

## Lack of Insurance Coverage Affect Access to Healthcare

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### ABSTRACT

The overall purpose of this study was to determine how lack of insurance affect access to health care. Access to health care is a supply side issue indicating the level of service that the health care system offers individual and it is necessary to expand on information that can provide insight on the availability of healthcare services. Among the findings was that there is a significant relationship between access to healthcare services and health insurance coverage among uninsured and insured population. About 61.9% (13033) indicated that they did not enrolled in Medicare compared to only 22.5% (4728) people that indicated of having Medicare advantage and only 9% (1898) people indicated of having Medicare plus Medicare supplemental plan. Overall, only 6.6% (1396) indicated that they have other Medicare plan.

**Keywords:** healthcare services, access, medicare, health insurance coverage

### INTRODUCTION

Medicaid as a leading health insurance coverage for many low-income population and those in poverty continues to be a subject of scrutiny under the Affordable Care Act (ACA) as politicians, healthcare providers and researchers are constantly examining the characteristics of the uninsured population and financial implications of not having coverage. Many uninsured people expressed the high cost of insurance as the main reason for not obtaining health care coverage and about 45% adults in 2016 indicated that they are uninsured because the cost of insurance coverage was too high. Most of these people are either not eligible for financial assistance for coverage, do not have access to coverage through a job or the states of their residents did not expand Medicaid, and some simply did not know they can get help for financial assistance under the ACA. In most cases adults are more likely to be uninsured than children while minority with low social economic status are at higher risk of being uninsured (Kaiser Family Foundation, 2017).

According to the Centers for Disease Control and Prevention (CDC) (2012), there are about 133 million Americans who have at minimum one chronic disease, which translates into nearly 1 out of every 2 adults. There is an opportunity for accountable care organizations (ACOs) to target the most vulnerable subgroups, specifically those who are both socially disadvantaged and clinically vulnerable. The Affordable Care Act seeks to reduce health care costs by encouraging doctors, hospitals and other health care providers to form networks that coordinate patient care and become eligible for bonuses when they deliver that care more efficiently. Therefore, the Affordable Care Act encourages the formation of accountable care organizations (ACOs) in the Medicare program and allowing providers to make more if they keep their patients healthy. As a result of this, about 6 million Medicare beneficiaries are now in an ACO; and combined with the private sector, at least 744 organizations have become ACOs since 2011 and an estimated 23.5 million American are now being served by an ACO (Gold, 2015).

The uninsured are less likely to receive preventive care and services for major health conditions and chronic diseases compared to those with insurance and access to health care. Among low-income people, it is totally depends on the state of residents that expanded Medicaid; while there are healthcare coverage gains in some states that expanded Medicaid, other people has not been fortunate because they are not residing in the states that expanded Medicaid. Overall, about 27.6 million in 2016 remain uninsured while as of February 2017, over 10 million people were enrolled in state or federal Marketplace plans. Medicaid enrollment had since grown by 17 million (29%) as of June 2017 (Kaiser Family Foundation, 2017).

Forgoing healthcare services, especially those who have chronic diseases, can pose a bigger threat as more dollars will be spent treating the progression of chronic disease rather than sustaining it or preventing it altogether. Even with the implementation of the Accountable Care Act (ACA) 2010, the most vulnerable population will be overlooked as the cost burden of such groups could threaten the sustainability of government-funded organizations. Identifying where these individuals obtain care and type of insurance they have could assist with health promotion efforts within the community (Lewis et al., 2012).

The most vulnerable population includes those who are considered socially disadvantaged and clinically vulnerable. The socially disadvantaged include those who have low income, low education levels reside in poor and destitute neighborhoods; whereas, the clinically vulnerable include those who are considered high risk, and therefore susceptible to poor health if the proper medical care is not obtained (Lewis et al, 2012). Bisgaier and Rhodes (2011) identified socioeconomic status (SES) to contain numerous factors such as, social class (i.e., individual, household and neighborhood), race and ethnicity, gender, educational level, income and financial constraints.

