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medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION

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The Role of Medicaid for People with Respiratory Disease

Introduction

Chronic respiratory diseases include lung conditions in which a person's airways are obstructed, constricted or damaged, making it difficult to breathe. These conditions include illnesses such as asthma and chronic obstructive pulmonary disease (COPD), an umbrella term for diseases such as emphysema and chronic bronchitis. Chronic respiratory diseases affect millions of Americans—over 17 million adults suffer from asthma,[1] and 12 million have been diagnosed with COPD[2] — and disproportionately impact people with low incomes. These diseases are the third leading cause of death in the United States[3] and cost billions in direct treatment costs and indirect costs of lost productivity. Often, chronic respiratory illness is caused by preventable factors such as smoking or poor air quality. Many people can effectively manage their symptoms through use of treatments such as prescription medication, but cost can be a barrier to accessing these treatments.[4] Medicaid, the nation's health coverage program for people with low incomes, enables beneficiaries living with chronic respiratory disease to access services and supports that they need to manage their conditions.

Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid eligibility to cover all individuals up to 138% of poverty, including adults without children, a group that has historically been ineligible for the program. Many in the newly enrolled Medicaid population will likely have been uninsured and enter the program with undiagnosed or untreated respiratory conditions. This brief examines Medicaid's role in providing care for adults with respiratory disease and the program's potential to expand access to a range of medical and community services and supports for these new beneficiaries. It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to prevalence of chronic respiratory disease and, within the population with such illnesses, compares their 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.]

Findings

Prevalence & Health Status

Among nonelderly adults with incomes at or below 138% of poverty, Medicaid beneficiaries were more than twice as likely as the uninsured to have a respiratory disease, with 23% and 10% of these groups, respectively, having a chronic respiratory illness (see Table 1). The higher prevalence rate among Medicaid enrollees is likely a result, at least in part, of Medicaid eligibility rules that explicitly extend coverage to people in poor health, such as the medically needy and individuals with disabilities. Though lower, the prevalence rate among uninsured adults indicates that a notable share is living with chronic respiratory illness. The actual rate of disease may be even higher, as uninsured adults are more likely than those with coverage to have undiagnosed chronic illness.[5]

Table 1: Health Status of Medicaid and Uninsured Nonelderly Adults ≤138% FPL

	Medicaid		Uninsured	
Prevalence of Respiratory Disease	23%[a]		10%	
	With Respiratory Disease	**Without Respiratory Disease**	**With Respiratory Disease**	**Without Respiratory Disease**
Had Other Chronic Condition				
Other Physical Condition	62%[ab]	36%[a]	39%	15%
Chronic Mental Condition	52%[ab]	31%[a]	27%	12%
Fair or Poor Health Status	50%[ab]	33%[a]	34%	16%

[a] Statistically significant difference from Uninsured population, p < .05
[b] Statistically different from Medicaid population without respiratory disease, p < .05
SOURCE: Kaiser Family Foundation analysis of 2009 Medicaid Expenditure Panel Survey data.

Further, nearly two in three Medicaid beneficiaries with a respiratory disease also had a physical comorbidity, and around half had a mental comorbidity—a reflection of this group's often complex health care needs. Considerable shares of the uninsured with respiratory disease also had either a physical comorbidity (39%) or a mental comorbidity (27%). While the prevalence of other chronic conditions was lower among adults without respiratory disease, Medicaid beneficiaries in this group were more than twice as likely as uninsured adults to have another physical or mental condition.

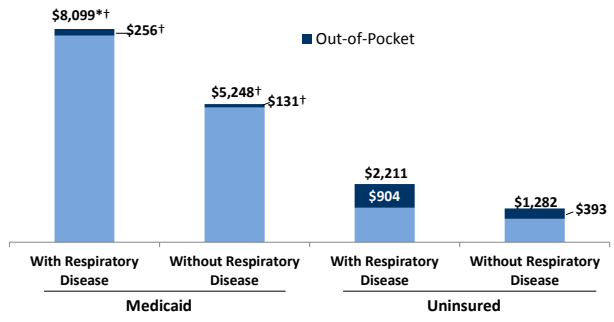
Significant differences also existed between these groups of Medicaid and uninsured adults in self-reported health status. Half of Medicaid beneficiaries with respiratory disease reported that their health status was fair or poor, while approximately one in three of the uninsured with these conditions had this view of their health. Moreover, one in three Medicaid adults without respiratory disease indicated that their health was fair or poor, while around half of that share of uninsured adults without these conditions gave that response.

