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Access to Care for Low-Income Medicaid and Privately Insured Adults in 2012 in the National Health Interview Survey: A Context for Findings from a New Audit Study

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Executive Summary

This brief uses national data to provide context for a 10-state study on the availability of new patient appointments for primary care which was conducted between October 2012 and March 2013 using a simulated patient (audit) methodology. The audit study found that the number of primary care practices willing to accept new Medicaid patients was substantially smaller than the number willing to accept new private patients, but that practices typically offered appointments within a week of the call to both Medicaid and private callers. While the audit highlights the more restricted choice of providers with appointment availability for new Medicaid as opposed to private patients, it is unclear whether less choice translates to worse access to care.

We use 2012 data from the National Health Interview Survey to examine primary care access and service receipt among low-income adults. We find that the vast majority (~86%) of both Medicaid and privately insured (defined as having employer-sponsored coverage) low-income adults who had been insured for 12 months or more had a usual source of care and that two-thirds had had a general doctor visit in the prior year. Moreover, only a relatively small minority of Medicaid enrollees reported problems finding providers or accessing care because of affordability concerns, and adults with Medicaid coverage received preventive care and screening at similar rates to low-income adults with private coverage.

Thus, despite the more restricted number of providers with new patient appointment availability for Medicaid patients that is evidenced by the audit study, the access measures from the National Health Interview Survey suggest that established and new Medicaid enrollees were getting connected to primary care providers at high rates in 2012.

It will be important to continue tracking primary care access in the coming years to assess whether primary care capacity, particularly in Medicaid, keeps pace with the increased demand for care that is expected to come about under the Affordable Care Act.

Introduction and Summary

This brief uses the National Health Interview Survey (NHIS) to provide context for and complement the findings from a new audit study of primary care appointment availability conducted between October 2012 and March 2013 in 10 states.[1] In the audit study (see appendix for more details on the audit study and its findings), trained interviewers (posing as new patients) called primary care clinics seeking appointments. The audit found that 58% practices that participated in Medicaid offered new patient appointments to the Medicaid callers. By contrast, 85 percent of the practices serving private patients offered appointments to private callers (typically calling for the private plan with the largest market share in the county) —27 percentage points higher than the rate for Medicaid calls. Practices that offered new patient appointments typically had wait times that were about a week for both Medicaid and private calls. Taken as a whole, the audit study provides evidence that while the set of practices serving new patients was more limited for Medicaid patients, appointments for primary care were generally available on a timely basis for both new Medicaid and private patients.

The audit study provides rigorous evidence contrasting provider appointment availability and timeliness for new patients with different types of insurance. However, the audit is not designed to replicate the

process that actual patients would use when searching for a new primary care provider. Moreover, it does not consider primary care appointment availability or wait times for established patients who already have a usual source of care. To assess the extent to which the more restricted provider choice found on the audit may be translating into differential access to primary care for established Medicaid and privately insured adults, we use nationally representative data from the 2012 National Health Interview Survey (NHIS). We compare reports of provider access problems among newly enrolled and established Medicaid patients and privately insured patients. In addition, we go beyond provider access, to consider access problems related to affordability concerns and assess receipt of preventive care and screenings and the presence of a usual source of care. Analyses are restricted to individuals with household incomes below 250% of the federal poverty level to provide a more comparable sample across demographics and economic resources. Analyses are also conducted that assess the access experiences for low-income uninsured adults in comparison to those of Medicaid-covered adults.

Consistent with the findings from the audit study, the NHIS indicates that adults who were new to Medicaid coverage were more likely than adults who were new to private coverage to report that they had difficulties finding a general doctor or provider (such as a nurse practitioner or physician assistant) with availability in the past 12 months; 11.3 percent of new Medicaid enrollees reported that they had had this experience compared to 6.2 percent of new private enrollees; however, the difference in reported difficulties finding a general doctor is not statistically significant when we control for observed differences between Medicaid and ESI enrollees. We also found that Medicaid enrollees who had been continuously insured were less likely than new Medicaid enrollees to report having difficulties finding a general doctor or provider with availability.

For measures of access and service use not reflected in the audit study, there is little difference between adults with Medicaid and private coverage. Among those fully insured in the prior year, 85 percent of both the Medicaid and privately insured groups said they had a usual source of care and over 60 percent said that they had had a general doctor visit in the prior year. Medicaid-covered adults reported receiving preventive services at similar rates to low-income privately insured adults. Among the other access measures, affordability concerns were higher among the low-income adults with ESI as opposed to Medicaid coverage. For these measures, low-income adults with ESI were more likely than Medicaid-covered adults to report that they had delayed or not gotten needed care because of affordability concerns and that they had had skipped medication doses or otherwise changed their use of prescription drugs in order to save money.

The patterns from the NHIS suggest that established low-income Medicaid and privately insured adults were generally experiencing comparable levels of primary care access but that when Medicaid and privately insured adults do experience primary care access barriers, Medicaid enrollees were more likely to experience difficulties getting access to providers, whereas privately insured adults were more likely to experience cost barriers. Moreover, the NHIS data indicate that provider access barriers are relatively rare among established Medicaid-covered and privately insured patients who are seeking primary care. The data also highlight the importance of other dimensions of access, such as the affordability of care.

