medicaid programs under the ACA (not shown), where the uninsured rate was lowest in March 2015.¹

Despite overall improvements in access between December 2013 and March 2015, there was no change in some access measures. In March 2015, while 73.4 percent of 50- to 64-year-olds reported having a routine medical checkup within the prior 12 months, this was not a significant change from December 2013 (not shown). Similarly, between

FIGURE 1
50- to 64-Year-Olds with a Usual Source of Care in December 2013 and March 2015

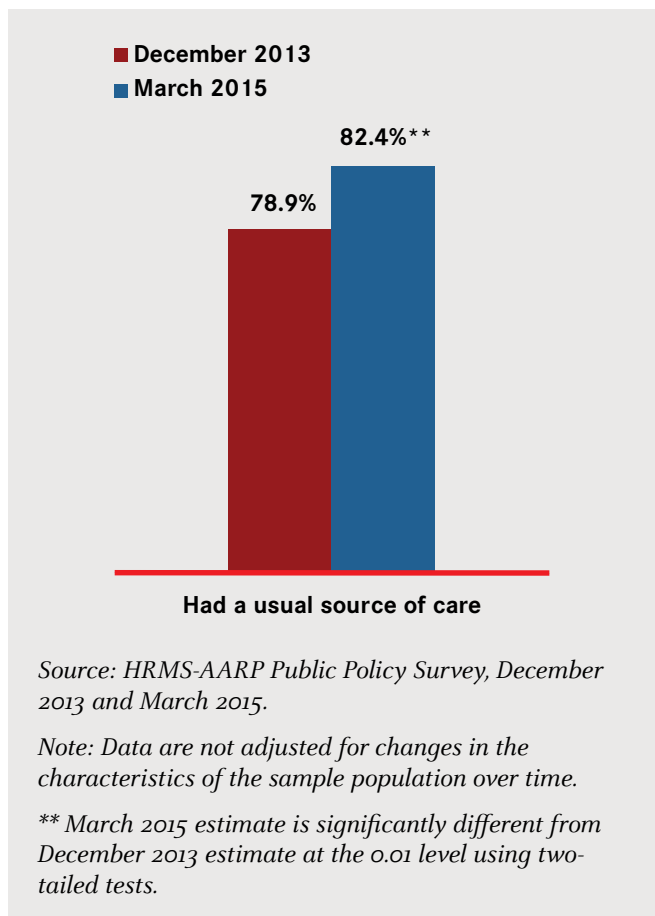
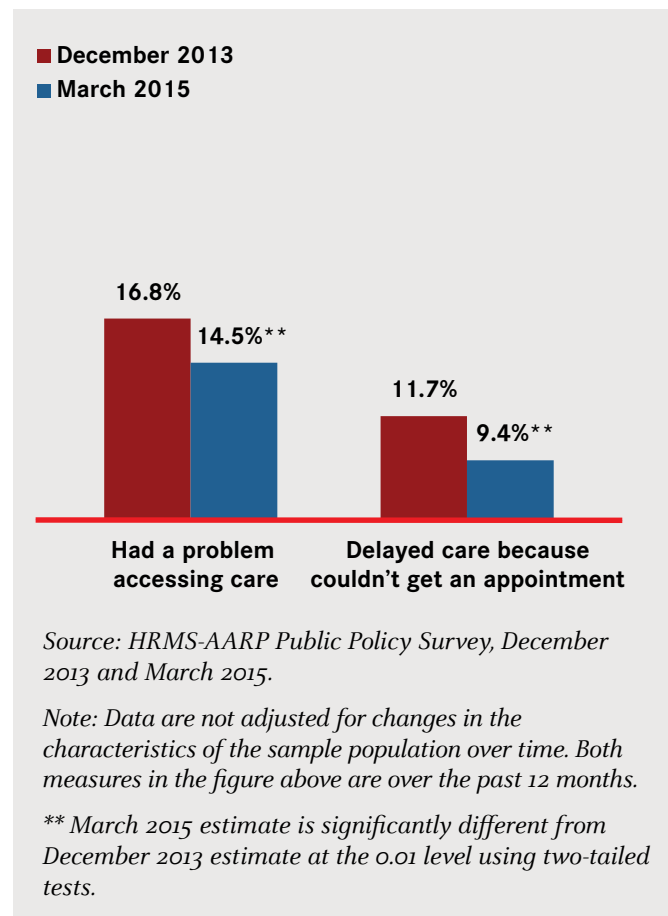


FIGURE 2
50- to 64-Year-Olds with Trouble Accessing Care in December 2013 and March 2015



December 2013 and March 2015, the share of 50- to 64-year-olds who reported having trouble finding a doctor with availability, who were told a doctor's office was not accepting new patients, or who were told a doctor's office did not accept their insurance type also did not change significantly.²

Individuals with Continuous Health Insurance Coverage Have Better Access to Care

As of March 2015, 50- to 64-year-olds with continuous coverage (insurance all year) were more likely than those with no insurance or insurance for only part of the year to have a usual source of care other than emergency rooms and to have had a routine checkup in the past 12 months (figure 3).

