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From The Centers for Disease Control and Prevention:

From The National Network of Public Health Institutes:

From Northeastern University's Institute on Urban Health Research and Practice:

Funding for this qualitative ndings report 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 Of ce 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).

I: EXECUTIVE SUMMARY

( ), 2010,
( ) 2006
(58) (Graves & Swartz, 2012; Henry J. Kaiser Family Foundation, 2012; Long 2010; Long, Stockley, & Dahlen, 2011; Patel & McDonough, 2010; Raymond, 2011). An Act Providing Access to Affordable, Quality, Accountable Health Care, 58
(McDonough, Rosman, Butt, Tucker, & Howe, 2008; Patel & McDonough, 2010).

(McDonough, 2011)

(Patel & McDonough, 2010; Raymond, 2011a)
(McDonough, Rosman, Phelps, & Shannon, 2006)
(Auerbach, 2013; McDonough et al., 2006)

(Hall, 2010)

A. OVERVIEW OF CHAPTER 58 IN MA

An Act Providing Access to Affordable, Quality, Accountable Health Care, (McDonough et al., 2008; Patel & McDonough, 2010)

In spite of this, features of the 1988 legislation still stand in Massachusetts, including:

–

[1] McDonough et al., 2006

[2] An attempt to achieve universal health care through a "play-or-pay" employer mandate

[3] Wachen & Leida, 2012

[4] Expanded eligibility for MassHealth and the Children's Ds

(Hyde & Tovar, 2006; U.S. Census Bureau, 2010)

(Hyde & Tovar, 2006)

(Hyde & Tovar, 2006)

(Wall, 1998)

C. COMPARING CHAPTER 58 AND THE AFFORDABLE CARE ACT

Overview

(McDonough, 2011)

(Patel & McDonough, 2010; U.S. Department of Health and Human Services, 2013)

The titles of the ACA are as follows:

(Health Care For All Massachusetts, 2009).

Health care workforce

(Dyck, n.d.; McDonough, 2011)

(McDonough, 2011; U.S. Department of Health and Human Services, 2013)

An Act to Promote Cost Containment, Transparency, and Ef ciency in the Delivery of Quality Health Care

TABLE 1: CO PARISO OF AJOR PROVISIO S I ASSACHUSETTS'S CHAPTER 58 A D THE ACA

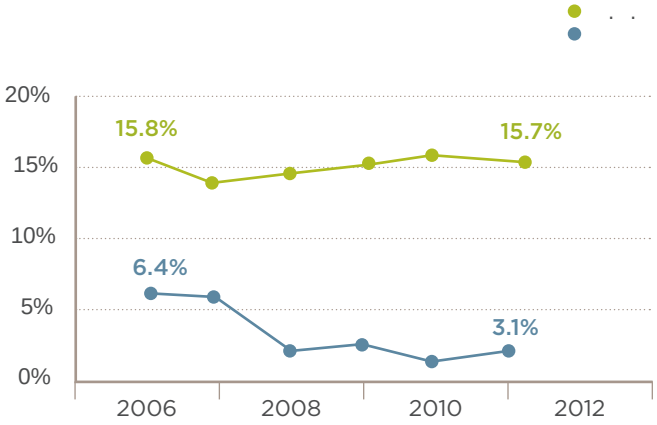
I s a ce a et Re o s	Systemic insurance market reforms require guaranteed issue, community rating, and coverage standards.
State-based Exc a ge	Health insurance marketplaces enable individuals and small businesses to compare and purchase private insurance that meets certain coverage and cost standards.

