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ISSUE BRIEF

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Cost and Access Challenges: A Comparison of Experiences Between Uninsured and Privately Insured Adults Aged 55 to 64 with Seniors on Medicare

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INTRODUCTION

Federal and state officials are moving forward to implement key provisions of the Patient Protection and Affordable Care Act (ACA) of 2010 that will expand access to health coverage for many Americans, including those who are approaching retirement but too young for Medicare. Uninsured adults aged 55 to 64 currently face significant difficulties finding affordable and comprehensive coverage in the individual market, either because they cannot afford the premiums for people their age or because they face elevated premiums based on medical underwriting.[1] Insurance market changes made by the ACA, such as expanding access to coverage through Medicaid and health insurance exchanges, prohibiting insurers from denying coverage to individuals based on their medical history, limiting variation in rates by age, and subsidizing insurance for lower-income individuals, are expected to be particularly beneficial for adults in their late fifties and early sixties.[2] Other recent proposals, such as raising the age of Medicare eligibility or repealing/replacing parts of the ACA, could have significant implications for individuals in this age group.[3]

Today, 86 percent of all adults aged 55 to 64 have health insurance: 63 percent have coverage sponsored by employers, 6 percent have individually purchased policies, and 16 percent have coverage under public programs, such as Medicare or Medicaid.[4] Research indicates that many uninsured adults between the ages of 55 and 64 delay medical care until they turn age 65 and become eligible for Medicare.[5] To set the context for understanding potential policy changes that could directly affect uninsured adults aged 55 to 64, this paper analyzes data from the nationally representative 2010 and 2007 Health Tracking Household Survey and the 2003 Community Tracking Study Household Survey, both conducted by the Center for Studying Health System Change. This paper examines and compares the experiences of adults aged 55 to 64 – with and without health insurance coverage – to the experiences of seniors on Medicare, focusing on access and cost issues.

Key findings include the following:

- About four in ten (41%) uninsured adults aged 55 to 64 reported having unmet needs or delaying care in 2010, with concerns about costs cited as a factor in almost every instance (96%). Almost one-third (30%) of uninsured adults aged 55 to 64 lived in families that had problems paying medical bills.
- Medicare seniors report significantly lower rates of unmet needs or delayed care (8%) than uninsured adults aged 55 to 64 (41%) and similar rates to adults aged 55 to 64 with private insurance (17%), after controlling for health status, income, and other demographic factors.
- Over the years, the share of individuals with problems accessing care has remained relatively constant among seniors on Medicare (from 7% in 2003 to 8% in 2010); in contrast, it has significantly increased among uninsured adults aged 55 to 64 (from 32% in 2003 to 41% in 2010) and among same-age adults with private insurance (from 11% in 2003 to 17% in 2010).
- Medicare appears to have muted the effects of rising costs for prescription drugs for seniors between 2003 and 2010 relative to adults aged 55 to 64 with private insurance, likely because of the addition of a Medicare drug benefit in 2006. However, problems paying medical bills increased for insured 55- to 64-year-olds and Medicare seniors alike.

These findings underscore the health care cost and access challenges currently facing uninsured adults in their late fifties and early sixties.

SURVEY METHODOLOGY AND SAMPLE

This research brief presents findings from three surveys conducted by the Center for Studying Health System Change: the 2010 and 2007 Health Tracking Household Surveys and the 2003 Community Tracking Study Household Survey. All three surveys were conducted over the phone, using nationally representative samples of the civilian, non-institutionalized population. Sample sizes include about 47,000 people for the 2003 survey, 18,000 people for the 2007 survey and 17,000 people for the 2010 survey. The analysis examines differences between three groups: non-institutionalized Medicare beneficiaries aged 65 and older; adults aged 55 to 64 with private insurance; and adults aged 55 to 64 who are uninsured. Insurance status reflects coverage on the day of the interview and includes coverage obtained through employer-sponsored and individually purchased private insurance. After narrowing the survey sample to these groups, sample sizes were about 12,800 people in 2003; 5,900 people in 2007; and 5,500 people in 2010. In the 2010 survey sample, there were 319 uninsured adults aged 55 to 64; 2,533 insured adults aged 55 to 64; and 3,076 Medicare seniors. For more information about the survey and statistical methods used in the analysis, see **Appendix A**.

Among 55- to 64-year-olds, the uninsured have lower incomes and are in poorer health than those with private insurance and include a disproportionately large share of Hispanic adults (**Table 1**). Nearly three-quarters (72%) of uninsured adults aged 55 to 64 in the sample lived in families with incomes at or below 300 percent of the federal poverty level (FPL) (about $69,000 for a family of three in 2012), compared to about one-third (33%) of privately insured adults aged 55 to 64. More than one-third (36%) of the uninsured adults aged 55 to 64 were in fair or poor health versus less than one-quarter (23%) of privately insured adults aged 55 to 64.

Uninsured adults aged 55 to 64 also have lower incomes than seniors on Medicare, with a substantially higher portion living on incomes below 300 percent of poverty (72% versus 51%), and are in poorer health (based on self-assessed health status, 36% versus 27%), although the elderly are more likely to report having multiple chronic conditions (46% versus 28%). In contrast, insured adults aged 55 to 64 tend to have higher incomes than seniors (as might be expected because of employment) and better self-assessed health (although they also have fewer chronic conditions).

