Universal Health Insurance Access Efforts in Massachusetts

Lessons Learned for Public Health Systems Across the United States

Funding for this study has been provided by the National Network of Public Health Institutes (NNPHI) through a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC – 5U38HM000520-05).
NNPHI and Health Resources in Action have collaborated with CDC's Office of the Associate Director for Policy on this project.
The views and opinions of these authors are not necessarily those of CDC or the U.S. Department of Health and Human Services (HHS).

Overview

PRODUCTS

- **Literature and Data Review** on the effects of Chapter 58 on public health practice and population health outcomes
- **Qualitative Findings Report** based upon the reflections of 29 MA public health, health care, and legislative leaders on the passage and implementation of Chapter 58
- **Case Study** distilling research findings and detailing lessons learned for public health systems across the U.S.

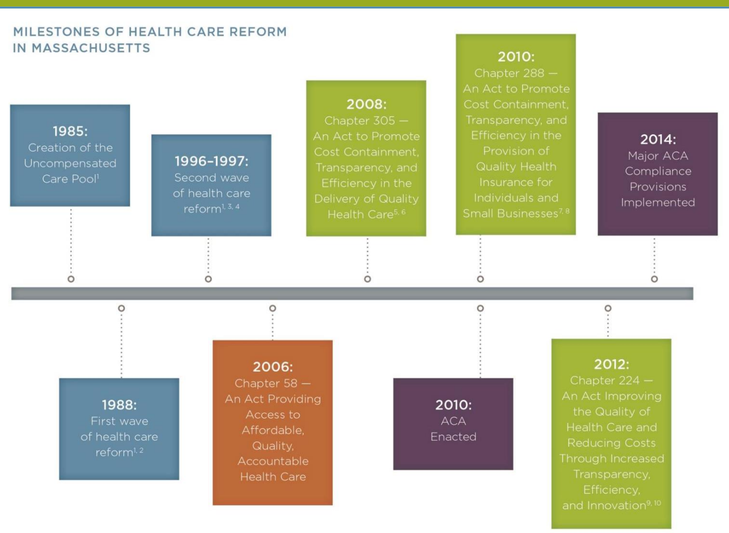
STUDY AIMS

The Affordable Care Act was modeled after MA's 2006 health care reform efforts, entitled *An Act Providing Access to Affordable, Quality, Accountable Health Care* **(Chapter 58)**.

This study aimed to:

- Examine the impact of Chapter 58 upon MA's public health and safety net systems
- Draw lessons learned to:
  - Inform the ACA's implementation
  - Forecast potential effects on public health practice
  - Highlight opportunities to improve population health outcomes

MILESTONES OF HEALTH CARE REFORM IN MASSACHUSETTS



COMPONENTS of Chapter 58

- **Medicaid Expansion** (known as Mass Health)
- **Commonwealth Health Insurance Connector**, a health insurance exchange established to enable residents to access both subsidized and non-subsidized private health insurance
- **Insurance Market Reforms** introduced
- **Requirements for Individuals and Employers** established

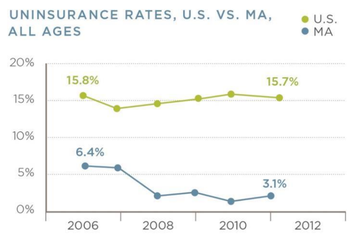
PUBLIC HEALTH PROVISIONS of Chapter 58

- A one-time $12 million increase to public health line items, such as tobacco control (Section 2)
- Establishment of the MA Health Disparities Council and requirements around collecting data on race and ethnicity (Section 3, Part 6)
- Commissioning of a formal study of the potential role of community health workers (Section 110)
- A mandated smoking-cessation benefit to MA's Medicaid program enrollees (Section 108)

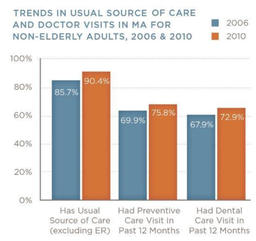
MA's UNIQUE CONTEXT

- Direct safety net services primarily provided by non-governmental providers
- MA Department of Public Health contracts out many public health services and functions
- 351 cities and towns with autonomous local health departments

UNINSURANCE RATES, U.S. VS. MA, ALL AGES



TRENDS IN USUAL SOURCE OF CARE AND DOCTOR VISITS IN MA FOR NON-ELDERLY ADULTS, 2006 & 2010



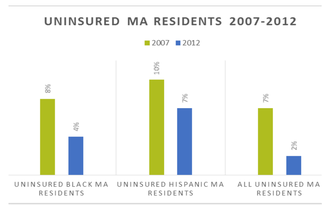
Source: *Massachusetts Health Reform Survey, 2006–2010. Percentage changes between 2006 and 2010 are statistically significant.*

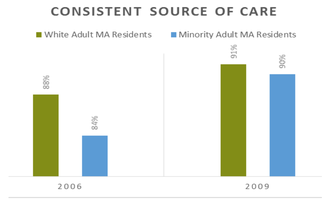
CONNECTIONS WITH PRIMARY AND PREVENTIVE CARE ARE INCREASING

Source: *Massachusetts Health Reform Survey, 2006–2010. Percentage changes between 2006 and 2010 are statistically significant.*

