

10 YEARS OF IMPACT: A LITERATURE REVIEW OF CHAPTER 58 OF THE ACTS OF 2006

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EXECUTIVE SUMMARY

After several years of discussion and debate, Governor Mitt Romney signed Chapter 58 of the Acts of 2006—“An Act Providing Access to Affordable, Quality, Accountable Health Care”—on April 12, 2006. The groundbreaking law sought near-universal health care coverage for the residents of Massachusetts by expanding Medicaid, creating a new program of subsidized insurance, enacting changes to the health insurance market, and requiring adults to have health insurance unless an affordable option was not available. In the years following Chapter 58’s passage, researchers and policy analysts undertook scores of studies to assess its effects on many aspects of the health care system and the Commonwealth. On the occasion of Chapter 58’s 10th anniversary, this fact sheet presents a summary of the effects as reported in those studies.

INSURANCE COVERAGE

- Massachusetts became the state with the highest rate of insurance coverage soon after 2006 and maintains that status today.
- Children benefited greatly, as the percentage without coverage just prior to reform was more than halved after reform.
- The coverage gap among racial and ethnic groups narrowed post-reform.
- Certain populations gained coverage at a faster rate than the general population: people with high health care needs, working adults with disabilities, younger adults, people with low incomes, and women.

ACCESS TO CARE

- Coverage expansion led to overall improvements in access, but gains were uneven across different groups.
- Unmet need among Latino, black, and middle-income individuals and those in fair or poor health continued to be a challenge post-reform.
- A recent survey shows that nearly half of non-elderly adults reported difficulty finding a provider accepting new patients or their type of insurance or difficulty getting an appointment as soon as they felt they needed it.

HEALTH CARE UTILIZATION

- As coverage increased, so did utilization, but it did so differently by population and health care service. For example, increases in utilization were significantly higher among nonwhite patients and patients of low and middle income.
- The overall use of preventive care in Massachusetts rose, but increases in the use of specific preventive care screenings varied.
- Hospital readmission rates rose slightly in the early years post-reform; readmissions for some diagnoses, such as substance use disorder treatment, grew while readmissions for others, such as psychoses, fell.

HEALTH OUTCOMES

- Health care reform has been associated with overall improvements in health, particularly for people of lower incomes.
- Reform improved body mass index levels and increased the probability of individuals reporting excellent or very good health.
- The greatest gains in health status were among racial and ethnic minorities, women, those with low incomes, and adults ages 60 to 64.
- There were reductions in mortality, the largest coming in geographic areas with lower incomes and lower levels of insurance coverage prior to reform.

ECONOMIC IMPACTS

- Chapter 58 helped reduce financial distress, most significantly among people who had limited access to credit markets pre-reform.
- Reform increased job mobility and the likelihood of earning self-employment income for certain groups.
- The growth in health care administrative occupations was more rapid in Massachusetts than in the rest of the country.
- There were mixed results for employers—one study found premiums increased due to reform and another challenged that finding—but in the early years post-reform a majority of employers agreed that reform had been good for Massachusetts.
- There continues to be an important role for safety net providers – both community health centers and hospitals.

AFFORDABILITY FOR CONSUMERS

- Immediately following 2006, increased coverage contributed to fewer reported problems paying medical bills, particularly for low-income adults.
- Chapter 58's individual mandate made insurance more affordable for those purchasing it individually, by bringing healthier people into the pool across which costs are spread.
- Overall, however, Massachusetts has not escaped the long-term national trends in health care costs, and affordability challenges remain. A significant percentage of insured Massachusetts residents continue to report that health care spending causes them financial problems, that they go without needed care because of health care costs, and that they are worried about their ability to pay medical bills in the future.

CONCLUSION

With innovations to the health care system on the horizon, Massachusetts stands ready to build on its long tradition of reform. Chapter 58 laid the groundwork for long-lasting impacts in the state, but opportunities for further reform, especially those related to costs, persist.