	S a t es betwee CHAPTER 58 & ACA	D e e ces betwee CHAPTER 58 & ACA	
		C a te 58	A o dab e Ca e Act
S bs d es o P vate Cove age	Subsidies are provided to low-income individuals to purchase private insurance.	Commonwealth Care (MA's health insurance program for adults who meet income and other eligibility requirements) provides subsidized private health coverage on a sliding scale for individuals with incomes up to 300% Federal Poverty Level (FPL). Individuals with incomes below 150% FPL are eligible for fully subsidized coverage. (Health Connector, n.d.-a)	Premium subsidies are provided on a sliding scale for individuals with incomes between 100% and 400% FPL to purchase private insurance in an Exchange. Cost-sharing subsidies are available for those with incomes between 100-250% FPL. An individual's expected contribution ranges from 2-9.5% depending on household income.
SHOP (S a B s ess Hea t O t o s P og a) Exc a ge E g b ty & S bs d es	Certain businesses are required to offer health insurance to their employees or face nancial penalties.	Businesses with 50 or fewer employees may offer health bene ts to employees and a Section 125 plan (health insurance plans employees can pay for on a pre-tax basis) through the Health Connector's Commonwealth Choice plans. (Health Connector, n.d.-b) Chapter 58 does not provide subsidies to small businesses.	Businesses with 100 or fewer employees can access SHOP; however, states can limit participation to businesses with 50 or fewer full-time equivalent employees until 2016 and then expand to businesses with 100+ employees in 2017 or later. Businesses with fewer than 25 employees and average annual wages of $50,000 or less may be eligible for a business tax credit if they pay at least 50% of their employees' health insurance costs.
Ex a s o o R b c Cove age	Medicaid coverage will be expanded.	Medicaid was expanded to cover children with family incomes up to 300% FPL. Eligibility levels for adults (parents –133% FPL, pregnant women 200% FPL, and long-term unemployed 100% FPL) remained the same; though, enrollment caps for certain Medicaid programs for adults were raised.	Medicaid was broadly expanded to all individuals under age 65 with incomes up to 133% FPL (plus a 5% automatic income disregard) based on modi ed adjusted gross income. In 2012, the US Supreme Court decided that states have the option of whether or not to accept the expansion.

I d v d a

A. OVERVIEW

FIGURE 2: U I SURA CE RATES, U.S. VS. A, ALL AGES



Source: MA CHIA Household Insurance Survey (2006–2011) and U.S. Census Bureau Current Population Survey (CPS) (2006-2011). [1]

[1]Estimates for the MA rates are from the Center for Health Information and Analysis (CHIA). See http://www.mass.gov/chia/docs/r/ pubs/13/ mhisreport-1-29-13.pdf for survey methodology. Estimates for the U.S. rates are from the Current Population Survey (CPS) U.S. Census Bureau.

B. HEALTH INSURANCE COVERAGE AND TYPE

Overall Health Insurance Coverage Rates

Figure 2 (Center for Health Information and Analysis, 2013)

(Center for Health Information and Analysis, 2013)

(Center for Health Information and Analysis, 2013)

(Long, Stockley, & Dahlen, 2012).

Types of insurance coverage

(Division of Health Care Finance and Policy, 2011) Figure 3

(Long et al., 2011)

(Long et al., 2012)

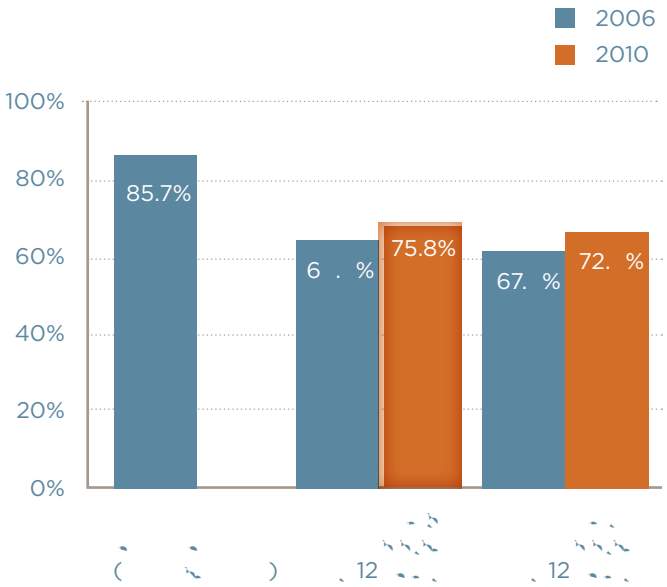
(Long et al., 2011)

C. ACCESS TO CARE AND UTILIZATION

(Blue Cross Blue Shield of MA Foundation, 2011)