Spending

Among those with respiratory disease, average annual spending by Medicaid adults ($8,099) was over three times the amount for uninsured adults ($2,211) in 2009 (Figure 1). These spending figures include spending for all services, and the relatively high total reflects the substantial health care needs and high comorbidity rate among this population. Likewise, annual total spending among those without respiratory disease was more than four times greater for Medicaid adults than for the uninsured ($5,248 versus $1,282).

Figure 1

Total Annual Per Capita Health Expenditures Among Low-Income Adults Ages 18-64, by Insurance and Respiratory Disease Status, 2009



Notes: * Differences within Medicaid population significant at the 0.01 level, two-tailed test.
† Differences between Medicaid and uninsured significant at the 0.01 level, two-tailed test.
Source: KCMU analysis of the 2009 Medical Expenditure Panel Survey.

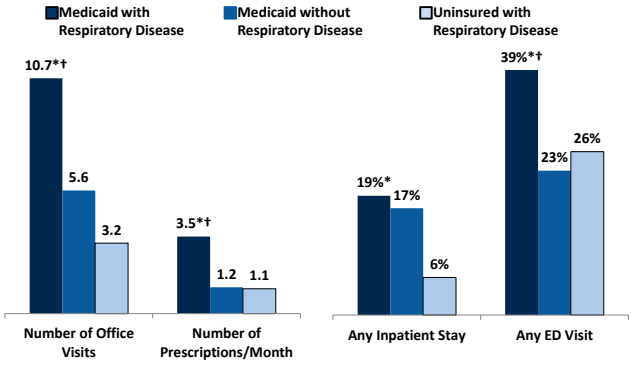
Despite lower overall spending, uninsured adults with respiratory disease faced average annual out-of-pocket costs for health care ($904 per year) that were more than three times as great as those for Medicaid adults with these conditions ($256 per year). Among adults without respiratory disease, annual out-of-pocket spending was three times greater for the uninsured ($393) than for Medicaid beneficiaries ($131). The low out-of-pocket spending totals for Medicaid adults reflects program rules restricting cost-sharing to nominal amounts.

Utilization

The spending patterns above reflect differences in utilization by insurance coverage. Among low-income adults with respiratory disease, Medicaid beneficiaries had more provider office visits (10.7 vs. 3.2) and filled more prescriptions (3.5 per month vs. 1.1 per month) than the uninsured (Figure 2). Moreover, Medicaid adults with respiratory disease were more than three times more likely than the corresponding group of the uninsured to have had an inpatient stay (19% versus 6%) or an emergency department visit (39% versus 26%) in the previous year. As with spending, utilization was higher among Medicaid enrollees with respiratory disease than among those without, with the exception of inpatient stays (which were statistically similar across the two groups).

Figure 2

Service Utilization Among Medicaid and Uninsured Nonelderly Adults at or below 138% FPL, 2009



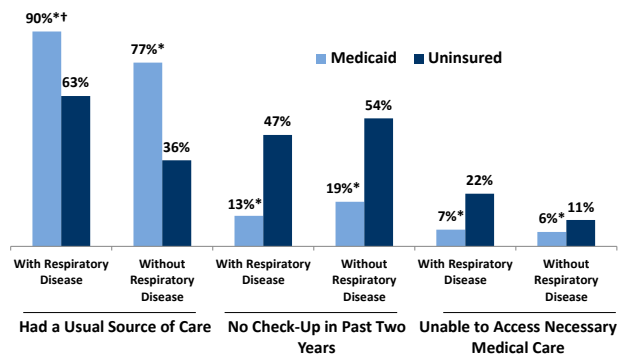
*Statistically different from Uninsured (p<0.05). †Statistically different from without respiratory disease (p<0.05)
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Access

