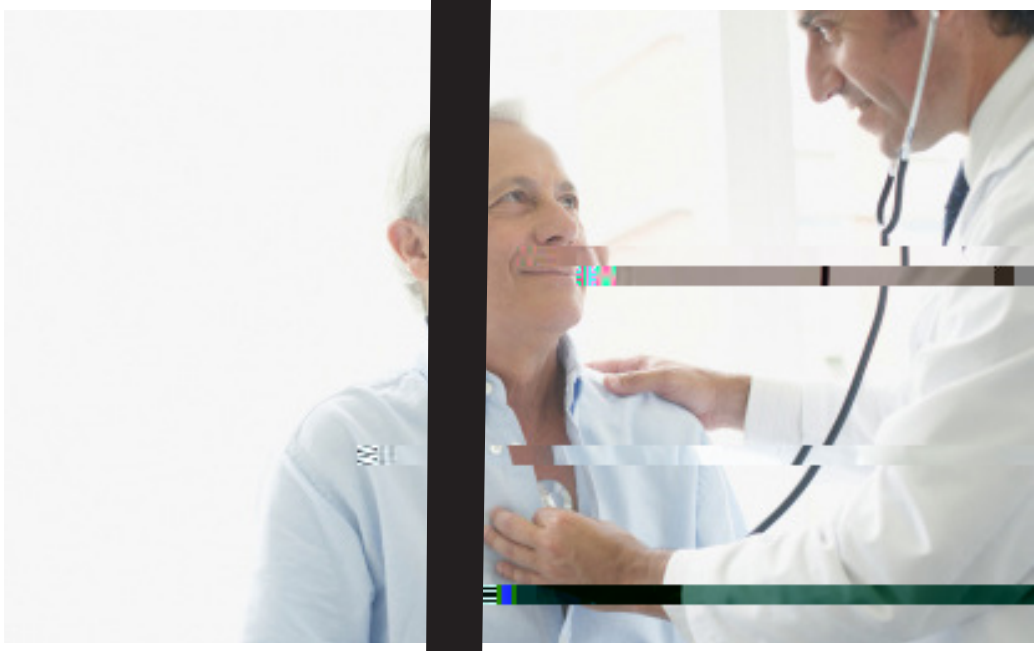

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Introduction

The federal Patient Protection and Affordable Care Act (ACA) was largely modeled after the Massachusetts (MA) 2006 landmark health care reform effort, Chapter 58 of the Acts of 2006 (Chapter 58), entitled *An Act Providing Access to Affordable, Quality, Accountable Health Care*.[1–6]

This case study examines the impact of Chapter 58 in MA provide lessons learned to states to inform their ongoing implementation of the ACA, forecast potential effects on public health practice, and highlight opportunities to improve population health outcomes.

Background

Prior to the passage of Chapter 58 in 2006, the uninsured rate in MA (6.4%) was signi cantly lower than that of the U.S. as a whole (15.8%) — a result of numerous reforms over two decades that strengthened MA's safety net structure, introduced insurance market reform, and expanded health insurance access. While MA's Chapter 58 built on these prior efforts through transforming the state's health insurance landscape, expanding affordable insurance options, and impacting the public's health

Findings and Lessons Learned

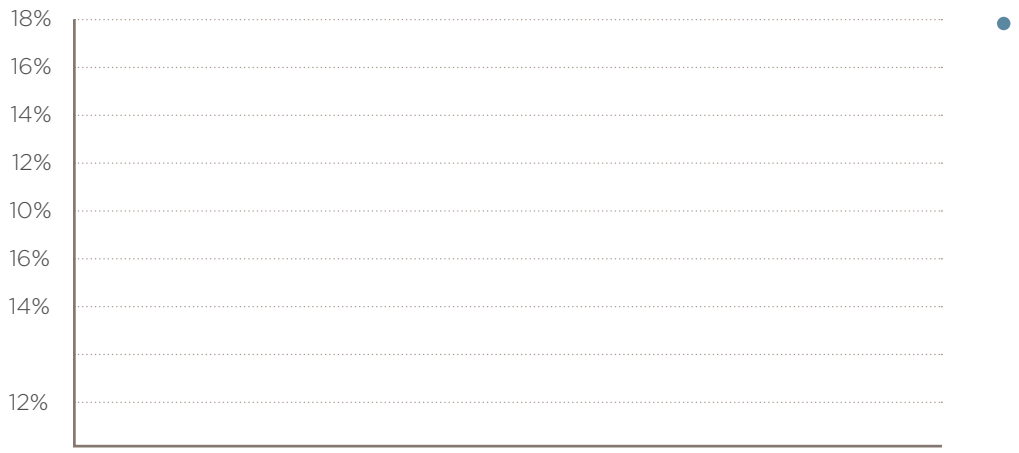
With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, there is much speculation about how national health care reform efforts may impact public health and its organization, delivery, and outcomes at the state and local levels.