INTRODUCTION

Chapter 58 of the Acts of 2006—“An Act Providing Access To Affordable, Quality, Accountable Health Care”—was signed into law by Governor Mitt Romney on April 12, 2006. It was the result of several years of discussion and debate among leaders of the state legislature, the governor’s office, and all of the important actors in the health care system, and it built on the previous two decades of reform.¹ The law enacted changes to the health insurance market and sought near-universal health care coverage through these means:

- Expanding MassHealth, the Massachusetts Medicaid program;
- Creating publicly subsidized private coverage (Commonwealth Care, now ConnectorCare), for low- and moderate-income people not eligible for MassHealth;
- Creating the Health Connector, a health insurance exchange, to make private coverage more accessible and affordable for individuals;
- Establishing “fair share” contribution requirements for employers; and
- Requiring that all adults have health insurance, unless an affordable option was not available.²

The adjectives “landmark” and “groundbreaking” are often attached to Chapter 58. They are certainly accurate, as Chapter 58 helped propel Massachusetts to the highest rate of health insurance coverage ever achieved by any state. In addition, many elements of Chapter 58 served as a blueprint for the federal Patient Protection and Affordable Care Act (ACA), enacted four years later. The promise of Chapter 58’s innovations did not escape the attention of researchers and policy analysts at the time of the law’s enactment. In the years following its passage, scores of studies assessed the effects of the law on coverage, access to care, health outcomes, affordability, the state’s economy, and more. The cost of the reforms themselves was an early topic of political and general interest, and the subject of competing analyses.³

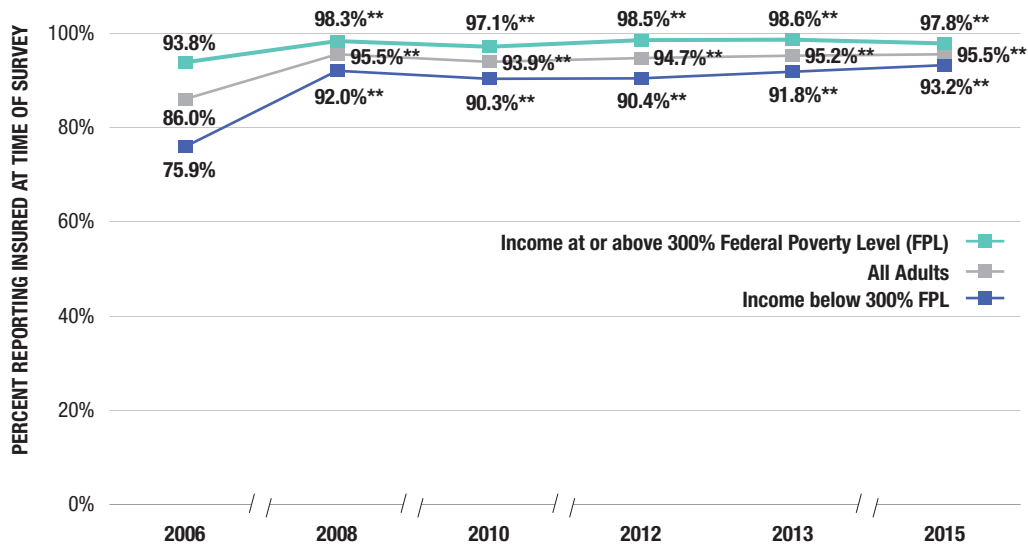
On the occasion of the 10th anniversary of Chapter 58’s enactment, this fact sheet presents a summary of its effects, as reported in the many studies that have focused on Massachusetts’ reform. This high-level review conveys the general tenor of the findings in various categories; a full [bibliography](#) of all of the research is available as a companion to the fact sheet. Many of these studies were conducted in the early years post-implementation; for those that were not later repeated, we cannot assume that their findings would still hold true today.

