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Some Chronically Ill Adults Wait for Medicare

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When uninsured adults with common chronic illnesses became eligible for Medicare, they saw doctors and were hospitalized more often and reported greater medical expenses than people who had had insurance. And their increased use of medical services continued at least until at least age 72, researchers are reporting today.

Their study, published in The [New England Journal of Medicine](#), is one of the first to follow a large group of people through that crucial time of transition from being ineligible for Medicare to receiving Medicare benefits.

Its researchers, led by Dr. John Z. Ayanian, an associate professor of medicine and health care policy at Harvard Medical School, used data from the Health and Retirement Study, a federally financed study that included 9,760 adults who were 51 to 61 in 1992. Dr. Ayanian and his colleagues focused on 5,158 of them who survived to age 65 by 2004 and who either had private insurance or no insurance at all before receiving Medicare.

The participants were interviewed and surveyed about their health and medical care every two years until 2004. That allowed the [Harvard](#) researchers to ask what happened when people who had not had insurance suddenly could have their health care paid for by the federal government.

The effect that emerged — a surge in the use of health care by those who were previously uninsured — was concentrated in people with cardiovascular disease or [diabetes](#). Those are conditions, the investigators noted, in which treatment can prevent serious

consequences that can require extra doctor visits, hospitalizations and expense. In the study, 2,951 of the 5,158 participants had one of those conditions.

When such previously uninsured people became eligible for Medicare, they had 13 percent more doctor visits, 20 percent more hospitalizations, and reported 51 percent greater medical expenditures than those with the same diseases who had had insurance all along.

Although the findings made sense, said Jonathan Skinner, an economist at Dartmouth College, they were not a foregone conclusion.

“You might expect that if you fall into habits of not using much health care, you might continue not to use it,” Dr. Skinner said. Instead, the study found a sort of pent-up demand among the uninsured.

“It shows how unfair our system is,” said Louise Russell, a research professor at the Institute for Health at Rutgers University in New Brunswick, N.J. “These people were not getting care, and they were at least as in need of it as the people who were insured.”

The study also shows that it may be less expensive than expected to provide universal health insurance, Dr. Ayanian and his colleagues concluded. Medicare is bearing the brunt when uninsured people put off seeing doctors or seeking medical care until they turn 65.

“A lot of the prior research focused on the health benefits of extending insurance coverage,” Dr. Ayanian said. “Our study suggested that it may be cost effective.”

But, economists note, it has to cost more to insure everyone than it does to leave some people out.

“The quick interpretation is, ‘Well this saves money,’ but it’s a partial savings,” said Mark Pauly, a health economist at the Wharton School

of the University of Pennsylvania. “You get some money back, but it’s still going to cost money.”

Dr. Mark McClellan, the former head of Medicare who is now a visiting fellow at the Brookings Institution in Washington, said the study had limitations.

The uninsured, he said, were very different from the insured people in the study. They had much less education, their incomes were lower, they were more likely to smoke and to be depressed.

The researchers accounted for differences with statistical adjustment. But, Dr. McClellan said, statistics can never completely solve the problem of large differences between groups.

For example, he said, the characteristics of the uninsured are also correlated with caring more about the present than the future. A trait like that, he added, “may lead to the need for more medical services down the road.”

That does not mean that the uninsured do not need health insurance, he said, but it does raise the question of what is the most effective way to provide it. For example, instead of just paying for doctor visits and leaving it to patients to find doctors and seek care, it may be better to also provide case managers who will contact patients and prompt them to take medications like drugs for high [blood pressure](#) or to report on their blood sugar levels if they have diabetes.

“Health insurance is supposed to not just prevent the complications of chronic diseases but also to keep you healthier,” Dr. McClellan said. “And Medicare historically has not done a very good job of that.”

Even now, he said, with expanded screening services, only about half of Medicare beneficiaries avail themselves of them.

Dr. Alan Garber, a health economist at Stanford, also raised the question of how best to expand medical services. Reducing costs, he added, should not be the driving factor.

“There are many good reasons to advocate coverage of the uninsured,” Dr. Garber said. “At the top of the list, though, is a belief that coverage expansions can improve health. If they also reduce costs, that is icing on the cake.”