

An Interim Report Card on Massachusetts Health Care Reform

Part 1: Increasing Access

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A Pioneer Institute White Paper

by Amy M. Lischko and Anand Gopalsami



PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

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INTRODUCTION

On April 12, 2006, Chapter 58 of the Acts of 2006, entitled “An Act Providing Access to Affordable, Quality, Accountable Health Care” was passed reforming the Massachusetts health care system. The goals of the legislation were to make health insurance affordable to most every resident and establish mechanisms to help control health care inflation.¹

The legislation was the product of over two years of work by Administration officials, legislators, health care providers, insurers, and consumer groups. The legislation reformed the health care system by focusing on the role of the individual within the health care system. Specifically, the law modernized health insurance laws, eliminated some of the barriers to purchasing health insurance, transitioned existing government assistance from hospitals to the individual in the form of subsidies to purchase health insurance, encouraged personal responsibility, and attempted to contain health care costs.

Early in 2009 Pioneer Institute proposed a framework for evaluating the reform’s effectiveness.² The evaluation framework focused on four major areas:

- Reduction of barriers to access;
- Equitable financing, based on ability to pay;
- Administrative efficiency; and
- Efficacy, efficiency, and quality of care.

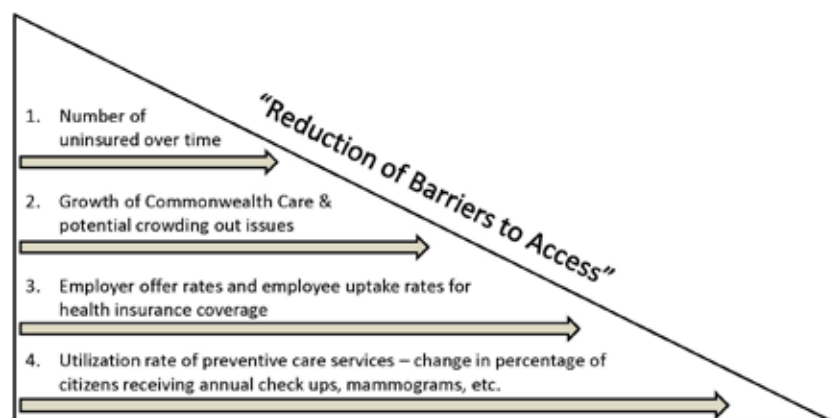
In each area, a series of metrics were proposed from which the reform could be comprehensively evaluated. The reform has already been evaluated on a number of fronts, particularly around the issue of access and costs. However, all available data have not been queried and the results have not been integrated and discussed in a manner to provide a comprehensive picture of the reform’s performance.

In addition, a number of outstanding questions remain. To assess the reform’s impact on access, an examination should be undertaken to determine whether increases in the delivery of preventive care and primary care services have occurred and have these increases resulted in offsets to costly emergency department utilization as originally envisioned. Is there evidence of improvements in health status? Have individuals transitioned from private to public coverage? It is important to explore these and other impacts of the reform in a unified manner with a focus on outcomes. This requires integration and synthesis of all available data and a robust analysis of the results.

As policy discussions for national reform continue in Washington, evaluating the Massachusetts reforms using a quantitative outcomes approach to identify what has and has not worked well and where outstanding issues remain, could prove invaluable to national and state policymakers helping to shape the future of our health care system.

This report is the first in a series of four. The focus of this report is on the reduction of barriers to access. The analysis will be organized by the four scorecard metrics presented in Figure 1.

Figure 1: Access Metrics



No new data collection was performed to conduct this evaluation. Rather, a systematic approach was taken to evaluate available data. Unfortunately, good data are not readily available for all of the proposed scorecard metrics. When this situation occurred, several different pieces of data were synthesized to arrive at a conclusion. A grade was assigned to each of the scorecard metrics as follows:

A = Excellent performance, high level of certainty that the goal has been achieved

B = Good performance, moderate level of certainty that the goal has been achieved

C = Mixed results, the available evidence is inconsistent, more research is needed

D = Poor performance, a high level of certainty that the goal has not been achieved

I = Current evidence is insufficient to assess whether the goal has been achieved

BACKGROUND

Prior to 2006, Massachusetts had been a leader among states in providing health care and health care coverage to its population. Massachusetts employers consistently have had one of the highest offer rates in the nation. In addition, Massachusetts had a strong safety net, including a generous Medicaid program and a network of safety net providers – community health centers and hospitals – that provided care to low-income uninsured individuals which was largely reimbursed through the Commonwealth’s Uncompensated Care Pool (UCP).

In the years leading up to the reform, rising health care costs and health insurance premiums resulted in a growing number of uninsured residents in Massachusetts and increased demand on the health care system – including public programs and the UCP. These factors also had an impact on the private sector with costs of

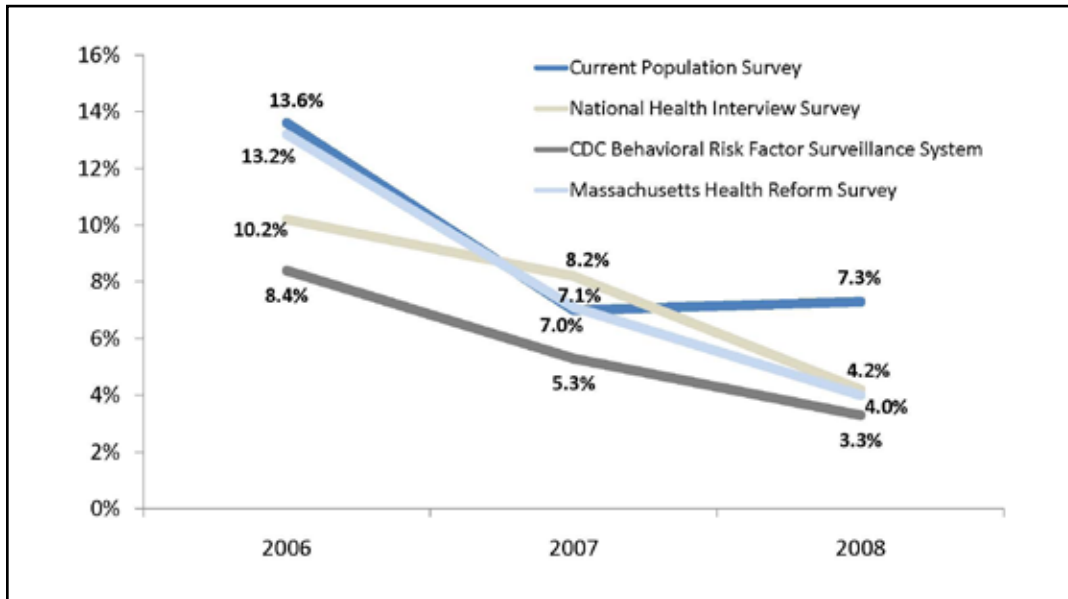
the uninsured increasingly being shifted to the privately insured.