The NHIS analysis also showed that relative to low-income adults with Medicaid coverage, low-income uninsured adults were more likely to report both provider and affordability access issues and less likely to report that they had a usual source of care and that they were receiving preventive care and screenings. The pattern of results from the NHIS indicates that many low-income uninsured adults face substantial financial barriers to care which is consistent with the findings from the audit; in the ten states, the median cost of a new patient visit for the uninsured was $120 and just 15.4 percent of the uninsured callers were offered an appointment that required a payment of $75 or less at the time of the visit.

Both the audit findings and the NHIS analyses pertain to the period before the major coverage provisions of the Affordable Care Act (ACA) were implemented. These provisions, which include a Medicaid expansion and federal subsidies for coverage available through the new marketplaces, are expected to increase the number with health insurance coverage by millions in 2014.[2] It will be important to continue tracking primary care access in the coming years to assess whether primary care capacity, particularly in Medicaid, keeps pace with the increased demand for care that is expected to result under the ACA.

Data and Methods

The core data set for the analysis is the 2012 NHIS, an annual face-to-face household survey of the civilian non-institutionalized population which is fielded

continuously over the course of the year. The NHIS has a nationally representative sample of approximately 35,000 households each year. This analysis focuses on low-income adults, defined as those age 19 to 64 with incomes below 250 percent of the federal poverty level to provide a comparison of the experiences of low-income adults with Medicaid and employer-sponsored insurance (ESI).[3]

The primary analysis sample for this brief includes 1,806 low-income adults who had Medicaid coverage at the time of the survey and who had been insured for the full prior 12 months and 3,517 low-income adults who had employer-sponsored insurance (ESI) at the time of the survey and who had been insured for the full prior 12 months.[4] The information available on the NHIS does not allow us to distinguish adults who had had Medicaid or ESI continuously over the prior year from those who were continuously insured but had changes in their insurance type over the course of the year. We refer to the adults with Medicaid at the time of the survey who had been insured for a full 12 months as *Established Medicaid Patients* and those with ESI at the time of the survey who had been insured for a full 12 months as *Established ESI Patients*. Medicaid coverage is defined as those who report Medicaid or other public coverage excluding Medicare, while private coverage includes just those with ESI. We also exclude those with Supplemental Security Income from the Medicaid sample because these individuals are likely to have more complex health needs than the general adult population. We focus on coverage through ESI as opposed to nongroup coverage because policies available through the nongroup market in 2012 are unlikely to be indicative of the coverage to which low-income adults will have access through the new Marketplaces under the ACA.

Because the audit study examined appointment availability for new patients, we supplemented our analysis with tabulations on provider access for a group of adults whom we could identify as newly enrolling in Medicaid or ESI—namely adults who had Medicaid or ESI at the time of the survey but who had been uninsured at some point in the prior year—using data from both the 2011 and 2012 NHIS to increase the precision of the estimates. While it is not possible to establish whether the respondent is describing provider access experiences while they had Medicaid or ESI or for the period during which they were uninsured, this analysis may be suggestive of provider access issues experienced by new as opposed to established enrollees.

With one exception (whether the adult currently has a usual source of care), all the measures that are examined reflect reported experiences over the 12-month reference period prior to the survey. The following outcomes are examined:

Access Problems Related to Provider and Appointment Availability: had trouble or was unable to find a general doctor or provider with availability (the latter is a subset of the group that reported that they had had trouble finding a general doctor or provider with availability); had difficulty finding a doctor or clinic who would accept respondent as a new patient or finding a doctor or clinic who would accept respondent's health care coverage, and delayed care because they could not get an appointment soon enough. The first two measures referring to the availability of care from a general doctor or provider likely reflect primary care access and as such, most closely parallel the audit study. In contrast, the latter three measures could pertain to experiences the respondent had getting access to specialty care. We also created a composite indicator, "any difficulty reported with provider access" which took the value "1" if the respondent reported trouble finding a general doctor or provider with availability, had difficulty finding a doctor or clinic taking new patients, had difficulty finding a doctor or clinic who took their insurance type, or delayed care because they could not get an appointment soon enough.

Access Problems and Financial Burdens Related to Affordability Issues: had an unmet need for medical care or prescription drugs because the respondent could not afford medical care or prescription drugs; delayed medical care because of costs; skipped medication doses to save money, took less medication to save money, or delayed filling a prescription to save money. We created two composite measures: one called "any unmet medical care/ prescription drug need due to affordability concerns," which took the value "1" if the respondent reported an unmet need for medical care or prescription drugs and one called "any change in prescription drug behavior to save money," which took the value "1" if the respondent reported that they skipped medication doses to save money, took less medication to save money, or delayed filling a prescription to save money.

Usual Source of Care and Primary Care Receipt: Presence of a usual source of care that is not an emergency room; any office visit in the prior 12 months; any visit to a general doctor in the prior 12 months; received preventive care and screenings in the

prior 12 months, including blood pressure check or blood cholesterol level check; received test for high blood sugar, pap smear, or mammogram; received information about health issues associated with diet and smoking; and received a flu vaccination.