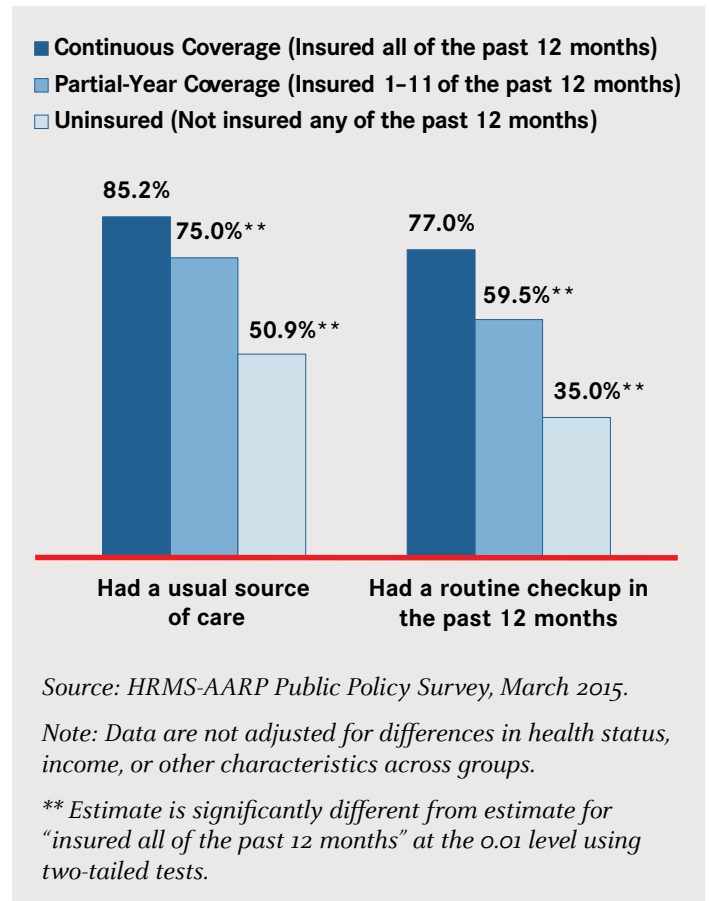
However, even with continuous coverage, a sizable portion of 50- to 64-year-old adults still report difficulty accessing health care services. Nearly 14 percent (13.9 percent) of 50- to 64-year-olds with continuous coverage report having a problem accessing care, and 9.3 percent report delaying care due to difficulty getting an appointment (not shown). Although these figures were higher for those with no insurance coverage or insurance for only part of the year, these numbers suggest that health insurance coverage is not the only factor that affects access to care.

Some Groups Still Experience More Difficulty Accessing Care

Certain subgroups of 50- to 64-year-olds remain less likely to have a usual source of care or are more likely to report difficulty in accessing care. These disparities exist even among those with continuous health insurance coverage (appendix table 1). In our March 2015 survey, we found these disparities:

- **Hispanics:** Insured Hispanics were less likely than insured non-Hispanic whites and blacks to report having a usual source of care other than emergency rooms. In fact, between December 2013 and March 2015, the data showed no significant improvements in this measure of access to care for Hispanic 50- to 64-year-olds.
- **Individuals with family incomes at or below 138 percent of the Federal Poverty Level (FPL):** Insured 50- to 64-year-olds with family incomes at or below 138 percent of the FPL were more

FIGURE 3
Access to Care Measures for 50- to 64-Year-Olds with Continuous Coverage as of March 2015



likely to report having experienced a problem accessing care than those with incomes over 138 percent of the FPL.

- **Individuals in fair or poor health:** Nearly a quarter (22.7 percent) of insured 50- to 64-year-olds in fair or poor health reported having a problem accessing care, compared with 9.8 percent of those in excellent or very good health.
- **Individuals with public coverage:** 50- to 64-year-olds with public coverage (Medicare and Medicaid) were more likely to report a problem accessing care than those with private coverage. They were also more likely to report a delay in care due to difficulty getting an appointment than those with private coverage. (Many individuals with private coverage are

more likely to have higher incomes and fewer health problems, so this disparity may in part be attributable to other factors.)

