MONITORING ACCESS TO CARE IN MASSACHUSETTS: COMPARING PUBLIC COVERAGE WITH EMPLOYER-SPONSORED INSURANCE COVERAGE

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EXECUTIVE SUMMARY

The 2013 Massachusetts Health Reform Survey (MHRS) highlights the state's ongoing success at maintaining near universal health insurance coverage and high levels of health care use following the 2006 health care reform initiative.[1] At the same time, Massachusetts residents are more likely to report being in good health, with significant declines in both all-cause mortality and mortality for causes amenable to health care under reform.[2,3] Massachusetts' health reform efforts have relied on a strong system of public health insurance that covers a substantial number of the low- and moderate-income residents of the Commonwealth. While MassHealth (the Medicaid program in Massachusetts) and Commonwealth Care[4] (collectively referred to as public coverage in this analysis) provide substantially better access to care than being uninsured, findings from the 2013 MHRS show that problems with access to care were more prevalent for adults with public coverage than for those with employer-sponsored insurance (ESI).[5]

This policy brief extends that analysis of the MHRS. Our analysis compares the reported experience of adults with public coverage with those of adults with ESI coverage on a range of measures of access to care:

1. **Gaps in the connection to the health care system**—e.g., individual did not have a usual source of care, individual had difficulty finding a provider.
2. **Gaps and potential gaps in receipt of services over the prior year**—e.g., individual did not have health care visits, individual had unmet need for care.
3. **Receipt of potentially inappropriate or inadequate care over the prior year**—e.g., individual reported frequent emergency department (ED) use or ED use for nonemergency conditions, individual rated the quality of care he or she received as fair or poor.
4. **Challenges about the affordability of care over the prior year and in the future**—e.g., individual reported high out-of-pocket health care spending, problems paying medical bills, medical debt, or concerns about ability to pay medical bills in the future.

1 Long SK and Dimmock TH. 2014. *Health Insurance Coverage and Health Care Access and Affordability in Massachusetts: Affordability Still a Challenge.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available at www.bluecrossfoundation.org/sites/default/files/download/publication/MHRS_2013_Report_FINAL.pdf.

2 Van Der Wees PJ,, Zaslavsky AM, Ayanian JZ. 2013. *Improvements in Health Status after Massachusetts Health Care Reform.* Millbank Quarterly. 91(4):663-689.

3 Sommers BD, Long SK, and Baicker K. 2014. *Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study.* Annals of Internal Medicine. 160(9):585-93.

4 With the implementation of the Affordable Care Act, the Commonwealth Care program was ended and most of its members were shifted either to MassHealth or to a newly created ConnectorCare program.

5 Long SK and Dimmock TH. 2014. *Health Insurance Coverage and Health Care Access and Affordability in Massachusetts: Affordability Still a Challenge.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available at www.bluecrossfoundation.org/sites/default/files/download/publication/MHRS_2013_Report_FINAL.pdf.

We compare simple differences in access between adults with public coverage and those with ESI and regression-adjusted differences that control for variations in health care needs between the two groups (Model I) and variations in health care needs and socioeconomic status between the two groups (Model II). Adults with public coverage tended to have greater health care needs and lower socioeconomic status than adults with ESI; the regression models that control for those variations are intended to identify any gaps in access that remain.

FINDINGS

In summarizing the findings, we focus on the gaps in access revealed in the unadjusted data and in the regression-adjusted model that controls for variations in the health care needs and socioeconomic status of adults with public coverage and those with ESI.

Gaps in connections to the health care system. Adults with public coverage were more likely than those with ESI to report that they had difficulty finding a provider in the prior year (32.9 versus 12.4 percent) and that they went without needed care in the prior year because of difficulty seeing a provider (17.8 versus 6.6 percent). These public coverage–ESI gaps in connections to the health care system persist after controlling for differences in health care needs and socioeconomic status, indicating that adults with public coverage had more difficulties engaging the health care system than did similar adults with ESI.

Gaps and potential gaps in receipt of services. Adults with public coverage were less likely than adults with ESI *not* to have had a visit to a doctor or mid-level provider over the prior year (5.7 versus 10.3 percent) but more likely not to have had a dental care visit (44.9 versus 20.8 percent) and more likely to have gone without needed care of any kind (46.4 versus 22.5 percent). However, after controlling for the differences in health care needs and socioeconomic status, only the public coverage–ESI gap in unmet need for health care services persists. That is, adults with public coverage had more unmet health care needs than similar adults with ESI.

Receipt of potentially inappropriate/inadequate care. Adults with public coverage relied more heavily on the ED for care than did adults with ESI, reporting two or more ED visits in the prior year (37.9 versus 7.0 percent) and reporting that the most recent ED visit was for nonemergency care (26.0 versus 7.8 percent). Adults with public coverage were also more likely to report that the quality of care they received in any setting was fair or poor (14.2 versus 6.5 percent). The public coverage–ESI gaps in ED use persist after controlling for variations in health care needs and socioeconomic status, with adults with public coverage more likely to have relied on the ED than similar adults with ESI.