I. INVESTING IN ENROLLMENT EFFORTS IS KEY TO SUCCESS

MA invested in an array of successful strategies to maximize insurance enrollment among eligible residents, resulting in a substantial decrease in uninsurance rates ( ). These strategies included:

- Conducting public education campaigns to increase consumer awareness of new bene ts and employer knowledge of new responsibilities;
- Utilizing community health workers (CHWs) and other trained community-based staff for outreach and navigation to help uninsured populations understand coverage options and connect with primary care providers;
- Facilitating enrollment by training enrollment specialists and ensuring convenient community access points;
- Streamlining the bene t enrollment processes with an integrated eligibility system, single application form, and automatic enrollment of those identi ed via the uncompensated care pool data; and
- Infusing a blend of public and private funding to support these approaches.

FIGURE 1: UNINSURANCE RATES, U.S. VS. MA, ALL AGES



II. CONNECTIONS WITH PRIMARY AND PREVENTIVE CARE ARE INCREASING

Over 90% of MA residents reported having a personal health care provider in 2010 and 76% reported having had a preventive care visit in the previous year ( ). These indicators suggest that expansion in insurance coverage led to a signi cant increase in access to health care services

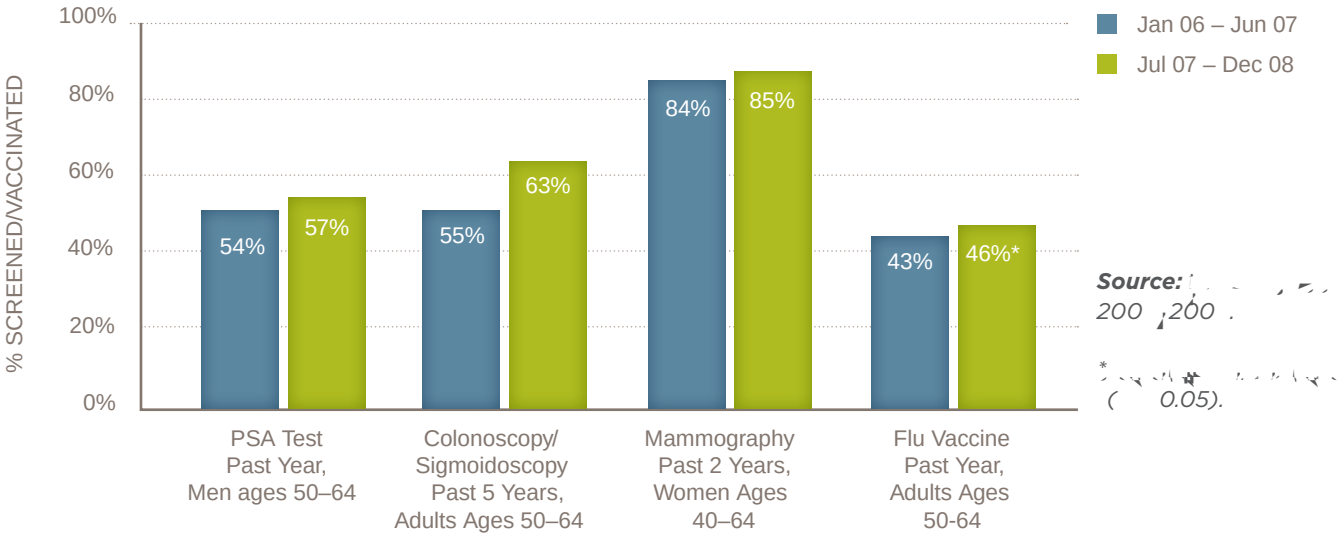
IV. WHILE SOME HEALTH INDICATORS ARE BEGINNING TO SHOW IMPROVEMENT, IT IS TOO EARLY FOR LONG-TERM HEALTH OUTCOMES TO MANIFEST