Hispanics, low-income adults, and those in fair or poor health are still more likely to be uninsured and experience more difficulty affording care than their counterparts, as noted in other papers in this series.

CONCLUSION AND POLICY RECOMMENDATIONS

As the uninsured rate among 50- to 64-year-olds fell by nearly half between December 2013 and March 2015, access to care among this group improved. Our findings are consistent with prior research among all adults showing that coverage increases access to care (Institute of Medicine 2009).

However, the gains in insurance coverage have not translated into across-the-board improvements in access to health care services. Disparities in access to care continue to exist among 50- to 64-year-olds. Among those with continuous insurance coverage, those who are Hispanic, low-income, receiving public coverage, or in fair or poor health are more likely to face barriers in access to care.

Timely access to health care services may require more than health insurance coverage alone. Other financial and nonfinancial barriers may affect access, such as lack of transportation or time off work, poor coverage plan designs that make selecting the most appropriate plan difficult, language and literacy barriers, lack of information and resources for efficiently accessing health care systems, provider unavailability and unresponsiveness, and high out-of-pocket costs.

Barriers to accessing care could present major challenges for managing chronic conditions and coordinating care, particularly for those in fair or poor health. To build upon gains in access for 50- to 64-year-olds and to reduce disparities for vulnerable subgroups, federal and state policy makers should consider the following policy ideas that have been shown to improve health care access:

- Support expansion of community-based initiatives that address social determinants of health and integrate health and social services.
- Target education and outreach efforts to help

vulnerable populations understand and select the most suitable coverage for their financial and health needs and how to access care.

- Support education efforts to improve health literacy among vulnerable populations and newly insured individuals.
- Encourage adoption of electronic health records and expand use of health information technology.³
- Improve and enforce requirements for health plans to ensure timely access to care and access to an adequate number of in-network primary care physicians and specialists.⁴
- Fund continual research to determine existing and emerging disparities in access to and affordability of care, and identify best practices in addressing these disparities.
- Improve access to health care in rural and underserved areas by
 - Providing incentives and assistance in recruiting and retaining health care personnel in underserved areas;
 - Providing funding for and technical assistance to rural and community health centers;⁵
 - Supporting development of alternative strategies to provide access to health care, such as telemedicine and improved transportation resources; and
 - Improving language access services and promoting cultural competency among providers.

APPENDIX

Data and Methods

This analysis uses data collected by the Urban Institute's Health Reform Monitoring Survey (HRMS), a quarterly Internet-based survey of adults under the age of 65 designed to provide rapid feedback on implementation of the ACA before data from federal surveys are available. The survey data used for this paper and other analyses in AARP Public Policy Institute's "Monitoring the Impact of Health Reform on Americans Ages 50–64" series are from oversamples of 50- to 64-year-old adults

(HRMS-AARP Public Policy). The Urban Institute and GfK Custom Research conducted the survey, and AARP Public Policy Institute provided funding to increase the sample size for this age group. GfK Custom Research fielded the HRMS-AARP Public Policy oversample survey in December 2013, March 2014, December 2014, and March 2015 and included approximately 8,000 adults ages 50 to 64 for each survey period.

The HRMS-AARP Public Policy is weighted to be nationally representative. Results presented here were not adjusted for changes in the demographic characteristics of the HRMS-AARP Public Policy sample between December 2013 and March 2015. Comparisons within subgroups were not adjusted for socioeconomic, geographic, or health status differences across groups. More information on the HRMS is available at <http://hrms.urban.org/>.

APPENDIX TABLE 1
Access to Care in March 2015 for 50- to 64-Year-Olds with Continuous Coverage, by Demographic Characteristics, Insurance Type, and Self-Reported Health Status