One complication associated with comparing and interpreting outcomes for low-income privately and publicly insured adults is that they differ along a number of other dimensions that could affect their use of services and care experiences. As seen in table 1, those who had Medicaid coverage were less likely than those with ESI to be ages 18 to 30 and more likely to be ages 31 to 45; female; to be in poor, fair, or good health, have mental health problems, and have functional limitations; to have one of seven chronic health problems; to be black or Hispanic or be a noncitizen; to have been pregnant in the past 12 months; to have lower income and less education; to be married, a parent, or unemployed; and to live in the Northeast. They were less likely to live in the Midwest or South.

We present mean levels and both unadjusted and adjusted differences in the outcomes between Medicaid and private coverage and between newly insured Medicaid and established Medicaid enrollees, where the adjusted differences control for the observed demographic, health, and socioeconomic factors included in table 1. While ideally, we would control for the neighborhood in which the respondent lives and where they seek care, we can only control for region of residence. Therefore, we use education, income, and other socioeconomic and demographic indicators as proxy measures. By adjusting for observed differences between the two groups, we can assess the extent of differences in these outcomes between Medicaid-covered and ESI-covered adults and between new and established Medicaid enrollees, taking into account the observed differences in their characteristics that could affect their access to care. Because of ongoing debate across the country about whether to expand Medicaid to low-income adults, we also provide estimates on these measures for low-income uninsured adults to assess how their access to care compared to low-income adults with private and public coverage.

This NHIS analysis has a number of limitations. While reports on the presence or absence of insurance coverage are fairly reliable, information on the type of coverage is subject to greater measurement error on household surveys.[5] Therefore, there may be some misclassification of Medicaid and ESI coverage. Also, the outcomes are based on reports from the respondent which reflects subjective assessments of unmet needs, which might not align with clinical judgment. The measures reported here may also be subject to recall or social desirability bias. It is possible that Medicaid-covered and ESI-covered adults may report differently on similar experiences, such as different expectations on how easy it should be to find a provider. Moreover, the national estimates presented here do not necessarily reflect the situation in the states included in the audit study. Finally, despite controlling for observed demographic, health, and socioeconomic characteristics of low-income adults in the three insurance groups examined here, there may be unobserved differences across groups related to willingness to seek care and local circumstances which affect the outcomes. Therefore, this analysis cannot be interpreted as providing definitive evidence of a causal nature.

Findings

Access for Medicaid Versus ESI-Insured Low-Income Adults

Access Problems Related to Finding a General Doctor or Provider Among Established Medicaid and ESI-Insured Patients. We find that under 5 percent of adults with established Medicaid coverage and 2 percent of low-income adults with ESI report that that they had trouble finding a general doctor or provider in the past year (table 2). Among low-income adults, 4.0 percent with Medicaid said that they had had trouble finding a general doctor or provider with availability, and 1.0 percent said that they were unable to find a general doctor or provider with availability—this compares to 1.8 and 0.4 percent for low-income adults with ESI coverage, respectively. While low-income adults with Medicaid coverage were 2.2 percentage points more likely than those ESI to say they had trouble finding a general doctor or provider with availability, that difference was smaller (1.3 percentage points) when we control for observed differences in the characteristics of low-income adults with Medicaid as opposed to those with ESI.

Access Problems Related to Finding a General Doctor or Provider Among Newly Enrolled Versus Established Medicaid and ESI-Insured Patients. When we assess the experiences of adults who were enrolled in Medicaid or ESI at the time of the survey but who had been uninsured for some period of the prior 12 months to assess whether new enrollees may be having systematically different experiences than established enrollees, we find that those who were new

Table 1: Demographic, Health, and Socioeconomic Characteristics of All Low-Income Adults (19 to 64), by Full-Year

