



Health Resources in Action

Advancing Public Health and Medical Research

Health Resources in Action (HRiA) is a national non-profit public health and medical research organization, located in Boston, whose mission is to help people live healthier lives and build healthy communities through policy, research, prevention and health promotion.



UNIVERSAL HEALTH INSURANCE ACCESS EFFORTS
IN MASSACHUSETTS: A CASE STUDY

Lessons Learned for Public Health Systems across the U.S.

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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 significantly 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 through a variety of other provisions, the federal ACA contains more comprehensive provisions to address preventive services, health care cost and quality, and other areas. MA has since passed additional rounds of legislation addressing these and other issues; however, the lessons presented herein focus primarily on the impact of Chapter 58. For a detailed comparison of Chapter 58 versus the ACA, and for a timeline of MA's health care reform efforts to date, see Appendices A and B, respectively.

Generalizability

Many of the lessons learned in MA can be applied to states across the nation, despite MA's unique public health enterprise. In contrast to the county/regional infrastructure and state provision of clinical public health services in most other states, MA's governmental public health system is highly decentralized, with funding and the provision of local public health services delegated to individual town and city governments. As a result, with the exception of the largest cities, many public health services across the state are contracted to area non-profit organizations and community health centers.

Given these distinctions, this case study explores the effects of Chapter 58 on non-governmental safety net providers in addition to the public health system.

Methodology

Research was conducted in two phases: a comprehensive review compiled findings from peer-reviewed and grey literature regarding the effects of Chapter 58 on public health practice and population health outcomes, and 27 qualitative interviews of 29 high-level key informants provided first-hand insight into the process and impacts of Chapter 58's passage and implementation, all of which were reported anonymously unless specific permission was granted. This background research has been documented in more detailed reports. The following represents a distillation of the research findings and lessons learned.



Findings and Lessons Learned

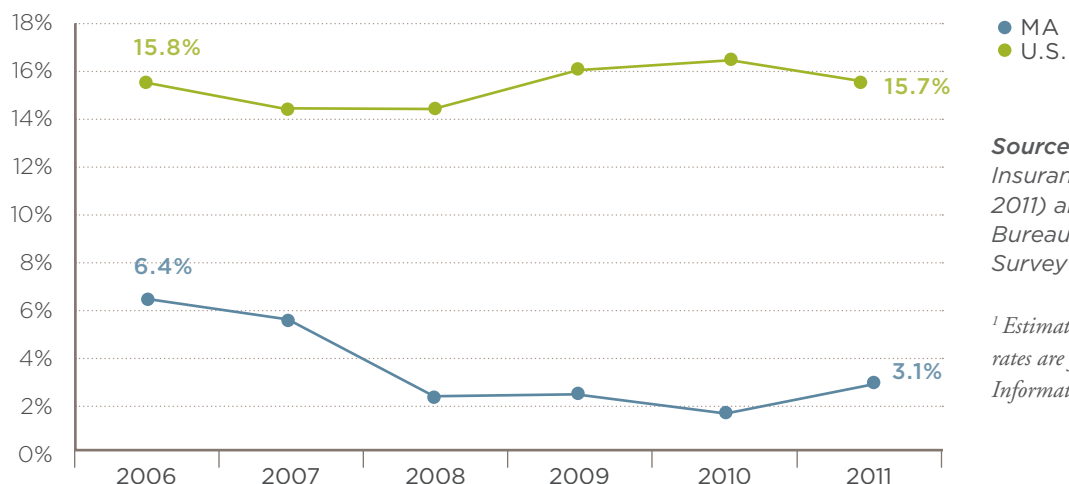
With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, there is much speculation about how national health care reform efforts may impact public health and its organization, delivery, and outcomes at the state and local levels.

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 (Figure 1). These strategies included:

- Conducting public education campaigns to increase consumer awareness of new benefits 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 benefit enrollment processes with an integrated eligibility system, single application form, and automatic enrollment of those identified 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



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

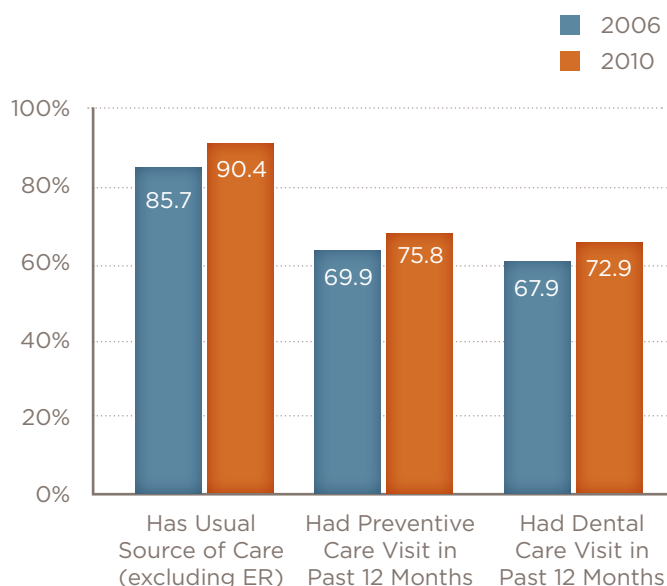
¹ Estimates for the Massachusetts rates are from the Center for Health Information and Analysis (CHIA).



