Access to Health Care of Your Choice

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When it comes to older adults accessing health care services, the type of coverage they have is the most important factor driving utilization. We often hear that shortages of physicians and other medical professionals are major obstacles, but the features of health care plans and the amount of out-of-pocket spending are really what determine whether patients seek the health care services they need [1].

Recent surveys and studies show that, for consumers aged 65 years and older, health care access is most affected by financial and coverage features of the health insurance plan, leaving the issue of provider availability to market forces [2]. Because keeping the cost of care low is so important for consumers, 7 out of 8 Medicare beneficiaries choose to supplement the federal government health care program with additional coverage. In 2012, about 1.5 million North Carolinians (16% of the state's population) participated in Medicare, and about 1 of 4 purchased supplementary insurance (Medigap), in which enrollment is concentrated in plans with relatively low premiums [3]. Additionally, the Henry J. Kaiser Family Foundation reports that 64% of beneficiaries had some other form of supplemental coverage, such as an employer-sponsored plan (25%), Medicare Advantage plan (14%), Medicaid (14%), or some combination of coverage without Medigap (10%). The remaining 12% of Medicare enrollees, about 1 in 8 beneficiaries, had no supplemental coverage [3].

Although most health care consumers keep the same plan from year to year, Medicare offers beneficiaries a yearly opportunity to change plans. The Medicare Rights Center manages a hotline, and each Medicare consumer case is recorded in a database. An analysis of people calling about dropping a Medicare Advantage plan revealed that provider access problems represented only about one-fourth of disenrollments [4].

What do consumers aged 18 years and older want most in their health care plan? According to a Kaiser Family Foundation poll, the most important aspect of a health plan is being able to see the doctors that patients want, without paying more. The poll revealed that having a plan that covers a wide range of services was the second most valued aspect. When considering the costs of insurance, the most important features include the premium (67%), the deductible (62%), and the maximum annual out-of-pocket spending limit (58%). However, when ranking both financial and nonfinancial factors, over one-half of adults ranked several factors as very important: choice of providers (56%), range of services available (55%), and amount of copayments and/or coinsurance (54%) [2].

A challenge to health care access is the network optimization that health insurers sometimes initiate. Because these business decisions can affect beneficiaries, the Centers for Medicare & Medicaid Services (CMS) placed guidelines on insurers so that patient care is not interrupted unnecessarily. Usually insurers provide assistance, such as suggesting alternative physicians and planning for any care transition for those in active treatment, consistent with Medicare requirements for continuity of care. Some insurers take additional precautions, including proactive outreach to ensure uninterrupted care for enrollees with select conditions and outreach to providers who will remain in network to confirm their capacity to take on additional patients. Beneficiaries undergoing active treatment, or those with specific concerns about traveling long distances, can contact their insurer to request continuing care with an out-of-network provider on a short-term basis at no additional cost.

In 2014, on behalf of its 38 million members, AARP wrote to the head of CMS, which oversees Medicare Advantage, and urged the adoption of policy changes to make sure Medicare beneficiaries are protected and properly notified by any Medicare Advantage provider if network changes take place [5]. CMS agreed to many of these policy changes, which began in 2015 [6].

For most people under age 65 years in North Carolina, only private or employer-provided health care coverage is available; the few exceptions are children in poverty or those meeting special circumstances for disabilities. Private health care is available, often with tax subsidies, via Healthcare.gov. Currently, North Carolinians who earn between 44–100% of the federal poverty limit (if parents) or 0–100% of the federal poverty limit (if childless) must choose between foregoing coverage or purchasing coverage without subsidies. This gap in coverage represents 244,000 people and disproportionately affects the nonwhite population, where 48% lack access [7]. This lack of access due to affordability is even more acute for older workers, since they are frequently managing a chronic medical condition and need medical care.

The availability of affordable insurance coverage and the high costs of care, not physician shortages, most influence whether or not patients are seeking the care they need. North Carolina has an opportunity to tackle this problem by making health care coverage more available and affordable to limited-income residents who remain uninsured. NCMJ

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