Since Chapter 58 passed in 2006, some health indicators have shown improvements. The following include highlights of trends for selected preventive care, chronic and infectious disease, and hospitalization indicators. Additional indicator trends can be found in the full literature review.

For many health indicators, the full impact of reform will take many years to manifest. Additionally, while the most recent, publicly available data were used for the study's analyses, there is a time lag in data availability. Finally, for many indicators, it is not possible to completely disentangle the effects of Chapter 58 from other factors, such as concurrent public health programs and campaigns and the economic recession.

There were modest increases in some preventive screenings after insurance access expanded; yet there is still room for further growth (•). Colon cancer screening and u vaccination rates notably increased post-Chapter 58. Insurance coverage alone does not appear to be suf cient to signi cantly improve appropriate utilization of all recommended clinical preventive services; thus, continued public health outreach efforts are vital.

FIGURE 3. SCREENINGS AND FLU VACCINATIONS — ADULTS <65 IN MA



Source: *200 ,200 .*

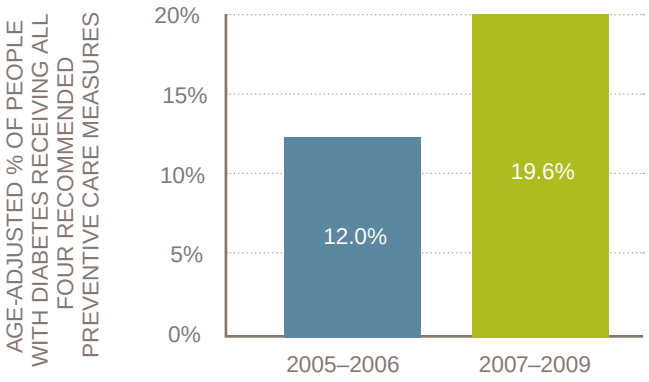
(0.05).

In the three-year period following the implementation of Chapter 58, the proportion of individuals with diabetes receiving recommended preventive care* increased signi cantly from 12% to 19.6% (•).

Annual eye and foot exams, annual flu shot, and twice yearly checks of A1C levels. (Standards of Medical Care in Diabetes, 2013. American Diabetes Association)

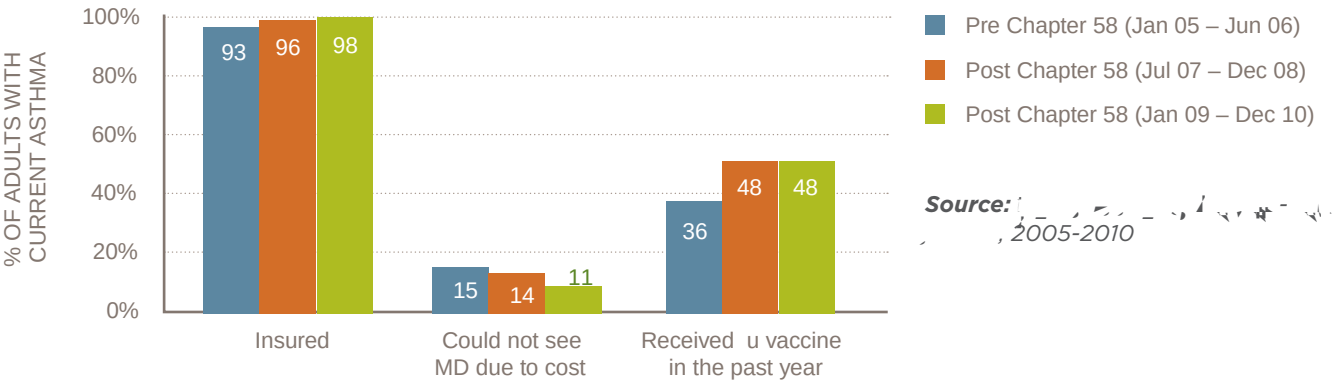
After the implementation of MA's Chapter 58, fewer residents challenged by asthma reported cost as a barrier to seeing a physician. Concurrently, there was a statistically signi cant increase in delivery of recommended annual u shots to asthma patients, 48% after Chapter 58 vs. 36% before (•).