Table 1. Characteristics of the Study Population

Characteristics		Medicare, Aged 65+	Private Insurance, Aged 55-64	Uninsured, Aged 55-64
Gender	Male	43%	49%	49%
	Female	57%	51%	51%
Race/ethnicity	White	82%	81%	60%
	African-American	8%	9%	8%
	Hispanic	6%	5%	23%
	Other	4%	4%	9%
Family income, as a share of the federal poverty level (FPL)	< 150% of FPL	23%	8%	40%
	150-300% of FPL	28%	17%	32%
	300%+ of FPL	49%	76%	28%
Number of chronic conditions[1]	None	25%	38%	50%
	1	29%	31%	22%
	2	24%	19%	15%
	3	13%	8%	7%
	4 or more	8%	4%	5%
Health status	Excellent or very good	43%	54%	33%
	Good	30%	30%	30%
	Fair or poor	27%	17%	36%

Sources: Center for Studying Health System Change 2007 and 2010 Health Tracking Household Surveys.
[1] Includes diabetes, arthritis, asthma, chronic obstructive pulmonary disease, hypertension, coronary heart disease, skin cancer, cancer (other than skin cancer), benign prostate disease, and depression.

STUDY RESULTS

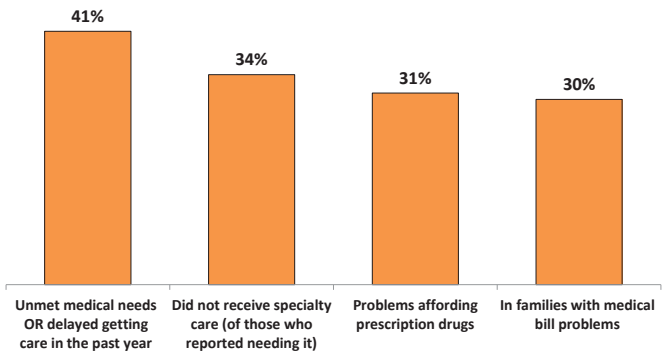
Many uninsured adults aged 55 to 64 postponed needed care, did not get needed specialty care, and reported having problems paying their medical bills in 2010.

As expected, uninsured adults aged 55 to 64 often had difficulty accessing or paying for medical care in 2010. To assess unmet medical needs and delayed care, survey respondents were asked (1) "During the past 12 months, was there any time when you didn't get the medical care you needed?" and (2) "Was there any time during the past 12 months when you put off or postponed getting medical care that you thought you needed?" with follow-up questions asking about the reason for postponed care as applicable. Survey respondents were also asked "In the past 12 months, did you or a doctor think you needed to see a specialist?" with a follow-up question to determine whether or not they received specialty care during that timeframe.

Over two-fifths (41%) of uninsured adults aged 55 to 64 had unmet needs or delayed care, and more than one-third (34%) of the uninsured adults aged 55 to 64 who reported needing specialty care did not receive it (**Exhibit 1**). Of those who had unmet needs or delayed care, almost all (96%) attributed these problems to concerns about costs (**Appendix Table B.2**). Similarly, almost one-third (31%) of uninsured adults aged 55 to 64 had problems affording needed prescription drugs.

EXHIBIT 1

A large portion of uninsured adults ages 55 to 64 reported trouble accessing or affording needed medical care, 2010



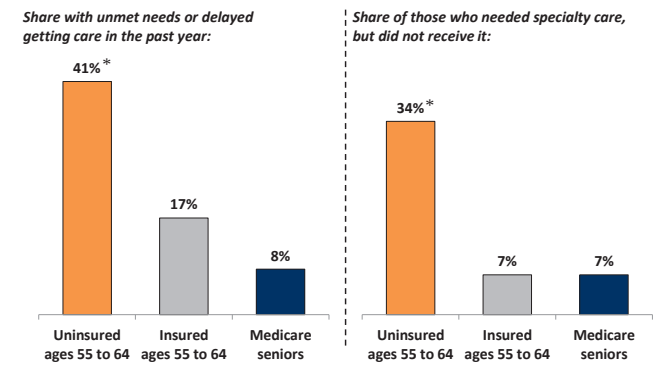
SOURCE: 2010 Health Tracking Household Survey.

To determine whether survey respondents had problems affording prescription drugs and problems paying medical bills, respondents were asked: (1) "During the past 12 months, was there any time you needed prescription medicines but didn't get them because you couldn't afford it?" and (2) "During the past 12 months, (have you/has your family) had any problems paying medical bills?" Nearly one-third (30%) of the uninsured adults aged 55 to 64 were in a family that had problems paying medical bills, of whom about two-fifths (38%) had $5,000 or more in medical debt (**Exhibit 1** and **Appendix Table B.3**). Further, many uninsured adults aged 55 to 64 in families with medical bill problems believed that it would take some time to pay off their debt, with about two-fifths (39%) estimating that it would take at least five years.