In 2004, the Commonwealth’s household insurance survey estimated that there were 460,000 people in Massachusetts without health insurance, up from 418,000 just two years earlier. Around the same time, a study by the Urban Institute³ estimated that the total cost of caring for the uninsured in Massachusetts was slightly over \$1 billion. This prompted Governor Romney and the legislature to develop solutions to solve this issue.

Several aspects of the legislation relate specifically to increasing access to coverage for Massachusetts residents as follows:

- Modest MassHealth expansion: The legislation expanded Medicaid (MassHealth) coverage, through the SCHIP program, to children in families who earn between 200% and 300% of the Federal Poverty Level (FPL). It expanded eligibility to 300% of the FPL for the Insurance Partnership Program to previously uninsured individuals working for small firms (<50 employees), and also removed enrollment caps on various programs.
- Establishment of new premium assistance program: A new program called “Commonwealth Care Health Insurance Program” was established by the legislation. This program provides subsidies towards the purchase of private health insurance products for adults with incomes below 300% of the FPL. Full subsidies are available for those with incomes less than 150% of the FPL, with sliding scale subsidies available between 150 and 300% of the FPL.
- Individual responsibility: The legislation embraced personal responsibility as a cornerstone of health care reform. Beginning January 1, 2008, all residents of the Commonwealth ages 18 and older were

Figure 2: Massachusetts Uninsured Rates, 2006-2008, Ages 0-64



Sources: Current Population Survey, Bureau of Census, National Health Interview Survey, CDC. Behavioral Risk Factor Survey, CDC .DHC FP, Estimates of Health Insurance Coverage in Massachusetts from the 2009 Massachusetts Health Insurance Survey, The Urban Institute.

required to obtain and maintain a minimum level of health insurance. Those who did not purchase health insurance nor enroll in the appropriate health insurance program would face penalties if insurance coverage is deemed affordable for them.

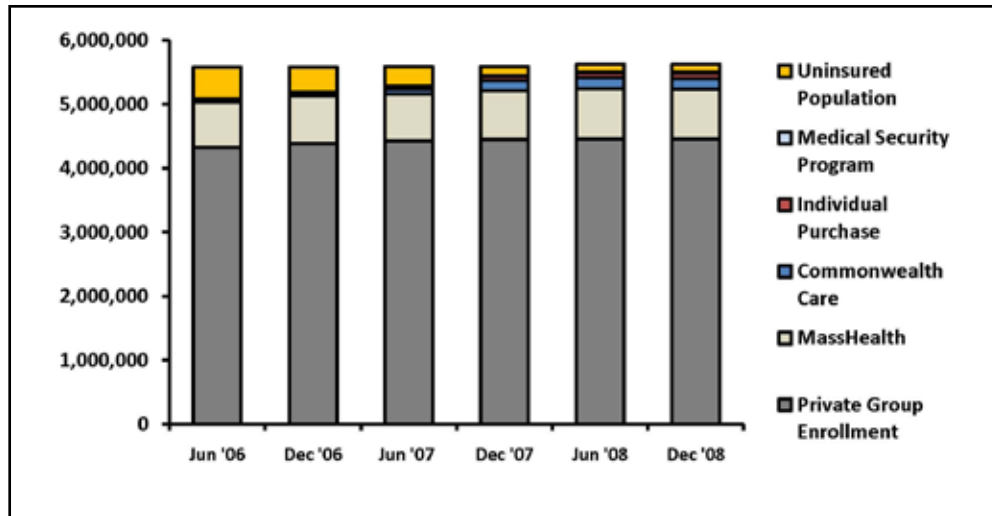
- **Employer responsibility:** Under the legislation, employers with more than 11 full time equivalent employees must facilitate pre-tax availability of health insurance coverage to their employees. In addition, employers with 11 or more full time equivalent employees that do not make a “fair and reasonable” contribution toward employee health insurance premiums are charged a per employee fee. The fee is limited to \$295 per year per employee. An employer is considered to offer a “fair and reasonable contribution” if 25% of his employees are enrolled in the employer’s group plan or he contributes at least 33% of the individual premium.⁴

**SCORECARD METRIC 1:
NUMBER OF UNINSURED OVER
TIME AND RATE OF CHANGE**

Discrepancies remain regarding the overall number of uninsured individuals.^{5 6 7} However, all national and state survey results directionally indicate that Massachusetts has reduced its rate of uninsured as shown in Figure 2 above.

In addition to survey results, another approach to estimating the uninsured rate is used here. Using available administrative data, the number of enrollees in each coverage type before and after the passage of the law is enumerated. This calculation is reliant upon accurate reporting by insurance carriers and the various public programs, and may also be problematic due to the timing of reporting of the various entities. For example, is reporting consistently done on a single day, or for a period of time? Figure 3 displays the results of this “bottom-up analysis.” The population figures for Massachusetts include a total population growth from 2006-2008 of approximately 48,000 people, and an increase in the insured population of approximately 400,000

Figure 3: Bottom-up Analysis of Uninsured Rates in Massachusetts, June 2006 – March 2009



Sources: DHC FP, Health Care in Massachusetts: Key Indicators, August 2009. Commonwealth Care Board Meeting Summary Report, June 2009

people. This calculation provides further evidence that the number of people insured by the reform efforts has been significant.

The decrease in the uninsured population coincides with increases in Commonwealth Care enrollment, individually purchased plan enrollment (Commonwealth Choice and other non-group products), and increases in private employer-sponsored health insurance and MassHealth coverage.