Challenges to affordability of care. Problems with health care costs were more common for adults with public coverage than for adults with ESI (49.1 versus 32.9 percent), including going without needed health care due to costs (24.1 versus 9.4 percent) and problems with health care spending (34.3 versus 26.4 percent). However, after controlling for variations in health care needs and socioeconomic status, the comparison reverses, so that adults with public coverage were less likely than similar adults with ESI to report problems with health care spending.

DISCUSSION

Across the 15 measures examined, adults with public coverage had better access to care than adults with ESI coverage with similar health care needs and socioeconomic status on one measure, similar access on nine measures, and worse access on five measures. The three areas with five measures where adults with public coverage fared worse than similar adults with ESI were difficulties with provider access, unmet need for health care, and reliance on the ED. The area where adults with public coverage were doing better than similar adults with ESI was related to affordability of care. It appears that public coverage provided greater financial protection from high levels of health care spending than ESI, reflecting the generally lower levels of cost sharing present in the MassHealth and Commonwealth Care programs compared with typical ESI coverage.

The persistence of gaps in access to care for full-year insured adults with public coverage raises concerns about systemic barriers to care within the Massachusetts health care system, while the high prevalence of affordability challenges for both public and ESI coverage raises concerns about affordability for all adults. Nearly a third of adults with public coverage reported difficulties finding a provider over the prior year, and almost half reported going without needed care, including dental care. Almost half of adults with public coverage did not have a dental care visit in the prior year. While it is not possible to attribute the high levels of ED use among the adults with public coverage to these gaps in access to health care providers and dentists, it is certainly possible that such barriers could lead to an increased reliance on the ED for care that could have been provided in the community. Addressing the gaps in the extent to which adults with public coverage are obtaining the right care, at the right time, in the right setting, offers the potential for improved quality of care and lower health care costs for the public programs in Massachusetts. Identifying effective strategies to bolster access to care for adults with public coverage will require a better understanding of the barriers to care they face, including the apparent gaps in physician and dental care networks.

I. INTRODUCTION

Massachusetts has a strong system of public health insurance that covers a substantial number of the low- and moderate-income residents of the Commonwealth. In March 2015, 1.9 million people were enrolled in public coverage programs including MassHealth (the Medicaid program in Massachusetts) and subsidized health insurance programs operated by the Commonwealth Health Connector.[6] This enrollment represented more than a quarter of the insurance coverage in the Bay State. While MassHealth and Commonwealth Care[7] (collectively referred to as public coverage in this analysis) provide substantially better access to care than being uninsured, findings from the 2013 Massachusetts Health Reform Survey (MHRS) show that problems with access to care were more prevalent for adults with public coverage than for those with employer-sponsored insurance (ESI) coverage.[8] This policy brief extends the 2013 MHRS analysis by comparing access for those with public coverage with access for those with ESI across a range of measures.

The work builds on the framework developed by the Medicaid and CHIP Payment and Access Commission (MACPAC)[9] and the California HealthCare Foundation[10] to assess access to care, providing three different comparisons: simple differences in access between those with public coverage and those with ESI, regression-adjusted differences that control for variations in health care needs between the two groups (Model I), and regression-adjusted differences that control for variations in both health care needs and socioeconomic status between the two groups (Model II). We use this regression framework to compare access to care under public coverage and ESI for similar adults, with "similar" meaning the same health care needs in Model I and meaning the same health care needs and the same socioeconomic status in Model II. Controlling for variations between those with public coverage and those with ESI is likely to matter in comparing access to care because adults with public coverage in Massachusetts were more likely to report that their health status is fair or poor, more likely to report health conditions and activity limitations, and more likely to have lower socioeconomic status than those with ESI.[11]

The next section describes the data and methods used in the analysis. Section III presents the findings, with a focus on gaps in access to care between adults with public coverage and ESI that persist after controlling for variations in health care needs and socioeconomic status (Model II). The final section provides a summary of the findings and potential policy implications for Massachusetts.

6 Communication from the Office of Medicaid, Executive Office of Health and Human Services, and board meeting materials from the Health Insurance Connector Authority from April 2015. Available at https://betterhealthconnector.com/wp-content/uploads/board_meetings/2015/2015-04-09/SummaryReport-March2015.pdf.

7 With the implementation of the Affordable Care Act, the Commonwealth Care program was ended and most of its members were shifted either to MassHealth or to a newly created ConnectorCare program.

8 Long SK and Dimmock TH. 2014. *Health Insurance Coverage and Health Care Access and Affordability in Massachusetts: Affordability Still a Challenge.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available at www.bluecrossfoundation.org/sites/default/files/download/publication/MHRS_2013_Report_FINAL.pdf.

9 MACPAC. 2011. Report to Congress on Medicaid and CHIP. Washington, DC: MACPAC. Available at www.macpac.gov/reports.

10 Gold M and Kenney GM. 2014. *Monitoring Access: Measures to Ensure Medi-Cal Enrollees Get the Care They Need.* Oakland, CA: California HealthCare Foundation. Available at http://www.chcf.org/publications/2014/05/monitoring-access-medical.

