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## National Reform: What Can We Learn from Evaluations of Massachusetts?

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### INTRODUCTION

The 2010 *Patient Protection and Affordable Care Act (ACA)* is modeled on Massachusetts' 2006 landmark reform—*An Act Providing Access to Affordable, Quality, Accountable Health Care*. As in Massachusetts, national reform includes public program expansions; the creation of health insurance exchanges; premium and cost-sharing subsidies; an individual mandate; and requirements for employers, among other provisions (Henry J. Kaiser Family Foundation, 2010). This brief provides a synthesis of what we know about the impacts of Massachusetts' health reform and an assessment of what these findings mean for the ACA and for the evaluation of the ACA's impacts.

### MASSACHUSETTS' REFORM

We discuss findings from the range of studies that examine the effects of Massachusetts' health reform on non-elderly adults, focusing on work that has evaluated insurance coverage; health care access and use; and the affordability of care.

### COVERAGE

#### Strong Gains in Coverage

Table 1 summarizes the literature on the impacts of health reform on health insurance coverage for non-elderly adults in Massachusetts.<sup>i</sup> Despite the differences in data sources and methods, there is general consistency in the core findings across the studies. The studies all find gains in insurance coverage for non-elderly adults under health reform, with estimates of the increase in coverage ranging

#### KEY FINDINGS

##### *Impact of Massachusetts' Reform on Non-Elderly Adults*

- ✓ There have been strong gains in insurance coverage for non-elderly adults under health reform.
- ✓ Over time, uninsurance in Massachusetts has been consistently much lower than in the nation broadly.
- ✓ There is no evidence that the expansion of public coverage has led to the crowd-out of employer-sponsored coverage.
- ✓ There is evidence of gains in access to and use of care in under reform, although not across all measures.
- ✓ There have been improvements in the affordability of care, particularly as measured by the share of adults forgoing care due to costs, although these improvements have tended to erode over time.

from 2 to 8 percentage points over the 2007 to 2009 post-reform period.<sup>ii</sup>

Figure 1 illustrates the gains in insurance coverage for non-elderly adults in Massachusetts relative to the rest of the country over the 2006 to 2009 period, using the Current Population Survey (CPS), the National Health Interview Survey (NHIS), and the American Community Survey (ACS).<sup>iii</sup> As shown in the figure, the patterns of uninsurance for Massachusetts are quite similar across the surveys, as are the patterns for the nation as a whole. Moreover, across the surveys and over time, uninsurance in Massachusetts is consistently much lower than in the nation broadly, with the rate of uninsurance falling in Massachusetts since 2006 while increasing for the nation as a whole.

**Table 1:** Summary of Studies Addressing the Impacts of Health Reform on Insurance Coverage for Non-Elderly Adults in Massachusetts\*

