kaiser commission on KEY FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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The Role of Medicaid for Adults with Chronic Illnesses

Introduction

Medicaid is the nation's health coverage program for the low-income population, covering over 60 million people, or one in five Americans. Medicaid beneficiaries are a diverse group that includes low-income parents, children, and pregnant women, low-income Medicare beneficiaries, and people with disabilities. Many individuals covered through Medicaid have special needs, which is a result of the program's eligibility rules that explicitly extend coverage to disabled and medically needy groups. Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid to nearly all people with income at or below 138% of the federal poverty level (FPL). This expansion would extend coverage to millions of currently uninsured adults, particularly non-elderly adults without dependent children who have typically been excluded from the program. Since this newly eligible group is largely uninsured and faces limited access to the health care system as a result, they may have substantial unmet need for health care services.

Understanding the current and future role of Medicaid for adults with chronic illnesses can aid policymakers in designing programs to efficiently and effectively meet the needs of enrollees. Specifically, decisions related to benefit design, delivery systems, and provider networks may be better informed with information on Medicaid's current role for individuals with chronic illnesses, how well the program serves these individuals, and how the health needs of the newly-eligible compare to those already enrolled. This brief summarizes a series of policy briefs that examine Medicaid's role for adults with chronic illnesses including diabetes, cardiovascular disease (CVD), respiratory disease, and mental illness.[*] It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to health needs, health care spending, access to care, and utilization of services. [A more detailed description of the data and methods for the analysis in this brief is included in the Appendix at the end of the report.] The information provides a profile of Medicaid's role in supporting population health and how this role could change through the expansion of eligibility in 2014.

[*] Separate pieces examine each of these conditions individually. See: http://www.kff.org/medicaid/8383.cfm.

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Findings

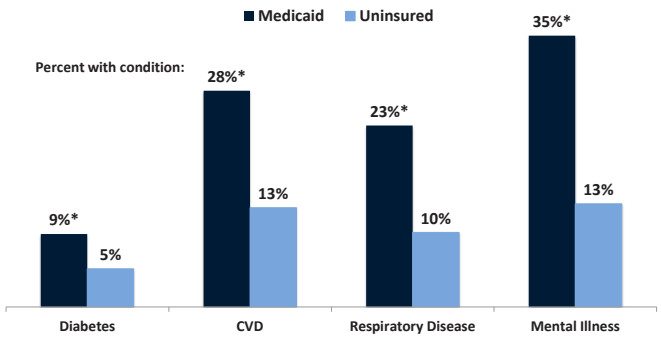
Prevalence

Among nonelderly adult Medicaid enrollees in 2009, the prevalence of chronic conditions varied by disease (Figure 1). Around one in ten adult Medicaid enrollees had diagnosed diabetes, and higher shares had diagnosed cardiovascular disease (28%) or respiratory disease (23%). Over a third (35%) had a diagnosed mental illness.

The prevalence of all four conditions was higher among Medicaid adults than among the uninsured (Figure 1). The higher rate of chronic illness among Medicaid beneficiaries is likely a result of Medicaid rules that explicitly extend program eligibility to people in poor health, such as the medically needy and people with disabilities. While lower than prevalence rates among Medicaid enrollees, there are still notable levels of chronic illness among the uninsured, indicating the considerable health care needs among potentially newly eligible adults. Among the uninsured, prevalence of the four conditions ranged from 5% for diabetes to 13% for mental illness. It is quite possible that the uninsured (who are less likely than those with Medicaid to see a medical provider) also have undiagnosed illness that do not appear in the prevalence rates above but still would require treatment.[1]

Figure 1

Prevalence of Chronic Illnesses among Medicaid and Uninsured Nonelderly Adults ≤138% FPL, 2009