11 Long SK and Dimmock TH. 2014.

II. DATA AND METHODS

DATA

This policy brief relies on data from the 2013 Massachusetts Health Reform Survey (MHRS).[12] The MHRS has been conducted yearly since 2006 (with the exception of 2011 and 2014) to monitor and understand the state's health care system.[13] The MHRS is conducted with a stratified random sample of approximately 3,000 working-age adults (19 to 64). The sample size in 2013 was 3,024 adults. The survey is conducted by telephone (landline and cell phone) in English and Spanish. The 2013 response rate was 30.4 percent. In addition to questions on insurance status, the survey includes questions that focus on the individual's access to and use of health care, out-of-pocket health care costs and medical debt, and health and disability status. With few exceptions, the MHRS relies on questions drawn from established, well-validated surveys.[14]

Like all surveys, the MHRS relies on self-reported information. The quality of the MHRS data depends on the survey respondents' ability to understand the questions and the response categories, to remember the relevant information, and to report the information accurately. We would expect the quality of the information reported by the respondents to be better for more recent circumstances and events and for events with greater saliency (e.g., current insurance status). Problems with recall are more likely for events that are more distant in time (e.g., number of doctor visits over the prior 12 months), while problems with misreporting are more likely for sensitive questions (e.g., problems paying medical bills) or questions that are more difficult to answer (e.g., the amount of out-of-pocket health care spending over the prior 12 months).

Defining coverage type. Identifying type of health insurance coverage in surveys is challenging and subject to error. Individuals generally know if they have health insurance coverage but are not always sure of the type of coverage. Research has shown a significant undercount of public coverage enrollment based on survey data, particularly for Medicaid coverage,[15] and qualitative research with large national surveys has found that many respondents struggle to correctly report their coverage type.[16,17] Given the tendency of public coverage to be underreported in surveys, it is likely that we underestimate the level of public coverage in the MHRS.

12 The 2013 MHRS was funded by the Blue Cross Blue Shield of Massachusetts of Foundation and the Robert Wood Johnson Foundation. The MHRS was fielded by SSRS, in conjunction with the Urban Institute.

13 For a more detailed description of the MHRS, see Long SK and Dimmock TH. 2014.

14 These include government-sponsored surveys, such as the National Health Interview Survey, the Medical Expenditure Panel Survey, and Consumer Assessment of Healthcare Providers and Systems, and special surveys such as the Massachusetts Division of Health Care Finance and Policy's Survey of Health Insurance Status, the Commonwealth Fund's Biennial Health Insurance Survey and Consumerism in Health Care Survey, the Kaiser Family Foundation's Low-Income Survey, the Urban Institute's National Survey of America's Families, and the RAND Corporation's Survey of Individual Market Candidates in California, among others.

15 Call K, et al. 2013. "Comparing Errors in Medicaid Reporting across Surveys: Evidence to Date." *Health Services Research* 48 (2 Pt 1): 652-664.

16 Pascale J. 2008. "Measurement Error in Health Insurance Reporting." *Inquiry* 45 (4): 422–37.

17 Pascale J, et al. 2013. "Preparing to Measure Health Coverage in Federal Surveys Post-Reform: Lessons from Massachusetts." *Inquiry* 50 (2): 106–123.

Measures of gaps in access to care. In the analysis, we focus on four types of gaps in access to care or potential gaps in access to care:

1. **Gaps in the connection to the health care system**—e.g., individual did not have a usual source of care, individual had difficulty finding a provider.
2. **Gaps and potential gaps in receipt of services over the prior year**—e.g., individual did not have health care visits, individual had unmet need for care.
3. **Receipt of potentially inappropriate or inadequate care over the prior year**—e.g., individual reported frequent emergency department use (ED) or ED use for nonemergency conditions, individual rated the quality of care he or she received as fair or poor.
4. **Challenges about the affordability of care over the prior year and in the future**—e.g., individual reported high out-of-pocket health care spending, problems paying medical bills, medical debt, or concerns about ability to pay medical bills in the future.

Since many of the access measures are based on access to and use of care over the prior year, we limit the analysis sample to adults who reported insurance coverage for all of the prior year. We assign individuals to a coverage type (i.e., ESI or public coverage) based on their current health insurance coverage. For this brief, if an individual reported ESI and some other type of coverage, he or she is assigned to ESI. As noted above, public coverage includes MassHealth and Commonwealth Care.

METHODS

We rely on both simple (unadjusted) comparisons and regression-adjusted comparisons by type of health insurance coverage. Two different sets of regression adjustments are used to make the underlying populations in the health insurance groups more comparable.[18] Each set of adjustments is intended to capture particular characteristics of the adults. The first set of adjustments (Model I) is designed to make the individuals in the two insurance groups more comparable in terms of their observed health care needs, including factors that should affect an individual's need for health care. The second set of adjustments (Model II) adds socioeconomic factors that should not directly affect an individual's need for health care but may still affect access, as they affect family resources. Model II is designed to make the individuals in each insurance group more comparable in terms of their observed health care needs and their socioeconomic status. The variables in the models include:

- **Model I:** age, gender, self-reported health status, presence of a health condition, and presence of a health-related activity limitation.
- **Model II:** Model I variables *plus* race/ethnicity, citizenship status, language, marital status, parent status, household size, education, work status, family income relative to the poverty level, and region of the state.