Medicare seniors reported problems accessing care and paying medical bills at a significantly lower rate than uninsured adults aged 55 to 64 and at a similar rate to adults aged 55 to 64 with private insurance in 2010, after controlling for health status, income, and other demographics. Uninsured adults aged 55 to 64 had many more problems accessing medical care than privately insured adults aged 55 to 64 and Medicare seniors (**Exhibit 2 and Appendix Table B.1**). More than twice the share of uninsured versus insured adults aged 55 to 64 had unmet needs or delayed care (41% versus 17%), and the differences remained statistically significant even after controlling for health status, income, and other

EXHIBIT 2

Access problems are far more common among the uninsured, ages 55 to 64 than among same age adults with private insurance or seniors on Medicare, 2010



NOTES: This exhibit shows actual, unadjusted percentages. Asterisks (*) indicates that the difference with Medicare beneficiaries ages 65 and older is statistically significant at 95% confidence level after controlling for demographics, health status, and income.
SOURCE: 2010 Health Tracking Household Survey.

demographics. Similarly, more than three times the share of uninsured adults aged 55 to 64 compared to Medicare seniors had unmet medical needs or delayed seeking care (41% versus 8%). Disparities were even greater among those who needed specialty care: four times as many uninsured adults aged 55 to 64 went without specialty care than insured adults aged 55 to 64 and Medicare seniors (34% of uninsured adults aged 55 to 64 versus 7% of insured adults aged 55 to 64 and 7% of Medicare seniors in need of specialty care).

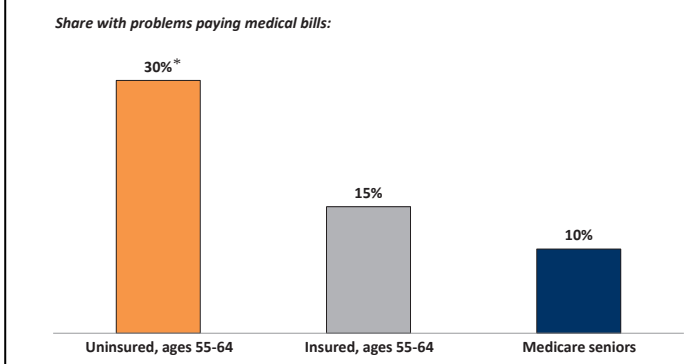
Privately insured adults aged 55 to 64 generally had similar access to care as Medicare seniors, and most differences in access for insured adults aged 55 to 64 and Medicare seniors were not statistically significant after controlling for demographics, health status, and income. Privately insured adults aged 55 to 64 delayed care over the past year more often than Medicare seniors (13% versus 6%), and this difference remained statistically significant after controlling for demographics, health status, and income; however, no other differences between the insured adults aged 55 to 64 and Medicare seniors were statistically significant.

More than two-thirds (71%) of privately insured adults aged 55 to 64 who reported unmet needs or delayed care attributed these problems to worries about the cost and half (50%) experienced delivery system barriers, such as not being able to get an appointment soon enough (30%) (**Appendix Table B.2**). For Medicare seniors, the most frequently reported reason for unmet need or delayed care was delivery system barriers (64%), followed by worries about the cost (56%). Almost one in five (18%) Medicare seniors with unmet needs or delayed care mentioned that their doctor or hospital would not accept their insurance, although this group makes up a small share of the Medicare senior population overall (less than 2%).

Not surprisingly, uninsured adults aged 55 to 64 had more problems affording needed care and had more medical bill problems than privately insured adults aged 55 to 64 and Medicare seniors (**Exhibit 3**). Almost one-third (31%) of uninsured adults aged 55 to 64 had problems affording needed prescription drugs compared to 9 percent of privately insured adults of the same age and 8 percent of Medicare seniors; these differences between uninsured 55- to 64-year-olds and Medicare seniors were statistically significant even after controlling for differences in demographics, health status, and income (**Appendix Table B.1**).

EXHIBIT 3

Problems paying medical bills are more common among uninsured adults ages 55-64 than among same-age adults with private insurance or seniors on Medicare, 2010



NOTES: This exhibit shows actual, unadjusted percentages. Asterisks (*) indicates that the difference with Medicare beneficiaries ages 65 and older is statistically significant at 95% confidence level after controlling for demographics, health status, and income.
SOURCE: 2010 Health Tracking Household Survey.

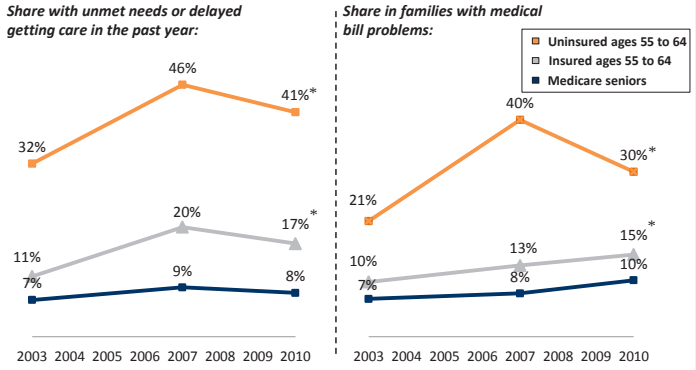
Similarly, almost one-third (30%) of uninsured adults aged 55 to 64 had medical bill problems compared to about one-seventh (15%) of privately insured adults aged 55 to 64 and one-tenth (10%) of Medicare seniors. Differences in medical bill problems between Medicare seniors and privately insured adults aged 55 to 64 were not statistically significant, after controlling for health status, income and other demographics.[6] About one-fifth (21%) of insured adults aged 55 to 64 with medical bill problems had $5,000 or more in medical debt and 12 percent reported needing 5 or more years to pay off their debt (**Appendix Table B.3**). Among Medicare seniors with medical bill problems, 13 percent reported $5,000 or more in medical debt and 18 percent reported needing 5 or more years to pay off their debt.

