

Health Outcomes and Access to Care According to Type of Insurance Coverage: Implications for the Affordable Care Act

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Introduction

- Many studies, to date, have been conducted on health disparities and inequalities between the insured and the uninsured.
- However, no prior study has examined health characteristics (e.g., self-reported health status, chronic diseases or risk behaviours) of those who are covered privately, publically, and those who are uninsured and likely to qualify for coverage under the ACA enactment.
- Considering the recognized relationship between health insurance and health outcomes along with the increased newly insured populations, it is essential to examine the differences in general health status and health service use between these groups.

Purpose

The purpose of this study is to assess health disparities and inequalities in regards to the insurance status: private, public, the uninsured but likely eligible for Medicaid expansion (EME), and the uninsured but likely required to purchase health plans through the health exchange market (RPIE)

Hypotheses

- **Primary:** The uninsured population would have poorer health outcomes and access to care than the insured, and that these relationships would hold firm regardless of the type of insurance.
- **Secondary:** (1) Different types of insurance would be associated with differences in overall level of health and health inequalities. (2) Disparities and inequalities in health would be smaller within the insured (private vs. public) than between the insured and the uninsured (private vs. RPIE and public vs. EME).

Methods

- **Data:** Medical Expenditure Panel Survey 2012 (MEPS) of the Agency for Healthcare Research and Quality (AHRQ).
- **Sample:** 16,866 US adults aged 27-64 who had health insurance coverage were examined.
 - The elderly population, those 65 years and older, were excluded to avoid confounding with individuals using Medicare (near-universal coverage; Franks, Clancy, Gold, & Nutting, 1993; Shi, 2000).
 - Respondents younger than 27 were also excluded because the ACA enables health insurance plans to extend coverage of children up to 26 years old (the possible effects of changing insurance status; 47% of US young adults ages 19-25 stayed or joined their parent's health plan in 2011 [Collins, Robertson, Garber, & Doty, 2012]).

- **Procedure:** We classified respondents by indicators of age, family income, household size, and insurance status.
 - **Private:** Individuals with private coverage purchased individually or through an employer or group.
 - **Public:** Individuals who were covered primarily through Medicaid and those with other income-determined coverage sponsored by federal or state payers and Medicare.
 - **EME:** Individuals who reported no health coverage and had a family income equal to or lower than 133% of the federal poverty level (FPL) in 2012.
 - **RPIE:** Individuals who reported no health insurance and had a family income above 133% of FPL in 2012.

*Note that each Federal Poverty Level was adjusted according to the number of family members.

Statistical Analyses

- A series of bivariate analyses were used to examine insurance type differences in socio-demographic and health characteristics.
- In order to achieve a joint significance level of $\alpha < 0.05$ for multiple comparisons, Bonferroni adjustments were made.
- Multiple logistic regression models were used to assess the independent effects of type of health insurance with primary health indicators. All regression models were controlled for selected socio-demographics and the frequency of visits to health service.