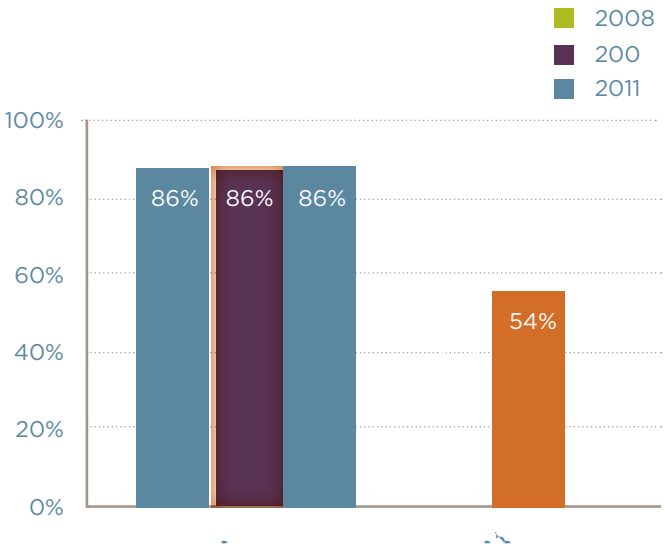
Source: Membership reported to DHCFP by health plans and MassHealth; Commonwealth Care enrollment data are from the Health Connector.

FIGURE 4. TRE DS I USUAL SOURCE OF CARE A D DOCTOR VISITS I A FOR O -ELDERL Y ADULTS, 2006 & 2010



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

FIGURE 5. O -ELDERL Y ADULTS WITH A DOCTOR VISIT I THE PAST 12 O THS B Y I SURA CE STATUS I A



Source: Center for Health Information and Analysis, 2012, retrieved from http://www.mass.gov/chia/docs/r/pubs/13/mhis-2011-detailed-tables-2-17-12.xlsx

Figure 5

%

% (Center for Health Information and Analysis, 2013)

%

%

(Center for Health Information and Analysis, 2013)

E.

HIV

Figure 8

(Auerbach, 2013; Center for Health Law and Policy Innovation of Harvard Law School, 2012)

(Greenwald, 2011)

(Cranston, 2012)

(Cranston, 2012)

(Center for Health Law and Policy Innovation of Harvard Law School, 2012)

FIGURE 8: TRE DS I HIV DIAG OSES A D ORTALIT Y I A, 1999–2009

Note: Number of diagnoses re ects year of diagnosis for HIV infection among all individuals reported with HIV infection, with or without an AIDS diagnosis.

Source: MDPH HIV/AIDS Surveillance Program, 2012

TABLE 2: U BER OF OUTPATIE T ED VISITS I ASSACHUSETTS, FISCAL YEAR (F_Y) 2006 A D F_Y2010

	2006	2010	% I c ease	C a ge A a G owt Rate
Tota ED V s ts	2,265,064	2,401,315	6.0%	-0.3%
P eve tab e/Avo dab e ED V s ts	1,108,002	1,178,068	6.3%	-0.6%

Source: MA Health Care Cost Trends: Ef ciency of Emergency Department Utilization in MA, August 2012

TABLE 3: AVERAGE COST PER OUTPATIE T ED VISIT I ASSACHUSETTS, F_Y2006 A D F_Y2010

	2006	2010	% C a ge
Ave age Cost e Q t at e t ED V s t (a)	$403	$515	27.9%
Ave age Cost e P eve tab e/Avo dab e ED V s t	$372	$474	27.4%