## **STATEMENT OF THE PROBLEM**

The overarching problem is that there has not been enough research on the non-elderly adult population and the causes associated with the lack of access to healthcare services. In addition, there is a deficit of research looking at the vulnerable or neediest subset within the non-elderly adult population. As of 2016, uninsured nonelderly adults were three times as likely as adults with private coverage that postponed or did not get a needed prescription drug due to cost while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care. People without coverage are less likely than those with coverage to obtain all the recommended services (Kaiser Family Foundation, 2016).

People without health coverage are less likely than those with insurance to have regular outpatient care, and they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health. In most cases, when they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and have higher mortality rates than those with insurance. Overall, about 27.6 million nonelderly individuals remain without coverage in 2016 (Kaiser Family Foundation, 2016). The cost burden of vulnerable populations stands to threaten the sustainability of government-funded organizations. Moreover, the information on access to care and recourse for non-elderly adults is scarce and deficient.

The National Center for Health Statistics (HCHS) (2016) indicated that for the uninsured, it is anticipated that the ACA will help provide and encourage healthcare coverage for all American citizens, however what is unknown is the availability of reliable healthcare services for the individuals who perpetually fall through the gaps. Therefore additional research evaluating the impact of the ACA on accessibility to healthcare services and the quality of care would identify if offering affordable healthcare significantly reduces the impediment to healthcare services.

## **PURPOSE OF THE STUDY**

The purpose of this study was to determine how lack of insurance affect access to health care. Access to health care is a supply issue indicating the level of service, which the health care system offers individual and it is necessary to expand on information that can provide insight on the availability of healthcare services. One of the ACA main objective is to improve disease prevention through the expansion of health insurance coverage and access to preventive care. Nevertheless, there is a lack of information on access to care among non-elderly adults population. Individuals who are socially disadvantaged and who are considered clinically vulnerable are continuously faced with barriers when it comes to accessing healthcare services (Lewis et al., 2012).

Anderson et al. (2002) found that there was a correlation between communities and access to care, while also identifying a greater risk for Latino's and Asian's. Therefore, being within the vulnerable population and being a minority increases a person's risk of experiencing an inadequate access to healthcare services. The identification of where these individuals obtain care and the distinctions, in terms of age, race, health status and type of insurance, could reduce health access disparities. In addition, the identification of subgroup that is susceptible to experiencing

**Table 1.** Participants' race and ethnicity

Factors	Measure	
	N	%
Race/Ethnicity		
African American	1026	4.9
Asian	2761	13.1
Latino/Hispanic	5326	25.3
White	11216	53.3
Indian/Alaska Native	199	.9
Other	527	2.5
Total	21055	100.0

**Table 2.** General health condition of the participants

Factors	Measure	
	N	%
Health Condition		
Excellent	3384	20.7
Very Good	6097	33.1
Good	6647	28.3
Fair	3635	13.6
Poor	1262	4.4
Total	21005	100.0

a lack of healthcare services would enable organizations to individualize communication efforts and effectively educate individuals on the available services.

## RESEARCH DESIGN/DATA

This study analyze access to healthcare services among non-elderly adults in the context of socioeconomic factors, different racial / ethnic groups and insurance status by using the Statistical Package for Social Sciences (SPSS) for the results. The lack of access to healthcare services among the vulnerable population is a societal and moral concern, thus creating a need to identify common characteristics among the targeted demographic and provide an opportunity for prevention and action. The study also investigate accessibility of healthcare services, analyzed health behavior of the non-elderly population, and the characteristics of the uninsured among racial / ethnic groups.