18 Institute of Medicine. 2002. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press.

If a gap in access between those with public coverage and ESI is eliminated by controlling for health care needs, as in Model I, this implies that public coverage was as effective as ESI in providing access to care for adults with similar health care needs. If a gap in access between those with public coverage and ESI remains after controlling for variations in health care needs but is eliminated by the addition of measures to control for variations in socioeconomic status, as in Model II, this implies that public coverage was as effective as ESI for adults with similar heath care needs and socioeconomic status. The latter finding would also indicate, however, that a gap in access to care existed that was related to an individual's socioeconomic status, regardless of the type of coverage the individual had. That is, part of the gap in access to care between public coverage and ESI reflects the lower economic resources of those with public coverage.

In conducting the analysis, we limit the sample to the observations with complete data for the variables included in the regression models.[19] The final sample size for the analysis is 2,356 non-elderly adults with full-year insurance coverage who had public coverage or ESI at the time of the survey. Adults with other types of coverage (e.g., Medicare, Commonwealth Choice) are excluded from this analysis.

Both sets of adjustments are limited to the measures that are available in the MHRS and may not control for all of the differences in the characteristics of adults with ESI and those with public coverage. To the extent that there are unmeasured differences between the population groups that affect their health care needs (such as severity of health conditions), the public coverage–ESI gaps reported here will include the effects of those unmeasured differences. That is, the gaps in access and use between those with public coverage and those with ESI that persist after adjusting for observed characteristics may not be wholly attributable to insurance status, as there may be additional unobserved factors related to health and disability status, health-seeking behavior, and socioeconomic status that influence both insurance status and access to care.

All tabulations using the MHRS have been prepared using weights that adjust for the complex design of the survey, undercoverage, and survey nonresponse using the survey estimation procedures (svy) in Stata.[20] In the text, we focus on estimates of public coverage–ESI gaps in access that are statistically significant at the five percent level or greater. Because we are conducting multiple comparisons, it is important to acknowledge that with a five percent level of statistical significance for the tests of access gaps, we would expect to estimate one difference in 20 comparisons as statistically significant when it is not, due to chance. Thus evidence of gaps in access between adults with public coverage and adults with ESI will be more compelling if there is consistent evidence across a range of measures.

In presenting the findings, we focus first on the simple (unadjusted) comparisons of adults with public coverage and ESI, and then address the impact of controlling for differences in health care needs and socioeconomic status between the two groups of adults on those comparisons.

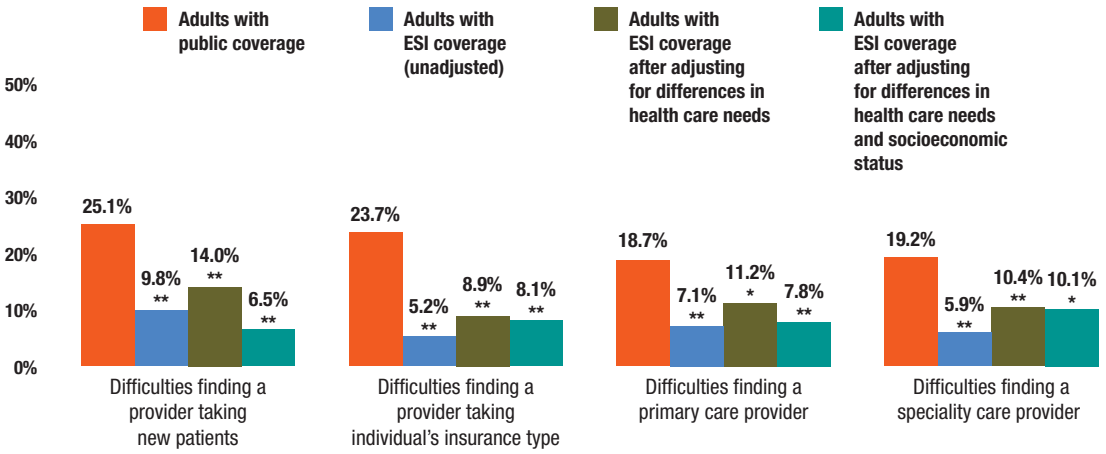
19 Item nonresponse is generally quite low in the MHRS, with the exception of family income, which is missing entirely or in part for about 10 percent of respondents. We impute values for missing family income using hot-deck imputation methods.

20 StataCorp. 2013. Stata Statistical Software: Release 13. College Station, TX: StataCorp LP.

III. FINDINGS

Gaps in connections to the health care system. The majority of full-year insured adults in Massachusetts with both public coverage and ESI had strong ties to the health care system, as indicated by the low shares reporting that they did not have a usual source of care (Table 1 on the following page). Table 1 reports the simple (unadjusted) estimates in the first block of columns, the regression-adjusted estimates based on Model I (adjusting for health care needs) in the second block of columns, and the regression-adjusted estimates based on Model II (adjusting for health care needs and socioeconomic status) in the third block of columns. As shown in the first block of columns, there is no significant difference in the shares of adults with public coverage and of adults with ESI reporting that they did not have a usual source of care. However, the adults with public coverage were more likely than those with ESI to report that they had difficulty finding a provider in the prior year (32.9 versus 12.4 percent) and that they went without needed care in the prior year because of difficulty seeing a provider (17.8 versus 6.6 percent).