G. HOSPITALIZATIONS AND PREVENTABLE ADMISSIONS

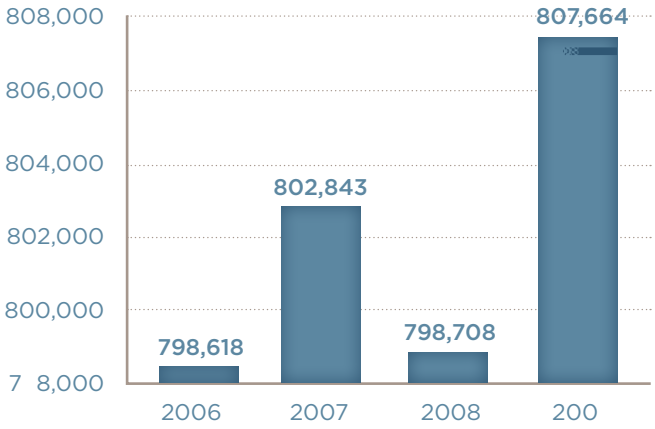
%

Figures 10 and 11

%

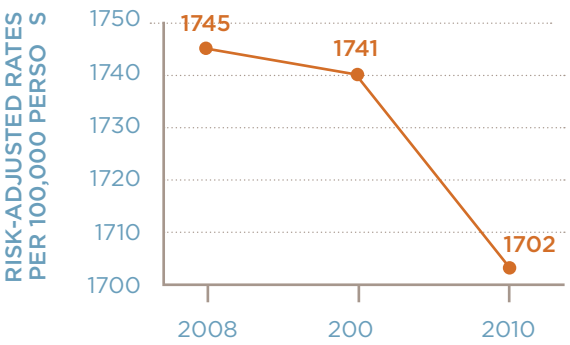
% Figure 12

FIGURE 10. **TOTAL U BER OF HOSPITALIZATIO S I A, 2006-2009**



Source: Massachusetts Center for Health Information and Analysis, Hospital Utilization Database, 2005-2009. Rates calculated by the Massachusetts Department of Public Health MassCHIP program, http://www.mass.gov/dph/masschip

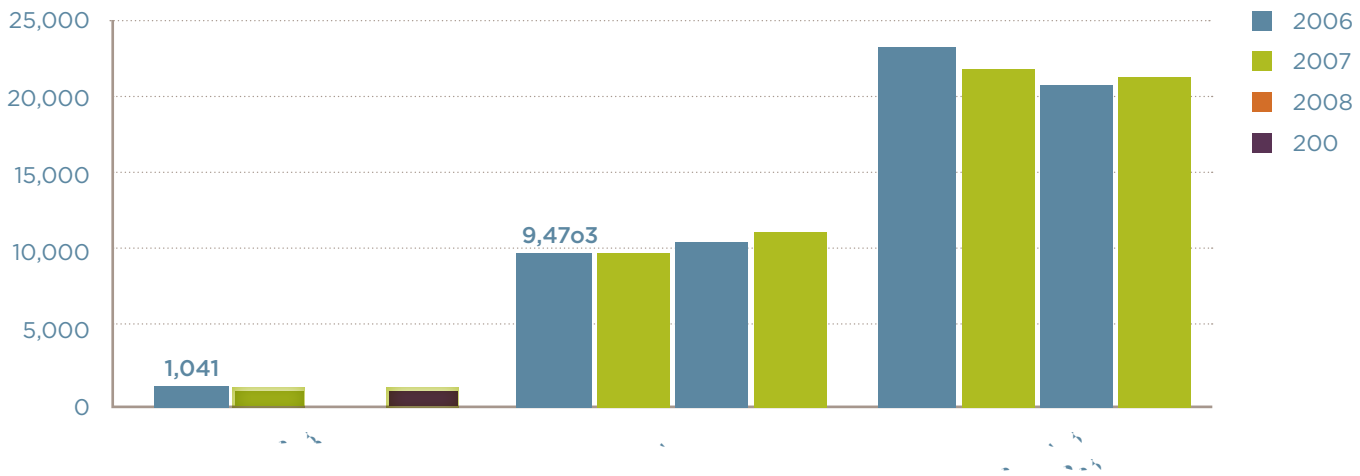
FIGURE 11: **PREVE TABLE HOSPITALIZATIO S I A, 2008-2010**



Notes: Risk-adjusted rate per 100,000 persons. Years shown are scal years. Analysis and methodology by the Massachusetts Center for Health Information and Analysis (CHIA).