Study	Data Source	Summary of Key Findings <sup>a</sup>
Long (2008) in <i>Health Affairs</i> <sup>b</sup>	MHRS <sup>c</sup>	Increase in insurance coverage (up 5.6 percentage points in Fall 2007), with increases in ESI and public/other coverage; Reduction in ever uninsured over the past year
Long and Stockley (2009), Urban Institute publication <sup>b</sup>	MHRS	Increase in insurance coverage (up 7.9 percentage points in Fall 2008), with increases in ESI and public/other coverage; Reduction in ever uninsured and always uninsured over the past year
Long and Stockley (2010) in <i>Health Affairs</i> <sup>b</sup>	MHRS	Increase in insurance coverage (up 7.7 percentage points in Fall 2009), with increases in ESI and public/other coverage; Reduction in ever uninsured and always uninsured over the past year
Zhu et al. (2010) in <i>Journal of General Internal Medicine</i>	BRFSS	Increase in insurance coverage <sup>d</sup>
Tinsley, Andrews, Hawk, and Cohen (2010) in <i>Morbidity and Mortality Weekly Report</i>	BRFSS	Insurance coverage increased (up 5 percentage points in 2007/2008), with private coverage (ESI and direct purchase) reduced and public coverage increased
Clark et al. (2011) in <i>Health Affairs</i>	BRFSS	Increase in insurance coverage (up 2 to 3 percentage points in 2007/2008), with increase in public/other coverage and no change in ESI coverage
Long and Stockley (2011) in <i>Health Services Research</i>	NHIS	Increase in insurance coverage (up 2 to 3 percentage points in 2007/2008), with increase in public/other coverage and no change in ESI coverage
Yelowitz and Cannon (2010), CATO Institute publication	CPS	Increase in insurance coverage (up 6.7 percentage points in 2007/2008), with an increase in private coverage (ESI and direct purchase)
Long, Stockley and Yemane (2009) in <i>American Economic Review</i>	CPS	Insurance coverage increased (up 6.6 percentage points in 2007), with increases in ESI and public/other coverage
Massachusetts Division of Health Care Finance and Policy (2010) <i>Health Care in Massachusetts: Key Indicators</i>	Administrative Data	Insurance coverage in the state increased by 8 percent (410,000 persons) between June 2006 and March 2010, with gains in both public and private group coverage

\*Notes: MHRS is Massachusetts Health Reform Survey; BRFSS is Behavioral Risk Factor Surveillance System; NHIS is National Health Interview Survey; CPS is Current Population Survey; ESI is employer-sponsored insurance

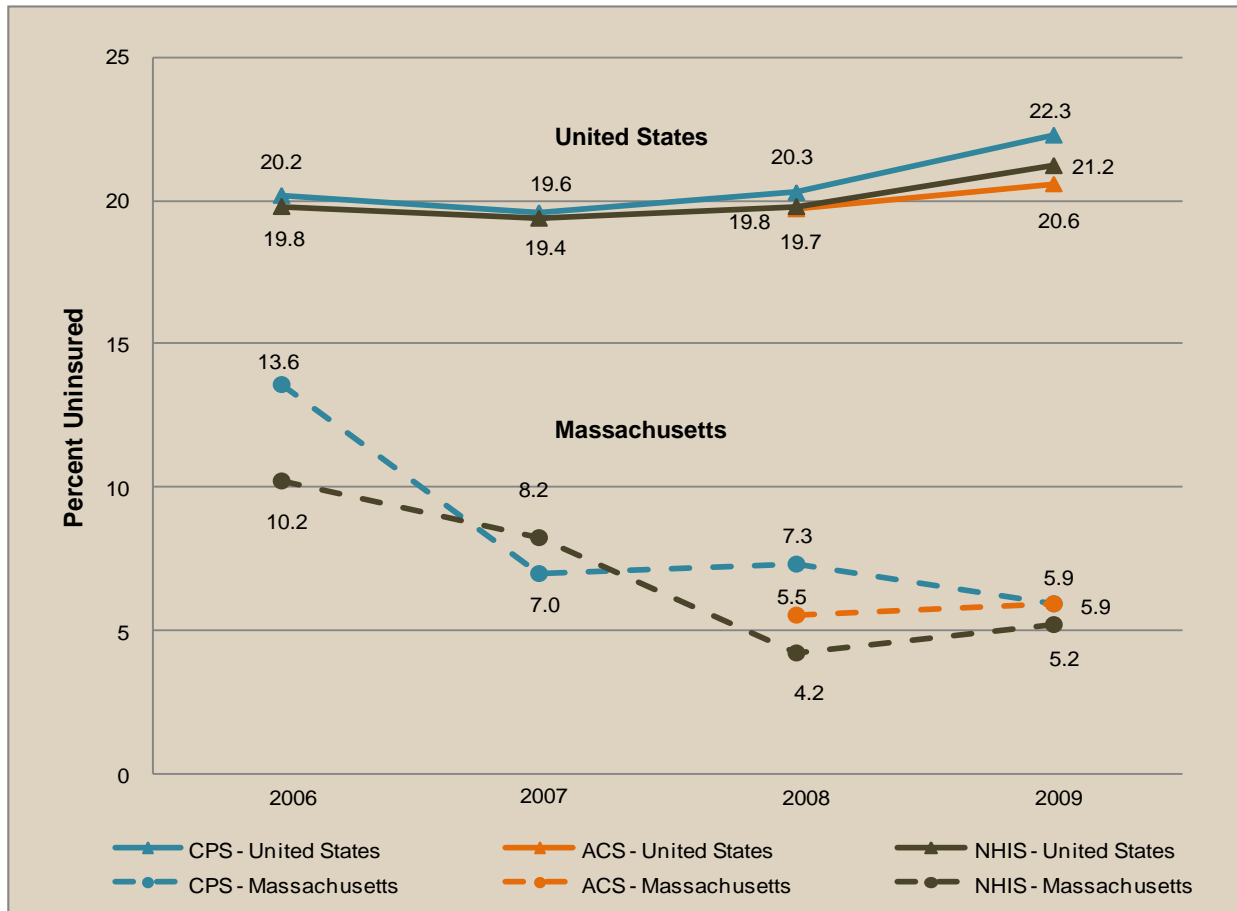
<sup>a</sup> Findings are based on regression-adjusted estimates unless otherwise noted.