	All Low Income	Full Year Insurance Status		Difference	
		Medicaid	ESI		
Age					
18-30	42.3	45.2	50.4	-5.2	***
31-45	35.8	39.1	31.1	8.0	***
50-64	22.0	15.7	18.5	-2.8	**
Gender					
Male	46.6	32.7	46.1	-13.4	***
Female	53.4	67.3	53.9	13.4	***
Health Status					
Excellent/ Very good	53.5	49.8	65.0	-15.2	***
Good/Fair/Poor	46.5	50.2	35.0	15.2	***
Mental Health Problem	17.8	19.5	12.0	7.4	***
Functional Limitation	31.8	31.6	23.9	7.7	***
At Least One Chronic Condition	36.9	38.9	31.7	7.2	***
Heart Disease/Condition	8.1	8.6	5.5	3.0	***
Hypertension	22.0	22.5	16.7	5.7	***
Stroke	2.2	2.0	1.1	1.0	**
Asthma	14.7	16.8	13.5	3.3	**
Emphysema	1.8	2.2	0.8	1.4	***
Diabetes	7.7	8.6	5.3	3.4	***
Weak/ Failing Kidneys	1.8	2.0	0.7	1.4	***
BMI (mean)	26.8	27.1	26.8	0.4	
Missing	4.3	4.6	2.9	1.7	**
Race/Ethnicity					
White, non-Hispanic	51.8	40.6	62.9	-22.3	***
Black, non-Hispanic	16.8	22.4	15.0	7.4	***
Hispanic	25.2	30.3	15.9	14.4	***
Other race, non-Hispanic	6.2	6.7	6.2	0.5	
Noncitizen	15.4	17.2	5.8	11.4	***
Married	34.9	30.9	37.7	-6.8	***
Pregnant in Prior 12 Months	1.5	3.9	1.1	2.8	***
Family Income					
Less than or Equal to 138% of FPL	59.2	77.8	43.1	34.7	***
138-249% of FPL	40.8	22.2	56.9	-34.7	***
Education					
Less than High School	22.9	32.6	10.9	21.7	***
High School Graduate	30.8	32.8	27.5	5.3	***
Some College	33.8	28.4	43.6	-15.2	***
College Graduate	12.4	6.2	18.0	-11.8	***
Homeowner	43.1	32.2	53.8	-21.6	***
Parent of Dependent Child in the Household	39.1	56.3	39.1	17.2	***
Employment					
Full-time	39.6	24.7	54.7	-29.9	***
Part-time	17.4	18.5	18.7	-0.2	
Not Working	43.0	56.8	26.6	30.2	***
Spouse Full-time	15.8	12.6	19.6	-6.9	***
Spouse Part-time	4.4	4.5	3.9	0.6	
Spouse not Working	13.1	12.0	12.9	-0.8	
Government Employee	5.1	3.8	9.8	-6.0	***
Firm Size Missing	3.0	2.9	3.4	-0.5	
Firm Size Less than 50 workers	34.1	28.7	34.2	-5.5	***
Firm Size Greater than or Equal to 50 workers	19.8	11.3	35.7	-24.4	***
Worked Job for a Year or More	39.9	28.8	55.1	-26.3	***
Region					
Northeast	15.7	25.1	16.6	8.5	***
Midwest	22.2	20.9	27.1	-6.3	***
South	38.6	27.2	35.3	-8.1	***
West	23.5	26.8	21.0	5.8	***
Sample Size	**13,133**	**1,806**	**3,517**		

Source: 2012 NHIS

Note: Low-Income is defined as living in a household with family income at or below 250% of FPL. MI commands used to adjust standard errors for multiply imputed income data. Medicaid and ESI status is only recorded at the time of the survey, while the full-year insurance status can be a combination of different insurances. Medicaid excludes those with Supplemental Security Income. ESI is employer-sponsored insurance. FPL is the federal poverty level. BMI is body mass index, for which we report the mean value for each group. Medicaid and ESI columns remove observations for which there is missing information on the covariates.

* (**) (***) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

Table 2: Access and Use Experiences of All Low-Income Adults (19 to 64), by Full-Year Insurance Status

	All Low Income	Full Year Insurance Status		Difference			
		Medicaid	ESI	Unadjusted		Adjusted	
Access Problems Related to Provider and Appointment Availability							
Any Provider Access Problem	12.3	14.4	8.3	6.1	***	4.0	***
Difficulties Finding a General Doctor or Provider with Availability	4.6	4.0	1.8	2.2	***	1.3	*
Was not able to find a general doctor or provider with availability	1.7	1.0	0.4	0.6	*	-0.3	
Difficulties Finding a Provider or Delayed Care Due Because Could not Get an Appointment	10.5	13.9	7.7	6.2	***	4.5	***
Was told by doctor's office or clinic would not accept as a new patient	3.5	4.9	1.6	3.3	***	2.3	***
Was told by doctor's office or clinic would not accept their health care coverage	4.4	6.8	2.6	4.2	***	3.5	***
Delayed care because couldn't get an appointment soon enough	6.5	8.4	5.2	3.2	***	2.3	**
Access Problems and Financial Burdens related to Affordability Issues							
Any Unmet Need due to Affordability Concerns	24.6	11.0	11.6	-0.7		-6.4	***
Medical care	16.2	5.1	6.0	-0.9		-3.8	***
Prescription drugs	15.9	7.8	7.8	0.0		-5.4	***
Any Delayed Medical Care due to Affordability Concerns	19.5	6.9	9.3	-2.3	**	-2.9	**
Any Change in Prescription Drug Behavior to Save Money	16.3	8.9	10.5	-1.6		-6.2	***
Skipped medication doses to save money	10.7	5.3	6.2	-0.9		-4.8	***
Took less medication to save money	11.2	6.2	6.6	-0.4		-4.4	***
Delayed filling a prescription to save money	13.9	7.1	9.0	-2.0	**	-5.9	***
Usual Source of Care and Primary Care Receipt:							
Had a Usual Source of Care	69.0	85.4	85.6	-0.2		-0.8	
Doctor's office or HMO	62.6	53.8	75.4	-21.6	***	-18.0	***
Clinic or health center	33.5	42.0	22.0	19.9	***	16.3	***
Other Place	3.9	4.2	2.6	1.6	**	1.7	*
Any Office Visit	72.9	85.6	82.7	2.9	**	0.0	
Any General Doctor Visit	55.3	66.1	64.4	1.7		-1.8	
Had Preventive Care							
Had blood pressure checked	71.7	81.2	80.8	0.4		0.4	
Had blood cholesterol checked	45.6	55.0	51.2	3.8	*	-0.4	
Received fasting test for high blood sugar or diabetes	32.2	39.2	35.1	4.1	**	-0.1	
Received pap smear or pap test (women aged 18 or older)	49.9	60.4	56.9	3.4		3.4	
Received mammogram (women aged 30 or older)	32.4	34.8	37.9	-3.1		-3.8	
Received test for colon cancer (adults aged 40 or older)	13.1	16.1	16.7	-0.6		-1.4	
Been talked to about diet	22.8	28.7	23.2	5.5	***	2.2	
Been talked to about smoking (adults who smoke every \ some days)	46.1	54.9	49.6	5.3		0.3	
Received flu vaccination	24.5	27.7	30.3	-2.6	*	-5.1	***
Sample Size	**13,133**	**1,806**	**3,517**				