THE EFFECTS OF REFORM

INSURANCE COVERAGE

The most direct effect of the state’s 2006 reform was the rapid increase in the number and percentage of Massachusetts residents with health insurance, and the stability of that level in the years following reform. Massachusetts became the state with the highest rate of insurance coverage soon after 2006 and maintains that status today, even as other states have gained ground with the coverage expansions of the ACA.⁴ During the economic downturn beginning in 2008, Massachusetts’ coverage dipped slightly but remained well above pre-reform levels.⁵ Figure 1 demonstrates the trend for adults.

FIGURE 1: HEALTH INSURANCE COVERAGE FOR ADULTS AGES 19 TO 64 IN MASSACHUSETTS, 2006–2015



Source: 2006–2015 Massachusetts Health Reform Survey (N=18,286). The survey was not fielded in 2011 or 2014. Data for 2007 and 2009 not shown.

Note: These are simple (unadjusted) estimates.

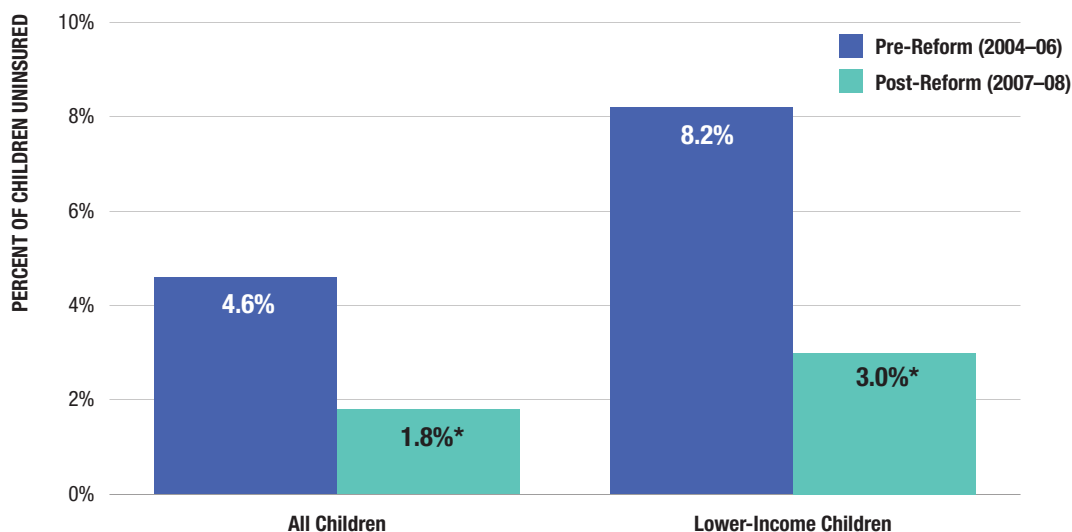
*(**) Significantly different from the value in 2006 at the .05 (.01) level, two-tailed test.

^(^) For 2013 and 2015: Significantly different from the value in 2012 at the .05 (.01) level, two-tailed test.

#(##) For 2015: Significantly different from the value in 2013 at the .05 (.01) level, two-tailed test.

Children also benefited greatly from Chapter 58. The percentage of children without coverage just prior to reform was more than halved after reform. The relative change was even greater for low-income children. (See Figure 2.) Statistical analysis showed that the change was largely attributed to reform, even though Chapter 58 did not include an insurance mandate for children. Researchers suggested that coverage provisions of the law directed at parents had a strong spillover effect on their children.⁶

FIGURE 2: CHANGE IN LACK OF HEALTH INSURANCE AMONG CHILDREN FROM PRE-REFORM TO POST-REFORM



Source: Kenney, Long & Luque 2010.

* Significantly different from the pre-reform value at the .05 level, two-tailed test.