Figure 1. General Health Status

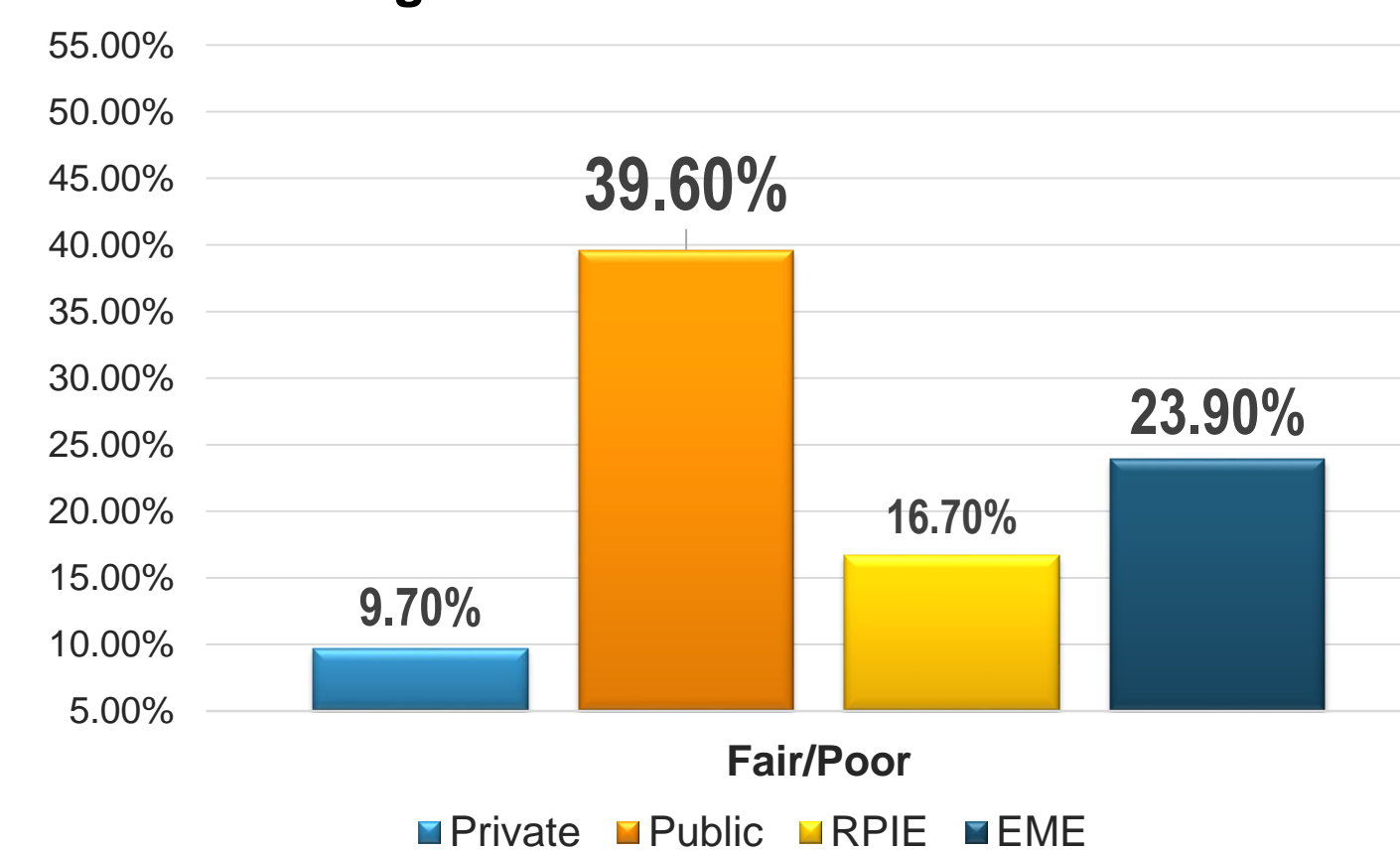


Figure 2. Had a Routine Checkup in 2012

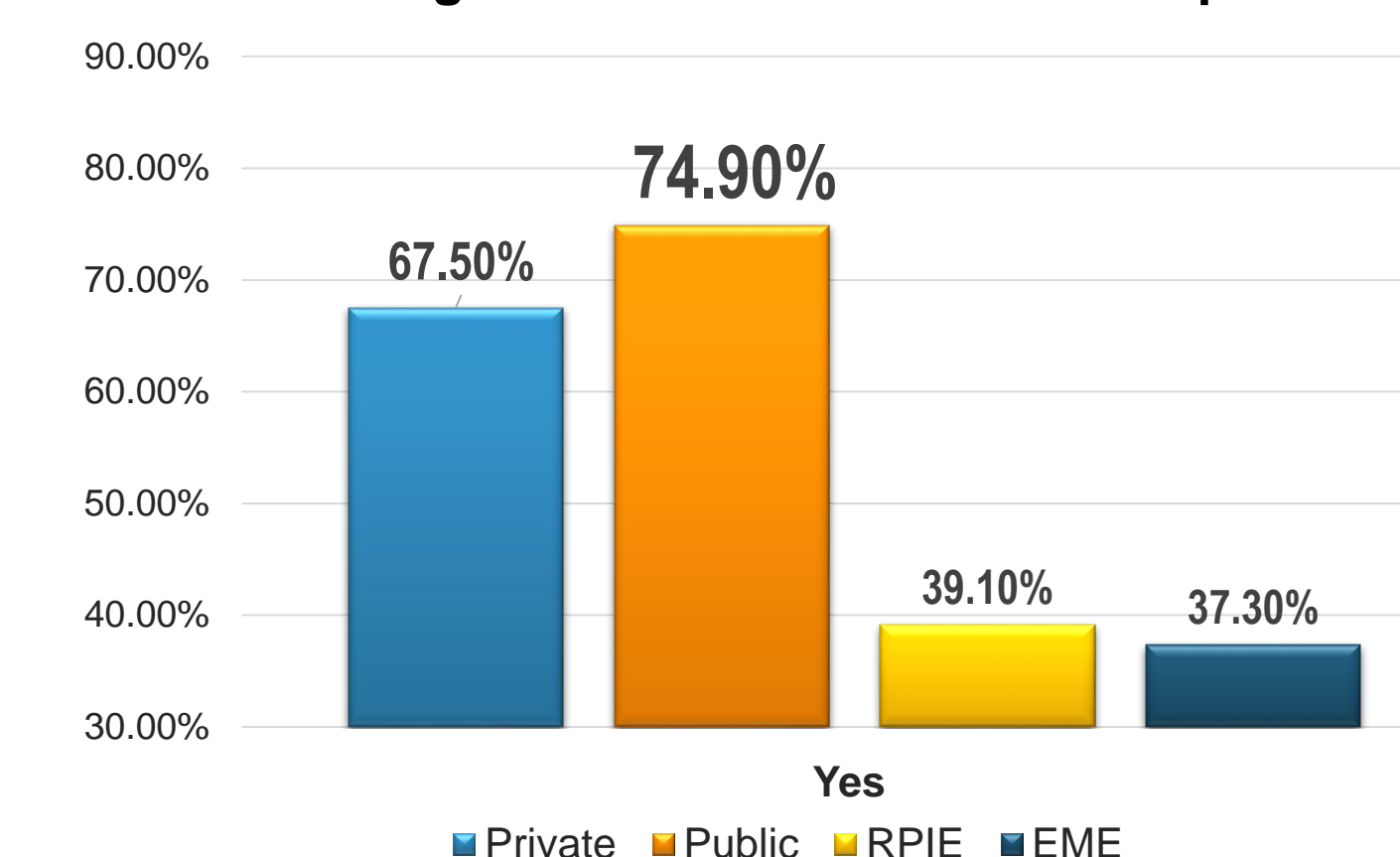


Figure 3. Linear Regression: The Number of Visits & Health Status

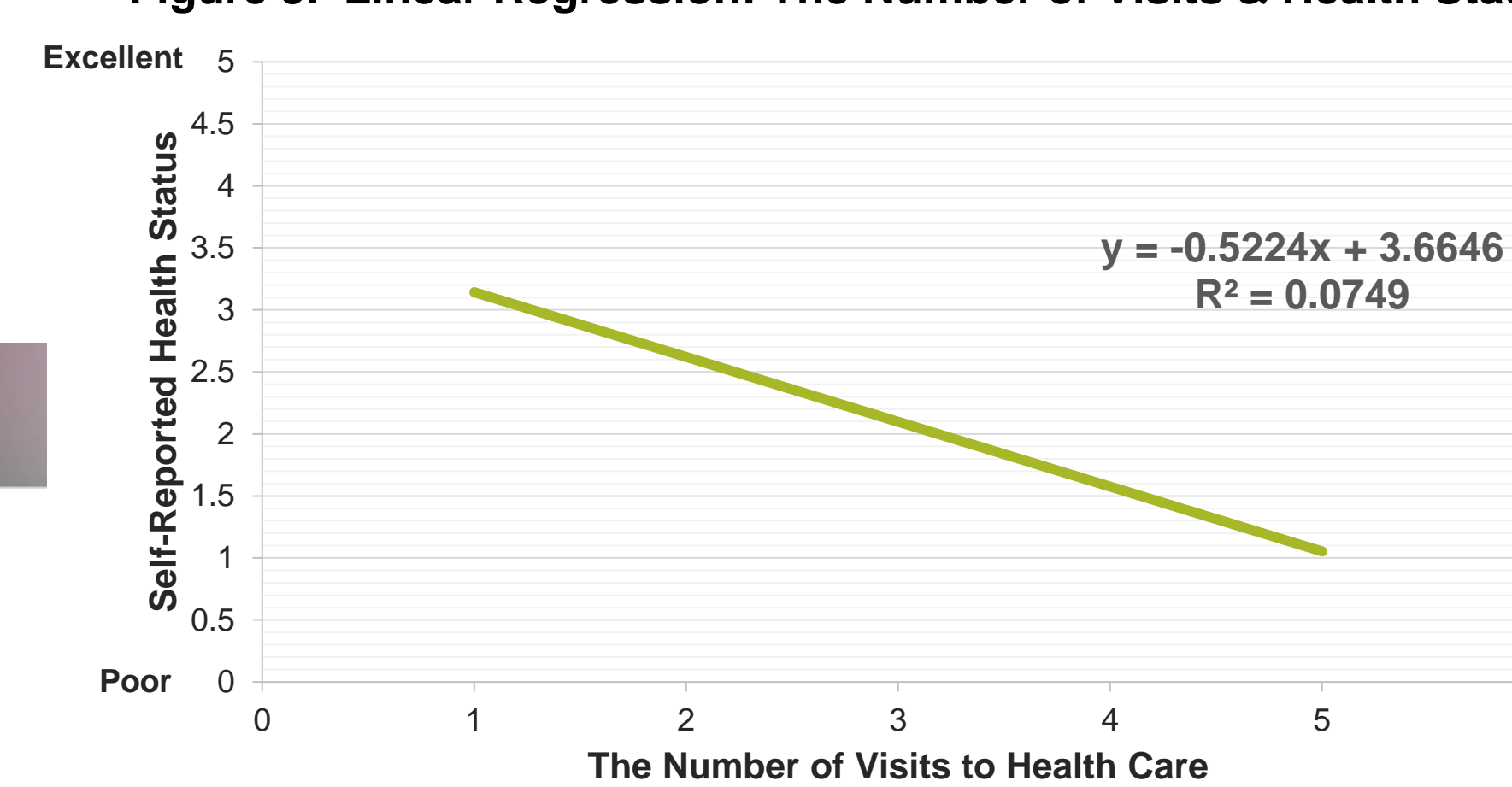


Table 1. Correlations between the number of visits to care and General Health Status

Type of Insurance	Variable	Self-Reported Health
Private	# of visits to health care	- 0.194***
Public	# of visits to health care	- 0.348***
Uninsured with RPIE	# of visits to health care	- 0.216***
Uninsured with EME	# of visits to health care	- 0.222***

Table 2. Health Service Utilization by the Type of Health Insurance Status

# of visits to care	Insured		Uninsured	
	Private	Public	RPIE	EME
0	29.00%	22.40%	59.30%	62.60%
1	19.20%	12.90%	13.70%	11.80%
2	16.00%	13.30%	8.90%	9.10%
3	11.30%	11.20%	6.20%	5.30%
4	8.20%	11.60%	4.70%	3.40%
5 to 9	10.70%	15.50%	5.00%	4.60%
10 or more	5.60%	13.10%	2.20%	3.20%

Note. Adjusted odds ratios were obtained from the multiple logistic regression controlling for age, sex, race, education, employment status. * p < .05, ** p < .01, *** p < .001; Data from Medical Expenditure Panel Survey (MEPS) 2012