FIGURE 4. TRENDS IN DIABETES MANAGEMENT IN MA, 2005-2009



Source: *, 2005-200*

FIGURE 5. ASTHMA CARE INDICATORS IN MA, 2005-2010



Source: *, 2005-2010*

Note:

Source: , 2012

New HIV diagnosis rates in MA, already trending downward, displayed a further sharp drop of 25% over the three years following Chapter 58 (-), while the national rate rose by 2%. The Massachusetts Department of Public Health and HIV organizations in the state believe that this was the result of increasing access to care and treatment for HIV-positive residents. The hypothesis is that "treatment is prevention."

In other words, diagnosing and treating HIV-positive patients early lowered their viral loads sufficiently to decrease the likelihood of infecting others. Additional evidence of this was that Medicaid spending on inpatient hospitalizations, as well as mortality rates for people with HIV, decreased during this time period.[9,10]

- € ,

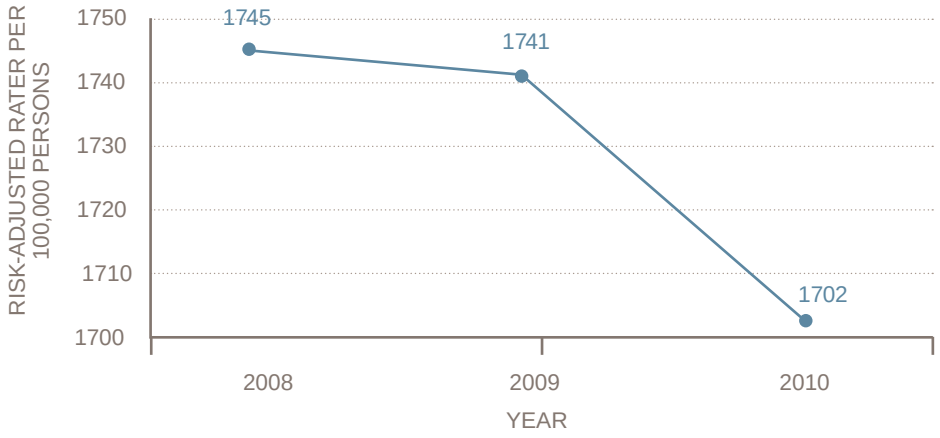
Preliminary data show that post-Chapter 58, preventable hospitalizations have shown an overall decline, but not for all causes (*f*).

It is important to note that this trend varied considerably across diagnoses. For example, hospitalizations for bacterial pneumonia decreased by 9% from 2006-2009, while asthma admissions rose by 12% („). It will be informative to track data on avoidable hospitalizations and readmissions over time and obtain a better understanding of the differing trends so they can be addressed.

… †

Disease development and behavioral changes take many years to manifest. Not enough time has elapsed since the implementation of Chapter 58 to see the full impact of expanded coverage and access on chronic conditions or long-term health outcomes. Tracking such variables will be key to monitoring success.

FIGURE 7: PREVENTABLE HOSPITALIZATIONS, MASSACHUSETTS 2008-2010



Notes: *100,000*

Source: *2012, -2012/ 2013*

V. INSURANCE EXPANSION DOES NOT NECESSARILY EQUATE TO EXPANDED ACCESS TO HEALTH CARE

Legislators and policy makers hoped that expanded health insurance coverage would address the health care access needs of the uninsured. However, a small but signi cant percentage (3%) of the population remained uninsured and a notable proportion (unquanti ed but recounted qualitatively) continued to experience challenges to accessing care. Some of these reasons are explicated below and have implications for public health.

