



Changes in Health Care Financing & Organization (HCFO)

findings brief

key findings

- Increasing outpatient waiting times in the Veterans Health Administration (VA) system by 10 percent increases demand for Medigap insurance by 5 percent among Medicare-eligible veterans.
- A representative patient would be indifferent between waiting an average of five more days for VA appointments and paying an additional \$300 in annual premiums.

Time is Money: Outpatient Waiting Times and Health Insurance Choices of Elderly Veterans in the United States

Overview

Waiting times are a means to balance supply and demand when prices are fixed at levels that are too low to serve this balancing function. Outside of the United States, patients seeking outpatient care or elective surgery face substantial waiting times for these services. In contrast, the United States has had relatively short wait times, due to higher health care prices and because a significant fraction of the population lacks health insurance (which reduces demand).¹ The current role of the uninsured in helping balance health care supply and demand is expected to change with the passage of the 2010 Patient Protection and Affordable Care Act (ACA). A main goal of the ACA is to expand insurance coverage and reduce uninsurance in the working-age population.

The insurance coverage expansions in the ACA, coupled with possible cuts in Medicare fees to physicians, may result in many

Americans facing a delay for services for the first time. After similar reforms were passed in Massachusetts in 2006, waiting times for primary care physician appointments grew.² In a HCFO-funded study,³ Steve Pizer, Ph.D., and Julia Prentice, Ph.D., of the Boston VA Research Institute, investigated the effect of waiting times on health care utilization and insurance choices among elderly American veterans who have access to both the VA health system and Medicare-financed care.

“The passage of ACA means that many patients in the United States may experience long waits for the first time,” said Dr. Pizer. “No research was available on patient reactions to these waits because this will be a new experience for Americans. We were able to capitalize on the unique situation in the VA to ask how much patients would be willing to pay to avoid longer waits.”



Robert Wood Johnson Foundation

Changes in Health Care Financing and Organization is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.

The VA provides free or low-cost care to approximately four million veterans each year through its public hospitals and outreach clinics. Veterans using the VA often face a tradeoff between cost (low to no-cost services) and convenience (facilities are often inconveniently located and patients may face waiting times). Veterans may also be eligible for Medicare. Medicare coverage is far less comprehensive with higher out-of-pocket costs, but waiting times for services are typically much shorter.

Dr. Pizer and Dr. Prentice used the variation in wait times for VA services to observe the health care financing decisions of these veterans and measure how their decisions were affected by waiting times. In particular, the researchers focused their attention on the decision to purchase Medicare supplemental insurance (also known as Medigap coverage). By observing the changes in demand for Medigap in conjunction with VA waiting times, they sought to identify the premium equivalent of waiting time for enrollees.

Methods

The main data source for the project was the 2001-2003 Medicare Current Beneficiary Survey (MCBS) Cost and Use files. MCBS contains information on Medicare eligibility, plan choice, utilization, and spending. As VA researchers, Dr. Pizer and Dr. Prentice were able to utilize a crosswalk and link MCBS data to VA administrative data for VA utilization, service-connected disability, facility-level waiting times, and patient distance to VA facilities. Each person's resident zip code was taken from MCBS and they were assigned to the nearest VA facility. They also linked county-level data on Medicare HMO plan characteristics from the Medicare Personal Plan Finder database and state-level measures of Medigap premiums.

The sample for the study consisted of non-institutionalized individuals enrolled in Medicare Parts A and B with reported military service. Veterans with Medicaid coverage or supplemental coverage from

an employer were excluded because their insurance choices were very different from the rest of the population. Individuals who died during the study period were also excluded from the sample. The final sample size was 1,369 unique individuals and 1,932 person-years.

The researchers began by measuring the effect of VA waiting times on outpatient VA and Medicare utilization. Next, they estimated a model of Medicare plan choice, accounting for the simultaneous determination of plan choice and Medicare or VA utilization. Finally, they simulated the effect of a change in VA waiting time on health care utilization and Medicare plan choice.

Results

As expected, longer VA wait times were positively and significantly associated with Medicare visits. There was no significant effect on VA visits. Dr. Pizer and Dr. Prentice concluded that while one might expect that VA visits would decline with higher wait times, veterans may be highly attached to their VA providers and they may not want to disrupt those patient-provider relationships. This is one reason veterans may continue to utilize the VA despite long waits.