Results

Figure 1. Adjusted Odds Ratio of Reporting Fair/Poor Health

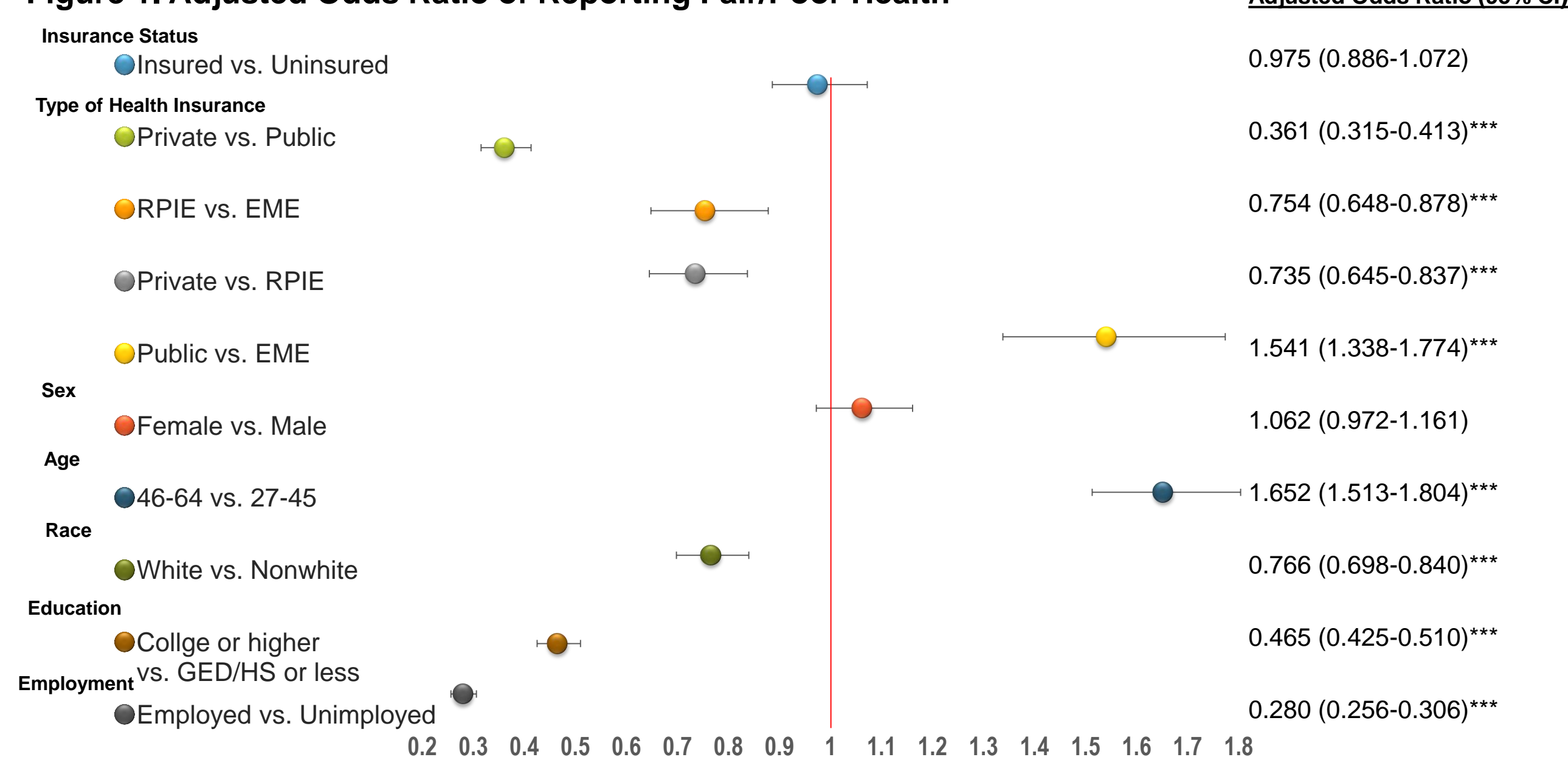