Access to care has remained relatively unchanged over time for seniors on Medicare but has eroded for insured and uninsured adults.

Problems accessing needed care have increased for both uninsured and insured adults aged 55 to 64 (**Exhibit 4** and **Appendix Table B.4**). The share of uninsured adults aged 55 to 64 who had unmet needs or delayed care increased from 32 percent in 2003 to 41 percent in 2010.[7] Part of this increase in unmet needs or delayed care may be attributable to changes in the health profile of the uninsured as the population expanded.[8] Similarly, the share of privately insured adults of this age who had unmet medical needs or who delayed care increased from 11 percent to 17 percent between 2003 and 2010. In contrast, among Medicare seniors, problems with access to care did not significantly change between 2003 and 2010. The share of Medicare seniors who had unmet needs or delayed care increased from 7 to 8 percent, but this change was not statistically significant.

EXHIBIT 4

The share of adults ages 55-64, both insured and uninsured, reporting access problems has increased over time No similar change observed for seniors on Medicare, 2003-2010



NOTES: Asterisks (*) indicates that the difference between 2003 and 2010 is statistically significant at the 95% confidence level.
SOURCE: 2003 Community Tracking Study Household Survey and the 2007 and 2010 Health Tracking Household Surveys.

Medicare appears to have muted the effects of rising prescription drug costs for seniors between 2003 and 2010 relative to adults aged 55 to 64 with private insurance.

From 2003 to 2010, adults aged 55 to 64 experienced increasing difficulty affording prescription drugs (**Appendix Table B.4**). Uninsured adults aged 55 to 64 were three times as likely to have problems affording prescription drugs compared to privately insured persons of the same age (31% for uninsured compared to 9% privately insured in 2010). Difficulty affording prescription drugs increased for both uninsured and privately insured people aged 55-64 between 2003 and 2010, although the increase for uninsured was not statistically significant. In contrast, the share of Medicare seniors with problems affording prescription drugs remained stable between 2003 and 2010 (changing from 9% to 8%, although this result was not statistically significant). The introduction of the Part D prescription drug benefit in 2006 may have helped protect Medicare beneficiaries from a general decline in the affordability of pharmaceuticals.

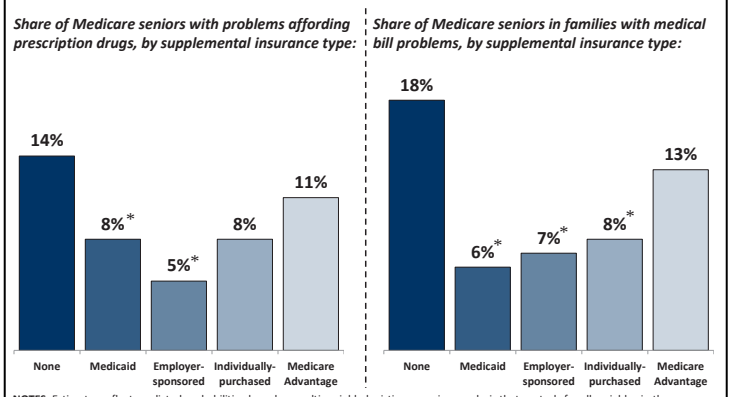
Medical bill problems appeared to be on the rise for privately insured 55- to 64-year-olds and Medicare seniors alike (**Exhibit 4**). The share of uninsured adults aged 55 to 64 with problems paying medical bills grew from about one-fifth (21%) in 2003 to nearly one-third (30%) in 2010, although the difference between the years was not statistically significant, perhaps owing to a small sample size. However, there was a statistically significant increase in the share of privately insured adults aged 55 to 64 with problems paying medical bills, from 10 percent in 2003 to 15 percent in 2010. A small but growing share of Medicare seniors had problems paying medical bills, increasing from 7 percent of Medicare seniors in 2003 to 10 percent in 2010.

Medicare seniors who lacked supplemental coverage, had lower-incomes or were African-American had more problems accessing and affording medical care than other seniors on Medicare in 2010.

Although a relatively small share of seniors on Medicare reported barriers to care or difficulty paying their medical bills, some subgroups had more problems accessing and affording care than others, even after controlling for health, income, and demographic differences (**Exhibit 5**, see **Appendix Table B.5** for additional subgroups and details). Almost one-fifth (18%) of seniors on Medicare without supplemental coverage had problems paying medical bills, a larger share than among those with employer-sponsored insurance (7%), Medigap (8%), or Medicaid (6%). Medicaid appeared to protect some low-income seniors from medical bill problems, but Medicare seniors with relatively low incomes (under 150% of the federal poverty level) as a whole were still twice as likely as seniors with incomes at or above 300 percent of poverty to have had problems paying medical bills in 2010 (13% versus 5%). Medicare seniors with incomes below 150 percent of poverty were also more likely than those with incomes at or above 300 percent of poverty to report unmet needs or delayed care (10% versus 7%). African-American seniors had more problems with health expenses than white beneficiaries: 12 percent of African-American seniors could not afford prescription drugs (compared to 7% of white seniors) and 15 percent of African-American seniors had problems paying medical bills (versus 8% of white seniors). Differences between Hispanic seniors and white seniors were not significantly significant.