Indicator		Had a Usual Source of Care	Had a Routine Checkup	Had Any Problem Accessing Care	Delayed Care Due to Difficulty Getting an Appointment
Gender	Male [^]	83.9%	74.6%	13.2%	9.0%
	Female	86.3%*	79.1%**	14.5%	9.6%
Family Income	At or below 138% FPL [^]	82.6%	79.0%	21.0%	11.6%
	139%–399% FPL	83.3%	76.0%	14.7%**	9.7%
	At or above 400% FPL	87.1%	77.0%	11.3%**	8.4%*
Race and Ethnicity	White, non-Hispanic [^]	85.7%	75.2%	14.0%	9.5%
	Black, non-Hispanic	89.9%**	86.7%**	11.3%	7.1%
	Other, non-Hispanic	79.6%*	75.8%	14.1%	9.4%
	Hispanic	79.7%**	80.2%*	15.4%	10.0%
Insurance Type	Private [^]	85.0%	75.6%	12.4%	8.8%
	Public	85.8%	84.0%**	21.2%**	11.8%*
Self-Reported Health Status	Excellent or very good [^]	84.7%	73.4%	9.8%	6.8%
	Good	84.6%	77.8%**	14.8%**	9.7%**
	Fair or poor	87.5%	84.6%**	22.7%**	15.1%**

Source: HRMS-AARP Public Policy Survey, March 2015.

Note: Data are not adjusted for differences in health status, income, or other characteristics across groups. Continuous coverage is defined as insured for all of the 12 months prior to March 2015. All measures of access to care are over the past 12 months.

[^] denotes reference population.

*/** Estimate is significantly different from estimate for reference population at the 0.05/0.01 level using two-tailed tests.

REFERENCES

Ali, Mohammed K., Kai McKevver Bullard, Giuseppina Imperatore, Lawrence Barker, and Edward W. Gregg. 2012. "Characteristics Associated with Poor Glycemic Control among Adults with Self-Reported Diagnosed Diabetes – National Health and Nutrition Examination Survey, United States, 2007–2010." *Morbidity and Mortality Weekly Report* 61 (02): 32–37. <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6102a6.htm>.

Artiga, Samantha, Katherine Young, Rachel Garfield, and Melissa Majerol. 2015. *Racial and Ethnic Disparities in Access to and Utilization of Care among Insured Adults*. Washington, DC: Kaiser Family Foundation. <http://kff.org/disparities-policy/issue-brief/racial-and-ethnic-disparities-in-access-to-and-utilization-of-care-among-insured-adults/>.

Blewett, Lynn A., Pamela J. Johnson, Brian Lee, and Peter B. Scal. 2008. "When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services." *Journal of General Internal Medicine* 23 (9): 1354–60.

Collins, Sara R., Michelle M. Doty, and Tracy Garber. 2010. *Realizing Health Reform's Potential: Adults Ages 50–64 and the Affordable Care Act of 2010*. New York: The Commonwealth Fund. http://www.commonwealthfund.org/-/media/files/publications/issue-brief/2010/dec/1460_collins_adults_50_to_64_aca_reform_brief_v2.pdf.

Institute of Medicine. 2009. *America's Uninsured Crisis: Consequences for Health and Health Care*. Washington, DC: National Academies Press.

Skopec, Laura, Timothy Waidmann, Jane Sung, and Olivia Dean. 2015. *Monitoring the Impact of Health Reform on Americans Ages 50–64: Uninsured Rate Dropped by Nearly Half between December 2013 and March 2015*. Washington, DC: AARP Public Policy Institute. <http://www.aarp.org/ppi/info-2015/uninsured-rate-dropped-by-nearly-half-between-december-2013-and-march-2015.html>.

Spatz, Erica S., Joseph S. Ross, Mayur M. Desai, Maureen E. Canavan, and Harlan M. Krumholz. 2010. "Beyond Insurance Coverage: Usual Source of Care in the Treatment of Hypertension and Hypercholesterolemia. Data from the 2003–2006 National Health and Nutrition Examination Survey." *American Heart Journal* 160 (1): 115–21.

- 1 There was no significant change in the share of 50- to 64-year-olds with a change in their source of care or in the share of 50- to 64-year-olds who had trouble accessing care in states that did not expand Medicaid.
- 2 In March 2015, the share of 50- to 64-year-olds who had trouble finding a doctor with availability was 3.5 percent; the share of 50- to 64-year-olds who had been told a doctor's office was not accepting new patients was 4.2 percent; and the share of 50- to 64-year-olds who had been told a doctor's office didn't accept their insurance type was 6 percent.
- 3 Adoption of health information technology can reduce health disparities if used effectively. See <http://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/interoperability-electronic-health-and-medical-records/health-improving-disparities-access-healthcare-communities/>.
- 4 Network adequacy standards regulate health plans' ability to meet the needs of consumers by providing reasonable access to a sufficient number of in-network primary care and specialty physicians and covered health services. See http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf.
- 5 Rural and community health centers have been found to reduce disparities by providing a regular source of care for the underserved. See <http://mcr.sagepub.com/content/58/2/234.abstract>.

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