<sup>b</sup> The research based on the MHRS is updated each year as another round of data becomes available.

<sup>c</sup> Studies using the MHRS, which provides data for Massachusetts only, have relied on pre-post comparisons. In contrast, studies using other data sources have generally taken advantage of the availability of data for other states to use the stronger difference-in-differences model to assess the impacts of health reform in Massachusetts.

<sup>d</sup> Point estimate not available.

**Figure 1.** Trends in Uninsurance in the United States and Massachusetts for Non-Elderly Adults, 2006-2009



### No Evidence of Crowd-Out

Beyond the impact on insurance coverage overall, an important issue in assessing the implications of health reform on insurance coverage is the extent to which expansions of public coverage substitute for or “crowd out” existing employer-sponsored coverage. If individuals give up their employer-sponsored coverage to enroll in public coverage, the net gain in overall insurance coverage from the public expansion will be lowered.

As shown in Table 1, studies focusing on changes in employer-sponsored insurance (ESI) coverage under health reform using the MHRS (Long 2008, Long and Stockley 2009, Long and Stockley 2010) and the CPS (Long, Stockley, and Yemane 2009) find increased ESI coverage, while work using the NHIS (Long and Stockley 2011) finds no change in ESI coverage under reform. Thus, there is no evidence that the expansion of public coverage in Massachusetts has led to a

reduction in ESI coverage in the state. Administrative data from the Massachusetts Division of Health Care Finance and Policy provides further support for this conclusion (2010). Moreover, employers indicated that they were more likely to offer coverage to their workers in 2009 than they were in 2005 (76% versus 70%), and data on total enrollment in private group plans in the state indicate an increase of 28,000 people between 2006 and 2010. (DHCFP 2009 Massachusetts Employer Survey, data drawn from all MA employers).

## ACCESS TO AND USE OF HEALTH CARE

### Some Gains, Still Room for Improvement

The expansion of health insurance coverage in Massachusetts was expected to provide better access to health care providers and increased use of care for those who gained coverage, as these

individuals would face lower costs for using services. Moreover, Massachusetts created new standards (“minimum creditable coverage” standards) for the benefits that a health plan must cover in order for the plan to count as coverage under the individual mandate.<sup>iv</sup> These new standards apply both to those obtaining coverage under health reform and to those who were previously insured—and with more benefits covered, access to and use of care was expected to improve for both groups.