From these data one can conclude that the health reform legislation has been a success in decreasing

the number of uninsured in Massachusetts. Conservative estimates report that over 300,000 people who did not have access to insurance before 2006 now are covered. While the overall numbers are impressive, some gaps in coverage remain. Importantly, 6.8% of people between 150-299% of the FPL remain uninsured. Recent downturns in the economy coupled with rising premiums may cause coverage rates to recede in upcoming months. Figure 4 shows a small decline in the number of insured for the most recent reporting period.

Figure 4: Massachusetts, Number of Insured 0-64, 2006-2009

Date	Jun '06	Dec '06	Jun '07	Dec '07	Jun '08	Dec '08	Mar '09
Total Population (0-64)	5,580,307	5,580,307	5,589,888	5,589,888	5,627,543	5,627,543	NA
Total Insured Population (0-64)	5,078,000	5,193,327	5,280,800	5,445,177	5,503,617	5,498,726	5,484,003
Uninsured Rate (0-64)	9.00%	6.93%	5.53%	2.59%	2.20%	2.29%	NA
Change in Uninsured Rate		-2.07%	-1.41%	-2.94%	-0.39%	0.09%	NA

Sources: American Community Survey, 2006 – 2008, DHC FP, Health Care in Massachusetts: Key Indicators, August 2009
Commonwealth Care Board Meeting Summary Report, June 2009

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However, the underlying forces that kept Massachusetts ahead of the nation in coverage rates before the reform continue to support coverage rates post reform:

- Expansive public programs providing coverage to nearly 1 in 5 Massachusetts residents between the ages of 0-64; and
- Strong, longstanding employer commitment to providing health insurance.

These steps, coupled with the new requirement that everyone maintain health insurance, if affordable, seem to work well in providing a relatively high level of access. The ability to adopt similar mechanisms on a national scale may be effective components of increasing access to health insurance in state-level and national reform initiatives.

Because all of the available data trend in the same direction with significant reductions in the number of uninsured, this Scorecard Metric receives a grade of A.

Overall grade for Scorecard Metric 1 = A

SCORECARD METRIC 2: SIZE AND GROWTH OF COMMONWEALTH CARE PROGRAM AND MEASURE OF CROWD-OUT

Scorecard Metric 2 is comprised of two different components. The first component measures the size and growth of the Commonwealth Care program, while the second assesses the complex issue of crowd-out. Crowd-out is the phenomenon whereby new public programs, or expansions of existing public programs designed to extend coverage to the uninsured, prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy. Crowd-out can also manifest itself by employers dropping coverage or reducing eligibility for

coverage so their low-income employees will be covered by the public program.

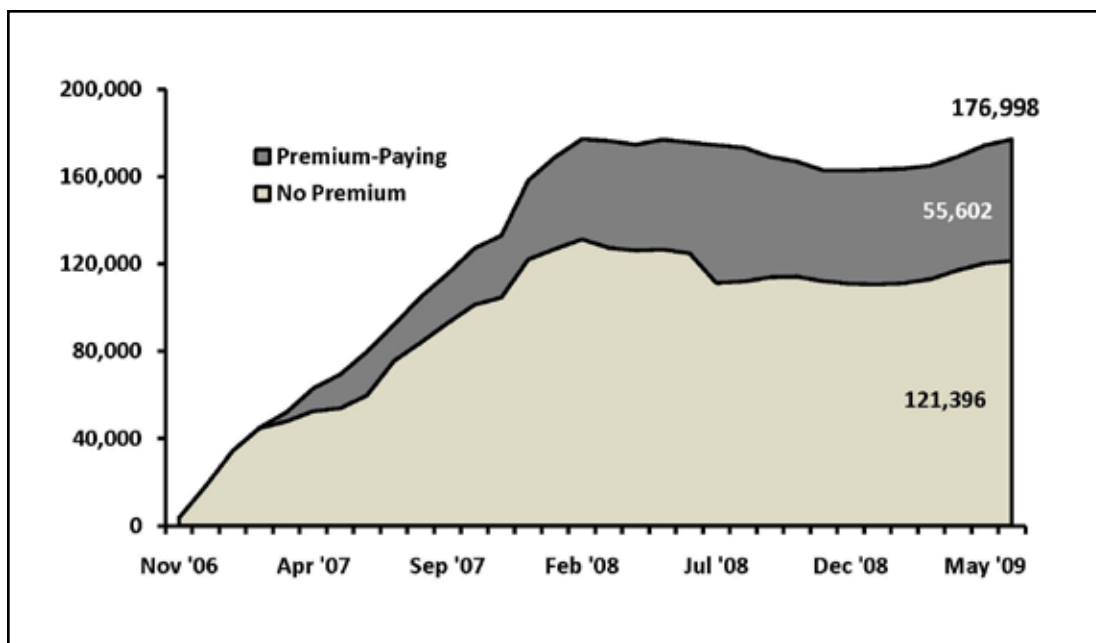
Commonwealth Care's primary objective is to enroll all qualified, uninsured adults with no other means of access to insurance into subsidized coverage. Because policymakers were concerned about crowd-out, the legislation included provisions to limit individuals with access to employer-sponsored health insurance from eligibility. Specifically, individuals who were eligible for employer-sponsored health insurance coverage in the previous six months for which their employer contributed at least 20% for a family policy or 33% for an individual policy are precluded from enrolling in Commonwealth Care. Individuals must self-report the availability of employer-sponsored coverage on their application. In addition, they must not have accepted employer financial incentives to decline employer insurance. The law did not preclude individuals with other insurance prior to the reform (purchasing in the non-group market, for instance) from accessing this newly subsidized insurance.