FIGURE 1: TYPES OF DIFFICULTIES FINDING A PROVIDER UNDER PUBLIC COVERAGE AND ESI COVERAGE FOR ADULTS 19 TO 64 WITH FULL-YEAR INSURANCE COVERAGE, 2013



Source: MHRS, 2013.
Notes: Public coverage includes MassHealth and Commonwealth Care. ESI is employer-sponsored insurance. See notes for Table 1 (p. 10).
* (**) Significantly different from zero at the .05 (.01) level, two-tailed test.

Looking in greater depth at provider access issues in Massachusetts, we find that there were gaps between adults with public coverage and those with ESI in difficulties finding a provider (Figure 1) and in unmet need due to difficulties seeing a provider (Figure 2). These include gaps in difficulties finding a provider who was accepting new patients or taking the individual's insurance type, and gaps in difficulties finding primary care providers and specialty care providers (Figure 1). These gaps in access resulted in unmet health care needs as shown in Figure 2. Specifically, respondents with public coverage reported significantly higher rates of unmet need due to difficulties finding a provider, difficulties getting an appointment, and difficulties with provider hours or location (Figure 2).

TABLE 1: COMPARING ACCESS TO CARE UNDER PUBLIC COVERAGE AND ESI COVERAGE FOR ADULTS 19 TO 64 WITH FULL-YEAR INSURANCE COVERAGE, 2013

	Simple (Unadjusted) Estimates			Model I Regression-Adjusted Estimates for Adults with ESI Coverage		Model II Regression-Adjusted Estimates for Adults with ESI Coverage	
	Adults with Public Coverage %	Adults with ESI Coverage %	Percentage Point Difference	%	Percentage Point Difference	%	Percentage Point Difference
Gaps in Connection to the Health Care System							
Did not have a usual source of care (or used emergency room as usual source of care)	12.1	7.9	4.1	8.5	3.5	8.6	3.5
Had difficulty finding a provider in the prior year	32.9	12.4	20.5**	18.2	14.7**	13.9	19.1**
Went without needed health care because of difficulties seeing a provider in the prior year	17.8	6.6	11.1**	10.7	7.1*	7.8	9.9*
Gaps and Potential Gaps in Receipt of Services							
Did not have a doctor (general doctor or specialist) visit or mid-level provider visit in the prior year	5.7	10.3	-4.6*	6.8	-1.2	9.5	-3.8
Did not have a general doctor or mid-level provider in the prior year	9.2	12.5	-3.2	10.2	-1.0	13.2	-4.0
Did not have a preventive care visit in the prior year	6.8	3.6	3.2	5.3	1.4	5.4	1.4
Did not have a dental visit in the prior year	44.9	20.8	24.1**	25.8	19.0**	35.6	9.3
Went without needed health care for any reason in the prior year	46.4	22.5	23.9**	34.2	12.2**	32.0	14.4**
Receipt of Potentially Inappropriate/Inadequate Care							
Had two or more emergency department (ED) visits in the prior year	37.9	7.0	30.9**	16.7	21.2**	23.0	14.9**
Most recent ED visit was for a nonemergency condition [a]	26.0	7.8	18.2**	11.7	14.3**	16.7	9.3**
Rated quality of care received over the prior year as fair or poor	14.2	6.4	7.8**	12.5	1.7	13.1	1.1
Concerns about Affordability of Care							
Health care costs caused one or more problems for family over the prior year	49.1	32.9	16.1**	44.1	4.9	49.0	0.0
Went without needed health care because of costs of care in the prior year	24.1	9.4	14.7**	16.9	7.1*	17.0	7.0
Had problems due to health care spending over the prior year	34.3	26.4	8.0*	38.1	-3.8	45.7	-11.4**
Somewhat or very worried about ability to pay medical bills in the future	60.3	54.5	5.8	60.2	0.1	64.0	-3.6
Sample size	**630**	**1,726**	**2,356**	**2,356**		**2,356**	

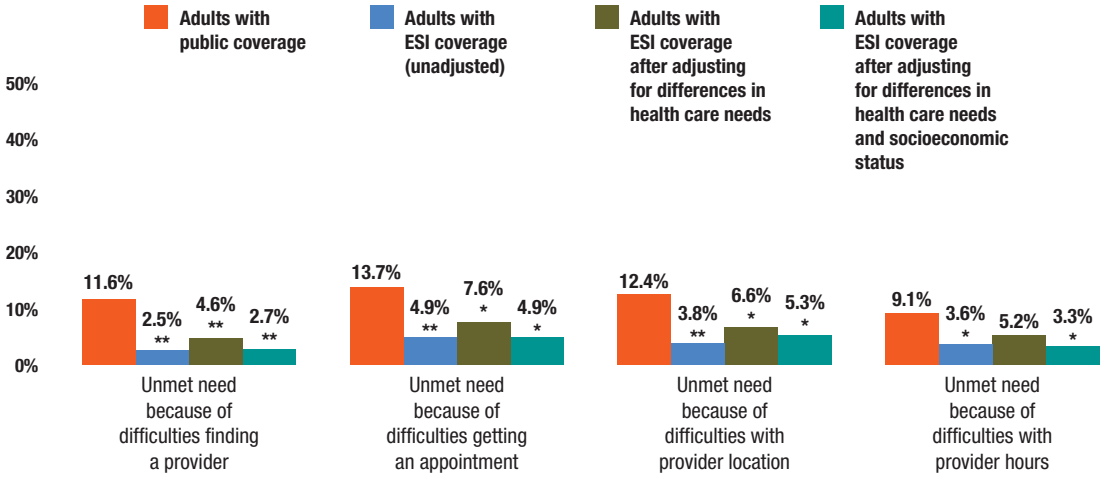
Source: Massachusetts Health Reform Survey, 2013.