Source: National Health Interview Survey, 2012

Note: Low-Income is defined as living in a household with family income at or below 250% of FPL. The regression-adjusted differences are derived from multivariate regression models that control for age; gender; general and mental health status; presence of a chronic condition: heart disease, hypertension, stroke, asthma, emphysema, diabetes, and weak or failing kidneys; BMI; Pregnant in the past year; race/ethnicity; marriage status; family income; education; home ownership; parent status; employment; and region. Medicaid and ESI status is only recorded at the time of the survey, while the full-year insurance status can be a combination of different insurances. Medicaid excludes those with Supplemental Security Income. ESI is employer-sponsored insurance. FPL is the federal poverty level. Insured columns remove observations for which there is missing information on the covariates.

* (**) (***) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

Table 3: Gaps in Access of Health Care for Low-Income Insured Adults (19 to 64), by Full-Year Insurance Status

	Medicaid		Difference			
	Insured Full-Year	Not Insured Full-Year	Unadjusted		Adjusted	
Any Provider Access Problem	15.3	27.1	-11.8	***	-9.8	***
Difficulties Finding a General Doctor or Provider	4.5	11.3	-6.8	***	-6.0	***
Was not able to find a general doctor or provider with availability	1.2	2.8	-1.6	**	-1.5	**
Difficulties Finding a Provider or Delayed Care Due Because Could not Get an Appointment	14.5	24.9	-10.4	***	-8.4	***
Was told by doctor's office or clinic would not accept as a new patient	4.9	11.4	-6.4	***	-5.4	***
Was told by doctor's office or clinic would not accept their health care coverage	7.1	16.0	-8.9	***	-7.7	***
Delayed care because couldn't get an appointment soon enough	8.9	14.8	-5.9	***	-4.5	***
Sample Size	**3,552**	**797**				

	ESI		Difference			
	Insured Full-Year	Not Insured Full-Year	Unadjusted		Adjusted	
Any Provider Access Problem	8.9^^^	16.5 ^^^	-7.6	***	-6.6	***
Difficulties Finding a General Doctor or Provider	1.7^^^	6.2 ^^^[a]	-4.5	***	-4.1	***
Was not able to find a general doctor or provider with availability	0.4^^^	2.1	-1.7	**	-1.6	**
Difficulties Finding a Provider or Delayed Care Due Because Could not Get an Appointment	8.4^^^	14.0 ^^^	-5.6	***	-4.6	***
Was told by doctor's office or clinic would not accept as a new patient	1.7^^^	4.8 ^^^	-3.0	***	-2.4	**
Was told by doctor's office or clinic would not accept their health care coverage	2.7^^^	4.6 ^^^	-1.9	**	-1.9	**
Delayed care because couldn't get an appointment soon enough	5.8^^^	9.0 ^^[a]	-3.2	**	-2.8	*
Sample Size	**6,803**	**769**				

Source: National Health Interview Survey, 2011/2012

Notes: Low-Income is defined as living in a household with family income at or below 250% of FPL. The regression-adjusted differences are derived from multivariate regression models that control for age; gender; general and mental health status; presence of a chronic condition: heart disease, hypertension, stroke, asthma, emphysema, diabetes, and weak or failing kidneys; BMI; Pregnant in the past year; race/ethnicity; marriage status; family income; education; home ownership; parent status; employment; and region. Medicaid and ESI status is only recorded at the time of the survey, while the full-year insurance status can be a combination of different insurances. Medicaid excludes those with Supplemental Security Income. ESI is employer-sponsored insurance. Insurance groups remove observations for which there is missing information on the covariates. FPL is the federal poverty level.

* (**) (***) indicates difference between the full-year and part-year insured for Medicaid and ESI groups is significant at the .10 (.05) (.01) level.

^ (^^) (^^^) indicates unadjusted difference between Medicaid and ESI for the full-year and part-year insured groups is significant at the .10 (.05) (.01) level.

