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The article “Medicare Eligibility and Physician Utilization Among Adults With Coronary Heart Disease and Stroke” by Jerome Dugan, Ph.D., Salim S. Virani, M.D., and Vivian Ho, Ph.D., appeared in the June 2012 issue of *Medical Care*. Dugan authored the paper as a doctoral student of Ho at Rice University. He is currently an assistant professor at the University of Maryland. Virani is an assistant professor at Baylor College of Medicine and a staff cardiologist at the Michael E. DeBakey Veterans Affairs Medical Center. Ho is the James A. Baker III Institute Chair in Health Economics, as well as a professor at Rice University and Baylor College of Medicine.

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# HEALTH POLICY research

James A. Baker III Institute for Public Policy-Baylor College of Medicine  
Joint Program in Health Policy Research

## Do all chronically ill persons benefit equally from Medicare?

No, says Jerome Dugan, Ph.D. Most adults in the United States can sign up for relatively generous insurance coverage through Medicare at age 65. Overall, generous insurance benefits lead to more physician visits and fewer financial barriers to care for Medicare beneficiaries, relative to their experience just prior to turning 65. However, reports Dugan in the June 2012 issue of *Medical Care*, reaching Medicare eligibility is associated with reductions in the regular use of physician services for blacks with coronary heart disease or who have suffered a stroke.

Coronary heart disease and stroke (CHDS) are the two largest components of cardiovascular disease (CVD), the leading cause of disability and death in the United States. A total of 633,566 deaths were attributable to CHDS in 2007. Patients with these illnesses require continual monitoring and oftentimes treatment involving expensive procedures and medications. Thus, health insurance plays a crucial role in managing disease and improving health outcomes for CHDS patients.

Dugan and his co-authors analyzed data from the 1997 to 2010 National Health Interview Surveys to compare physician visits, access to care and insurance coverage for persons with CHDS just before (versus after) receiving Medicare coverage. One or more office visits annually were chosen to proxy for basic access and use of nonemergency physician services. Two or more office visits were chosen to proxy for a schedule of care required to routinely monitor risk factors (e.g., weight, blood pressure, cholesterol and blood glucose levels) to avoid future acute events.

A total of 30.6 percent of survey respondents with CHDS were covered under Medicare at

age 64. By age 65 Medicare coverage for this group jumped to 85.5 percent. Correspondingly, these patients increased their propensity to make one or more office visits by 1.7 percent at age 65. Hispanics with CHDS, as well as adults with some college education with CHDS, also reported an increased propensity to make two or more office visits at age 65 (9.5 percent and 2.4 percent, respectively). However, blacks with CHDS decreased their propensity to make two or more office visits at age 65.

Dugan and his co-authors observe that their results are consistent with previous studies that have found lower rates of hospital use after controlling for the health status for blacks relative to both whites and Hispanics. They speculate that the deductible that Medicare beneficiaries must pay before receiving insured physician services or the 20 percent co-pay may be too much for many low-income black Medicare beneficiaries to expend. Poor insurance coverage for medications may also discourage these patients from seeking care at age 65, despite Medicare coverage. Another explanation may be attributed to the ability of whites and highly educated patients to better utilize Medicare.

The authors conclude that there may still be shortcomings in the Medicare program for socioeconomically disadvantaged patients with CHDS. Further research should determine whether financial challenges, lack of understanding on how to access the health care system or misunderstandings of the importance of receiving regular care are most crucial for eliminating these socioeconomic disparities.

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**HEALTH POLICY** research presents a summary of findings on current health policy issues. It is provided by **Vivian Ho, Ph.D.**, James A. Baker III Institute Chair in Health Economics at the James A. Baker III Institute for Public Policy, in collaboration with **Laura Petersen, M.D., M.P.H.**, chief of the Section of Health Services Research in the Department of Medicine at Baylor College of Medicine.

This publication aims to make research results accessible to regional and national health policymakers. The views expressed herein are those of the study authors and do not necessarily represent those of the Baker Institute or of Baylor College of Medicine.

The Baker Institute and Baylor College of Medicine's Section of Health Services Research work with scholars from across Rice University and Baylor College of Medicine to address issues of health care — access, financing, organization, delivery and outcomes. Special emphasis is given to issues of health care quality and cost.

Rice University  
James A. Baker III Institute for Public Policy MS-40  
Health Economics Program  
P.O. Box 1892  
Houston, Texas 77251-1892

For further information about the program, please contact:

Health Economics Program  
James A. Baker III Institute for Public Policy  
Rice University MS-40  
P.O. Box 1892  
Houston, Texas 77251-1892  
phone: 713.348.4374  
email: [healthecon@rice.edu](mailto:healthecon@rice.edu)

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