Figure . Adjusted Odds Ratio of Having a Heart Problem

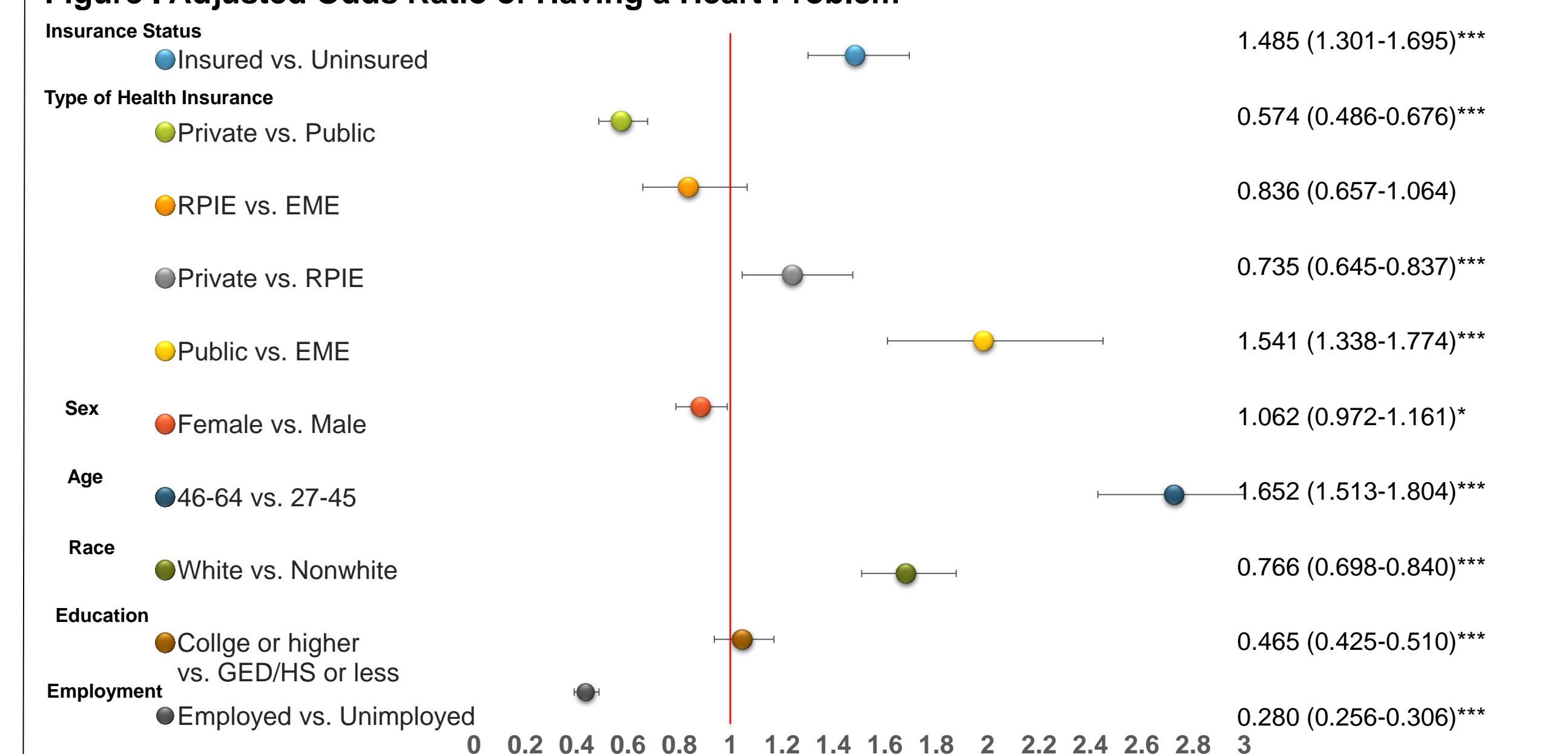


Figure 1. Adjusted