The Commonwealth Care program began enrollment in October 2006. Figure 5 shows a rapid 27% month-over-month rise in enrollment in the Commonwealth Care program from November 2006 to February 2008. This rapid enrollment worked to reduce the overall uninsured rate, however, growth has slowed in the past eighteen months and as of May 2009, rests below February 2008 levels.⁸

In assessing the issue of crowd-out, it is important to measure how many of these newly insured came from the ranks of uninsured without access to employer sponsored health insurance. In Massachusetts, crowd-out can manifest itself in several different ways:

- 1) Employers can restrict eligibility for health insurance coverage;
- 2) Employees can "choose" employment opportunities (two part-time jobs, for

Figure 5: Commonwealth Care Enrollment Nov 2006 – June 2009



Source: Commonwealth Care Board Meeting Summary Report, June 2009

instance) that offer higher wages but not health insurance because of availability of public options; and

- 3) Employees eligible for employer-sponsored health insurance may decline it to enroll in Commonwealth Care (this should be rare since the law precludes these individuals from accessing Commonwealth Care).

Crowd-out is more likely to occur in the 150-300% FPL income group since individuals with lower incomes are less likely to be working in industries or jobs that offer insurance coverage. To fully assess this question, one would need to have data on prior insurance status and source of coverage for all individuals enrolling in the new subsidized program, Commonwealth Care. Alternatively, one could compare the overall enrollment in Commonwealth Care with the enrollment in the Uncompensated Care Pool (UCP) pre- and post-reform to determine whether enrollment in Commonwealth Care has been primarily from the ranks of the uninsured.

However, this is not a straight-forward comparison. First, not everyone eligible for

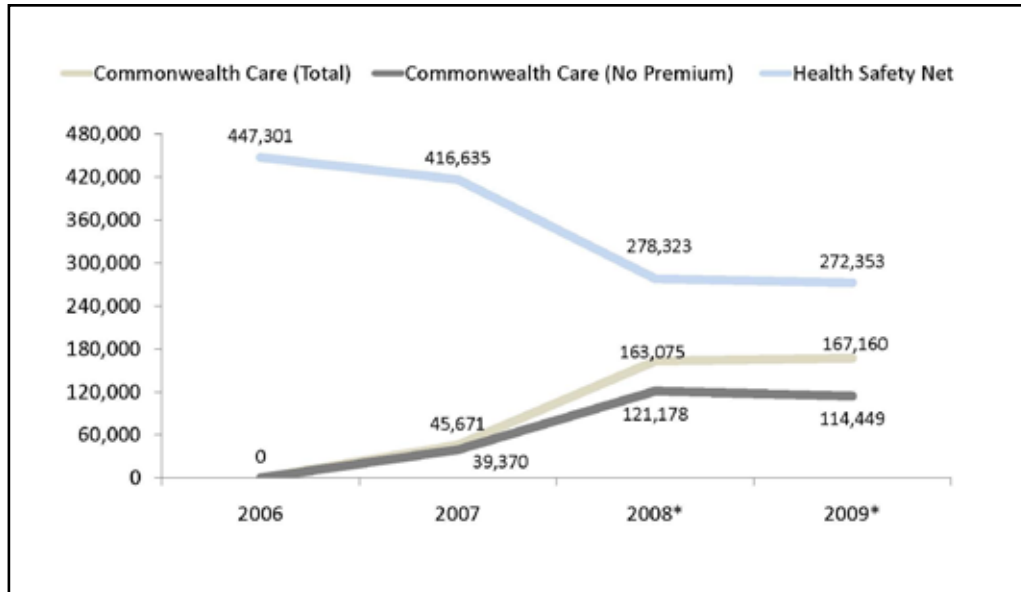
Commonwealth Care received services from the UCP prior to the reform. Second, not everyone who received care from the UCP pre-reform is eligible for Commonwealth Care (undocumented immigrants, for instance). Finally, many people who were utilizing the UCP prior to reform likely had access to employer-sponsored health insurance as the law did not preclude them from accessing that “program.” So, simply looking at the movement from the UCP to Commonwealth Care is not sufficient to answer this complex question.

Figures 6 and 7 below compare the growth of the Commonwealth Care program with the decline of users accessing the UCP and the Health Safety Net program (HSN) (the successor program to the UCP).

Figure 6 shows that the decrease in Health Safety Net users from 2006 to 2009 is 174,948 while the enrollment in Commonwealth Care is 167,160. Thus, the overall growth of Commonwealth Care compares favorably with the reduction of people utilizing the HSN. Looking at the trends over time, a similar picture emerges, as shown in Figure 7.

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**Figure 6: Comparison of Commonwealth Care program to Health Safety Net Program
FY2006 – FY2009**



Sources: Commonwealth Care Board Meeting Summary Report, June 2009. DHCFP, Health Safety Net Reports, 2006-2009. * 2008 and 2009 Health Safety Net data annualized by extrapolation from 10 months of data

Figures 6 and 7 also indicate growth in the premium-paying population (higher income groups) from 2008-2009. This could be a result of greater outreach and enrollment of eligible populations and tougher penalties for noncompliance with the individual mandate over time. However, without information on previous insurance status, it could also be a sign of individual and/or employer behavior akin to crowd-out. The Commonwealth Care program should be required to collect information on previous insurance status in order to be able to directly assess this question.

Recent self-reported data from a household survey conducted by the Urban Institute found a 6% decrease in employer-sponsored insurance in the 150-299% FPL income group (Figure 8). This difference was statistically significant from 2008 to 2009. The source of coverage does not appear accurate (the Medicare increase appears improbable) and further investigation into these or other survey data is important in order to understand this trend. It is unlikely that people receiving benefits from Commonwealth Care believe they are on Medicare. However, these

data suggest some movement from private to public coverage. It is a trend worth watching.

While the size and growth of the Commonwealth Care program is impressive, the inconclusive data regarding crowd-out causes this Scorecard Metric to receive a grade of B. The state should work to collect better information of prior insurance status to more accurately measure and monitor crowd-out.