EXHIBIT 5

A larger share of Medicare seniors without supplemental insurance had difficulty affording medical care than Medicare seniors with additional protection



NOTES: Estimates reflect predicted probabilities based on multi-variable logistic regression analysis that controls for all variables in the table, as well as educational attainment, census region, and metro/non-metro location.
*Difference with reference group is statistically significant at 95% confidence level.
SOURCE: 2007 and 2010 Health Tracking Household Survey.

DISCUSSION

This study confirms the significant challenges facing adults aged 55 to 64 who lack health insurance, a group that more frequently reported problems accessing medical care and paying medical bills than adults of the same age who had private health insurance and older adults with Medicare coverage.[9] These differences in access to care between the uninsured 55- to 64-year olds, privately insured same age adults and Medicare seniors exist despite the fact that the uninsured 55- to 64-year olds are less likely than other groups to use medical services.[10] Medicare seniors and privately insured adults aged 55 to 64 reported similar levels of access and cost problems. Although access problems appear to be a growing concern for uninsured people aged 55 to 64, and even among 55- to 64-year-olds with private insurance, Medicare appears to have helped to protect seniors from this trend. This finding is noteworthy given anecdotal concerns about access to care that have arisen in the context of physician payment reductions in the Medicare program.

When taking a closer look at the experiences of Medicare seniors, this study found that certain subgroups reported more barriers to care than others. Medicare seniors who did not have supplemental coverage, lower-income seniors, and African-American seniors had more problems accessing needed care and paying for medical bills than other seniors covered by Medicare. Future studies should continue to explore whether certain subpopulations of Medicare beneficiaries have more barriers to care than others.

The 2010 health reform law is expected to improve access to health coverage for uninsured adults, especially for those in their late fifties and early sixties. The health reform law has created a temporary national high-risk pool for the uninsured with pre-existing conditions, and individuals aged 55 to 64 are the largest enrollment group to date, although only about 50,000 people were enrolled through the end of 2011.[11]

Beginning in 2014, uninsured adults aged 55 to 64 are expected to gain access to health insurance as a result of the creation of health insurance exchanges, new restrictions on age rating, and additional protections against pre-existing condition exclusions in the private marketplace. Further, uninsured adults aged 55 to 64 who have low or modest incomes will have access to Medicaid or subsidies to purchase private health insurance through the health insurance exchanges. Scaling back these coverage expansions and market reforms would likely lead to ongoing access and cost problems that may worsen as health costs continue to rise. Other policies under consideration, such as raising the age of Medicare eligibility, could also have cost and access implications for older Americans if health reform provisions are not fully implemented, such as extending the period of time some may be uninsured or potentially increasing the costs for privately insured seniors who must maintain their private insurance policies for a longer time. [12] As health reform is implemented and various types of Medicare reforms are considered to control costs, policymakers should continue to monitor not only the costs to Medicare or to the health care system more broadly, but also older adults' ability to access needed and affordable medical care.

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[2] "Patient Protection and Affordable Care Act" (P.L. 111-148) as enacted on March 23, 2010 and amended by the "Health Care and Education Reconciliation Act of 2010" (P.L. 111-152) as enacted on March 30, 2010

[3] See Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals," September 23, 2011; available at www.kff.org/medicare/8124.cfm. Urban Institute, "Changing the Age of Medicare Eligibility: Implications for Older Adults, Employers, and the Government", December 2003; available at: http://www.urban.org/publications/410902.html.

[4] Kaiser Family Foundation, "The Uninsured: A Primer", October 2011; available at: http://www.kff.org/uninsured/7451.cfm.

[5] J.M. McWilliams et al., "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," JAMA, vol. 290, no. 6 (2003), p. 757-764. Also see J.M. McWilliams et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," New England Journal of Medicine, vol. 357, no. 2 (2007), p. 143-153.

[6] It is not entirely clear why privately insured adults ages 55 to 64 report medical bill problems at about the same rate as seniors on Medicare, after controlling for health status, income and other demographics. Other studies have found that elderly households have higher out-of-pocket spending for medical care than non-elderly households, but these studies are based on aggregate findings and do not adjust for health status and income, and include adults who are younger than age 55. For example, see Kaiser Family Foundation, "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households," March 2011.

[7] The observed peak in access problems for the uninsured in 2007 may have actually occurred during the intervening years of data collection.

[8] Carrier E, Tracy Y, and Garfield RL. The Uninsured and Their Health Care Needs: How Have They Changed Since the Recession? Washington DC: Kaiser Family Foundation. October 2011.

[9] Similar findings for the uninsured have been reported in other studies. For example, see Carrier E, Tracy Y, and Garfield RL. The Uninsured and Their Health Care Needs: How Have They Changed Since the Recession? Washington DC: Kaiser Family Foundation. October 2011.