Odds Ratio of Having Diabetes

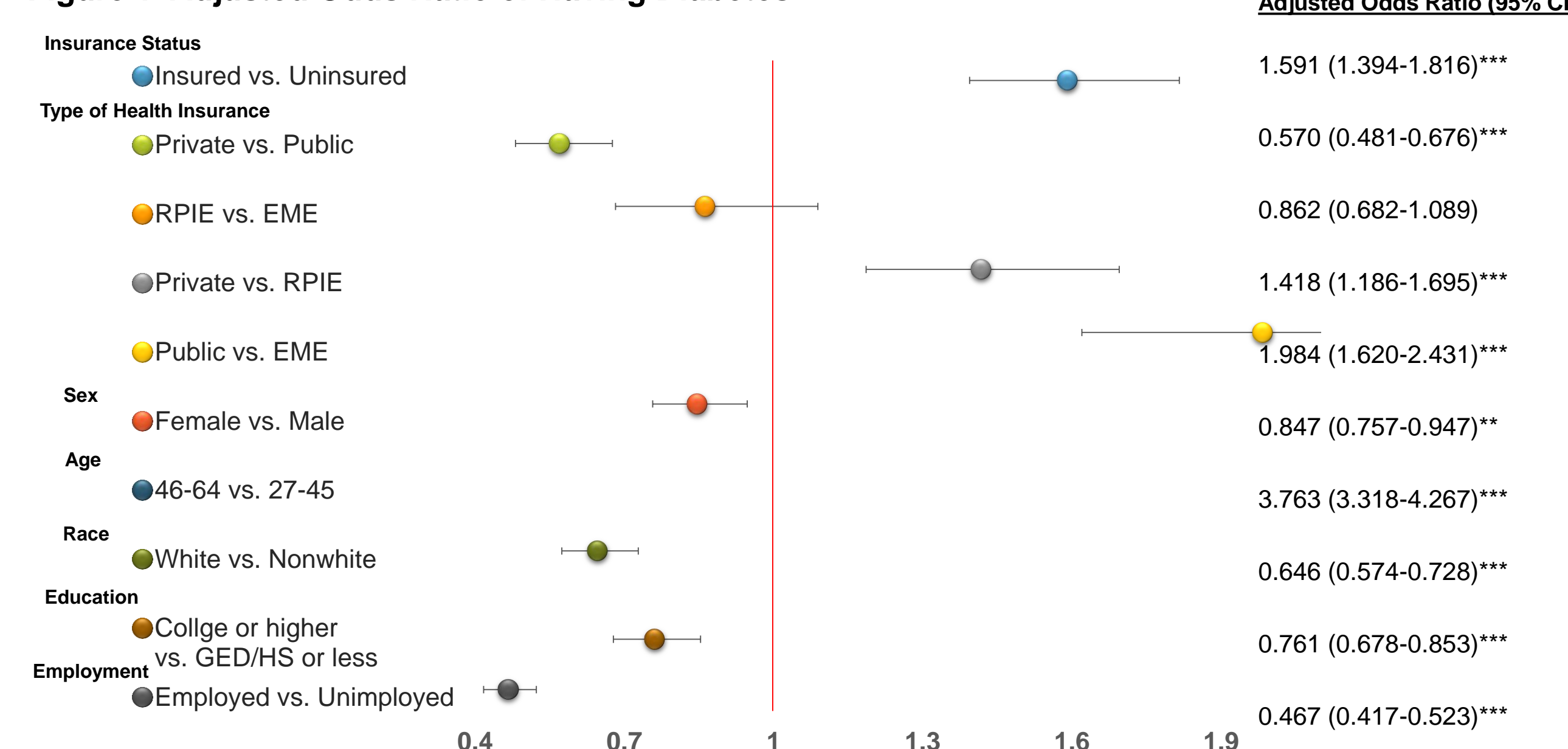
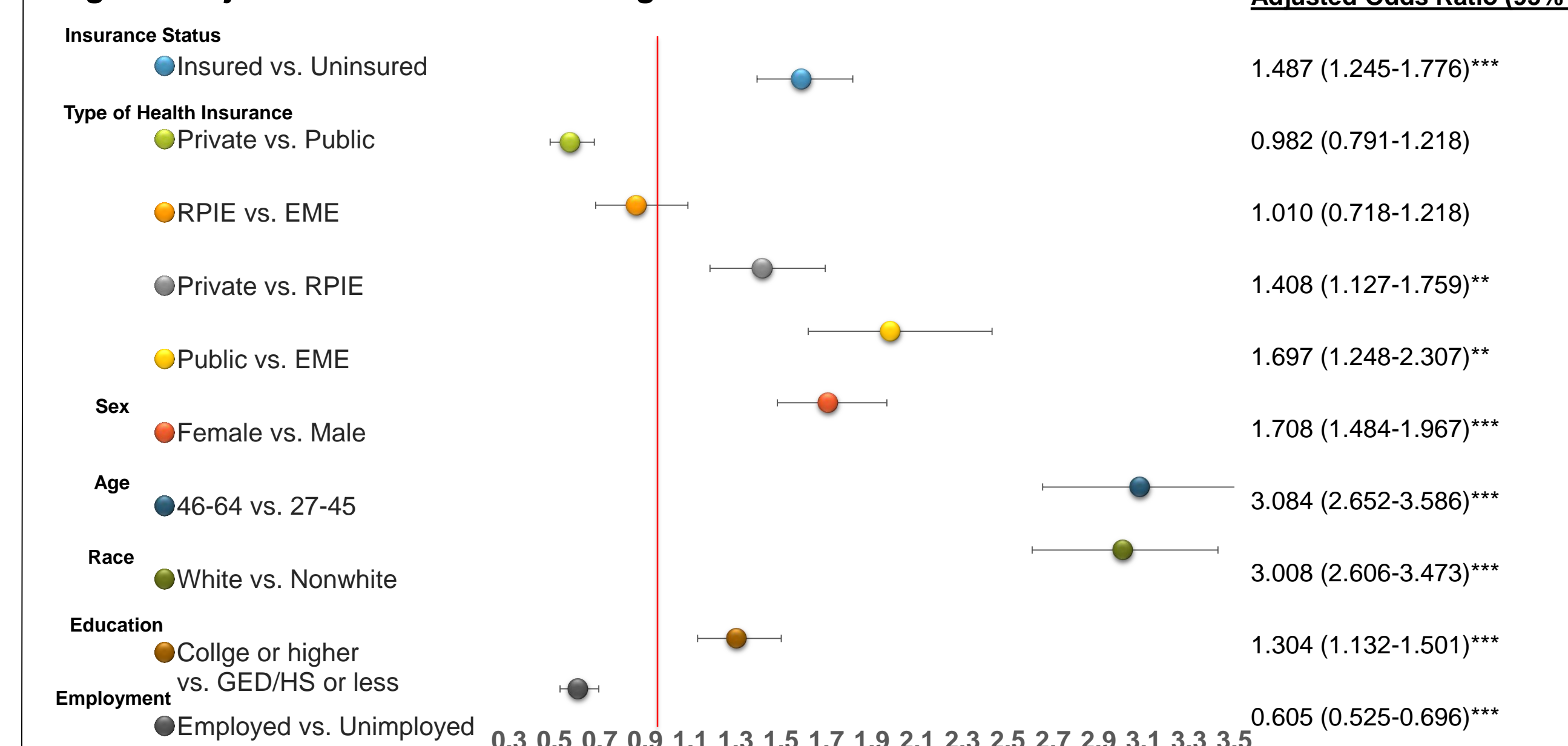