The coverage gap among racial and ethnic groups narrowed post-reform. According to U.S. Census Bureau data, in 2002–2003 the uninsured rate for non-Hispanic white people under age 65 in Massachusetts was 8.4 percent, compared with 14.8 percent for non-Hispanic black people and 16.6 percent for Hispanic people.⁷ By 2008 those rates were 2.2 percent, 2.6 percent, and 7.2 percent, respectively.⁸ And in 2015 the rates were 3.1 percent, 2.9 percent, and 7.8 percent.⁹

Certain other subpopulations, many with comparatively low levels of health insurance coverage prior to reform, benefited disproportionately from coverage expansion, gaining coverage at a faster rate than the general population. These groups included people with high health care needs,¹⁰ working adults with disabilities,¹¹ younger adults,¹² people with low incomes,¹³ women,¹⁴ and those who previously had been underinsured.¹⁵

Consumers reported that the reform law made health coverage more available and affordable. In focus groups, people with public coverage thought their benefits allowed better management of chronic conditions; those with employer-sponsored insurance (ESI) appreciated the security of coverage, but many struggled with the cost.¹⁶ While Latinos in focus groups also reported an increased sense of security after gaining insurance, many also said they felt intimidated and confused by the enrollment process and would not have been able to get coverage without help from a community organization.¹⁷

People with low incomes and high health care needs gained coverage at a faster rate than the general population.

The stability of ESI contributed to the consistently high level of coverage following reform. With new sources of public coverage for lower-income people and new requirements for employers, there were concerns that some employers would stop offering coverage to their employees—

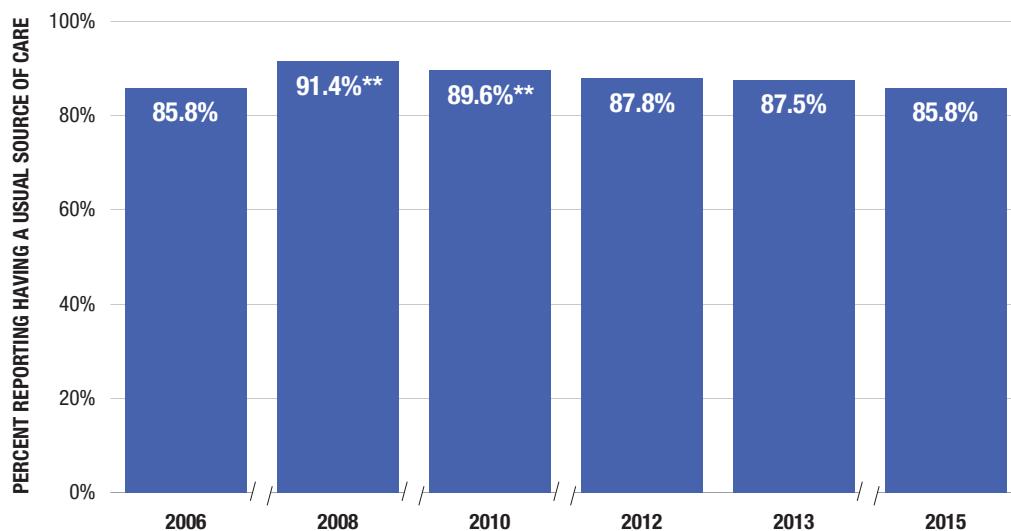
a phenomenon called “crowd-out.” These fears were not realized in the early years following reform. Data from 2008,¹⁸ 2010,¹⁹ 2011,²⁰ and 2012²¹ show that employer coverage did not decline in Massachusetts, while it did in the rest of the country.²² However, ESI coverage in Massachusetts did fall between 2013 and 2015, though it remains the dominant source of coverage in Massachusetts and nationally (ESI levels remained steady nationally in 2013 and 2014).²³

A contrary viewpoint held that gains in coverage due to reform were overstated and that there was evidence of crowd-out among low-income children and adults.²⁴ But the consensus among analysts was that the Massachusetts reform contributed greatly to near-universal coverage.

ACCESS TO CARE

Increases in insurance coverage after the passage of Chapter 58 led to overall improvements in access to care, but improvements were uneven across different groups. Connection to the health care system in Massachusetts changed little but remains robust in the post-reform period, with 85.8 percent of non-elderly adults in 2015 reporting that they had a place where they usually go if they are sick or need advice about their health, similar to the level reported in 2006.²⁵ (See Figure 3.)