Notes: Public coverage includes MassHealth and Commonwealth Care. ESI is employer-sponsored insurance. Mid-level providers include physician assistants, nurse practitioners, and midwives. Model I regression-adjusted estimates are derived from multivariate regression models that control for age, sex, self-reported health status, presence of a health condition, and presence of an activity limitation. Model II regression-adjusted estimates are derived from multivariate regression models that control for the variables in the first model (Model I) plus socioeconomic status based on race/ethnicity, citizenship status, language, marital status, parent status, number of adults in household, education, work status, family income relative to the poverty level, and region. The regression-adjusted means that are reported for adults with ESI are based on those models and are derived using the characteristics of the adults with public coverage.

a. A condition that the respondent thought could have been treated by a regular doctor if one had been available.

*(**) Significantly different from the value in 2006 at the .05 (.01) level, two-tailed test.

FIGURE 2: UNMET NEED FOR HEALTH CARE DUE TO DIFFERENT TYPES OF DIFFICULTIES SEEING A PROVIDER IN THE PRIOR YEAR UNDER PUBLIC COVERAGE AND ESI COVERAGE FOR ADULTS 19 TO 64 WITH FULL-YEAR INSURANCE COVERAGE, 2013



Source: MHRS, 2013.
Notes: Public coverage includes MassHealth and Commonwealth Care. ESI is employer-sponsored insurance. See notes for Table 1 (p. 10).
* (**) Significantly different from zero at the .05 (.01) level, two-tailed test.

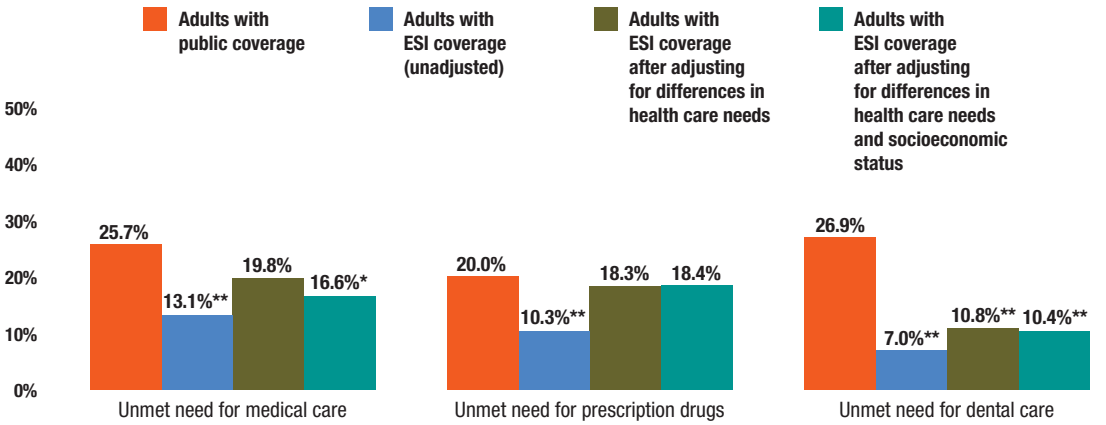
These public coverage–ESI gaps in connections to the health care system persist after controlling for variations in health care needs (Model I) and variations in health care needs and socioeconomic status (Model II) in the regression models (Table 1, second and third block of columns).

Gaps and potential gaps in receipt of services. Despite the greater gaps in access to providers in the health care system, full-year insured adults with public coverage were less likely than adults with ESI not to have had a visit to a doctor (either primary care or specialist) or mid-level provider (including a nurse practitioner, physician assistant, or midwife) over the prior year (5.7 versus 10.3 percent) (Table 1). However, the adults with public coverage were much more likely to report that they did not have a dental care visit (44.9 versus 20.8 percent) in the prior year, which may indicate that people with public coverage were more likely than those with ESI not to have insurance coverage for dental care. This likely contributes to the much higher share of adults with public coverage who reported that they went without needed health care in the prior year: 46.4 percent for adults with public coverage as compared with 22.5 percent for adults with ESI, based on the unadjusted estimates. Higher shares of adults with public coverage reported going without particular types of care, including medical care, prescription drugs, and dental care (Figure 3).

After controlling for the differences in health care needs and socioeconomic status (Model II) between adults with public coverage and adults with ESI, the differences in visits to doctors and mid-level providers and in dental care visits are no longer statistically significant (Table 1). Of note, gaps in dental care visits persist in Model I, which controls for differences in health care needs, but not Model II, which controls for both health care needs and socioeconomic status, highlighting the importance of economic resources in accessing dental care.