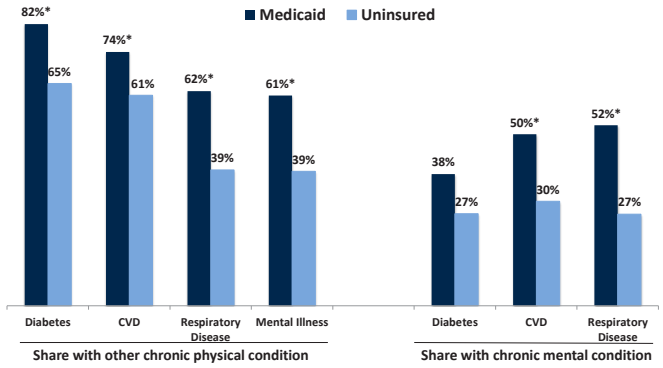


*Statistically different from Uninsured (p<0.05).
All insurance groups include only those nonelderly with full-year coverage or a full year without coverage.
Excludes dual eligibles.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Comorbidity, or an individual having more than one illness, is common among individuals with chronic conditions, and this pattern holds among low-income Medicaid and uninsured adults. In fact, a majority of Medicaid beneficiaries with each of the four conditions had an additional physical chronic condition—ranging from 61% to 82%—evidence of the complex health care needs of this population (Figure 2). Moreover, between 38% and 52% of nonelderly Medicaid enrollees with one of the three physical conditions (diabetes, CVD, and respiratory disease) also had a comorbid mental illness. Comorbidities were also common among uninsured adults with the four chronic conditions. The shares of these uninsured groups with a physical comorbidity ranged from 38% to 64%, and the shares of those with one of the three physical chronic conditions with a comorbid mental health condition were around three in ten.

Figure 2

Comorbidity among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



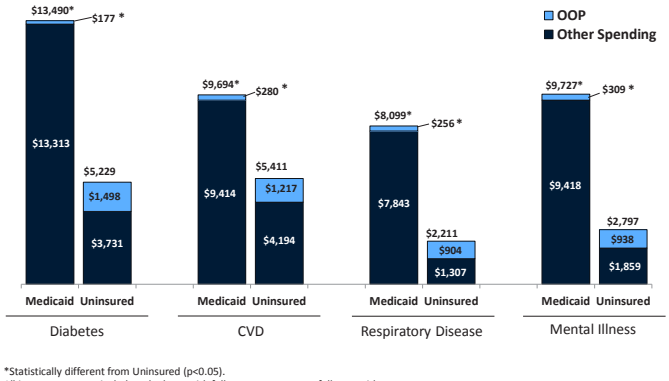
*Statistically different from Uninsured (p<0.05). All insurance groups include only those nonelderly with full-year coverage or a full year without coverage. Excludes dual eligibles.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Spending

Chronic illnesses may be costly to treat, and the presence of comorbid conditions—each with costly treatment needs—means that individuals with these illnesses may incur substantial health costs. Health spending for nonelderly adult Medicaid enrollees with chronic illness ranged from $8,099 per capita among those with respiratory disease to $13,490 per capita among those with diabetes (Figure 3). Individuals with diabetes had the highest per capita spending of the illnesses analyzed; this result is likely related to the fact that individuals with diabetes also had the highest comorbidity rates and the spending levels in Figure 3 represent spending on all services (not just spending for each disease). High spending levels among Medicaid beneficiaries with chronic illness are related to their poor health status: spending for nonelderly adult Medicaid beneficiaries without these conditions was significantly lower (around $5,000 per capita, data not shown).

Figure 3

Per Capita Spending among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



*Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Compared to Medicaid enrollees, uninsured low-income adults had per capita spending between $2,211 (respiratory disease) and $5,411 (CVD) (Figure 3). The differences in spending levels again reflect both the particularly complex health care needs of the Medicaid population with chronic illnesses and lower utilization among uninsured individuals with the same illnesses.

Conversely, out-of-pocket spending was consistently lower and more similar across the illness groups for Medicaid beneficiaries than for uninsured adults (Figure 3). For the illness groups in Medicaid, out-of-pocket spending per beneficiary fell between $177 per year for those with diabetes and $309 for those with mental health conditions. By contrast, those figures varied from $904 for uninsured adults with respiratory disease to $1,498 for those with diabetes, with the remainder of their overall spending coming from health care providers or uncompensated care funds. The substantial differences in out-of-pocket spending between Medicaid adults and the uninsured result from Medicaid rules that limit cost-sharing for beneficiaries to nominal amounts.