FIGURE 3: ACCESS TO USUAL SOURCE OF HEALTH CARE OVER THE PAST YEAR FOR ADULTS AGES 19 TO 64 IN MASSACHUSETTS, 2006–2015



Source: 2006–2015 Massachusetts Health Reform Survey (N=18,286). The survey was not fielded in 2011 or 2014. Data for 2007 and 2009 not shown.

Note: These are simple (unadjusted) estimates.

*(**) Significantly different from the value in 2006 at the .05 (.01) level, two-tailed test.

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There has been improved access to specific types of care under reform, including:

- Any type of doctor visit;²⁶
- Preventive care visits;²⁷ and
- Dental visits.²⁸

Improvements in access did not come immediately to all groups; there were some early obstacles, including levels of provider participation in public insurance programs.²⁹ In the first year after passage of Chapter 58, one in five adults reported difficulties scheduling an appointment with a provider or clinic because it was either not accepting new patients or not accepting patients with the type of insurance the person had.³⁰ This was especially difficult for low-income individuals, 29 percent of whom reported difficulty finding a provider.³¹ (These percentages subsequently declined and were lower in 2015 than in 2008.³²) During this early period, family planning providers in Massachusetts reported that long wait times and a lack of primary care physicians who accepted their insurance were barriers for women seeking primary care to access contraception.³³ Another study found essentially no progress in reducing unmet need among Latino, black, and middle-income individuals and those in fair or poor health, compared with the pre-reform period.³⁴

A recent survey shows that nearly half of non-elderly adults reported difficulty finding a provider accepting new patients or their type of insurance or difficulty getting an appointment as soon as they felt they needed it.³⁵

HEALTH CARE UTILIZATION

With more people covered by health insurance, Massachusetts saw increased utilization of care. Utilization increases differed by population and by health care service. There is some evidence of an increase in preventive care visits and the use of office-based care after health reform.³⁶ The incidence of having an annual flu vaccination rose 10 percentage points post-reform, though this increase was similar to those in neighboring states.³⁷ The number of children who reported visiting a doctor's office in a 12-month period also increased.³⁸

Overall use of preventive care in Massachusetts rose in the post-reform period, but increases in the use of specific preventive services varied. For example:

- Colorectal cancer screenings for adults age 50 to 64 increased, at a faster rate than in neighboring states;³⁹
- Cholesterol screenings increased, at a rate similar to that in neighboring states;⁴⁰
- Mammography screenings did not increase significantly, similar to what occurred in neighboring states; and
- The rate of cervical cancer screenings remained the same, while the rate of such screenings dropped in neighboring states.⁴¹

Statewide inpatient admissions for substance use disorder treatment remained essentially flat from 2006 to 2009 but increased 19 percent from 2009 to 2010; this could be due in part to a change in MassHealth policy in 2009 that limited the number of hours approved for outpatient services.⁴² Prior to rollbacks of MassHealth coverage for dental services, health reform was associated with a 7.2 percentage point increase in dental care usage for low-income individuals from 2007 to 2008 and an 11 percentage point increase from 2009 to 2010.⁴³