Despite the lack of differences in medical and dental care use between adults with public coverage and similar adults with ESI, adults with public coverage reported higher levels of unmet need for medical care and for dental care relative to similar adults with ESI after controlling for variations in health care needs and socioeconomic status based on Model II (Figure 3).

FIGURE 3: TYPES OF UNMET NEED FOR HEALTH CARE IN THE PRIOR YEAR UNDER PUBLIC COVERAGE AND ESI COVERAGE FOR ADULTS 19 TO 64 WITH FULL-YEAR INSURANCE COVERAGE, 2013



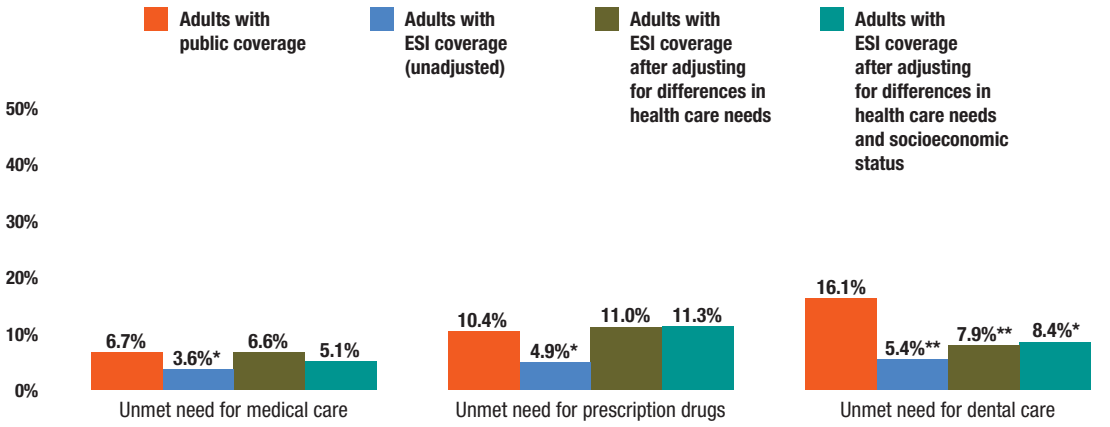
Source: MHRS, 2013.
Notes: Public coverage includes MassHealth and Commonwealth Care. ESI is employer-sponsored insurance. See notes for Table 1 (p. 10).
* (**) Significantly different from zero at the .05 (.01) level, two-tailed test.

Receipt of potentially inappropriate/inadequate care. Given the higher levels of unmet need overall and of unmet need due to provider access issues among adults with public coverage, as well as the lower cost-sharing requirements they face when seeking care in the emergency department (ED), it is perhaps not surprising that full-year insured adults with public coverage relied more heavily on the ED than did adults with ESI (Table 1). Over one-third (37.9 percent) of adults with public coverage reported two or more ED visits in the prior year, as compared with 7.0 percent of the adults with ESI based on the unadjusted estimates. The public-coverage adults were also more likely to report that their most recent ED visit was for a nonemergency condition that could have been treated by a regular doctor if one had been available (26.0 versus 7.8 percent). These ED differences persist after controlling for variations in health care needs and socioeconomic status (Model II) between adults with public coverage and those with ESI, as adults with public coverage continued to be more likely to rely on the ED than did similar adults with ESI.

Adults with public coverage were more likely to rate the quality of the care they received as fair or poor than adults with ESI (Table 1). In contrast to the estimates above on differential ED utilization, there is no difference in the share of adults with public coverage and adults with ESI who rated the quality of the care that they received as fair or poor after controlling for variations in health care needs and socioeconomic status.

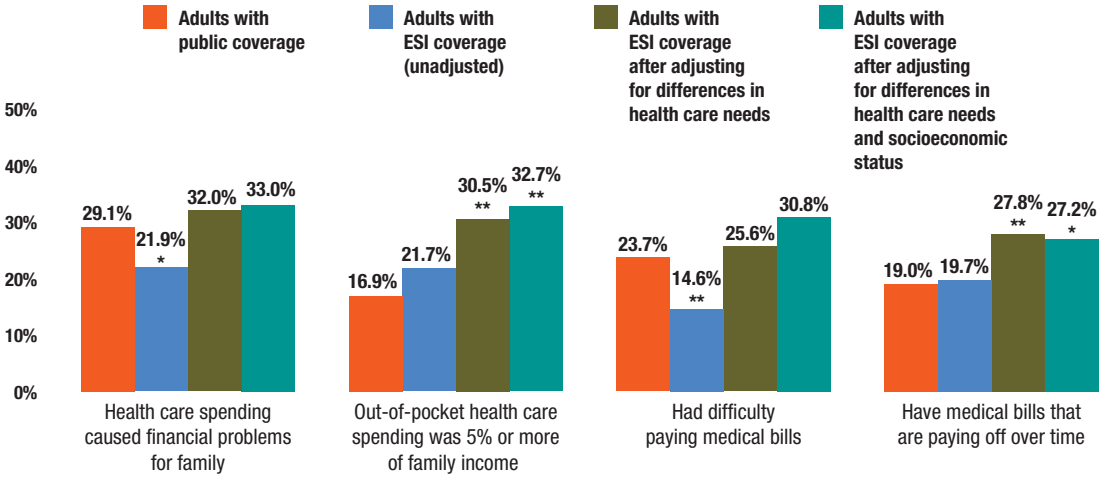
Concerns about affordability of care. Health care costs were a problem for many full-year insured adults in Massachusetts, with the problems particularly acute for adults with public coverage (Table 1). Almost half of the adults with public coverage (49.1 percent) reported that health care costs had caused financial or nonfinancial problems for their families over the prior year, as compared with 32.9 percent of adults with ESI. Those problems included going without needed health care due to costs, reported by 24.1 percent of adults with public coverage as compared with 9.4 percent of adults with ESI, and problems with health care spending, reported by 34.3 percent of adults with public coverage as compared with 26.4 percent of adults with ESI. The types of unmet need due to costs included unmet need for medical care, prescription drugs, and dental care, all of which were higher for adults with public coverage than for adults with ESI (Figure 4). Problems with spending included reported financial problems, high out-of-pocket spending, problems paying medical bills, and medical debt, where the public coverage–ESI comparisons are mixed (Figure 5). Of note, adults with public coverage were more likely to report that health care spending caused financial problems for their family and to report difficulties paying medical bills than adults with ESI. Adults with public coverage and adults with ESI were equally likely to be worried about their ability to pay their medical bills in the future, with more than half of both groups somewhat or very worried.