Table 2 summarizes the findings from research that has examined access to and use of care by non-elderly adults under health reform in Massachusetts. There has been less work on this topic than on insurance coverage, reflecting the more limited data sources available for examining access to and use of care overall and within individual states. Research on the impacts of health reform on health care access and use is also limited by the expected lag in the impact of the expansion of insurance coverage on the individual’s health care access and use and the nature of the access and use questions included in the surveys. The survey questions generally focus

on the individual’s experiences over the prior year (unlike measures of current insurance coverage). As a result, we have less timely information on changes in access to and use of health care under health reform than we do on insurance coverage.

Overall, the findings from studies using the MHRS are consistent with the expected lag in observing changes in health care access and use under health reform: there were few improvements in access to care or increases in health care use in 2007 (Long 2008), the first year after reform began, with greater gains observed in subsequent years (Long and Masi 2009, Long and Stockley 2010). By 2009, there were increases in the share of non-elderly adults reporting that they had a usual source of health care; increases in the shares reporting outpatient visits and the use of prescription drugs; and decreases in the shares reporting having foregone needed health care.<sup>v</sup> Studies based on the BRFSS and NHIS also provide evidence of some gains in access to and use of care under health reform, although the findings are not entirely consistent across the studies. For example, in work using the BRFSS, Tinsley et al. (2010) report an increase in the share of non-elderly adults with a

**Table 2:** Summary of Studies Addressing the Impacts of Health reform on Access to and Use of Care for Non-Elderly Adults in Massachusetts\*

Study	Data Source	Summary of Key Findings <sup>a</sup>
Long (2008) in <i>Health Affairs</i> <sup>b</sup>	MHRS	Increase in share with usual source of care; Increases in some types of outpatient visits; No change in share taking prescription drugs or emergency department use; Reductions in unmet need for care
Long and Masi (2009) in <i>Health Affairs</i> <sup>b</sup>	MHRS	Increase in share with usual source of care; Increases in some types of outpatient visits and share taking prescription drugs; No change in emergency department use; Some reductions in unmet need for care
Long and Stockley (2010) in <i>Health Affairs</i> <sup>b</sup>	MHRS	Increase in share with usual source of care, outpatient visits, and taking prescription drugs; No change in inpatient use or emergency department use; Reductions in unmet need for all types of care
Clark et al. (2011) in <i>Health Affairs</i>	BRFSS	No change in receipt of mammogram or Pap smear; Increase in receipt of colonoscopy; Increase in cholesterol screening for women but not men
Tinsley, Andrews, Hawk, and Cohen (2010) in <i>Morbidity and Mortality Weekly Report</i>	BRFSS	Increase in share with a personal health care provider; Increase in share with a routine checkup
Zhu et al. (2010) in <i>Journal of General Internal Medicine</i>	BRFSS	No change in share with a personal health care provider
Long and Stockley (2011) in <i>Health Services Research</i>	NHIS	No changes for most measures, with the exception of increases in delayed getting needed care because couldn't get an appointment and in likelihood of a visit to a nurse practitioner, physician assistant, or midwife

\*Notes: MHRS is Massachusetts Health Reform Survey; BRFSS is Behavioral Risk Factor Surveillance System; NHIS is National Health Interview Survey  
 a Findings are based on regression-adjusted estimates unless otherwise noted.

<sup>b</sup> The research based on the MHRS is updated each year as another round of data becomes available.

personal health care provider under health reform in Massachusetts, while Zhu et al. (2010) report no change in that measure.

Despite the gains in access to care under health reform in Massachusetts, it is important to note that the analyses reveal some persistent problems with access to health care that have continued under health reform. According to survey responses, roughly one in five non-elderly adults in Massachusetts did not get some type of needed care in the past 12 months (Long and Stockley 2010); more than one in four adults did not have a doctor visit in the past 12 months for a routine check-up (Tinsley et al. 2010); more than one in ten women went without a recent Pap smear (ages 18 to 64) or mammogram (ages 40-64) (Clark et al. 2011); and more than one in three adults ages 50 to 64 went without a recent colonoscopy (Clark et al. 2011).