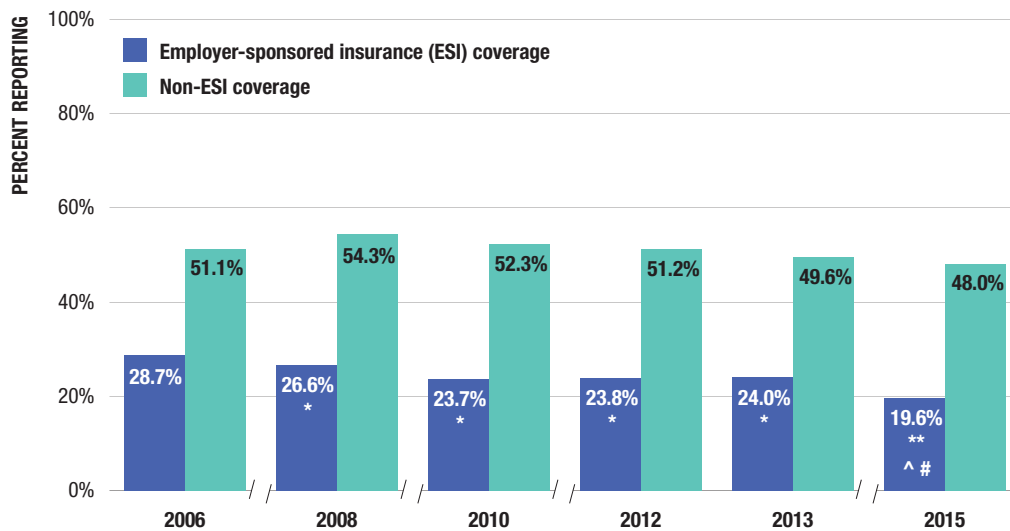
Emergency department (ED) use dropped slightly (but not statistically significantly) over time, with 30.2 percent of adults with insurance all year in 2015 reporting a visit to the ED in the past 12

months, compared with 33.9 percent of adults in 2006.⁴⁴ There were statistically significant drops in ED use for specific populations and in certain types of ED use.⁴⁵ The greatest change in ED use was for individuals with ESI.⁴⁶ (See Figure 4.) A study analyzing data from 2002 to 2008 found that an early impact of health reform was a reduction in non-urgent ED use during the day on weekdays. In contrast, reform had little effect on ED visits at night or during the weekend, when most primary care physician practices are closed.⁴⁷

Primary and preventive care increased following reform, while use of emergency departments declined for those with employer-sponsored insurance.

Collectively, 30-day hospital readmissions rose slightly in the early post-reform period, from 2006 to 2009. The number of readmissions for substance use disorder treatment, chest pain, and coronary artery disease grew, and readmissions for psychoses fell.⁴⁸ Intensive care unit utilization remained steady post-reform, but one study showed that reform was associated with a decrease of two days in the median length of a hospital stay for critically ill trauma patients.⁴⁹

FIGURE 4: EMERGENCY DEPARTMENT USE OVER THE PAST YEAR FOR FULL-YEAR INSURED ADULTS AGES 19 TO 64 IN MASSACHUSETTS, BY TYPE OF HEALTH INSURANCE COVERAGE, 2006–2015



Source: 2006–2015 Massachusetts Health Reform Survey (N=15,587). The survey was not fielded in 2011 or 2014. Data for 2007 and 2009 not shown.

Note: These are simple (unadjusted) estimates.

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There were overall increases after 2006 in major therapeutic procedures, outpatient surgical referrals, minimally invasive surgery, and joint replacement procedures.⁵⁰ Increases in utilization were significantly higher among nonwhite patients.⁵¹ Increases in major therapeutic procedures were also higher in low- and middle-income cohorts.⁵²

HEALTH OUTCOMES

Health care reform in Massachusetts has been associated with overall gains in general health, physical health, and mental health as compared with health outcomes in the other New England states.⁵³ Gains in health outcomes in all three categories were greater for individuals earning up to 300 percent of the federal poverty level (FPL)—the population likely to qualify for subsidized health insurance under Massachusetts health reform.⁵⁴ Reform resulted in improvements for Massachusetts residents in body mass index—an indicator of obesity—and it increased the probability of individuals reporting excellent or very good health.⁵⁵ The largest gains in health status among those reporting excellent or very good health were among minorities, women, those with low incomes, and near-elderly adults (ages 60 to 64).⁵⁶

The largest gains in health status improvement were among minorities, women, those with low incomes, and near-elderly adults.