Figure . Adjusted Odds Ratio of Having a Cancer



Limitations

- Using the Medical Expenditure Panel Survey (MEPS) national data base strengthens the representativeness of the study for the general population, however, because it does not sample institutionalized individuals, the results are not generalizable to persons who are in nursing homes, other long-term facilities, or prisons.
- The effects examined in the study may be limited to individuals' perceptions of their health status and the quality of the health service attributes.

Findings

- Bivariate analysis showed that the publicly insured reported worse health outcomes than the privately insured, RPIE, and EME on most health indicators despite better access to care.
- In the group comparison within the insured and uninsured, multiple logistic regression results indicated that all prevalence of chronic conditions except cancer differed significantly between the privately insured and publicly insured population, while it did not between RPIE and EME.
- In terms of the number of visit to medical offices, more than half of the both RPIE (59.3%) and EME (62.6%) had no visit in the past 12 months, compared with 29% of the privately insured and 22.4% of the publicly insured.
- For the women's cancer screening, women covered through private insurance were more likely to report having had all three screenings than were women with other insurance status.

Conclusion

- Based on our findings, it appears that the general health outcomes of those who are publicly insured are the worst despite the higher rates of visits to health care and better accessibility.
- Overall, having insurance coverage does not seem to contribute to better self-reported health. This study also suggests that effect of health coverage on health status may vary according to the type of insurance.

Implications

- Although policy interest has centered on narrowing the gap between the uninsured and the insured, increased access to healthcare with the Medicaid expansion under the ACA may not play as significant a role improving the general health status among the uninsured as much as anticipated.
- Given the discrimination, low profitability for public insurance, policy makers who must justify the ACA enactment should address the low physicians' acceptance of the publicly insured patients, and need to establish policies to ensure newly insured population can receive quality care, not quantity.