[a] indicates difference between Medicaid and ESI for the full-year and part-year insured groups is no longer significant at the .10 level when controlling for observed differences.

to Medicaid or ESI were more likely to say that they experienced provider access issues, including trouble finding a general doctor or provider with availability relative to adults who were enrolled in Medicaid at the time of the survey and who had been insured for the entire 12-month reference period (table 3). However, as indicated above, we do not know when the problem occurred for those who were uninsured at some point in the year.

Among the Medicaid enrollees who had been uninsured at some point in the prior 12 months, 11.3 percent said they had trouble finding a general doctor or provider with availability compared to 4.5 percent among the Medicaid enrollees who had been insured for the prior 12 months. While the new Medicaid enrollees were more likely to report difficulty finding a general doctor or provider, most who reported that they had had difficulty finding one with availability indicated that they had found one, with just 2.8 percent saying that they had been unable to find a general doctor with availability. For the ESI enrollees who had been uninsured at some point in the prior 12 months, 6.2 percent said they had trouble finding a general doctor or provider with availability compared with 1.7 percent among the ESI enrollees who had been insured for the prior 12 months. For all the measures examined, low-income adults who were newly enrolling in either Medicaid or ESI coverage were more likely to report that they had experienced provider access problems over the 12 months prior to the survey relative to those who had been insured for all 12 months, and Medicaid enrollees were more likely to report provider access problems relative to ESI enrollees who were insured for part or all of the year, respectively.

Access Problems Related to Provider Issues. Considering provider access issues that may arise beyond those related to finding a general doctor or provider with availability, 4.9 percent of adults with Medicaid coverage said that they had difficulties finding

a doctor's office or clinic (not limited to a general doctor) taking new patients and 6.8 percent said that they had difficulty finding a provider who took their insurance type compared with 1.6 and 2.6 percent for low-income adults with ESI, respectively. Overall, 8.4 percent of Medicaid enrollees said they had delayed getting care because they could not get an appointment compared with 5.2 percent of low-income adults with ESI. Controlling for observed differences between low income adults with Medicaid and ESI, we find that those with Medicaid coverage are 2.2 percentage points more likely to say that they had trouble finding a provider taking new patients and 3.5 percentage points more likely to say that they had trouble finding a provider who would take their insurance type. They were 2.3 percentage points more likely to have delayed getting care because they could not get an appointment soon enough. Overall, Medicaid enrollees were more likely (6.2 percentage points) to report having any difficulty finding a general doctor or provider, although the difference did diminish when controlling for observed differences (to a 4.5 percentage-point difference).

Access Problems Related to Affordability Issues. For both low-income Medicaid and ESI-covered adults, approximately 11 percent said that they experienced any unmet need due to affordability concerns. Less than 6 percent said that they had an unmet need for medical care specifically because of affordability concerns, and 8.0 percent said they had an unmet need for prescription drugs because of affordability concerns. While there are no significant unadjusted differences, when we take into account observed differences between these two groups, we find that low-income adults with Medicaid coverage were 3.8 and 5.4 percentage points less likely than low-income adults with employer-sponsored coverage to say they had experienced an unmet need for medical care or for prescription drugs because of affordability concerns, respectively. In both unadjusted and adjusted analysis, adults with Medicaid coverage also were significantly less likely than those with ESI to report that they had delayed medical care because of affordability concerns and less likely to say that they had delayed filling a prescription or to have made a related change in order to save money.

Adults with Medicaid coverage were less likely to say that they had made one of several specific changes to in the prescription drug or therapy regime due to affordability concerns. Controlling for other factors, we find that Medicaid enrollees were 2.9 percentage points less likely to say they delayed getting needed medical care because of affordability concerns and were 6.2 percentage points less likely to have delayed filling a prescription or have made some other change in response to cost concerns.

Usual Source of Care and Primary Care Receipt. Over four-fifths (85 percent) of low-income adults with Medicaid and ESI coverage said they had a usual source of care. The type of usual source of care differs for the two groups, with Medicaid-covered adults much more likely to say that they have a clinic or health center as their usual source of care relative to low-income privately insured adults (42.0 versus 22.0 percent). Over 60 percent of both low-income adults with Medicaid and ESI coverage said they had had a general doctor visit in the prior year. Across the different screening and preventive care measures included in the NHIS, Medicaid enrollees were more likely than low-income adults with ESI to have had their blood cholesterol levels checked, to have received a fasting test for high blood sugar, and to have been counseled about diet. When we control for observed differences between Medicaid-covered and ESI-covered adults, we find that Medicaid-covered adults were less likely to have received a flu vaccination.

Access for Medicaid Versus Uninsured Low-Income Adults

Table 4 shows that low-income uninsured adults were more likely to report both provider and affordability access issues and less likely to report that they had a usual source of care and that they were receiving preventive care and screenings. For example, in unadjusted analysis, uninsured were 26.1 percentage points more likely to have delayed getting medical care because of affordability concerns, 47.2 percentage points less likely to have a usual source of care, and between 11 and 32 percentage points less likely to have received such preventive services or screenings as receiving a cholesterol check or a flu vaccination. Even when we control for observed differences between the low-income uninsured and those with Medicaid coverage, large differences persist between low-income adults with Medicaid coverage and those who are uninsured, particularly for access problems that reflect affordability concerns and in terms of the receipt of primary care services.