FIGURE 4: TYPES OF UNMET NEED FOR HEALTH CARE DUE TO COSTS IN THE PRIOR YEAR UNDER PUBLIC COVERAGE AND ESI COVERAGE FOR ADULTS 19 TO 64 WITH FULL-YEAR INSURANCE COVERAGE, 2013



Source: MHRS, 2013.
Notes: Public coverage includes MassHealth and Commonwealth Care. ESI is employer-sponsored insurance. See notes for Table 1 (p. 10).
* (**) Significantly different from zero at the .05 (.01) level, two-tailed test.

FIGURE 5: TYPES OF FINANCIAL PROBLEMS DUE TO HEALTH CARE SPENDING IN THE PRIOR YEAR UNDER PUBLIC COVERAGE AND ESI COVERAGE FOR ADULTS 19 TO 64 WITH FULL-YEAR INSURANCE COVERAGE, 2013



Source: MHRS, 2013.
Notes: Public coverage includes MassHealth and Commonwealth Care. ESI is employer-sponsored insurance. See notes for Table 1 (p. 10).
* (**) Significantly different from zero at the .05 (.01) level, two-tailed test.

Controlling for differences in health care needs and socioeconomic status between adults with public coverage and adults with ESI yields a very different picture of affordability, with the overall gaps in problems due to health care costs and unmet health care needs due to costs eliminated and the direction of the gaps in problems with health care spending reversed. Adults with public coverage were less likely than similar adults with ESI to report problems with health care spending (Table 1), with those problems reflected in higher levels of high out-of-pocket spending and more problems with medical bills that were being paid off over time (Figure 5), based on the regression models.

IV. DISCUSSION

While access to care tends to be quite strong in Massachusetts relative to the nation as a whole,[21] there are substantial differences in access to care for Massachusetts residents with different types of health insurance coverage, as reported by those residents in the 2013 MHRS. Full-year insured nonelderly adults with public coverage tended to report poorer overall access to care than did those with ESI, with only some of those differences explained by the higher health care needs and lower socioeconomic status of the adults with public coverage. Across the 15 measures examined, adults with public coverage had better access to care than adults with ESI coverage with similar health care needs and socioeconomic status on one measure, similar access on nine measures, and worse access on five measures. The three areas with five measures where adults with public coverage fared worse than similar adults with ESI included difficulties with provider access, unmet need for health care, and reliance on the ED. The area where adults with public coverage were doing better than similar adults with ESI was related to affordability of care. It appears that public coverage provides greater financial protection from high levels of health care spending than ESI, reflecting the generally lower levels of cost sharing present in the MassHealth and Commonwealth Care programs compared with typical ESI coverage.

The persistence of gaps in access to care for full-year insured adults with public coverage raises concerns about systemic barriers to care within the Massachusetts health care system. Nearly a third of adults with public coverage reported difficulties finding a provider over the prior year, and almost half reported going without needed care, including dental care. Almost half of adults with public coverage did not have a dental care visit in the prior year. While it is not possible to attribute the high levels of ED use among the adults with public coverage to these gaps in access to health care providers and dentists, it is certainly possible that such barriers could lead to an increased reliance on the ED for care that could have been provided in the community. Addressing the gaps in the extent to which adults with public coverage are obtaining the right care, at the right time, in the right setting, offers the potential for improved quality of care and lower health care costs for the public programs in Massachusetts. Identifying effective strategies to bolster access to care for adults with public coverage will require a better understanding of the barriers to care they face, including the apparent gaps in physician and dental care networks.

21 Long SK, Nordahl K, and Seifert R. 2014. *Coverage and Access Remain Strong but Costs Are Still a Concern: Summary of Findings from the 2012 Massachusetts Health Reform Survey.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available at www.bluecrossfoundation.org/sites/default/files/download/publication/MHRS_Summary.pdf.

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