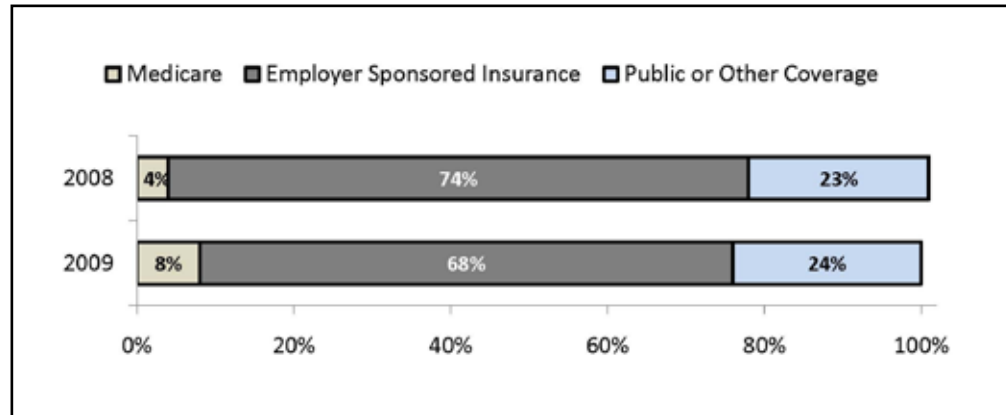
Overall grade for Scorecard Metric 2 = B

Figure 7: Year Over Year (YOY) Changes in Enrollment in Commonwealth Care Versus UCP/ Health Safety Net

YOY Change in Enrollees	2006-2007	2007-2008	2008-2009
Commonwealth Care (Total)	+45,671	+117,404	+4,084
Commonwealth Care (No Premium)	+39,370	+81,808	-(6,679)
Commonwealth Care (Premium)	+6,301	+35,596	+10,764
Health Safety Net	-(30,666)	-(138,312)	-(5,970)

Sources: Commonwealth Care Board Meeting Summary Report, June 2009. DHCFP, Health Safety Net Reports, 2006-2009

Figure 8: Health Insurance Coverage 0-64 at 150-299% FPL, 2008-2009



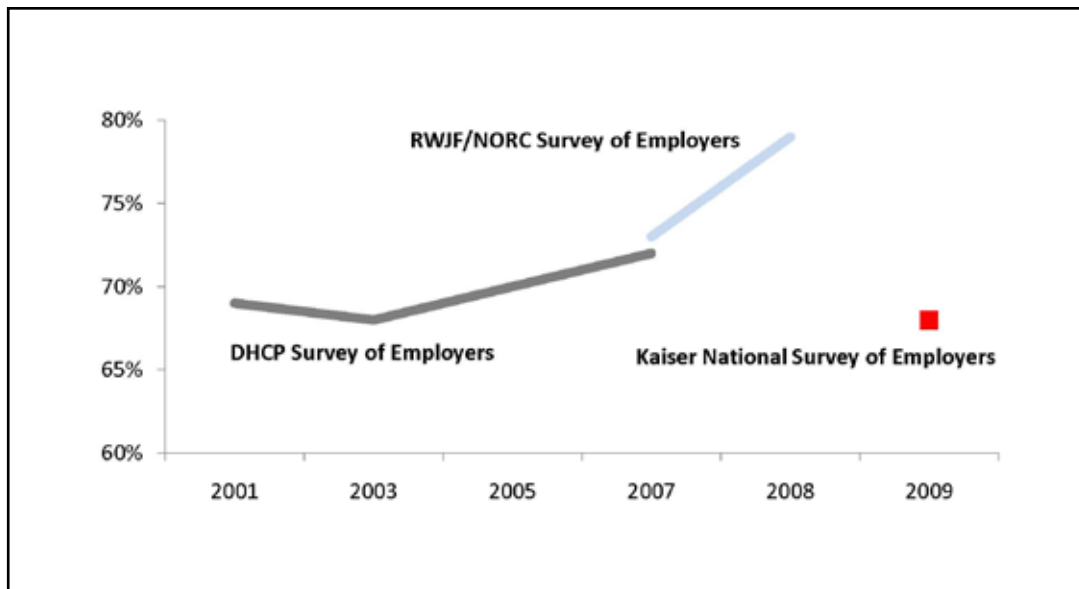
Sources: DHCFF, Estimates of Health Insurance Coverage in Massachusetts from the 2009 Massachusetts Health Insurance Survey, Sharon K. Long and Lokendra Phadera, The Urban Institute, October 2009.

SCORECARD METRIC 3: EMPLOYER OFFER AND EMPLOYEE TAKE-UP RATES FOR HEALTH INSURANCE COVERAGE

Massachusetts employers have consistently ranked above the national average in the provision of health insurance prior to the enactment of Chapter 58. Employers have faced additional

responsibilities either directly or indirectly with the passage of the reform legislation. This metric will examine the result of some of these added responsibilities. First, employer offer rates are assessed to determine whether the pressures of the individual mandate and employer requirements have had an impact on the decision to offer insurance to employees. Second, changes in take-up rates – that is the percent of employees eligible for an employer’s health insurance that sign up for that coverage – are measured to determine whether the individual mandate and the expansion of dependency coverage to age 26

Figure 9: Employer Insurance Offer Rates, 2001 – 2009



Sources: DHCFF, Massachusetts Employer Survey, 2007. Jon R. Gabel. *After the Mandates: Massachusetts Employers Continue to Support Health Reform As More Firms Offer Coverage*, Oct 2008. The Kaiser Family Foundation and Health Research & Educational Trust. *Employer Health Benefits Annual Survey*, 2009.

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has encouraged more employees to accept offers of employer-sponsored insurance.

As shown in Figure 9, overall Massachusetts employer offer rates appear to have increased in 2008 (blue line) and remain much higher than the national employer insurance offer rate of 60% (Kaiser Employer Health Benefits Survey, 2009).