Table 3 summarizes the findings from studies that have looked at the impacts of health reform on affordability of care for non-elderly adults in Massachusetts. This work has relied on the MHRS, the BRFSS and the NHIS.

As with the studies focusing on insurance coverage and health care access and use, the findings from these studies are generally consistent. All show improvements in the affordability of care for non-elderly adults, particularly in terms of reductions in the share of adults going without needed care because of costs—the one measure available across all three data sets. Findings from studies using the MHRS, which provides a broader set of measures on affordability of care, suggests that there were stronger gains in the affordability of care for individuals in the early period after health reform (Long 2008), with those gains eroded over time (Long and Masi 2009, Long and Stockley 2010).

As with access to care, it is important to note that affordability of care continues to be an issue for some adults in Massachusetts. For example, several of the studies report unmet need for health care due to costs for more than one in ten non-elderly adults in the state (Long and Stockley 2010, Long and Stockley 2011), with higher levels for some subgroups of adults (Clark et al. 2011). Long and Stockley (2010) also report roughly one in five non-elderly adults with high out-of-pocket health care costs, problems paying medical bills,

## AFFORDABILITY OF HEALTH CARE

### Health Care Costs are Less of a Barrier

While Massachusetts' 2006 health reform initiative did not tackle the high cost of health care in the state, the expansion of health insurance coverage and the establishment of the minimum creditable standards were expected to improve the affordability of health care for individuals.

**Table 3:** Summary of Studies Addressing the Impacts of Health Reform on the Affordability of Care for Non-Elderly Adults in Massachusetts\*

Study	Data Source	Summary of Key Findings <sup>a</sup>
Long (2008) in <i>Health Affairs</i> <sup>b</sup>	MHRS	Reductions in OOP spending, problems paying medical bills and medical debt, and unmet need due to costs
Long and Masi (2009), in <i>Health Affairs</i> <sup>b</sup>	MHRS	Reductions in OOP spending and unmet need due to costs; No change in problems paying medical bills and medical debt
Long and Stockley (2010) in <i>Health Affairs</i> <sup>b</sup>	MHRS	Reductions in OOP spending and unmet need due to costs; No change in problems paying medical bills and medical debt
Clark et al. (2011) in <i>Health Affairs</i>	BRFSS	Reduction in unmet need due to costs
Zhu et al. (2010) in <i>Journal of General Internal Medicine</i>	BRFSS	Reduction in unmet need due to costs
Long and Stockley (2011) in <i>Health Services Research</i>	NHIS	Some evidence of reductions in unmet need for care and delays in getting care because of costs

\*Notes: MHRS is Massachusetts Health Reform Survey; BRFSS is Behavioral Risk Factor Surveillance Survey; NHIS is National Health Interview Survey; OOP is out-of-pocket.

<sup>a</sup> Findings are based on regression-adjusted estimates unless otherwise noted.

<sup>b</sup> The research based on the MHRS is updated each year as another round of data becomes available.

and problems with medical debt.

## LESSONS FOR NATIONAL REFORM

### Complex Reforms Can Be Carried out Quickly and Effectively

Massachusetts has shown that a complex health reform initiative, including the deployment of a strong outreach and enrollment system (Dorn, Hill and Hogan 2009), can be implemented quickly and effectively (Raymond 2007, 2011). The net result has been significant gains in health insurance coverage and access to health care for the state's residents.

### The Gains of Reform Can be Sustained in a Weak Economy

More recently, Massachusetts has shown that, while difficult, sustaining the gains of health reform in a severe recession is possible. Uninsurance in the state remains at historically low levels and employer-sponsored insurance remains strong despite the severe economic recession that began in December 2007 and continues to affect the state's economy.