Discussion

The NHIS results provide important context to the findings from the audit study, which explored primary care appointment availability for new patients. Using rigorous methods, the audit study illustrates that the

Table 4: Access and Use Experiences of All Low-Income Adults (19 to 64), by Full-Year Insurance Status

	All Low Income	Full Year Insurance Status		Difference	
		Medicaid	Uninsured	Unadjusted	Adjusted
Access Problems Related to Provider and Appointment Availability					
Any Provider Access Problem	12.3	14.4	11.7	2.6 **	0.5
Difficulties Finding a General Doctor or Provider with Availability	4.6	4.0	7.1	-3.1 ***	-3.8 ***
Was not able to find a general doctor or provider with availability	1.7	1.0	3.4	-2.4 ***	-3.1 ***
Difficulties Finding a Provider or Delayed Care Due Because Could not Get an Appointment	10.5	13.9	8.2	5.7 ***	3.6 ***
Was told by doctor's office or clinic would not accept as a new patient	3.5	4.9	3.6	1.3 *	0.1
Was told by doctor's office or clinic would not accept their health care coverage	4.4	6.8	2.8	4.0 ***	2.8 ***
Delayed care because couldn't get an appointment soon enough	6.5	8.4	4.7	3.7 ***	2.7 ***
Access Problems and Financial Burdens related to Affordability Issues					
Any Unmet Need due to Affordability Concerns	24.6	11.0	38.9	-27.9 ***	-33.0 ***
Medical care	16.2	5.1	29.4	-24.3 ***	-27.4 ***
Prescription drugs	15.9	7.8	23.9	-16.1 ***	-20.8 ***
Any Delayed Medical Care due to Affordability Concerns	19.5	6.9	33.0	-26.1 ***	-28.2 ***
Any Change in Prescription Drug Behavior to Save Money	16.3	8.9	21.8	-12.9 ***	-17.4 ***
Skipped medication doses to save money	10.7	5.3	15.0	-9.7 ***	-13.3 ***
Took less medication to save money	11.2	6.2	15.3	-9.2 ***	-12.5 ***
Delayed filling a prescription to save money	13.9	7.1	18.5	-11.4 ***	-15.6 ***
Usual Source of Care and Primary Care Receipt:					
Had a Usual Source of Care	69.0	85.4	38.3	47.2 ***	43.1 ***
Doctor's office or HMO	62.6	53.8	36.8	17.0 ***	13.3 ***
Clinic or health center	33.5	42.0	56.9	-14.9 ***	-11.9 ***
Other Place	3.9	4.2	6.3	-2.1 **	-1.4
Any Office Visit	72.9	85.6	48.9	36.7 ***	29.2 ***
Any General Doctor Visit	55.3	66.1	32.2	33.9 ***	28.9 ***
Had Preventive Care					
Had blood pressure checked	71.7	81.2	49.4	31.8 ***	25.2 ***
Had blood cholesterol checked	45.6	55.0	26.2	28.8 ***	25.9 ***
Received fasting test for high blood sugar or diabetes	32.2	39.2	18.0	21.2 ***	17.7 ***
Received pap smear or pap test (women aged 18 or older)	49.9	60.4	32.3	28.1 ***	23.3 ***
Received mammogram (women aged 30 or older)	32.4	34.8	19.7	15.1 ***	17.2 ***
Received test for colon cancer (adults aged 40 or older)	13.1	16.1	4.3	11.8 ***	11.1 ***
Been talked to about diet	22.8	28.7	12.3	16.4 ***	12.1 ***
Been talked to about smoking (adults who smoke every \ some days)	46.1	54.9	29.9	25.0 ***	18.9 ***
Received flu vaccination	24.5	27.7	12.5	15.2 ***	12.5 ***
Sample Size	**13,133**	**1,816**	**3,707**		

Source: National Health Interview Survey, 2012

Note: Low-Income is defined as living in a household with family income at or below 250% of FPL. The regression-adjusted differences are derived from multivariate regression models that control for age; gender; general and mental health status; presence of a chronic condition: heart disease, hypertension, stroke, asthma, emphysema, diabetes, and weak or failing kidneys; BMI; Pregnant in the past year; race/ethnicity; marriage status; family income; education; home ownership; parent status; employment; and region. Medicaid and uninsured status is only recorded at the time of the survey, while the full-year insurance status can be a combination of different insurances. Medicaid excludes those with Supplemental Security Income. FPL is the federal poverty level. Medicaid and uninsured columns remove observations for which there is missing information on the covari-

* (**) (***) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

practices with openings for new patients are substantially more constrained for new Medicaid enrollees than for new privately insured patients—but that appointments offered were typically within a week of the call for both groups. The NHIS analysis underscores that Medicaid patients appear to be achieving comparable access to primary care despite more limited availability within their provider networks. In real world conditions, new Medicaid patients are likely to focus their search efforts on practices in their local communities, particularly, those that are known to provide access to Medicaid patients, such as community health centers. They are also likely to receive help in finding providers from their managed care plan or an enrollment broker, including information on which practices that serve Medicaid patients have open panels.