A secondary data set from California Health Interview Survey (CHIS) adult questionnaire, covering the 2016 calendar year was used in this study. The criteria for the research and keywords included choice of healthcare, low socioeconomic factors, health coverage and type of healthcare setting, minorities, racial / ethnic groups, access to healthcare, nonprofits and vulnerable populations. The CHIS adult questionnaire for the year 2016 provided insight to access to care by addressing the following questions: Does the lack of health insurance and lack of available resources result in a higher likelihood that non-elderly adults will forgo healthcare until their health condition worsens? What are the disparities found among non-elderly adults and access to care?

To obtain a distinct perspective of availability and accessibility to healthcare services it is essential to identify health insurance status, perception of health condition and usual source of care. The measurement of health insurance coverage included whether an individual had insurance in the past 12 months, if lack of insurance resulted in the delay of care and if they had no insurance at the time of care. In addition, to effectively evaluate health conditions, the identification of an individual susceptibility to (or has an existing) chronic disease, as well as if there was a delay in obtaining health. Health condition was determined by the observation of an individual's classification of their health, either as excellent, very good, good, fair or poor.

## FINDINGS

The findings identified disparities in access to care among the non-elderly population and other components derived from the CHIS questionnaire, included: self-reported racial / ethnic groups, educational attainment, poverty levels, source of healthcare, health condition, delay in medical care and insurance status. A filter was utilized to focus on the targeted population, non-elderly adults; greater than or equal to 65 years of age were excluded, resulting in 21055 participants in the analysis. The examination of the individual variables as it relates to having a usual source of healthcare are also provided in tables. **Table 1** shows the characteristics of non-elderly adults, ages 18-64 years of age. White non-elderly adults outweigh the other racial/ethnic subgroups at 53.3% compared to

**Table 3.** Time since last doctor's visit for routine check-up

Factors	Measure	
	N	%
<b>Health Condition</b>		
Inapplicable	71	.3
One year ago or less	16493	78.3
More than 1 up to 2 years ago	2145	10.2
More than 2 up to 5 years ago	1174	5.6
More than 5 years ago	749	3.6
Never	426	2.0
Total	21055	100.0

**Table 4.** Types of current health coverage source for all ages

Factors	Measure	
	N	%
<b>Race / ethnicity</b>		
Uninsured	1307	6.2
Medicare & Medicaid	1907	9.1
Medicare & others	5325	25.3
Medicare only	790	3.8
Medicaid	3720	17.7
Employment-based	6574	31.2
Privately purchased	1204	5.7
Other public	228	1.1
Total;	21055	100.0

Asian who has the second highest at 25.3%. **Table 2** also provided information about the general health condition of the participants and majority of respondents are in good condition.

Responded answers to question about the last doctor's visit for routine check-up within a year or less was very high at 78.3%. **Table 3** further gave details of those who responded to the question. Most Californians did not see any reason to delay needed care, however, about 9418 (44.7%) see a need to medical specialist in the past year while 11637 (55.3%) did not see a need to visit medication specialist.

For medical eligibility for uninsured, 57.1% are insured in all categories while only 5.6% indicated that they are not eligible. In **Table 4**, majority of Californians are insured, among them only 6.2% are not insured and majority, about 31.2% are covered by employment-based type of insurance and 25.3% are covered by Medicare and others, 17.7% are covered by Medicaid and 5.7% covered by private purchased type insurance.

For hypothesis testing, the prediction was that there is a relationship between access to healthcare services and health insurance coverage. The findings shows a variation among the insured and uninsured. Of significant in this study was that about 61.9% (13033) indicated that they did not enrolled in Medicare compared to only 22.5% (4728) people that indicated of having Medicare advantage and only 9% (1898) people indicated of having Medicare plus Medicare supplemental plan. Overall, only 6.6% (1396) indicated that they have other Medicare plan. Therefore, analysis does support the hypothesis that there is a relationship between the access to healthcare services, healthcare coverage and delay in medical care. There is also a relationship between access to healthcare services and the health condition.