A variety of issues that low-income and other vulnerable populations frequently face, such as isolation, personal resistance, lack of penetration of public awareness messages, wariness of government enrollment systems, etc., were impediments to enrollment. Newly eligible residents needed help to navigate the enrollment process and to understand how to use their bene ts. Many residents who gained insurance bene ts faced economic challenges at maintaining coverage (e.g., inability to afford premiums and/or copayments, employment shifts, etc.) that resulted in loss of, or gaps in, coverage and thus interruptions in care continuity.[10] In addition, some residents dropped their coverage when they

In addition, public health faced funding threats as a result of the perception that some programs would be unnecessary or duplicative under universal health coverage. Thus, a number of clinical public health programs, including substance abuse treatment, immunizations, infectious disease services, and family planning, were subject to legislative impacts. These changes had unintended consequences that impeded access to needed services. For example, while limited coverage for addiction treatment is offered by most health insurance plans, this service requires a co-pay that became a barrier for many destitute patients. Additionally, immunization supply was affected as providers shifted from a direct supply of free vaccines from the state to a system that required them to purchase vaccines up front while awaiting billing reimbursement.

Of note, the provider network reported that lengthy waits for appointments post-Chapter 58 often resulted from administrative delays in facility and provider credentialing by new insurance plans. Expediting contracting and credentialing processes could alleviate delays in care access.

Moreover, some safety net providers and most local health departments (LHDs) lack the infrastructure and resources needed for contracting with and billing insurers as well as for tracking the shifting insurance status of clients. These entities need resources if they are to create functioning payment systems and/or need to build partnerships with other entities to accomplish these tasks. Anticipatory planning and collaboration can expedite these processes.

The need to seek insurance reimbursement creates a barrier for those seeking con dential treatment for sensitive issues (e.g., STDs, HIV, family planning, and mental and behavioral health) due to the automatic generation of explanation of bene ts (EOB) documentation to policy holders. Previously, under certain conditions, subcontractors used state funding to provide these services con dentially without issuing an EOB.

These consequences illustrate a continued need for support and maintenance of some traditional public health services. To assure public health services are maintained, funding must be allocated for those public health services that cannot be shifted to the clinical service realm, such as outreach; contact follow-up; education and training of providers and the general public; disease and outbreak surveillance; and sensitive disease care.

VI. SAFETY NET SERVICES CONTINUE TO BE AN ESSENTIAL COMPONENT OF HEALTH CARE REFORM

As the number of uninsured people in MA fell, visits to community health centers (CHCs) and safety net hospitals grew and the number of vulnerable patients receiving care from safety net providers increased substantially.[11,12] From 2005 to 2009, there was a 31% increase in those served by CHCs ( ).[12] Of note, Table 1 illustrates that even with changes in payer mix, private insurance was not crowded out of the Federally Quali ed Health Care Center marketplace.

Covered patients sought care from safety net providers because they did not view them as providers of last resort. They valued the geographical and cultural accessibility, specialized services, such as translation and transportation, and their convenience and affordability ( ).

"We have wonderful hospitals, but they do not all have the ability to work with some of the complications that come with individuals who are challenged by poverty and language."

– Public health leader

TABLE 1: CHANGES IN PATIENT VOLUME AND INSURANCE STATUS AT FEDERALLY QUALIFIED HEALTH CARE CENTERS IN MA

	Calendar Year				
Patients	2005	2006	2007	2008	2009
Total (#)	431,005	446,559	482,503	535,255	564,740
Uninsured (%)	35.5	32.7	25.6	21.4	19.9
Medicaid/CHIP (%)	37.6	41.7	41.8	42.0	42.3
Medicare (%)	7.2	7.3	7.9	8.2	8.3
Commonwealth Care/ other public insurance (%)	0.8	0.5	5.5	8.8	10.1
Private health insurance (%)	18.9	17.8	19.2	19.5	19.4

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N : 100

Source: *., 2011*

TABLE 2: REASDf [(REA)12nO503.752 0 oJY ROtlTf 800 1 3TY00/CY RTSouR(es: as15. 0 Tc 0 Tw 1.5(c)47J ET (c)47J92.988
or are uninsuredAged 18-64 years, with income below 300% of veril line (n=309).