Source: Massachusetts Health Care Cost Trends Preventable Hospitalizations, August 2012, Appendix A. Accessed online November 2013 http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2012/preventable-hospitalizations-appendix-a.xls

FIGURE 12. **SELECTED PREVE TABLE HOSPITAL AD ISSIO S I A, 2005-2009**



Source: Massachusetts Center for Health Information and Analysis, Hospital Utilization Database, 2005-2009. Rates calculated by the Massachusetts Department of Public Health MassCHIP program, http://www.mass.gov/dph/masschip

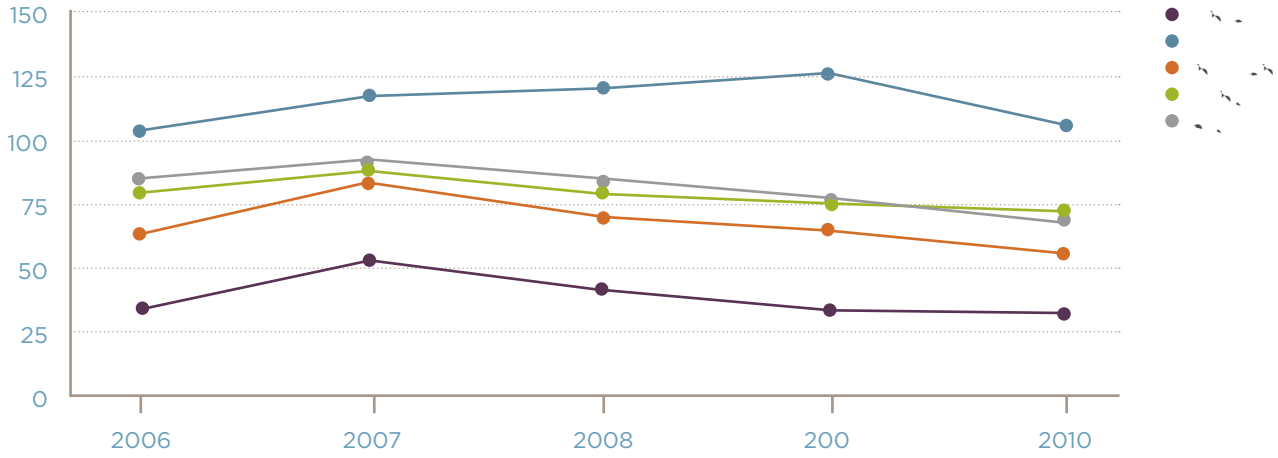
H: MORTALITY AND AMENABLE MORTALITY RATES

(Nolte & McKee, 2012)

%

Figure 13

FIGURE 13: ORTALIT Y A E ABLE TO HEALTHCARE I A, 2006-2010 B Y RACE A D ETH ICIT Y



Source: Massachusetts Department of Public Health. A Decade of Mortality 2000-2009, and Massachusetts Deaths 2010.
Note: These data have not yet been approved or released.