[10] Carrier E, Tracy Y, and Garfield RL. The Uninsured and Their Health Care Needs: How Have They Changed Since the Recession? Washington DC: Kaiser Family Foundation. October 2011.

[11] Kaiser Family Foundation, "Explaining Health Reform: Questions About the Temporary High-Risk Pool", July 1, 2010; available at: http://www.kff.org/healthreform/8066.cfm and Department of Health and Human Services "Covering People With Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Program", February 23, 2012; available at: http://www.cciio.cms.gov/resources/files/Files2/02242012/pcip-annual-report.pdf.

[12] Kaiser Family Foundation, "Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform," July 18, 2011; available at http://www.kff.org/medicare/8169.cfm.

APPENDIX A. METHODOLOGY

This research brief presents findings from three surveys conducted by the Center for Studying Health System Change: the 2010 and 2007 Health Tracking Household Surveys and the 2003 Community Tracking Study Household Survey, all funded by the Robert Wood Johnson Foundation. All three surveys were conducted over the phone, using nationally representative samples of the civilian, non-institutionalized population. For the first time, the 2010 survey included a cell phone sample because of declining percentages of households with landline phones. Sample sizes include about 47,000 people for the 2003 survey, 18,000 people for the 2007 survey and 17,000 people for the 2010 survey. Although all three surveys are nationally representative, the sample for the 2003 survey was largely clustered in 60 representative communities, while the 2007 and 2010 surveys were based on a random sample of the nation. Standard errors account for the complex sample design of the surveys. Questionnaire design, survey administration and the question wording of all measures in this study were similar across the three surveys.

The analysis examines differences between three groups: non-institutionalized Medicare beneficiaries aged 65 and older; adults aged 55 to 64 with private insurance; and uninsured adults aged 55 to 64. After narrowing the survey sample to these groups, sample sizes were about 12,800 people in 2003; 5,900 people in 2007; and 5,500 people in 2010. Insurance status reflects coverage on the day of the interview. Private insurance coverage for persons aged 55-64 includes coverage obtained through employer-sponsored and individually purchased private insurance. Among Medicare beneficiaries, individuals were assigned to coverage sources in a mutually exclusive, hierarchical fashion as follows: (1) fee for service (FFS) without supplemental coverage, (2) Medicaid, (3) Medicare Advantage, (4) FFS with employer-sponsored or military coverage, and (5) FFS with individually purchased private coverage, including Medigap. As a result, beneficiaries with more than one source of supplemental coverage (such as individuals with both Medicaid and Medicare Advantage coverage) are only grouped with the coverage type that is higher in the hierarchy (in this case, Medicaid).

Estimates of unmet need and delayed care were based on the following two questions: (1) “During the past 12 months, was there any time when you didn't get the medical care you needed?” and (2) “Was there any time during the past 12 months when you put off or postponed getting medical care that you thought you needed?” For those reporting either an unmet need or delayed care, follow-up questions were asked to determine why. Responses included worry about cost, problems with health insurance, problems with the availability of medical providers and personal reasons, such as lack of time or procrastination.

Estimates of access to specialty care were based on the following questions: (1) “In the past 12 months, did you or a doctor think you needed to see a specialist?” If they responded “yes” to the first question, respondents were then asked (2) “In the last 12 months, did you see a specialist?” Respondents who reported that they needed to see a specialist (#1), but did not see a specialist (#2) were classified as having needed but not received specialty care.

Difficulty affording prescription drugs was based on the following question: “During the past 12 months, was there any time you needed prescription medicines but didn't get them because you couldn't afford it?” Estimates of problems paying medical bills and medical debt were based on the follow question: “During the past 12 months, (have you/has your family) had any problems paying medical bills?” For those reporting problems paying medical bills in the last 12 months, follow-up questions were asked to determine the amount of debt still owed and paid off, time since the debt was first incurred and the estimated length of time respondents projected needing to pay the debt.

The findings in this study are based on respondent self-reporting, which may be subject to potential sources of bias. One limitation of the data is the possibility of reporting error that may lead to erroneous classifications of respondents (for example, into Medicare supplemental coverage classifications). In addition, reports of unmet need and other problems with access are based on the respondents’ perceptions as opposed to documented clinical need. However, the overall findings and averages seen in the study data are on par with the current literature and other surveys of seniors on Medicare and adults aged 55 to 64, suggesting that self-reporting errors had limited impact on the study results.

Differences in access to care and affordability of care between Medicare seniors, uninsured adults aged 55-64, and privately insured adults aged 55-64 were examined using multivariate logistic regression analysis that also controlled for differences in age, gender, race/ethnicity, number of chronic conditions, perceived general health, family income, educational attainment, as well as census region and metropolitan/nonmetropolitan location. The results are presented as regression-adjusted percentages in Appendix Table B.1 by computing three sets of predicted probabilities for each individual in the sample, assuming a different coverage type for each of the predictions (i.e. Medicare, private insurance, uninsured) with all other variables in the regression model set to their individual values. Thus, the regression-adjusted estimates reflect the average of the individual predictions when all people in the sample were assumed to have (1) Medicare; (2) private insurance for the 55-64-year-old group; and (3) uninsured for the 55-64-year-old group.

