“You've got a lot to prove” or “It’s not a hard process”: Experiences Gaining Access to Medicaid in Older Adulthood

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ABSTRACT
Medicaid provides an essential health safety net for people living in poverty or who become poor, particularly due to high health care needs and costs. Many adults over 65 will need Medicaid to cover health and long-term care costs, yet the process by which older adults gain access to Medicaid is unclear. In interviews with caregivers and staff at the Department of Social Services (DSS) in a large, urban county in North Carolina, I find that applicants have difficulty navigating the Medicaid application process, and that they perceive their own assets as a barrier to accessing this program. Alternately, I find that prior exposure to institutional care settings facilitated access to Medicaid. Employing an intersectional, life course approach, I use data from 11 waves of the Health and Retirement Survey to test these hypotheses. These findings have consequences for Medicaid policy for older adults across the US.

INTRODUCTION

Although the US does not have universal health care, they do have two public health insurance programs. One, Medicare, is essentially a universal program covering (primarily) individuals over 65. The other, Medicaid, is means-tested, targeted to individuals living below some threshold of poverty, which varies from state to state. Some people are eligible for both Medicare and Medicaid due to their age, health status, and income. This group, dual eligible beneficiaries, are often sicker, poorer, and more likely to be from a racially marginalized background than either the Medicare-only or Medicaid-only populations.

As the United States' population over 65 becomes increasingly large and increasingly racially and ethnically diverse, their health care needs have become more difficult to anticipate and to meet. Current research focuses on what their health care needs are, and the public costs associated with providing this coverage. Little is known, though, about how older adults become eligible for Medicaid, how they make sense of this experience, and what factors, at the individual and population level, impact the probability of becoming eligible for Medicaid at older ages. In this paper, I describe how older adults make sense of their experiences enrolling in Medicaid and I identify who is most at risk of enrollment at older ages.

BACKGROUND

Jamila Michener (2018) conducted a mixed methods study of Medicaid beneficiaries across the United States demonstrating how beneficiaries experience the fragmented landscape of this social policy. To do so, she conducted her study "in the 'field', where the participants live and work – these are important contexts for understanding what participants are saying" (Creswell 2013:20). By design, Michener (2018) and other qualitative researchers make an epistemological assumption that knowledge is co-created in the interviewer-interviewee relationship (Creswell 2013). Medicare-Medicaid dual eligible beneficiaries live in particular contexts and "develop subjective meanings in their experiences" (Creswell 2013:24). Prior work has not considered how duals construct their realities in reaction to unique, place-based experiences and how they make meaning of their situation.

Dual Eligibility

Most prior work on duals focuses on skilled nursing facility (SNF) or long-term care (LTC) use, and the costs associated with this care to both Medicare and Medicaid (e.g., Kane et al. 2013; Rahman et al. 2015). Kane et al. (2013) study older duals, who they consider "frailer" than younger or disabled duals, and their use of LTC. They find that the higher costs attributed to older duals is due to their high disease burden and LTC use (Kane et al. 2013).

Because Medicare does not cover LTC, and because the out-of-pocket costs are so high, many LTC recipients either are duals or become dual eligible by spending "just about everything [they] have to qualify for Medicaid" (Katz 2019:9). Duals are overrepresented in SNFs (a particular LTC option; Rahman et al. 2015), and Medicare and Medicaid bear the cost burden of providing this care to this population. This literature describes the public cost of providing for dual eligible beneficiaries but fails to describe how these recipients navigate these systems – who is left uncovered, what it is like to spend down one's assets while living (and dying) in a SNF, and how gaining access to one of these insurers might impact on beneficiaries.

Previous research has noted that some dual eligible beneficiaries had to "spend down" their assets to qualify for Medicaid (Katz 2019). These policies are in place in many states, including North Carolina, and assert that potential Medicaid beneficiaries might become eligible by, to put it bluntly, going broke (Katz 2019). As noted, Medicare was intended to prevent health care costs from causing financial crises among the elderly (Barr 2010), but to become Medicaid eligible, in many states, one must spend down a significant proportion of their wealth and assets first. It is possible that, for duals who were not living in poverty (at or below 100% of the FPL) prior to becoming Medicare eligible, it is their own assets and income that prevent them from accessing Medicaid benefits (NCDHSS 2019a).