Findings

EXPANSION OF HEALTH CARE COVERAGE IS REDUCING DISPARITIES



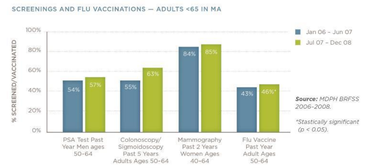


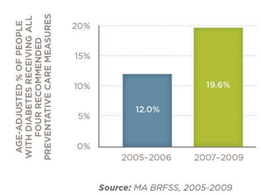
Investing in Enrollment Efforts is Key to Success

Strategies for Enrollment

- Conducting public education campaigns
- Utilizing community health workers for outreach and navigation
- Facilitating enrollment and ensuring convenient community access points
- Streamlining the benefit enrollment processes
- Infusing public and private funding to support these approaches

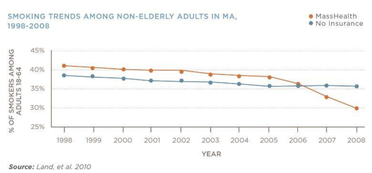
SOME HEALTH INDICATORS ARE BEGINNING TO SHOW IMPROVEMENT





Preventive Care Measures for Diabetes:
- Annual eye and foot exams
- Annual flu shots
- A1C level checks twice a year

Source: *MA BRFSS, 2005-2009*



Source: *Land, et al. 2010*

Case Study

As recounted by a MA Department of Public Health Leader…

MDPH has long provided tens of millions of dollars in grants to community-based substance abuse providers to buy detoxification (detox), residential, and other services for clients who lacked insurance. After Chapter 58 passed, MDPH assumed that those contracts could be reduced for detox services since more people would have insurance and insurance always covered detox. The remaining grant funding was mandated as the "payer of last resort." Almost immediately, however, the flaws in that approach became clear. Within six to nine months, the detox directors raised their concerns. They had seen an increase in clients with insurance, as expected, but each insurance plan required a co-pay in order to access care. Most clients who sought detox were penniless at the point they entered care. The facilities were in a bind: they didn't want to turn anyone away but they couldn't afford to waive the co-pays either. The providers had found it easier in the pre-Chapter 58 days when they could bill MDPH for the total cost of care for an uninsured patient. MDPH and the providers tried unsuccessfully to advocate for a global insurance policy to eliminate co-pays for detox. As a result, the detox facilities incurred greater debt. This was an example of an unintended and unwanted consequence.

Challenges

Measuring Impact

- The full impact of reform upon health indicators will take many years to manifest
- Time lag in availability of public data
- Difficult to disentangle the effects of Chapter 58 from other factors, such as concurrent public health programs and campaigns and the economic recession.

Access to Care

- Not everyone is eligible for and/or desires insurance (3% remained uninsured)
  Those who remained uninsured typically included the following populations: low-income, geographically isolated, racial and ethnic minorities, those of poor health status, those with lower educational levels, non-citizens, non-English speakers, males, young adults, and those who were unemployed or underemployed.
- Gaps in coverage can occur
- Care remained unaffordable to some
- Cultural and systems challenges were impediments to enrollment
- Insufficient infrastructure and billing systems
  - Administrative delays due to new provider and facility credentialing
  - Lack of infrastructure at safety net providers and most local health departments for:
    - Contracting with and billing insurance
    - Tracking clients' shifting insurance status
- Pre-existing provider shortages (no evidence of exacerbation due to health care reform)

Safety Net Services

- Demand for safety net services increased, even with falling uninsurance rates
- Safety net providers were not considered 'providers of last resort' by patients
- Financial challenges emerged, especially for safety net hospitals, whose costs outpaced revenue due to inadequate Medicaid hospital reimbursement rates
- Safety net services remain critical to provide services to vulnerable populations

Recommendations

1. **Get a seat at the table and communicate the public health message**
   "We learned the hard way that if we didn't fight for a seat at the table and struggle to demonstrate our value, others who were here would make decisions that affected us."
   - Former Public Health Commissioner John Auerbach
2. **Focus on population health improvement and workforce development**
3. **Collect population data to monitor health outcomes of reform**
4. **Rethink and reprioritize traditional public health functions**
   As clinically-oriented services shift to more traditional primary care realms, some functions still need to be maintained by public health (*see case study in the middle column*).

   Other clinical services that could benefit from remaining under the public health umbrella include infectious diseases with a population impact that require specialized treatment (e.g. TB), services requiring confidentiality that is not yet possible through the insurance system (e.g. family planning), outreach, contact tracing, and education.
5. **Maintain safety net functions (and prepare for demand increases)**
6. **Seek additional funding dedicated to public health**
   Establishment of a Prevention and Wellness Trust Fund

   The MA Prevention and Wellness Trust Fund was established through Chapter 224 passed in 2012 to provide a more intentional source of funding for community prevention.

   Monies from the trust fund must be used to:
   - Reduce the rate of common preventable health conditions
   - Increase healthy habits
   - Increase the adoption of effective health management and workplace wellness programs
   - Address health disparities
   - Build evidence on effective prevention programming

Authors: Brittany Chen, MPH; Shin-Yi Lao, RN, BSN; Yoojin Lee, MPP; Laurie Stillman, MM; & Toni Weintraub, MD, MPH

For More Info:

Health Resources in Action
Advancing Public Health and Medical Research
95 Berkeley Street, 2nd Floor
Boston, MA 02116
P: 617.451.0049 | F: 617.451.0062
TTY: 617.451.0007 | www.hria.org