In MA, safety net hospitals and community health centers (CHCs) differentially met nancial struggles following Chapter 58. These safety net providers, which disproportionately care for publicly funded as well as the remaining uninsured population, have:

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Public health advocates succeeded in adding a mandate to Chapter 58 for coverage of all FDA-approved tobacco cessation medications and behavioral counseling for the MA Medicaid (MassHealth) population. MassHealth-insured smokers took advantage of these treatments and thus, this bene t contributed to a striking 26% drop in smoking prevalence among this group (‹ and •). [16]

This decrease in smoking was also associated with a marked reduction in hospitalizations for cardiovascular disease among this population (49% to 46%).[16] Overall, this program demonstrated a return on investment (ROI) of $2.12 for each dollar invested.

FIGURE 9:

Source: *. 2010*

TABLE 3: PREVALENCE AND QUIT ATTEMPTS AMONG MASS HEALTH SMOKERS PRE- AND POST-CHAPTER 58

	2006	2008
Smoking Prevalence Among Mass Health Members	38% [v . 16% f a MA a]	28%
Successful Quit Attempts	6.6%	18.9%

Source: *, 2012.*

Œ Š ˆ

Patient navigation by non-traditional providers has bene ts beyond enrolling in insurance plans; these trusted advisors equip the newly insured to maximize the bene ts and opportunities for the health care system to improve their health. Chapter 58 catalyzed MA's successful community health workers initiative by commissioning a study of CHW roles that led

€€ ‡
‡ € €

Coordinated efforts to evaluate many outcome measures of Chapter 58 have not occurred. The few studies that have been conducted have focused on the number of insured individuals and their access to health care, but not necessarily on tracking changes in population health outcomes.

"Throughout this country, we should begin pulling together the resources to create meaningful, longitudinal research and evaluation of the community health impacts of medical payment reform."

– State Epidemiology Researcher

Collecting baseline information at the outset of ACA implementation and establishing systems and procedures to monitor the process and outcomes of health care reform efforts regularly is critical to developing an understanding of the ef cacy and impact of these efforts. Developing and pursuing this research agenda on a national level would be ideal. As more people across the U.S. obtain health insurance coon a nardj -0.092 TD [(co)15.9(on a naD [(Tf c -19.477 -1.292 Td t [8315 Tm [(– be 2.3)BTpincurr)9.8(h ia

"Sometimes public health just has to [be there] to ask the questions. How do we make sure that while we increase access, we are also doing things to keep people healthy overall? How do we make sure that we are increasing the number of smoking cessation programs and implementing programs that keep people from having asthma attacks? That's the public health concern and

- Š € , € ‡ such as immunizations, substance abuse services, and STD and TB clinics. Identify which functions can be shifted to clinical settings, and ‡ €€ for those services that should remain in the public health sphere;
- Identify and implement opportunities to € • ‡ € • • • Œ € ‡‡ to leverage opportunities to promote population health;
- • ‡ to public health departments and safety net providers needed to prepare for increases in patient volume and bill insurers for reimbursable services;
- • ‡ € effective strategies to maximize quality of care, reduce cost, and improve health outcomes; and
- • the process and outcomes of health care reform efforts.

’ ‡ • “

Public health leaders realized they missed an opportunity in the early rounds of health care reform to build in a formalized role for public health prevention. The state's public health association took a leadership role in rectifying this situation by forming a powerful coalition and messaging to help policymakers understand the essential value of public health in improving health and controlling costs. The MA Prevention and Wellness Trust Fund was established by legislation (Chapter 224) in the years following Chapter 58 to provide a more intentional funding source for community prevention. Monies from this trust 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; and/or build evidence on effective prevention programming. Allocating an ample and protected budget for public health strategies, and measuring their value, is an important vehicle for addressing population and community health issues. MA's innovative Prevention and Wellness Trust Fund is a model that can be replicated on a broad scale.