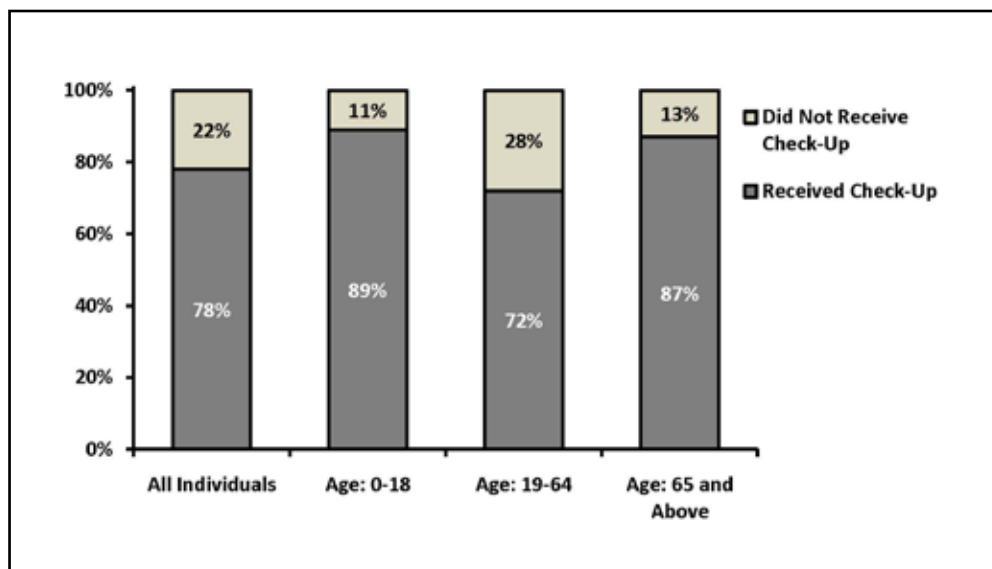
Data recently released by the Division of Health Care Finance and Policy from their annual Fair Share Reporting provide more detailed information regarding employer changes from 2007 to 2008. The report notes that “the percentage of firms meeting fair share contribution standards increased across the two time periods, particularly among smaller size firms,”⁹ suggesting that more employers are providing access to health insurance during 2008 than 2007. However, small drops in median contribution rates to employee premiums were found among small (11-25 Full Time Employees (FTEs)) and large (>1000 FTEs) firms. Not surprisingly, firms required to pay the “Fair Share Penalty” remained similar between the two time periods and included temporary help services, security guard and patrol services, janitorial services, restaurants and other service-oriented industries.

The most recently available detailed state survey data from employers, specific to Massachusetts, is from 2007. It is important to monitor not only offer rates by size of firm, but composition of employee workforce (part-time vs. full-time), income of employees, and eligibility for insurance coverage to adequately assess this question.

Moreover, the economic downturn beginning in the fourth quarter of 2007 may drive employers to reduce eligibility and/or contributions for coverage. Kaiser’s 2009 health survey reported that nationally, firms are decreasing the breadth of health benefits as a result of the economic downturn, but for the most part they are not eliminating coverage entirely.

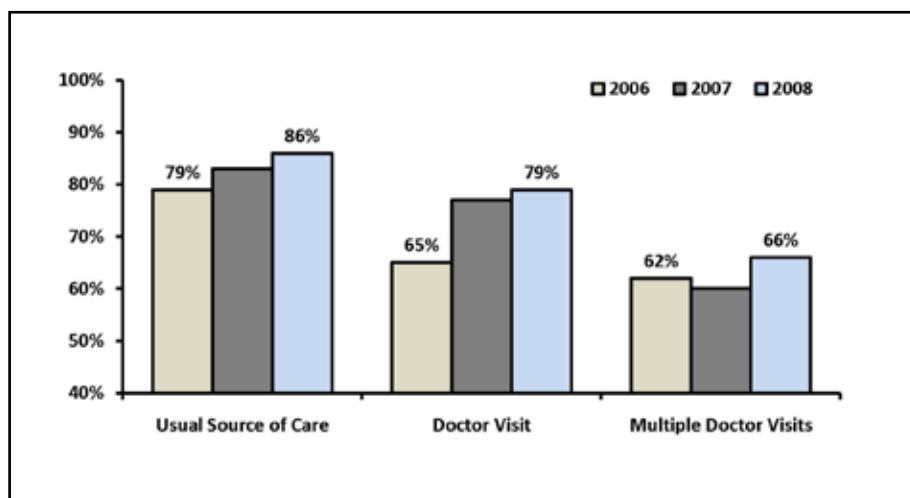
The 2007 average employee uptake in Massachusetts was approximately 80% (not shown) across all firm sizes, and across the Northeast region the value was 80% in 2009. While the recent 2009 take-up rate of employees has not ticked downwards in the Northeast region, the value may be different within Massachusetts alone. It is expected that the state will release results from its 2009 survey of employers soon, which will provide useful information to examine this issue in more detail. The Fair Share report noted above also shows small increases

Figure 10: Percentage of MA Residents Reporting a Minimum of One Preventative Care Visit 2008



Sources: DHCFP, Access to Health Care in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey. Sharon K. Long, Allison Cook, and Karen Stockley. Urban Institute, March 2009.

Figure 11: Health Care Utilization, Massachusetts Adults 2006-2008



Source: Presentation made by Sharon Long of The Urban Institute at the Blue Cross Blue Shield of Massachusetts Foundation's annual Summit on Access May 28, 2009.

in employee take-up rates (from 2007 to 2008) across all firm sizes. More current detailed data are necessary in order to fully assess this metric.

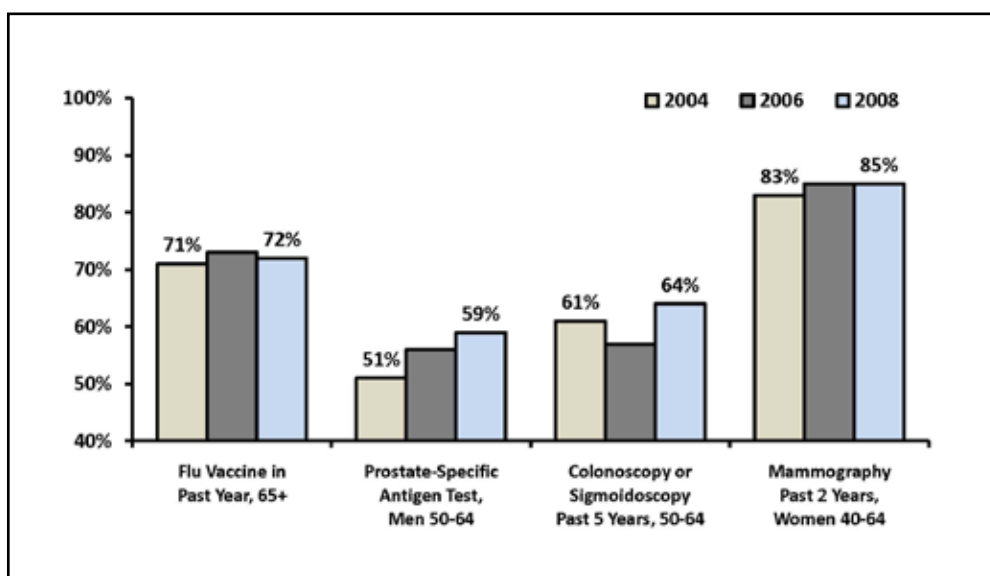
Because the data show good performance in this area and there is a moderate level of certainty that the trend has continued, this Scorecard Metric receives a grade of B.