Despite their more complex health needs, low-income Medicaid beneficiaries with respiratory disease had greater access to care than the corresponding group of the uninsured (Figure 3). Among those covered by Medicaid, nine in ten reported that they had a usual source of care, versus around six in ten of the uninsured. About half of uninsured adults reported that they had not had a check-up in the past two years, a finding that is particularly notable among the uninsured who have a respiratory disease. Far fewer shares of Medicaid enrollees reporting not having a check-up, regardless of respiratory disease status. Further, the uninsured with respiratory disease were more likely than Medicaid beneficiaries with these conditions to be unable to get necessary medical care (22% versus 7%), as were those without respiratory disease (11% versus 6%).

Figure 3

Access to Care Among Medicaid and Uninsured Nonelderly Adults at or below 138% FPL, 2009



*Statistically different from Uninsured (p<0.05). †Statistically different from without respiratory disease (p<0.05)
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Policy Implications

There is a high prevalence of respiratory disease among low-income adults covered by Medicaid, and most have at least one additional chronic health condition. This prevalence is in part a result of Medicaid eligibility rules that explicitly extend coverage to people with substantial health needs. Reflecting these needs, Medicaid adults with respiratory disease have higher spending and utilization rates than enrollees without these illnesses. Despite their substantial need and complex health status, Medicaid enrollees with respiratory disease are not more likely to report a problem getting needed medical care than those without.

Medicaid adults with respiratory disease were more likely than low-income uninsured adults with these illnesses to have access to and utilize services; they also had lower out-of-pocket costs despite higher overall spending for their care. These findings indicate the important role Medicaid plays in supporting the health and well-being of these individuals by providing access to critical health care services with minimal financial burden.

Though low-income uninsured adults have a lower prevalence of respiratory disease and comorbidity than their Medicaid counterparts, there is still a substantial share of uninsured adults who live with these illnesses. Many of these individuals may become eligible for Medicaid in 2014 and are likely to present with substantial health needs. The analysis in this brief suggests that these individuals may see improved access to health care services and prescription drugs that may help them manage their illnesses, as well as reduced out-of-pocket costs.

The ACA also offers opportunities for states 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 respiratory disease in this analysis indicates that there may be opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rate of mental health comorbidity among adults with respiratory disease presents 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. This 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 care for more many uninsured adults with chronic illness, 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 these challenges, the results of this analysis suggest that enrollment in Medicaid may provide timely access to important services that would enable newly eligible adults with respiratory disease 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 restricted our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We excluded 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 defined "low-income" as having family income at or below 138% of the federal poverty level. Medicaid beneficiaries with Medicare ("dual-eligibles") were excluded.

For this analysis, "pulmonary disease" included chronic obstructive pulmonary disease (COPD), asthma, and other respiratory disease. To identify individuals with pulmonary disease and comorbidities, we used 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" respiratory condition,[6] 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 used 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 were calculated as annual, per capita expenditures.

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[1] Akinbami LJ, Moorman JE, Liu X. Asthma prevalence, health care use, and mortality: United States, 2005–2009. National health statistics reports; no 32. Hyattsville, MD: National Center for Health Statistics. 2011.
[2] Akinbami LJ, Liu X. Chronic obstructive pulmonary disease among adults aged 18 and over in the United States, 1998–2009. NCHS data brief, no 63. Hyattsville, MD: National Center for Health Statistics. 2011.
[3] Murphy SL, Xu JQ, Kochanek KD. Deaths: Preliminary data for 2010. National vital statistics reports; vol 60 no 4. Hyattsville, MD: National Center for Health Statistics. 2012.
[4] Centers for Disease Control and Prevention. *Vital Signs: Asthma in the US.* May 2011. Available at: http://www.cdc.gov/VitalSigns/Asthma/.
[5] Wilper AP, Woolhandler S, Lasser K, et al. A national study of chronic disease prevalence and access to care in uninsured U.S. adults. *Ann Intern Med.* 2008 August, 149(3):170-6.
[6] 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_RD) is available on the Kaiser Family Foundation's website at www.kff.org.