There was a decline in mortality among non-elderly adults in Massachusetts, though other states that later expanded their Medicaid programs experienced even greater declines, perhaps reflecting the historically higher level of insurance coverage in Massachusetts relative to most other states.⁵⁷ Reductions in mortality were largest in Massachusetts counties with lower incomes and with lower insurance coverage rates before reform—areas likely to have had the greatest increases in access to care post-reform.⁵⁸ Although studies did not demonstrate a causal relationship connecting health care reform to the mortality rate, and despite no overall change in mortality for critically ill trauma patients, the overall decline in mortality suggests a beneficial impact of health reform.⁵⁹

ECONOMIC IMPACTS

Massachusetts reform affected both family finances and the state's economy. One analysis of credit report information found that Chapter 58 bolstered the traditional role of insurance by reducing financial distress—less debt, improved credit scores, fewer personal bankruptcies—most significantly for people who had limited access to credit markets pre-reform.⁶⁰ Another study, however, found no statistically significant decline in personal bankruptcies, though medical bankruptcies as a percentage of all bankruptcies were lower in Massachusetts than nationally both pre- and post-reform.⁶¹

At a societal level, reform had some effects on the job market and employment choices:

- The likelihood that older taxpayers and joint filers earned self-employment income increased (though offset by a decline in self-employment income among taxpayers ages 35 to 49 and single filers).⁶²
- Job mobility increased among young and low-income taxpayers.⁶³
- Growth in health care administrative occupations was more rapid in Massachusetts than in the rest of the country.⁶⁴
- Newly insured workers highly valued their ESI coverage and were willing to accept lower wages.⁶⁵

Some research found evidence of added costs for **employers**. One study estimated that health care reform in Massachusetts increased single-coverage ESI premiums by about 6 percent.⁶⁶

Another study challenged that finding, arguing there was no statistical evidence for changes in group premiums, but it found large reductions in non-group premiums in Massachusetts relative to the United States overall.⁶⁷ In the years immediately following implementation, a majority of employers agreed that the reform had been good for Massachusetts.⁶⁸

A number of analyses of reform's impact on **providers** focused on the safety net—community health centers (CHC) and hospitals. The consensus of the research is that even with the number of uninsured in the state greatly diminished, safety net providers still have an important role. Safety net providers serve as entry points to the health care system and help their patients navigate the system. Patients say they use them because they are convenient and affordable and because they prefer the type of care offered there; they are not seen as providers of last resort.⁶⁹ After reform, CHCs gained new patients and many previously uninsured patients gained insurance, but CHCs' overall financial status changed little: revenues and costs grew equivalently. Increased demand for care exacerbated existing shortages of primary care physicians and mid-level professionals such as nurse practitioners and pharmacists at health centers.⁷⁰ Safety net hospitals continued to play an important role in caring for disadvantaged patients; their financial performance declined considerably post-reform compared with that of non-safety net hospitals.⁷¹

There is still a role for safety net providers, even with many fewer uninsured people.

In the years immediately following implementation of reform, physicians supported the law in large numbers: a majority said the law either had no effect or was having a positive effect on their practices, except for concern about an increased administrative burden.⁷²

AFFORDABILITY FOR CONSUMERS

The cost of health care had been a challenge for many people in Massachusetts long before the passage of Chapter 58, and it has remained a challenge since, for the publicly and privately insured alike. In the years immediately after 2006, increased coverage contributed to fewer reported problems paying medical bills.⁷³ (See Figure 5.)