The audit study brings to light the importance of primary care provider assignment and selection processes, especially for new enrollees who do not have an established source of care. According to the NHIS, 62 percent of low-income uninsured adults said that they lacked a usual source of care. Therefore, many of the uninsured adults who gain Medicaid or marketplace coverage in 2014 or 2015 are likely to enter coverage without having an established source of care. New enrollees who lack established relationships with primary care providers or want to find a new primary care provider may require assistance identifying practices that take their insurance and currently have new patient appointment availability.[6] More work is needed to identify how closely public and private insurance plans, including those in the new marketplaces monitor their networks and the extent to which they provide up-to-date information to their new enrollees on practices with open panels.

Ensuring that the newly insured are directed toward primary care providers with capacity to absorb new patients will be critical to minimizing access problems for these groups. The pattern of findings from the audit indicated that appointment success rates would be much higher at FQHCs for Medicaid callers than at other offices,[7] which is consistent with the NHIS data showing that Medicaid-covered adults rely on clinics and community health centers at high rates.

The pressure on the primary care delivery system serving Medicaid patients, particularly in states that are experiencing large increases in Medicaid caseloads, may lead to greater delays in appointment availability for both new and established patients than found in 2012. It will be important to monitor access as major shifts occur in how care is financed and delivered. Efforts to expand Medicaid provider capacity—including policies aimed at expanding supply for both safety-net and private providers—and to ensure that clear information about provider ability to take new patients is available to both Medicaid-covered and new privately insured patients will likely be important to promoting more timely and efficient use of health care and maximizing the benefits of health reform.

Currently there is debate about the merits of expanding Medicaid coverage under the ACA. In the 25 states that, as of April 2014, have not opted for expansion, adults with incomes below the federal poverty level are not eligible for Medicaid unless they meet one of the eligibility categories that predate the ACA (e.g., disability or pregnancy). This leaves an estimated 5.8 million poor uninsured adults without any new financial assistance for health insurance coverage.[8] The findings from the NHIS indicate that low-income adults who remain uninsured in states that do not expand Medicaid will continue to experience substantial barriers to care and receive preventive care at very low rates.

Conclusions

Establishing a relationship with a primary care provider is an important first step toward increasing access for newly insured Medicaid enrollees. On the eve of national health reform, most Medicaid patients have a usual source of care and large majorities of Medicaid patients were not reporting problems finding doctors or accessing care because of affordability concerns. Adults with Medicaid coverage were comparable to low income adults with employer-sponsored insurance in receipt of preventive care, though rates of screening and counseling for both populations falls below recommended levels. Ensuring access to primary care for newly insured adults, regardless of insurance type, will be one key to the success of national health reform. The audit study highlights that before health reform, fewer practices were offering primary care appointments for new Medicaid enrollees than for new privately-insured patients. Efforts to identify providers where capacity still exists and ensuring that information about provider availability is made available to new Medicaid and Marketplace enrollees will likely be critical to promoting the timely and efficient use of health care.

Endnotes

[1] Rhodes K, Kenney G, Friedman A, et al. "Primary Care Access for New Patients on the Eve of Health Care Reform." *JAMA Intern Med.* 2014; Online First. doi:10.1001/jamainternmed.2014.20, https://archinte.jamanetwork.com/article.aspx?articleid=1857092

[2] Congressional Budget Office."2014 Budget and Economic Outlook: Appendix B, Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act". Washington, DC: Congressional Budget Office, 2014.

[3] Supplemental analyses were conducted on all adults with ESI (data not shown). We find that low-income adults with established Medicaid coverage were more likely than all adults with ESI report to report an access problem related to finding a general doctor or provider, as was the case when comparing low-income adults with Medicaid coverage to low-income adults with ESI (these differences persist when we control for differences in observed characteristics among both groups). Low-income Medicaid covered adults are more likely than all adults with ESI to have an unmet need due to affordability concerns, have delayed care due to affordability concerns, and to have made a change in prescription drug behavior to save money. However, these differences reverse in many cases or are no longer significant when we adjust for observed characteristics. Adults with ESI are more likely than their low-income Medicaid covered counterparts to have a usual source of care, have seen a general doctor in the prior 12 months, and to have had most of the screening and preventive care measures included in the NHIS, yet when we control for observed characteristics, these differences are no longer statistically significant.

[4] A total of 482 and 461 cases were excluded from the Medicaid and ESI samples (respectively) because they were not insured for full year. The NHIS asks about insurance coverage status and coverage type at the time of the survey and coverage status (but not type) over the prior year. In the NHIS, we can determine whether the individual had insurance coverage for the entire year, but not whether the individual had the same type of coverage over the entire year.

[5] Call KT, Davidson G, Davern M, and Nyman R. "Medicaid Undercount and Bias to Estimates of Uninsurance: New Estimates and Existing Evidence." *Health Services Research,* 43(3): 901–14, 2008. doi:10.1111/j.1475-6773.2007.00808.x.

[6] Rhodes et al. 2014.

[7] Saloner B, Kenney GM, Polsky D, et al. "The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings from an Audit Study." Washington, DC: The Urban Institute, 2014.

[8] Ibid.

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