Similarly, differences in access to care and affordability of care for Medicare seniors were examined using multivariate logistic regression analysis that simultaneously controlled for all factors in Appendix Table B.5, as well census region and metropolitan/nonmetropolitan location. The estimates in Appendix Table B.5 as well as Exhibit 5 reflect predicted marginals, controlling for all other factors in the regression model.

Acknowledgement

The survey data used for the analysis was sponsored by the Robert Wood Johnson Foundation.

APPENDIX B. TABLES

TABLE B.1
Measures of Access to Care, Actual and Adjusted for Demographics, 2010

	Aged 65+	Aged 55 to 64	
	Medicare	Privately insured	Uninsured
Weighted sample size	**36,892,000**	**25,027,000**	**5,374,000**
Actual (Unadjusted Percentages)			
Unmet medical needs in past year	2%	4%	25%*
Delayed getting care in the past year	6%	13%*	16%*
Unmet medical needs OR delayed getting care in the past year	8%	17%*	41%*
Needed but did not receive specialty care[1]	7%	7%*	34%*
Problems affording prescription drugs	8%	9%*	31%*
In families with medical bill problems	10%	15%*	30%*
Regression-Adjusted Percentages			
Unmet medical needs in past year	4%	3%	14%*
Delayed getting care in the past year	6%	12%*	12%*
Unmet medical needs OR delayed getting care in the past year	10%	14%	31%*
Needed but did not receive specialty care[1]	8%	6%	30%*
Problems affording prescription drugs	10%	8%	18%*
In families with medical bill problems	12%	14%	17%*

NOTES: Regression-adjusted estimates reflect predicted probabilities based on a multi-variable logistic regression analysis controlling for differences in age, gender, number of chronic conditions, perceived general health, family income, and educational attainment. [1]Sample for the "didn't receive needed specialty care" category only includes individuals who indicated that they needed specialty care in the past year.
*Difference with elderly Medicare is statistically significant at 95% confidence level.
SOURCE: Center for Studying Health System Change 2010 Health Tracking Household Survey.

TABLE B.2 Reasons for Delaying or Not Getting Needed Services			
	Aged 65+	Aged 55 to 64	
	Medicare	Privately insured	Uninsured
Weighted sample size	**6,103,000**	**9,016,000**	**3,574,000**
Percent with unmet medical needs OR delayed getting care in the past year	**8%**	**17%***	**41%***
Of those with unmet medical needs or delayed care…			
Percent worried about the cost	**56%**	**71%***	**96%**
Percent with health insurance barriers	**38%**	**35%**	**N/A**
Doctor or hospital wouldn't accept insurance	18%	12%*	N/A
Health plan would not pay for treatment	31%	30%	N/A
Change in insurance	1%	0%	N/A
Other insurance-related problem	0%	0%	N/A
Percent with delivery system barriers	**64%**	**50%***	**23%***
Could not get appointment soon enough	30%	30%*	12%*
Could not get there when the doctor's office was open	25%	22%	9%*
Takes too long to get there	18%	10%*	9%*
Could not get through on the telephone	22%	13%*	8%*
Had to wait in office or clinic too long	1%	0%	2%
Do not know where to go	2%	2%	0%
Cannot get referral from doctor	0%	0%	0%
Other problems related to system	5%	4%	1%*

NOTES: N/A denotes that the information is "not applicable".
*Difference with elderly Medicare is statistically significant at the p<.05 level.
SOURCE: Combined Center for Studying Health system change 2007 and 2010 Health Tracking Household Surveys.

TABLE B.3 Medical Debt and Problems Paying Medical Bills			
	Aged 65+	**Aged 55 to 64**	
	Medicare	**Privately insured**	**Uninsured**
Weighted sample size	**36,702,000**	**26,547,000**	**4,474,000**
Percent in families with medical bill problems	**10%**	**15%***	**30%***
Of those with medical bill problems…			
Amount owed in medical bills			
Paid off their medical debt	21%	19%	11%
$1 to $1,999	46%	36%*	27%*
$2,000 to $4,999	19%	24%	24%
$5,000 or more	13%	21%*	38%*
Time since bills first occurred			
Within past year	41%	43%	43%
1 to 2 years ago	22%	22%	23%
2 to 5 years ago	19%	23%*	22%*
5 or more years ago	18%	12%*	12%*
Estimated time to pay off			
Within 1 year	55%	57%	34%*
2 to 3 years	25%	22%	27%
4 to 5 years	6%	9%*	9%*
5 or more years	13%	12%	30%*
Amount of medical bills paid off			
None or a little	31%	27%	48%*
Some	24%	28%	27%
Most or all	45%	45%	26%*

*Difference with elderly Medicare is statistically significant at .05 level.
SOURCE: Combined Center for Studying Health System Change 2007 and 2010 Health Tracking Household Surveys.