### Increased Coverage Does Not Necessarily Equal Improved Access, Costs

Massachusetts' reform effort has also demonstrated that universal health coverage does not guarantee universal *access* to health care, nor does it slow the growth of health care costs. While Massachusetts has initiated a number of strategies to improve access to care,<sup>vi</sup> the state deferred addressing health care costs as part of the 2006 legislation in order to avoid a delay in expanding coverage. Currently, there is broad consensus in the state about the need to control health care costs, and there is much discussion about potential strategies for doing so. A recent proposal by Massachusetts Governor Deval Patrick would put a number of strategies into place, such as the promotion of integrated care networks and a move away from fee-for-service payments toward alternative payment methods (Patrick 2011). There have been efforts in this direction by providers and insurers in the state as well (Chernew et al. 2011). With escalating health care costs a serious problem in every state, there is a clear need for strong federal leadership to address the systematic problems with the health care payment

system across the nation in order to keep health care affordable.

### National Data Sources are Limited for State Applications

Finally, efforts to evaluate the impacts of health reform in Massachusetts have highlighted the limitations of current national data sources for assessing the impacts of national reform across the states. For national surveys, state sample sizes are often small, the range of issues addressed in the surveys are often limited, and there are often lags in data availability that affect the timeliness of efforts to assess the impacts of health reform. There are a number of strategies that would increase the value of existing surveys for evaluating national reform, including investing in state representative samples and larger state sample sizes, expanding survey content to address issues of particular relevance under health reform, and releasing data more quickly and in more accessible formats.<sup>vii</sup> For administrative data sources, there is a need for more uniform data collection efforts across the state to provide consistent data for Medicaid, CHIP, and exchange-based coverage. Consistent data in these areas will help to insure comparability across states and over time. Efforts to improve survey and administrative data are underway at a number of federal and state agencies and, to the extent they are successful, offer the prospect for more timely and in-depth tracking of the impacts of health reform in the future than has been possible for Massachusetts using national survey data.<sup>viii</sup>

<sup>i</sup> The focus here is on the findings for the overall population. A number of the studies also examine the impacts of reform on important subgroups of the population, including lower-income adults, younger adults, adults with chronic conditions, men and women, and racial/ethnic minorities, among others.

<sup>ii</sup> Differences in the precise point estimates likely reflect differences in data sources and methods as well as differences in the specific pre- and post-reform time periods used in the studies. In particular, post-reform time periods ranged from estimates for the first year after implementation began (2007) to estimates following the implementation of nearly all of the core elements of reform (2009).

<sup>iii</sup> Although the ACS does not provide data on insurance coverage for the pre-reform period in Massachusetts, the sample sizes in that survey are much larger than those of the CPS or NHIS, providing more precise state estimates than are possible from the other surveys.

<sup>iv</sup> For more information on the minimum creditable coverage standards, see [www.mahealthconnector.org](http://www.mahealthconnector.org).

<sup>v</sup> The MHRS provides the strongest data source for looking at the time path of changes in health care access and use in the state as it combines a relatively large sample size for Massachusetts, a fairly comprehensive set of access and use measures, and a more timely data release.

<sup>vi</sup> These include primary care physician recruitment programs through the state's Primary Care Office and a public-private program to repay loans for providers at community health centers.

vii Currently, access to the state identifiers in the NHIS and MEPS requires that the work be done in a Research Data Center.

viii Another strategy that could support improved evaluations of the impact of national health reform is greater coordination across state-sponsored surveys. We are aware of two such efforts: Richard Brown

and colleagues at the UCLA Center for Health Policy Research ([www.healthpolicy.ucla.edu](http://www.healthpolicy.ucla.edu)), who are focusing on state and local population surveys, and Kathleen Call and colleagues at SHADAC ([www.shadac.org/contentsurvey-resources](http://www.shadac.org/contentsurvey-resources)), who are focusing on state health insurance surveys.

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## ABOUT SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues, specifically as they relate to the state implementation of the Affordable Care Act (ACA). The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at [www.statereformevaluation.org](http://www.statereformevaluation.org).

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