Other work has examined barriers to accessing Medicaid eligibility and benefits (Michener 2018), as well as barriers to accessing other means-tested programs (Campbell 2014; Barnes and Henly 2018). According to Michener (2018), there may be variation in enrollment levels because people "may not have encountered an institution that encouraged them to enroll" (Michener 2018:78), because they don't know they are eligible (Sommers et al. 2012), because they feel stigmatized (Levinson and Rahardja 2004), or because they are unable to navigate the bureaucratic system (Stuber and Kronebusch 2004). It is reasonable to assume that all or some of barriers exist for duals over 65, but it is also possible that unique barriers exist due to their age and health conditions.

Individuals may be deterred from enrolling in welfare programs, generally, if they find the application process itself too difficult or degrading (Soss 1999). Going through a welfare program's application process may make potential recipients feel subordinated or stigmatized. In addition, long wait times can make potential beneficiaries feel unwelcome or unimportant (Soss 1999). Some programs have easier modes of access that limit these wait times or remove the need to visit a physical location to apply. Individuals can apply for Medicaid benefits online or in person at a local DSS office (NCDHSS 2019b). Older adults, who are likely to apply in person, may face wait times and stigmatization that may limit their uptake (Soss 1999).

Health Disparities

Socioeconomic status, often operationalized with educational attainment, is predictive of several health outcomes, including morbidity and mortality (Hayward and Gorman 2004; Geronimus et al. 2015; Chetty et al. 2016). Education is consistently associated with a variety of health outcomes in adulthood. Educational differentials in mortality increased between 1986 and 2006 for non-Hispanic white and non-Hispanic Black men and women (Hayward, Hummer and Sasson 2015). Socioeconomic status, then, has become an increasingly important predictor of health.

In the US, race is constructed in social and political contexts, and it is often related to socioeconomic disadvantage. The lived experiences of racialization and racism have profound impacts on differently raced bodies that reach beyond the contexts in which they were constructed. There are persistent racial inequities in both quantity and quality of education, and in the health and mortality benefits associated with higher educational attainment (Braveman et al. 2010, Montez et al. 2011). Several theories seek to explain both racial disparities in health as well as the contradictions that racial and ethnic groups pose to the seemingly robust relationship between SES and health (Pearson 2008).

The age-as-leveler hypothesis, persistent inequality hypothesis, and the cumulative disadvantage hypothesis offer distinct theoretical models for how race, ethnicity, sex, and other factors interact as populations age to produce distinct health patterns in late life (e.g., Brown, O'Rand, and Adkins 2012, Dupre 2007). In this study, I explore to what extent Medicaid enrollment at older ages follows these patterns and discuss the consequences for individuals who do experience this transition after age 65.

DATA AND METHODS

This is a mixed-methods study. First, I conduct qualitative interviews with 7 caregivers of Medicaid recipients over 65, 4 Department of Social Services (DSS) workers, and 2 Centralina Area Agency on Aging employees in Mecklenburg County in North Carolina. I conducted interviews in-person and over the phone from February to April 2020. Participants were recruited through the Social Coordinator at one skilled nursing facility (SNF) in Mecklenburg County. This staff member provided phone numbers for family members (caregivers), who were then contacted to determine whether they were interested in participating and to schedule a time for a phone interview. Semi-structured interviews lasted 30-60 minutes and respondents received $30 for their participation in this study. Table 1 displays participant characteristics.

Table 1. Sample Characteristics (Total N = 13)

CAREGIVERS N=7	Number (percent); Mean	**STAFF** N = 6	Number (percent); Mean
Sex		Sex	
Male	3 (42.9%)	Male	4 (66.7%)
Female	4 (57.1%)	Female	2 (33.3%)
Race		Race	
White	7 (100%)	White	4 (66.7%)
Black	0 (0%)	Black	2 (33.3%)
Age (respondent)	67	Age	49
Age (dual SNF resident)	82	Average Monthly Income	$6553
Length of SNF stay (years)	4.2		
Average Monthly Income	$4,743		

All interviews were recorded and transcribed. Transcriptions were uploaded into NVivo 12 for coding. I used an inductive approach to coding to allow for emergent themes and to capture my respondents' perceptions of their experiences (Charmaz 2006). I combined this with a deductive approach, drawing from the literature to examine a priori codes – such as uptake and barriers.