Next steps for public health systems across the nation

The public health sector should be at the table to inform health care reform efforts in order to achieve the three-part aim of improving health, reducing costs, and maintaining a high quality patient care experience. Universal insurance access does not necessarily mean population health needs and aims will be addressed, especially for vulnerable populations.

Prevention experts should articulate the value

[1] Graves JA & Swartz K. Health care reform and the dynamics of insurance coverage — Lessons from Massachusetts. New Engl J Med. 2010; 367(13): 1181–1184.

[2] Henry J. Kaiser Family Foundation. Massachusetts health care reform: Six years later. [Internet]. 2012. Retrieved from http://kff.org/health-costs/issue-brief/massachusetts-health-care-reform-six-years-later/

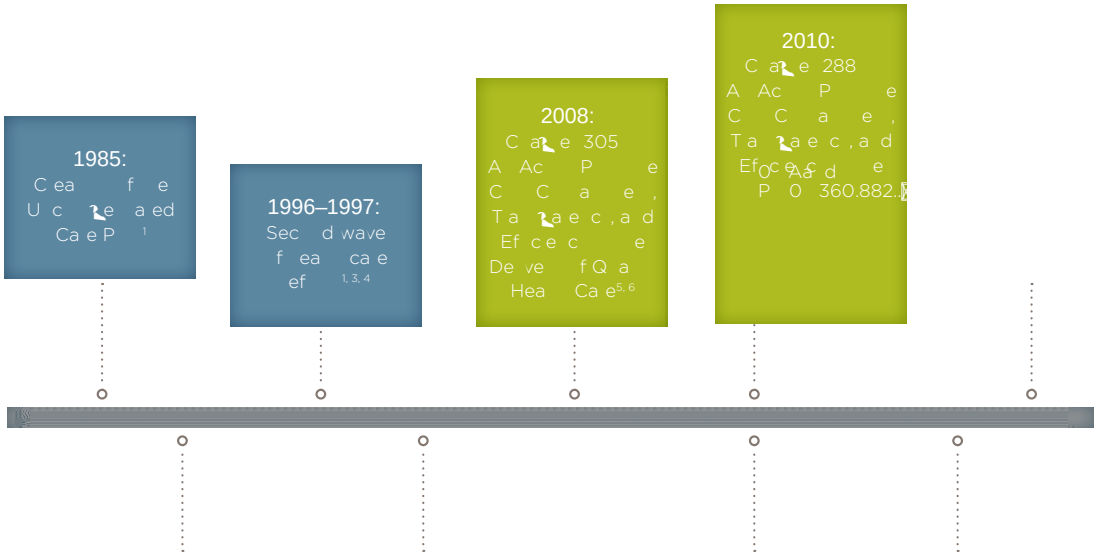
[3] Long SK. What is the evidence on health reform in Massachusetts and how might the lessons from Massachusetts apply to national health reform? [Internet]. 2010. Retrieved from http://www.urban.

Appendix A: Comparison of Major Provisions in Massachusetts's Chapter 58 and the ACA

		Chapter 58
Insurance Market Reforms	S e c a ce a e ef e e aa eed e, c a , a d c ve a e a da d .	S e c a ce a e ef a e ed aff dab a da d . I d v d a a d a e we e e ed a e . De e de c ve a e wa e a ded a e 25 w ea af e f de e de a .
State-based Exchange	Hea a ce a e ace e ab e d v d a a d a b e e c a e a d c a e va e a ce a ee ce a c ve a e a d c a da d .	T e C ec e ab ed
Subsidies for Private Coverage	S b d e a e v ded w- c e d v d a c a e va e a ce.	

		Chapter 58
SHOP (Small Business Health Options Program) Exchange Eligibility & Subsidies	Ce a b e e a e e ed ffe ea a ce e e ee face a c a e a e .	B e e w 50 fewe e ee a ffe ea be e e ee a d a Sec 125 a (ea
Expansion of Public Coverage	Med ca d c ve a e wa e a ded.	
Individual Coverage Requirement	I d v d a be e ed a a ce a a ee e e face a a c a e a . T e e e e a e a ed a a ca b b c a ce c ve a e.	

Appendix B: Milestones of Health Care Reform in Massachuset



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