I. SCREENING AND PREVENTIVE CARE

% %

Figure 9

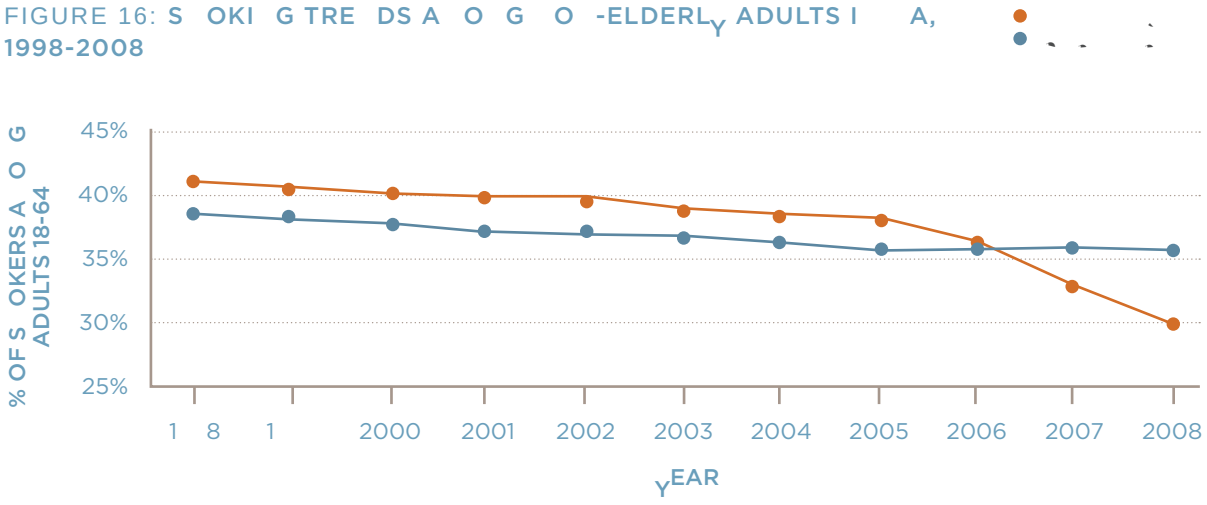
% %

Figure 10

(Keating, Kouri, He, West, & Winer, 2013)

(Keating et al., 2013)

FIGURE 16: S OKI G TRE DS A O G O -ELDERL Y ADULTS I A, 1998-2008



Source: Land, et al. 2010

J. SMOKING CESSATION

%

%

%

Figure 16 (Land et al., 2010)

%

%

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(Of ce of Surveillance, Epidemiology, and Laboratory Services, 2010)

%

%

Table 4 (Land et al., 2010)

%

%

%

(Land et al., 2010)

(Massachusetts Department of Public Health, 2012)

TABLE 4: **PREVALE CE A D QUIT ATTE PTS A O G EDICAID S OKERS PRE- A D POST-CHAPTER 58**

	2006	2008
S o g P eva e ce A o g ass Hea t e be s	38% [vs. 16% of total MA population]	28%
S ccesss Q t Atte ts	6.6%	18.9%

Source: MDPH, Tobacco Cessation and Prevention Program, 2012.

A. OVERVIEW

(Hall, 2010)

MA's safety net system, as defined for this literature review, is comprised of:

(American Public Health Association, 2009; Hall, 2010; Ku, Jones, Shin, Byrne, & Long, 2011; National Association of Public Hospitals and Health Systems, 2009)

B. INCREASED SAFETY NET PROVIDER UTILIZATION

(Ku, Jones, Shin, Byrne, et al., 2011; National Association of Public Hospitals and Health Systems, 2009)

(Raymond, 2011a)

(Hall, 2010; Ku, Jones, Shin, Byrne, et al., 2011)

C. INTENSIFIED ROLE OF SAFETY NET PROVIDERS IN ENROLLMENT

Safety net providers as patient navigators

TABLE 6: REASO S CARE SOUGHT FRO SAFET Y ET FACILIT Y I A

Reaso [a]	Sa ety et-Cove ed Ad ts, %[b]
Co ve e t	79.3
A o dab e	73.8
Ava ab ty o se v ces ot e t a ed ca ca e	52.0
P ob e gett g a a o t e t at a o -sa ety et ac ty	25.2
Sta ab e to s ea at e t's a y a g age	8.2

[a] Among patients who reported visiting a facility that provides care at low or no cost for those who have low incomes or are uninsured

[b] Aged 18-64 years, with income below 300% of the poverty line (n=309).

Source: Ku et al., 2011

%

(Ku, Jones, Shin, Byrne, et al., 2011)

Those that remained uninsured post-Chapter 58 were more likely to be:

%
%
%
%
%
%

(Auerbach, 2013; Bigby, 2011)

Table 6 (American Public Health Association, 2009; Ku, Jones, Shin, Byrne, et al., 2011; National Association of Public Hospitals and Health Systems, 2009)

(Ku, Jones, Shin, Byrne, et al., 2011; Snyder, Dolatshahi, Hess, & Kinsler, 2012)

E. FINANCIAL IMPACT OF CHAPTER 58 ON THE SAFETY NET AND PROVIDERS

Financing the safety net

The combination of the following factors led to the increased need for subsidies for safety net facilities even after Chapter 58:

FIGURE 18. HS TOTAL PAY E T TRE DS

Note: Numbers are rounded to the nearest million. The DHCFP reports did not indicate if the

(Ku et al., 2009)

(Hall, 2010)

Figure 17

(Division of Health Care Finance and Policy, 2012b)

Figure 18

Figure 19

G. CHALLENGES TO THE SAFETY NET'S CAPACITY

Administrative, billing, and infrastructure challenges

(American Public Health Association, 2009; Raymond, 2011a)

