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Massachusetts Has Sustained Coverage And Access Gains From Landmark 2006 Reforms

But Some Early Gains Have Eroded With Cost Pressures And Delivery System Constraints

Bethesda, MD -- Even in the face of economic hard times, Massachusetts has sustained gains in insurance coverage and access to care stemming from its landmark 2006 health reform and coverage expansion. However, some of the early gains in reducing barriers to care and improving the affordability of care had eroded by the fall of 2008, roughly two years after the Bay State began implementing the legislation signed into law by Gov. Mitt Romney in April 2006.

These findings are contained in a [study](#) by Urban Institute researchers published today on the *Health Affairs* Web site, the latest in a series of updates on implementation of the Massachusetts reforms funded by the Blue Cross Blue Shield of Massachusetts Foundation, the Commonwealth Fund, and the Robert Wood Johnson Foundation. The study reflects the results of interviews conducted in fall 2008 with a representative sample of Massachusetts adults, as well as earlier rounds of interviews from fall 2006 and fall 2007.

“Massachusetts is encountering the same increases in health care costs that plague the nation as a whole, as well as inefficiencies in its health care delivery system that predate the 2006 reform. The Massachusetts experience shows that major coverage expansions can be undertaken without addressing costs and provider constraints, but these factors, if they are not addressed eventually, can undercut the benefits from gaining insurance coverage by reducing access to care and the affordability of care,” said lead author Sharon Long, a senior fellow at the Urban Institute in Washington, D.C.

Massachusetts is addressing the challenges of cost control and delivery-system constraints through new legislation signed by Gov. Deval Patrick in August 2008. Under this legislation, Massachusetts is preparing to undertake fundamental reform of its delivery system, moving away from fee-for-service to a global payment system that emphasizes care coordination and collaboration. “Massachusetts once again looks to be in the forefront of designing innovative strategies that will provide guidance to national reform efforts,” write Long and coauthor Paul Masi, a research associate at the Urban Institute.

The study by Long and Masi is one of three articles published today on the *Health Affairs* Web site. Jon Kingsdale, executive director of the Commonwealth Health Insurance Connector Authority in Boston, Massachusetts, provides a Perspective on the Long and Masi study. Separately, Todd Gilmer and Richard Kronick of the University of California, San Diego, project that increases in health care costs will result in a rise of at least 6.9 million in the number of uninsured Americans over the three years from 2008 through 2010.

Coverage And Access Gains Have Persisted. Consistent with a Massachusetts uninsurance rate that had declined to an estimated 2.6 percent of all residents in the summer of 2008, sustained improvements in access to care were reflected in the fall 2008 interviews conducted by Long and Masi's team. For example, as compared to fall 2006, just prior to the implementation of many key reform elements, Massachusetts adults in fall 2008 were more likely to report that they had a usual source of health care and advice, and more likely to have had doctor and dental visits in the past 12 months. The gains in coverage and access were strongest for lower-income adults, those with incomes below 300 percent of the federal poverty level, but higher-income adults also realized coverage gains and improved access to doctor care.

More Difficulties Obtaining Care For Some As Demand For Care Increased. However, the researchers also found that, "paradoxically, the increases in health care use from fall 2007 to fall 2008 were coupled with indications that some adults were having more difficulty obtaining care in fall 2008 than in fall 2007." The shares of adults reporting that they did not get some types of needed care increased between fall 2007 and fall 2008, after having decreased in the year prior to that. In fact, as compared to fall 2006, unmet need was lower in fall 2008 only for preventive care screening and prescription drugs; unmet need for other types of care was no longer significantly different from pre-reform levels.

Delving into the reasons for the reported difficulties obtaining care in fall 2008, Long and Masi found that about one in five Massachusetts adults said that they were told that a doctor's office or clinic was either not accepting any new patients or not accepting patients with their type of coverage. These problems were much more common among lower-income adults and adults with public coverage than among higher-income adults and adults with private coverage. The authors attribute this to lower provider reimbursement rates and more limited provider networks under the Bay State's public programs, coupled with increased demand for care from the substantial expansion of public coverage under the 2006 reforms.

Some Of The Early Gains In The Affordability Of Health Care Have Eroded. In the first year after implementation of the reforms, the financial burden of health care on individuals dropped significantly across a number of measures, particularly for lower-income adults. While some of the gains in affordability persisted in fall 2008, the shares of adults reporting problems paying medical bills and problems with medical debt had moved back toward 2006 levels as health care costs continued to increase. Furthermore, by fall 2008, the share of lower-income adults with out-of-pocket spending of 10 percent or more of income was no longer significantly different from pre-reform levels, although higher-income and all residents reported no increase in out-of-pocket costs. Despite this, Massachusetts adults, including low-income adults, were no more likely to report having an unmet need for care due to cost, and the declines in unmet health care needs due to cost from 2006 to 2007 were sustained.

Kingsdale: Sequencing Reform, And Other Lessons From Massachusetts

In his Perspective, Kingsdale suggests that the Massachusetts experience shows the political wisdom of sequencing health reform, beginning with coverage expansion and then dealing with other challenges, particularly cost control. “To the standard arguments that we must reduce waste in order to control government spending and remain internationally competitive, we have added this imperative: only by controlling costs can Massachusetts sustain near-universal coverage,” writes Kingsdale, who oversees the Health Connector formed under the 2006 reforms. He argues that trying simultaneously to reform all aspects of the nearly one-fifth of the U.S. economy represented by health care would be an impossible challenge.

Generalizing from the Massachusetts experience, Kingsdale stresses the importance of flexibility and “learning as you go” during the implementation process. He also argues that implementation requires its own, campaign-like effort, which will set the stage for addressing the challenges of cost control and further delivery-system reforms.

After the embargo lifts, you can read the article by Long and Masi at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.4.w578>

You can read the Perspective by Kingsdale at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.4.w588>

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