## CONCLUSION AND DISCUSSION

This study was able to determined that there is a relationship between factors which individuals are predisposed to (e.g., poverty level, health coverage and health source), as well as other factors which include health condition and delay in medical care. Barriers to health services includes high cost of care, inadequate or no insurance coverage, lack of availability of services and lack of culturally competent care. These barriers can also leads to unmet health needs, delays in receiving appropriate care, inability to get preventive care, financial burdens and preventable hospitalizations. Others identified varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. The analysis does support the hypothesis that there is a relationship between having a usual source of care to obtain healthcare services, healthcare coverage, delays in obtaining medical care and health condition.

Analysis reported in this study also was consistent with other findings, that self-pay and Medicaid was the primary sources for nursing home costs. Medicare also had a high percentage of utilization but was not statistically significant. Single, elderly women compromise the majority of nursing home admissions and their payments, according to the present analysis, came from self-pay and Medicaid. Medicaid only pays for only a proportion of long time cost (LTC) costs and was intended to aid in acute care costs. This study also aided single, elderly women by making them more aware of high LTC costs and the need for LTC financing. The findings provides interesting

information on single, elderly women with the historic payer sources for nursing homes based on a similar demographic. It can be concluded that self-pay, as the primary payer source, implies that single, elderly women will need to have enough in their savings to cover the costs for their nursing home costs.

In order to achieve health equity for all access to comprehensive quality health care services is important for promoting and maintaining good health. Access to comprehensive quality health care services will greatly help to managing diseases and reducing unnecessary disability; preventing premature death among the low-income people, and helping the elderly through the several entities that provide free or discounted healthcare services to vulnerable subgroups. These groups are not limited to not-for-profit (NFP) hospitals, safety net hospitals (SNHs), community health centers (CHCs) and academic health centers (AHCs). Therefore, access to health services provide the best health outcomes by gaining entry into the health care systems through insurance coverage. In addition, accessing a location where needed health care services are provided and finding a health care provider whom the patient trusts and can communicate with, and developing personal relationship because access to health care influences one's overall physical, social and mental health status and quality of life (Office of Disease Prevention and Health Promotion (ODPHP) (2018).

The expansion of coverage for non-elderly adults, those who are among the most vulnerable population, will considerably affect healthcare organizations, resulting in organizations looking for ways to deal with the influx of these patients. The increase in Medicaid patients and the uninsured will prompt action to counteract the potentially costly impact, through grassroots efforts to attract the young and healthy non-elderly adults who are entering the new healthcare marketplace. Insured and uninsured non-elderly adults continue to face a lack of access to healthcare services. For the insured population it is essential that their healthcare providers and organizations establish the appropriate mechanisms to ensure that their members do not encounter barriers, which are within their control and are preventable.

Challenges are encountered from the healthcare entity perspective, such as lack of funding and resources about SNHs and CHCs or inadequate communication from NFP hospitals. The vulnerable populations are faced with barriers such as lack of transportation, poor quality health services, lack of funds and legal status. Therefore, such barriers elicit the utilization of emergency departments (EDs) as a safety net method. Considering the challenges there is a perpetuating inaccessibility to healthcare for the most vulnerable. Individuals and families who are uninsured or underinsured with low socioeconomic factors will either forgo healthcare services, go to the local safety net hospital, seek care from a community health clinic or use the emergency department for primary or non-emergent services (Bisgaier and Rhodes, 2011).

Health insurance coverage does improve the affordability of care and financial security among the low-income population. In 2016, about 30% of uninsured nonelderly adults were paying off at least one medical bill over time and medical debts contribute to over 52% of debt collections actions that appear on consumer credit reports in the U.S. Uninsured people are more at risk of falling into medical debt than people with insurance. It was also reported that uninsured nonelderly adults are much more likely than those insured to lack confidence in their ability to afford usual medical costs and major medical expenses or emergencies. Access to health coverage changes as a person's situation changes by either marital status or a loss of job. In most cases, not everyone that work or gainfully employed have access to coverage through their job (Kaiser Family Foundation, 2018).

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