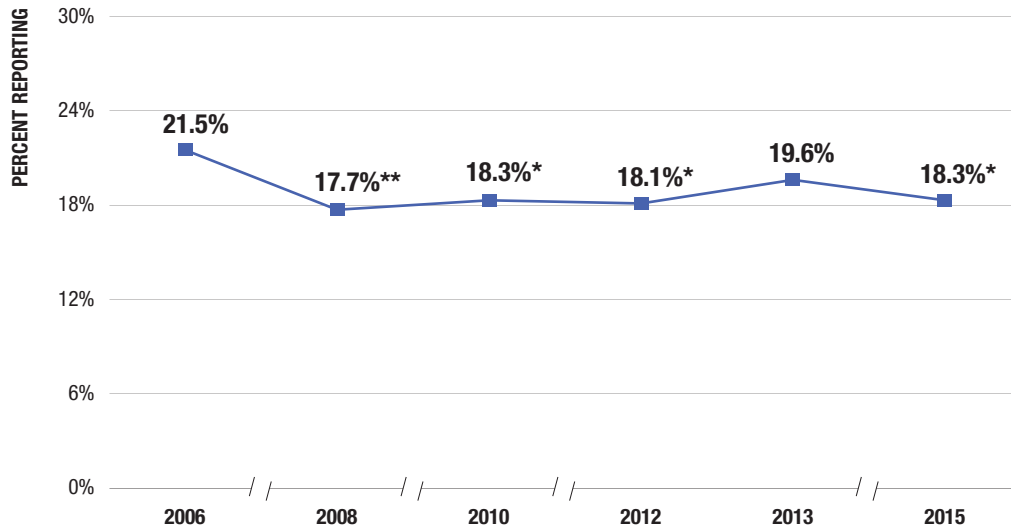
One of the important innovations of the Massachusetts reform was the individual mandate. An anticipated effect of the mandate was that it would bring healthier people into the individual insurance market, making insurance more affordable for all and risk more manageable for insurers. This is in fact what researchers found happened in the Massachusetts insurance market as a result of expanded and mandated coverage under reform.⁷⁴

Overall, however, Chapter 58 has not resulted in substantial gains in the affordability of health care for Massachusetts residents. In 2015, 43.1 percent of full-year-insured adults reported that health care spending caused them financial problems.⁷⁵

Despite the reform, Massachusetts has not escaped the long-term national trends in health care costs, long preceding Chapter 58, that directly affect affordability for consumers.⁷⁶ More than half (55 percent) of adults surveyed in 2015 said they were very or somewhat worried about their ability to pay medical bills in the future.⁷⁷ According to another study, between 2006 and 2008 out-of-pocket costs rose by 51

Most research found that Chapter 58 made individual insurance more affordable by bringing healthier people into the pool across which costs are spread.

FIGURE 5: PROBLEMS PAYING MEDICAL BILLS IN PAST 12 MONTHS, ALL ADULTS AGES 19 TO 64 IN MASSACHUSETTS, 2006-2015



Source: 2006–2015 Massachusetts Health Reform Survey (N=15,587). The survey was not fielded in 2011 or 2014. Data for 2007 and 2009 not shown.

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percent for individuals with incomes between 100 and 200 percent FPL, and by 24 percent for individuals with incomes between 200 and 300 percent FPL.⁷⁸ And affordability challenges have persisted. Financial difficulties were more pronounced for low- and middle-income adults.⁷⁹ In 2015, low-income insured adults were more than twice as likely as those with higher incomes to go without needed care due to costs.⁸⁰ After health reform, women experienced more problems affording health care than men.⁸¹ Before reform, women were as likely as men to report unmet need for health care due to costs, but in 2009 younger women (ages 18 to 45) were 5.8 percentage points more likely to report unmet need due to costs than were young men.⁸² Although health care reform was successful in motivating Latinos to seek out and enroll in health insurance, many reported that their access to care was limited due to difficulties affording co-payments and other cost sharing.⁸³

CONCLUSION

Ten years ago, Chapter 58 enacted bold and ambitious health care reform. Since then, Massachusetts has maintained the nation's highest rate of insurance coverage. Health care reform has had the greatest impact on lower-income residents of the state. Relatively disadvantaged in the health care system prior to reform, this group experienced more pronounced increases in insurance coverage, improvements in access and utilization, gains in health status, and reductions in mortality after health care reform.

The cost of health care has remained an issue, following a nationwide trend that predates Chapter 58. As many as one in five individuals in 2015 reported problems paying their medical bills over the last year, and the burden of health care costs weighed more heavily on insured adults with low incomes, individuals with non-ESI coverage, and individuals with health problems.⁸⁴

With innovations to the health care system and additional payment reforms on the horizon, Massachusetts stands ready to build on its long tradition of groundbreaking advances in shaping the delivery and purchase of health care. Chapter 58 laid the groundwork for long-lasting impacts in the state, but opportunities for further reform, especially those related to costs, persist.

ENDNOTES

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