Overall grade for Scorecard Metric 3 = B

SCORECARD METRIC 4: UTILIZATION RATES OF PREVENTIVE CARE SERVICES

While access to health insurance is important, access to care and improvements in overall health are the ultimate goals of any reform initiative. In particular, increasing access to primary care and preventive services is what many believe has the potential to lower costs, yield better outcomes, and reduce the demand for more expensive health care services. Therefore, it is important

Figure 12: Preventative Measures, Massachusetts, 2005 - 2008



Source: National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System – Prevalence and Trends Data, 2005-2008.

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to examine the available evidence to determine whether the reform has made positive strides in these areas.

The lack of detailed, publicly available data for the preventive metrics makes this analysis challenging. Different data sources were used to assess this important question. Figure 10 provides one post-reform data point assessing preventative care visits.

From these data it appears that there are a number of people in the target population for the reform (18-64) who did not receive an annual preventative visit. An examination of self-reported survey data across several access measures found promising increases in reports of usual source of care and once-a-year doctor visits from 2006 to 2008 (see Figure 11).

The Center for Disease Control and Prevention (CDC) requires states to conduct an annual survey to estimate preventative care utilization. Figure 12 indicates that while a greater proportion of Massachusetts residents have been receiving preventative treatment since the reform, the increments are relatively small. In addition, it is difficult to discern from these data whether any recent progress can be attributed to increased access to health insurance since increases in flu vaccinations among those not affected by the health care reform law (65+) also saw small increases over the same period.

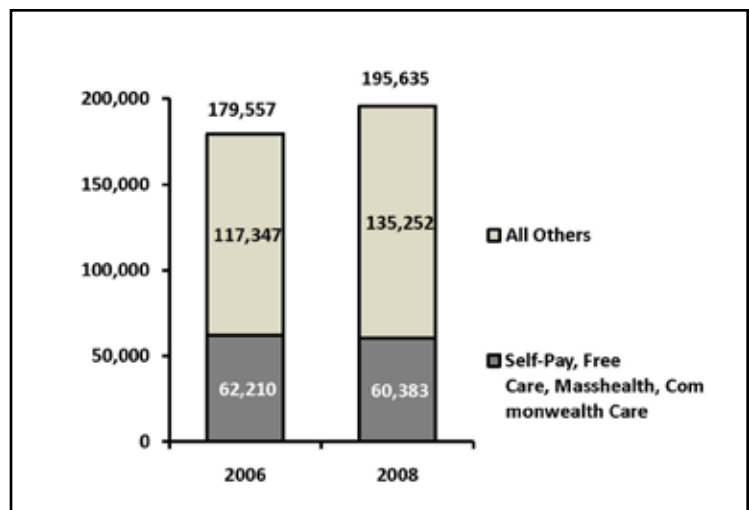
Another method for assessing whether adequate primary care is being delivered appropriately to the newly insured population is to measure emergency department (ED) utilization. Many policymakers believe that if access to insurance is improved, one should expect to see a decrease in the use of the emergency department, particularly for conditions that can be treated in a primary care setting. Recent synthesis of the literature casts some doubt on this thesis and suggests that “expansion of health insurance coverage on its own is likely to increase rather than decrease stress on overcrowded EDs.”¹⁰

Recent administrative data show increases in overall emergency department utilization from 2006 to 2008 in six hospitals in Massachusetts (Figure 13), although it was found that emergency department utilization decreased somewhat for the low-income, publicly-subsidized population. The data available to these researchers are limited and thus they are unable to provide rates of utilization by payer type which would be most useful to examine this question. Statewide data available from the Division of Health Care Finance and Policy (DHCFP) should be examined to further assess this trend.

Self-reported data from 2006-2008 show no change in emergency department utilization in adults.¹¹ Figure 14 displays the results using these self-reported data for 2008 alone. It was found that:

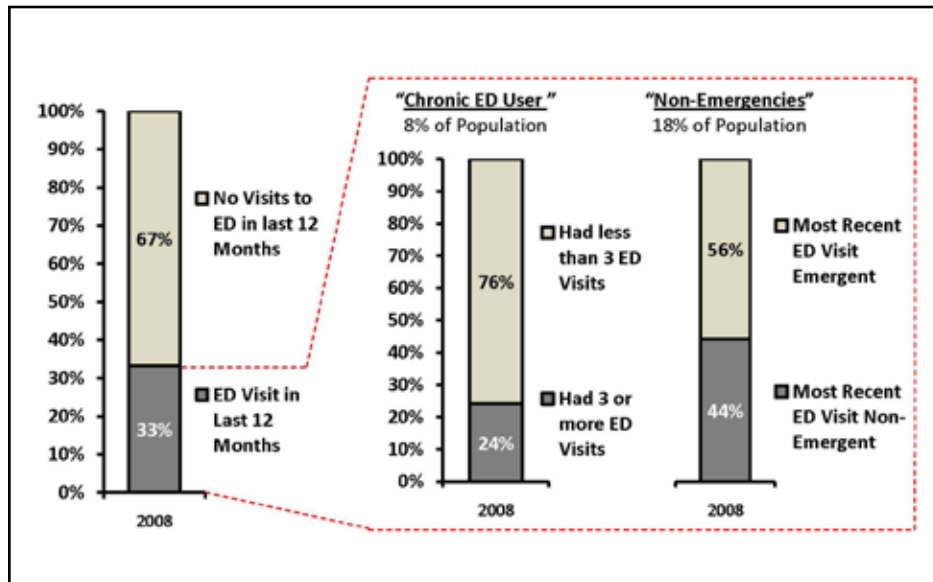
- 1 out of 3 people had reportedly used the ED within the past year (first bar on Figure 14);
- Of those who had used the ED at least once, about 25% are chronic users of the ED, or had gone 3 or more times, (second bar on Figure 14); and

Figure 13: Emergency Department Utilization in Six Massachusetts Hospitals, 2006 and 2008



Source: Smulowitz PB, Landon BE. *The Impact of Health Care Reform in Massachusetts on Emergency Department Use by Uninsured and Publicly Subsidized Individuals*. *Annals of Emergency Medicine*. Volume 54, No. 3; September 2009.