(American Public Health Association, 2009)

Provider shortages and barriers to care

(Ku et al., 2009; Ku, Jones, Shin, Byrne, et al., 2011; Sack, 2008)

(Ku et al., 2009)

(Massachusetts Medical Society, 2012)

(Ku, Jones, Shin, Byrne, et al., 2011)

Possible recommendations to address provider shortages include:

(Boston Public Health Commission, 2008; Ku, Jones, Shin, Bruen, & Hayes, 2011)

(Goodman & Fisher, 2008; Massachusetts Medical Society, 2012; McDonough, 2011)

(Goodman & Fisher, 2008)

A. OVERVIEW

(American Public Health Association, 2009)

(Dennis et al., 2012

(Center for Health Law and Economics, 2012)

B. ECONOMIC IMPACTS

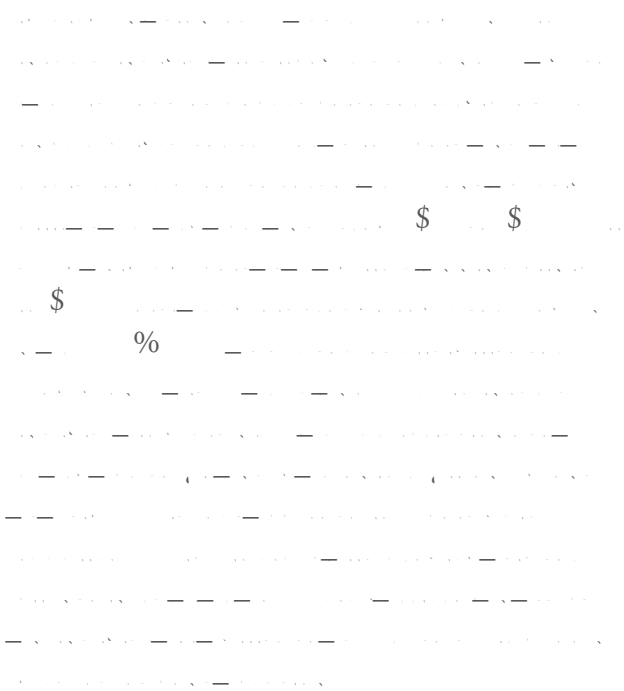
%

Programs that experienced disproportionate cuts were those that have important impacts on primary prevention including:

%
%
%
% _
%

(American Public Health Association, 2009)

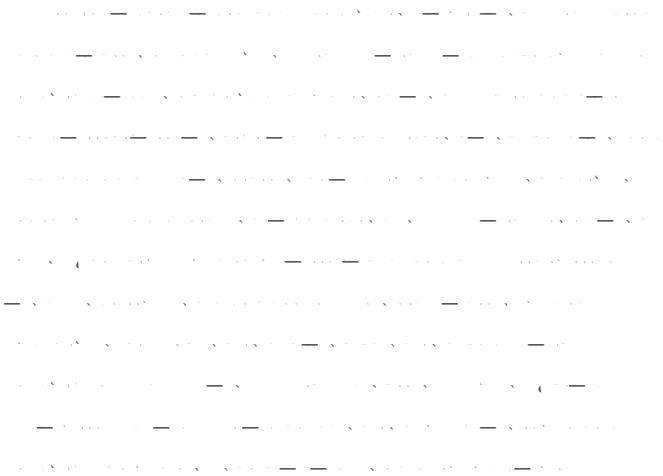
Mitigating barriers to family planning services, especially contraceptives



58

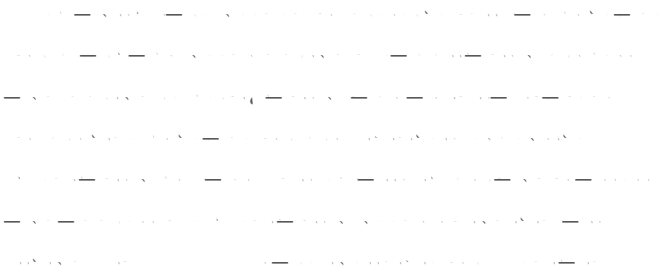
A. SUCCESSFUL STRATEGIES USED

Care navigation and coordination are vital services



(Fukuda, 2010)