TABLE B.4 Trends in Access to Care, 2003-2010			
	2003	**2007**	**2010**
Weighted sample size			
Medicare aged 65 and over (total)	32,806,000	32,768,000	36,892,000
Aged 55-64 (total)	22,387,000	26,349,000	30,401,000
Privately insured	19,616,000	23,397,000	25,027,000
Uninsured	2,771,000	2,953,000	5,374,000
Unmet medical needs in past year			
Medicare aged 65 and over (total)	2%	3%	2%
Aged 55-64 (total)	5%	8%	8%#
Privately insured	4%	6%	4%*
Uninsured	15%	22%	25%#
Delayed getting care in the past year			
Medicare aged 65 and over (total)	5%	6%	6%
Aged 55-64 (total)	9%	15%	14%#
Privately insured	7%	14%	13%#
Uninsured	17%	24%	16%
Unmet medical needs OR delayed getting care in the past year			
Medicare aged 65 and over (total)	7%	9%	8%
Aged 55-64 (total)	14%	23%	21%#
Privately insured	11%	20%	17%#*
Uninsured	32%	46%	41%#
Needed but did not receive specialty care[1]			
Medicare aged 65 and over (total)	N/A	6%	7%
Aged 55-64 (total)	N/A	11%	10%
Privately insured	N/A	9%	7%
Uninsured	N/A	--	--
Problems affording prescription drugs			
Medicare aged 65 and over (total)	9%	8%	8%
Aged 55-64 (total)	9%	11%	13%#
Privately insured	6%	8%	9%#
Uninsured	27%	33%	31%
In families with medical bill problems			
Medicare aged 65 and over (total)	7%	8%	10%#
Aged 55-64 (total)	12%	15%	17%#
Privately insured	10%	13%	15%#
Uninsured	21%	40%	30%

NOTES: "N/A" indicates that data was not available. Dashes (--) indicate that the category was excluded from analysis due to a sample size of less than 100. [1] Sample for the "didn't receive needed specialty care" category only includes individuals who indicated that they needed specialty care in the past year.

Change from 2003 is statistically significant .05 level.

*Change from 2007 is statistically significant at .05 level.

SOURCES: Center for Studying Health System Change 2003 Community Tracking Study Household Survey and 2007 and 2010 Health Tracking Household Surveys.

TABLE B.5
Measures of Access to Care for Medicare Beneficiaries Ages 65 and Older, by Type of Coverage and Demographics

	Weighted sample size	Unmet needs	Delayed care	Unmet needs or delayed care	Couldn't afford prescription drugs	Didn't receive needed specialty care[1]	Medical bill problems
Overall	**36,702,000**						
Age							
65 to 74 (reference)	21,593,000	4%	7%	11%	11%	6%	11%
75 to 84	11,809,000	2%*	5%*	6%*	6%*	7%	7%*
85 and older	3,330,000	2%	4%*	6%*	5%*	5%	6%
Gender							
Male (reference)	15,811,000	3%	4%	7%	7%	6%	10%
Female	20,891,000	3%	7%*	9%	9%	7%	9%*
Race/ethnicity							
White (reference)	29,916,000	3%	6%	8%	7%	6%	8%
African-American	3,093,000	3%	6%	9%	12%*	11%	15%*
Hispanic	2,209,000	4%	7%	10%	10%	7%	10%
Other	1,483,000	6%*	6%	13%	16%*	5%	14%
Coverage Type							
FFS, no supplemental coverage (reference)	3,346,000	3%	7%	10%	14%	8%	18%
Medicaid dual eligibles	3,312,000	4%	5%	8%	8%*	13%	6%*
FFS, employer-sponsored or military coverage	11,001,000	3%	6%	8%	5%*	5%	7%*
FFS, individually-purchased private coverage, including Medigap	9,528,000	3%	5%	8%	8%	7%	8%*
Medicare Advantage	6,004,000	2%	8%	11%	11%	5%	13%
Family income (as a percentage of the federal poverty level)							
Less than 150% (reference)	8,415,000	4%	7%	10%	10%	7%	13%
150 to 300%	10,369,000	3%	7%	10%	12%	5%	13%
300% and higher	17,918,000	3%	5%*	7%*	5%*	7%	5%*
Number of chronic conditions							
None (reference)	8,840,000	2%	5%	7%	5%	13%	7%
1	10,195,000	3%	5%	8%	8%*	7%*	9%
2	8,431,000	3%	5%	8%	9%*	6%*	9%
3	4,632,000	4%*	9%*	12%*	10%*	3%*	11%
4 or more	2,945,000	4%*	10%*	14%*	12%*	4%*	13%*
Health status							
Excellent or very good (reference)	15,676,000	2%	4%	6%	6%	6%	5%
Good	11,137,000	3%	5%	8%	7%	6%	10%*
Fair or poor	9,889,000	4%*	9%*	13%*	12%*	9%	13%*

NOTES: Estimates reflect predicted probabilities based on multi-variable logistic regression analysis that controls for all variables in the table, as well as educational attainment, census region, and metro/non-metro location. FFS is fee-for-service. Individuals were assigned to coverage sources in a mutually exclusive, hierarchical fashion as follows: (1) FFS without supplemental coverage, (2) Medicaid, (3) Medicare Advantage, (4) FFS with employer-sponsored or military coverage, and (5) FFS with individually-purchased private coverage, including Medigap. 1 Sample for the "didn't receive needed specialty care" category only includes individuals who indicated that they needed specialty care in the past year.

*Difference with reference group is statistically significant at 95% confidence level.

SOURCE: Center for Studying Health System Change 2007 and 2010 Health Tracking Household Surveys.

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