Utilization

The spending patterns in Figure 3 reflect differences in utilization by illness and coverage. Across the four illnesses, Medicaid beneficiaries with chronic illnesses had greater service utilization than the uninsured with the same illness (Table 1). Specifically, Medicaid adults had had roughly two to three times as many office visits in the previous year (10.2–12.3 versus 3.2–5.6) and prescriptions filled per month (3.3-5.3 versus 1.1-2.2) as the corresponding groups of the uninsured. Adults in Medicaid were also more likely than the uninsured to have had an inpatient stay or an emergency department (ED) visit in the previous year, though the differences in ED use were smaller than differences for other utilization measures. These higher relative rates of ED use among the uninsured could reflect the relative inelasticity of emergency service utilization compared to other, non-emergent services. The lower rates of other types of utilization, particularly office visits and prescription drug use, may indicate unmet need for services, especially when one considers the high rates of comorbidity among these individuals.

As with spending, utilization was higher among Medicaid enrollees with diabetes compared to other illnesses, with the exception of emergency department visits. Again, this group is most likely to have comorbid conditions and thus may have greater health needs than other groups.

Table 1
Service Utilization among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

	Medicaid	Uninsured
Number of Provider Office Visits		
Diabetes	12.3*	4.8
CVD	10.2*	5.6
Respiratory Disease	10.7*	3.2
Mental Illness	10.9*	5.0
Number of Prescriptions/Month		
Diabetes	5.3*	2.2
CVD	3.9*	1.9
Respiratory Disease	3.5*	1.1
Mental Illness	3.3*	1.3
Share who had an Inpatient Stay		
Diabetes	29%*	10%
CVD	22%*	9%
Respiratory Disease	19%*	6%
Mental Illness	22%*	7%
Share who had an Emergency Department Visit		
Diabetes	34%	34%
CVD	36%*	23%
Respiratory Disease	39%*	26%
Mental Illness	33%*	23%

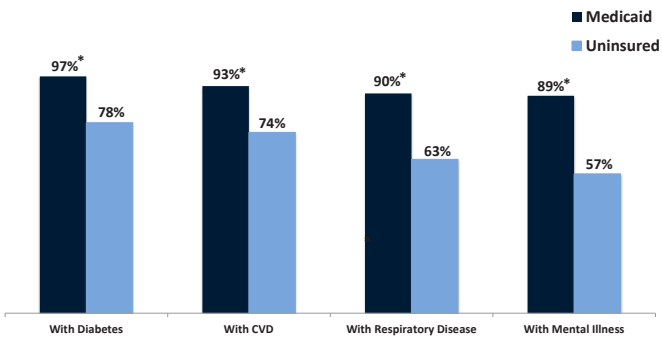
*Statistically significant difference from Uninsured, $p < .05$
SOURCE: KCMU analysis of 2009 Medicaid Expenditure Panel Survey data.

Access

Despite higher levels of comorbidity, nonelderly adult Medicaid enrollees with chronic illness report better access to care than uninsured adults with the same illnesses. Specifically, most Medicaid beneficiaries with chronic illness reported having a usual source of care (Figure 4), ranging from 89% of those with a mental illness to 97% of those with diabetes. Consistently lower shares of the uninsured with chronic illness reported having a usual source of care, and the trend across the illness groups was similar to that of the Medicaid population, ranging from 57% of those with mental illness to 78% of those with diabetes. Not having a usual source of care indicates disconnection from the health system and may be especially problematic for people with chronic conditions that require ongoing medical attention.

Figure 4

Usual Source of Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

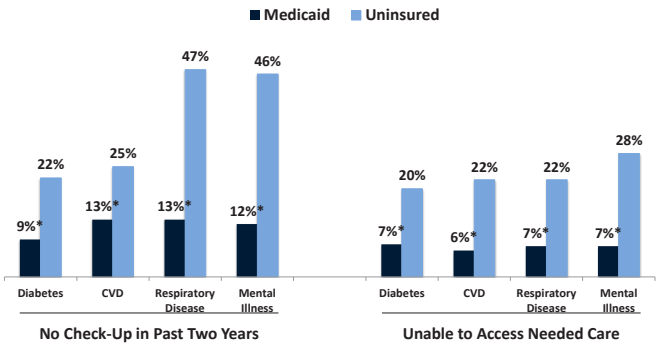


* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

On most measures of having a problem accessing care, nonelderly adult Medicaid beneficiaries with chronic disease were less likely than their uninsured counterparts to report a problem (Figure 5). Medicaid enrollees were much more likely to have a check-up in the past two years than their uninsured counterparts with the same illnesses. Notably high shares of uninsured adults with respiratory disease (47%) or mental illness (46%) reported not having a recent check-up, indicating potential barriers to regular care for their conditions. Further, all four groups of Medicaid beneficiaries were less likely than their uninsured counterparts to have been unable to access necessary medical care, with shares steady in the single digits among Medicaid adults and ranging from 20% to 28% among uninsured adults.