Financial barriers to obtaining medications must be addressed



(Fukuda, 2010)

Build connections with the state Medicaid program up front

Collaboration and buy-in

(Raymond, 2011a, 2012)

E. SUMMARY OF LESSONS LEARNED

General

Implementation

Access to care

Clinical public health services

Public health services

Data monitoring and tracking

Health insurance exchanges

(Corlette et al., 2011)

(Corlette et al., 2011)

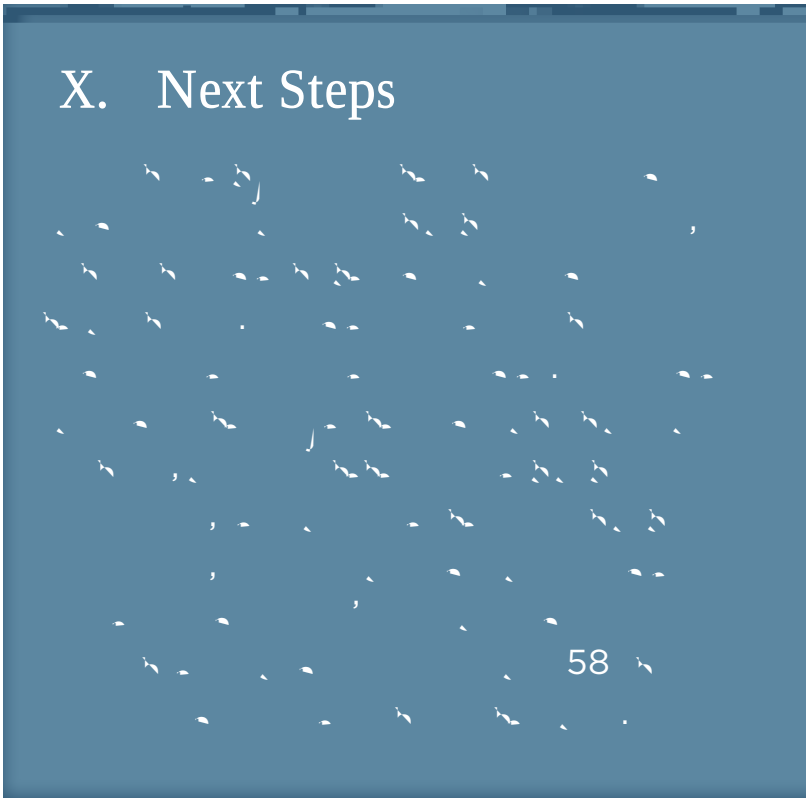
(Urff, 2011a)

LONG-TERM EFFECTS ON HEALTH OUTCOMES AND UTILIZATION

LOCAL HEALTH DEPARTMENTS

STRUCTURE AND FUNDING OF THE SAFETY NET

X. Next Steps



The role of community based public health programs in ensuring access to care under universal coverage.

New England Journal of Medicine

The Massachusetts and Utah Health Insurance Exchanges.

"No one asked me": Latinos' experiences With Massachusetts health care reform.

Massachusetts under the Affordable Care Act: Employer-related issues and policy options.

The Synthesis project.

Income, Poverty, and Health Insurance Coverage: 2011.

Reconciling the Massachusetts and federal indivdiual mandates for health insurance: A comparison of policy options.

Journal of Health Politics, Policy and Law.

Primary Care Task Force Report: 2008.

Massachusetts health care cost trends: Ef ciency of emergency department utilization in Massachussetts.

MassHealth: The Basics; Facts, Trends and National Context.

Health Safety Net: 2011 Annual report.

The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage.

Massachusetts case study: Health reforms lead to improved individual and public health outcomes and cost savings.

Massachusetts Healthcare Reform: Perspectives from the Prima6(wjf-)]ky ratateorads/preliminary-reports/2012-cost-t 0 -2. /6appe

Health Insurance Market Reforms: Guaranteed Issue.

%

Mass.gov

The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets.

Health Affairs

DATABASE SEARCH TERMS FOR PUBLISHED LITERATURE (INDIVIDUALLY OR IN COMBINATION):

He