Figure 14: Emergency Department Utilization, Massachusetts 2008



Source: Sharon Long and Karen Stockley. *Emergency Department Visits in Massachusetts: Who Uses Emergency Care and Why?* Urban Institute. September 2009.

- Of those who used the ED, 44% of the visits were for non-emergencies (third bar on Figure 14).

Over one-half of people using the emergency department for non-emergent visits (56%), reportedly were unable to get an appointment from their doctor as soon as needed. Self-reported data such as those reported above are useful for learning about motivations, which is not possible from administrative data. However, the state should continue to monitor and report on emergency department utilization using its administrative database to assess this question more thoroughly and look at capacity of primary care in areas where utilization of the emergency department is problematic.

Because data on the type and amount of preventative care being received by the newly insured are not available and the data on emergency department utilization are also weak, it is difficult to assign this Scorecard Metric a grade at this time. Therefore, this metric receives an Incomplete at this time.

Overall grade for Scorecard Metric 4 = I

CONCLUSIONS

Overall, the framework and scorecard metrics proposed by the Pioneer Institute were useful in summarizing the effects of the Massachusetts Health Care Reform on access. In some cases, additional and more recent data are necessary to form conclusions.

First, good evidence was found concluding that the reform has been successful at insuring more Massachusetts residents. Even though the self-reported survey data are not in agreement regarding the exact number of insured, by all accounts there has been a significant reduction in the number of people without health insurance in the Commonwealth.

Publicly available data also confirm that there has been significant enrollment in the Commonwealth Care program, although enrollment has tapered off some since the start of the program. However, the data are not refined enough to accurately assess whether any crowd-out has occurred, especially in the higher income categories, where more people are likely to be offered employer-sponsored insurance. This is a difficult question

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to answer and additional research is necessary to thoroughly examine this question.

Earlier data indicate that employers are committed to the provision of health insurance to their employees, although as costs continue to rise there is evidence of some retreat from premium contributions, especially among very small and very large firms. More current detailed data are needed to assess whether this situation has changed at all in the past few years. New survey data are expected soon from the DHCFP.

Further research is also necessary to assess whether newly insured people are accessing care more appropriately by seeking necessary preventative and primary care and whether there are actual improvements in their health. Although some data point to increases in appropriate care-seeking behavior, emergency department utilization for primary care treatable conditions remains high and provides some evidence that the provision of an insurance card alone may not be enough to improve access to timely health care and ultimately, improve health.

Overall, the scorecard for access earns a B. Although much of the evidence points in a positive direction, a fair amount of important clarifying data are missing. In addition, much of the data detailed in this report are from self-reported survey data. The Commonwealth may want to consider using its resources and data systems to devise new methods for measuring the outcomes of reform. For example, counting the insured in the future could be conducted using administrative data from private carriers, public program enrollment, and the like to arrive at more accurate estimates. Similarly, employer reporting data could be used to measure employer offer rates, employee take-up rates, and benefit levels and eligibility. Claims data collected on the newly insured Commonwealth Care enrollees can provide actual utilization data regarding primary care and preventative service use.

The next issue in this series will evaluate financing issues related to health care reform and will answer

the following questions: Have the three expected sources of revenue contributed to the costs of the reform in the ways that were anticipated? Have health care cost and utilization growth been effectively contained? Have the definitions of “affordability standard” and “minimum creditable coverage” allowed for sustainable subsidy levels for the new subsidized program?

Beyond access and financing, Pioneer’s series evaluating health care reform will also include detailed examinations of administration and cost-effective quality.

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About Pioneer:

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to change the intellectual climate in the Commonwealth by supporting scholarship that challenges the “conventional wisdom” on Massachusetts public policy issues.

Endnotes

1. The Health Care Quality and Cost Council, established via Section 16K of the law was tasked with developing health care quality improvement and cost containment goals.

2. Miltenberger M, and Poftak S. *Massachusetts Healthcare Reform: A Framework for Evaluation*. Policy Brief, Shamie Center for Better Government, Pioneer Institute, January 2009.

3. Holahan, John, Bovberg, Randall, Hadley, Jack, *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays and What Would Full Coverage Add to Spending?* Report for the BCBS of Massachusetts Foundation, November, 2004.

4. http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_5_16.pdf
http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_5_17.pdf

5. Estimates of the Uninsurance Rate in Massachusetts from *Survey Data: Why Are They So Different?* Revised August 28, 2008 to incorporate data from the 2008 Current Population Survey, DHCFP 2008.

6. Jacob A. Klerman, Michael Davern, Kathleen Thiede Call, Victoria Lynch, and Jeanne Ringel. *Understanding The Current Population Survey's Insurance Estimates And The Medicaid 'Undercount.'* Health Affairs Web Exclusive, September 10, 2009

7. Kathleen Thiede Call, Michael Davern, and Lynn A. Blewett, *Estimates Of Health Insurance Coverage: Comparing State Surveys With The Current Population Survey*, Health Affairs, January/February 2007; 26(1): 269-278.

8. Due to budget constraints, on August 31, 2009, approximately 30,000 special status legal immigrants lost their Commonwealth Care coverage. They are now being re-enrolled in a new pared-down Commonwealth Care plan. Numbers reported in this report do not reflect these changes.

9. DHCFP, Fair Share Contribution Data Trend Analysis Filing Years 2007 and 2008, October 2009.

10. Delia, Derek and Cantor, Joel. *Emergency Department Utilization and Capacity*. Robert Wood Johnson, The Synthesis Project, July 2009.

11. Long, Sharon and Masi, Paul. *Access and Affordability: An Update on Health Reform in Massachusetts*, Fall 2008. Health Affairs, 28, no. 4(2009) w578-w587, published online 28 May 2009.

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