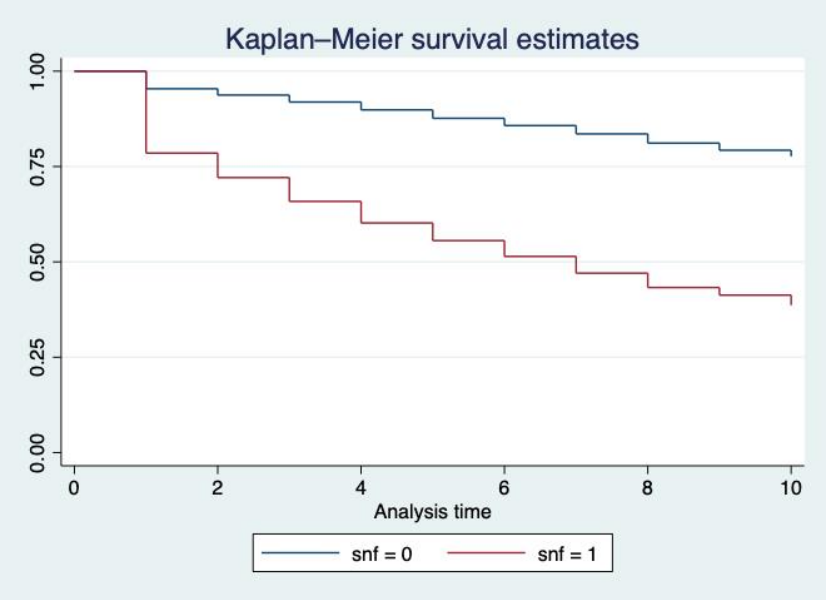
I initially coded using a priori codes drawn from study objectives and prior literature. Deductively, I looked for descriptions of the spend down process (Katz 2019), compliance costs or difficulties during navigating the application process (Moynihan, Herd and Harvey 2015; Stuber and Kronebusch 2004). I examine respondents' descriptions of why they applied to Medicaid, the Medicaid application process itself, and their interactions with DSS staff. I coded inductively, line-by-line and then instance-by-instance, allowing other themes to emerge from respondents' descriptions.

From this analysis, I hypothesize that (1) individuals who have previously experienced institutional care (in a SNF, assisted living facility, or hospice program) will enroll in Medicaid more rapidly than those who have not. In addition, that (2) individuals with low-incomes will enroll in Medicaid more rapidly than individuals with mid- or high-incomes.

I test these hypotheses with data from the Health and Retirement Study (HRS). The HRS is a longitudinal panel study conducted every two years and it includes information on demographic characteristics, nursing home residency, health insurance, timing of eligibility for Medicare, Medicaid, and dual eligibility, as well as mortality data. I include 11 waves in this analysis, from 1998-2018. I include only respondents who are observed alive during wave four (1998), who are a member of an HRS birth cohort, and who are the primary respondent (i.e., not a spouse) in a household. In addition, I keep only those respondents over 65. This is because Medicaid policy varies greatly between states for non-elderly populations.

I initially employ Kaplan-Meier estimates to describe the time to Medicaid enrollment for HRS respondents who have (SNF=1) and have not (SNF=0) reported a SNF stay in the past two years. The results demonstrate that HRS respondents who have not had a SNF stay "survive" without Medicaid at much greater rates than those who have had a SNF stay.

Figure 1. Kaplan-Meier Survival Estimates: Time to Medicaid Enrollment (N=108,402)



To further examine the relationship between institutional care settings and Medicaid enrollment I use Cox proportional hazard survival analysis, controlling for age, sex, race, and income, to determine if using these services predicts Medicaid enrollment. Next, I use Cox proportional hazard survival analysis, controlling again for age, sex, and race, to determine if income predicts Medicaid enrollment. I incorporate health status into additional models. Finally, I use Cox proportional hazard models to determine if institutional health service use predicts Medicaid eligibility, and to determine how long, after becoming eligible, one enrolls.

Additional results are forthcoming.

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