Figure 5

Barriers to Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Policy Implications

Medicaid plays an important role in providing access to care for people with chronic conditions. There is a high prevalence of chronic conditions among low-income, nonelderly adult Medicaid beneficiaries, and most of these individuals have complex care needs stemming from comorbid conditions. Reflecting these high needs, Medicaid enrollees with chronic conditions have relatively high spending and utilization rates. Notably, Medicaid seems to meet the health care needs of this high use population, as most report being linked to care and few report barriers to accessing services. Compared to Medicaid enrollees with the same illness, uninsured adults with chronic illness have poorer access to care, are less likely to utilize basic services, and have a greater out-of-pocket burden. Thus, while prevalence of chronic illness among uninsured low-income adults was lower than among Medicaid enrollees, many newly-eligible individuals may present with complex health needs.

The results of this analysis also suggest that the implementation of the Medicaid eligibility expansion in 2014 may provide improved access to a variety of health services and prescription medications, as well as reductions in out-of-pocket costs, for many currently uninsured adults with chronic conditions. The relatively comprehensive Medicaid benefits package and improved care management could also foster more appropriate care patterns for the uninsured at a greatly reduced out-of-pocket cost, potentially improving both their health and personal economic security, as these individuals have quite limited incomes. For these reasons, Medicaid eligibility may have a substantial, positive impact on the quality of life for poor, uninsured adults with chronic conditions, especially those without children—a vulnerable population that has historically been excluded from health coverage.

The ACA also offers opportunities to improve the care that Medicaid beneficiaries receive. The relatively high number of ED visits and hospital stays, as well as provider office visits and prescriptions filled, among Medicaid adults with chronic conditions in this analysis indicates that there are opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rates of mental health comorbidity among adults with chronic physical conditions present opportunities for improved coordination of physical and mental health services. The Medicaid health homes option in the ACA presents an opportunity for states to coordinate care across providers to prevent duplicative or inappropriate care, especially for patients with multiple conditions and complex health needs. The health homes option extends a 90% federal matching rate for state spending on health home services for eight quarters. Qualifying health home services include care coordination and management, referral to community and social supports, and transitional and follow-up care.

While the ACA provides a number of opportunities to improve access to and quality of care for many uninsured adults with chronic conditions, it will be critical for states to ensure adequate provider capacity in their Medicaid programs so that these new enrollees have adequate access to the primary, preventive, and specialized care necessary to adequately treat their conditions. If states can meet the challenges of effectively implementing the ACA Medicaid expansion, the results of this analysis suggest that enrollment in Medicaid may provide greater access to important services that would enable newly eligible adults with chronic conditions to better manage their conditions.

Appendix

This analysis draws on data from the 2009 Medical Expenditure Panel Survey (MEPS) household component. The publicly-available MEPS-HC dataset is a nationally-representative survey of healthcare access, utilization, and expenditure among the United States civilian, non-institutionalized population. We restrict our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We exclude those with coverage changes throughout the year to match the timing of insurance and access measures, which ask about all access and use over the past year. We define "low-income" as having family income at or below 138% FPL. Medicaid beneficiaries with Medicare ("dual-eligibles") are excluded.

To identify individuals with chronic conditions, we use the MEPS Medical Conditions file, which is based on self-reports of whether a person had been told by a health care provider that he or she had any "priority" condition,[2] self-reports of individuals taking a day or more of disability during the year for a condition and of a condition "bothering" a respondent, and ICD-9 codes, classified using Clinical Classification Codes, from the event files. We also use the HCUP Chronic Condition Indicator (CCI) to specify whether a condition was chronic; only chronic conditions are included in this analysis. Spending data include expenditures from all payers and on all health care services. All spending values are calculated as annual, per capita expenditures.

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[1] Wilper AP, Woolhandler S, Lasser KE, McComick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured US adults. *Health Affairs*. 2009;28(6):w1151-9

[2] See MEPS documentation available at http://meps.ahrq.gov/mepsweb/data_stats/download_data/pufs/h128/h128doc.shtml#Appendix4 for a list of priority conditions.

This publication (#8383) is available on the Kaiser Family Foundation's website at www.kff.org.