The researchers' estimates show that higher VA wait times increase Medicare utilization, and make veterans more likely to purchase Medigap coverage. Estimates from the models were used to simulate the effects of changes in waiting times on physician visits. This policy simulation predicted that an increase in waiting of about 10.4 days would increase Medicare use by approximately 10.7 percent. This change in Medicare visits, holding other variables constant, increases the probability of purchasing Medigap insurance by 8 percent. The results suggest that a representative patient in this sample would have been indifferent between an average increase in waiting times of approximately five days and an increase in Medigap premiums of \$300 per year.

“Patients are often committed to their physicians and tolerate long waiting times without switching doctors, but our results demonstrate that outpatient waiting times impose a serious burden on patients nonetheless,” said Dr. Prentice. “The veterans in our sample were willing to pay substantial insurance premiums to improve their access to care when VA waiting times are high.”

Study Limitations

The researchers acknowledge several important limitations to their study. First, although approximately one-quarter of Medicare beneficiaries are veterans, those that utilize the VA system are typically lower income, in poorer health, and more disabled than the average patient. This is likely due to a combination of factors including the VA's priority system, its low financial costs, and the inconvenience of its facilities. Higher income patients usually place a higher financial value on quick access to care and may be less inclined to use the VA system. As a result, these findings may not be generalizable to the broader Medicare population.

Second, although the researchers used strong instruments to conduct the study, not all veterans in the sample were equally affected. For example, some veterans use the VA for services that are not easily obtained through Medicare providers (e.g. substance abuse treatment). These veterans would be less likely to substitute Medicare services for VA services, regardless of waiting times. This suggests that the researchers' estimates of sensitivity to waiting times are probably lower than they would be if the study could be done on the entire Medicare population. Finally, the ability to study the effect of waiting times on smaller groups, such as those with a history of heavy VA use, is limited by the VA's data access restrictions that resulted in small sample sizes.

Policy Implications

Dr. Pizer and Dr. Prentice are cautious about generalizing the findings from this study to the broader U.S. population. However, their findings do suggest that many elderly Americans who have established relationships with physicians and low or moderate

incomes would be willing to pay substantial monthly premiums to avoid longer waiting times for services. This study offers valuable information on how waiting times and premiums affect beneficiaries' utilization of care in both systems. Policymakers may want to assess how these higher waits would affect enrollment in public programs and whether or not enrollees would be willing to pay a premium to reduce delays. Additionally, there is the possibility that longer waiting times may have the benefit of reducing demand for unnecessary care.

“Members of Congress will continue to grapple with the rising costs of federally funded health insurance programs as they prepare their annual budgets,” said Dr. Pizer. “Higher waiting times and higher beneficiary costs are two prominent ways to reduce the budget impact of these programs. Research like ours helps put a price tag on waiting times so policymakers can choose a sensible mix of these approaches along with other cost containment measures.”

Conclusion

As the ACA is phased in and more Americans have access to health insurance, demand for health care services will likely increase. This increase in demand could lead to longer waiting times than many Americans are accustomed to for outpatient and elective services. This study provides valuable information for public and private policymakers on how patients' health care decisions respond to changes in premiums and waiting times.

“Managing demand for care is one way to control costs and our research helps strike the right balance between waiting times and beneficiary cost-sharing,” said Dr. Prentice. “It is important to keep in mind, though, that demand management is only half the cost-containment battle. It is equally important to pursue supply-oriented measures like comparative effectiveness research and accountable care organizations.”

For More Information

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Endnotes

- 1 Fronstin, P. “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2009 Current Population Survey.” *EBRI Issue Brief*, No. 334, Employee Benefit Research Institute, Washington, DC, 2009.
- 2 Kowalczyk, L. “Across Mass., Wait to See Doctor Grows,” *The Boston Globe*, September 22, 2008. See also: http://www.boston.com/news/health/articles/2008/09/22/across_mass_wait_to_see_doctors_grows/.
- 3 Pizer, S.D. and Prentice, J.C. “Time is Money: Outpatient Waiting Times and Health Insurance Choices of Elderly Veterans in the United States,” *Journal of Health Economics*, Vol. 30, 2011, pp. 626-636.