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 (Figure 2). These indicators suggest that expansion in insurance coverage led to a significant increase in access to health care services among non-elderly adults.

FIGURE 2. TRENDS IN USUAL SOURCES OF CARE AND DOCTOR VISITS FOR NON-ELDERLY ADULTS IN MA, 2006 & 2010



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

III. EXPANSION OF HEALTH CARE COVERAGE IS REDUCING DISPARITIES

While gains in insurance coverage occurred in all populations in MA, the most dramatic increases were realized for people of color, a population with lower insurance rates pre-Chapter 58. As a result, post-Chapter 58 reports by white and minority adults of having a usual source of care equalized (91% vs. 90%). However, racial disparities in disease prevalence and mortality persist.

“People definitely need access to health care, but that by itself will not eliminate the disproportionate burden of illness and premature death...The most important barriers have to do with income and discrimination and racism and access to quality education and jobs with opportunity.”

– JOHN AUERBACH FROM MASSACHUSETTS REFORM HAS LESSENED SOME DISPARITIES, BUT GAPS REMAIN⁷



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

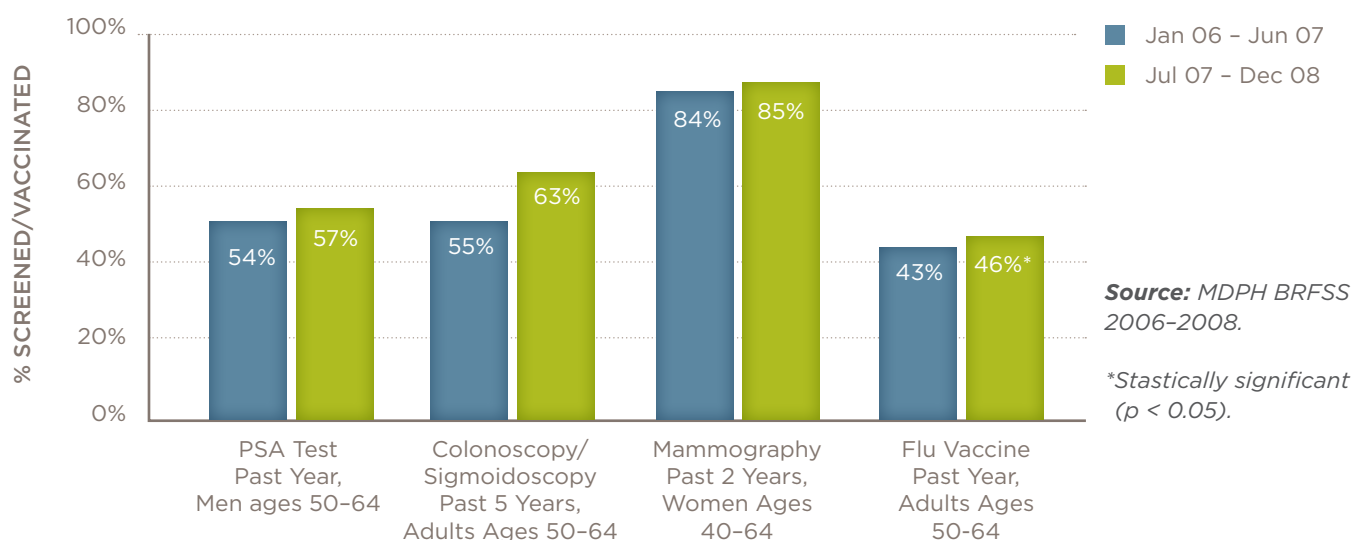
Since Chapter 58 passed in 2006, some health indicators have shown improvements. The following include highlights of trends for selected preventive care, chronic and infectious disease, and hospitalization indicators. Additional indicator trends can be found in the full literature review.

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.

Preventive screening

There were modest increases in some preventive screenings after insurance access expanded; yet there is still room for further growth (Figure 3). Colon cancer screening and flu vaccination rates notably increased post-Chapter 58. Insurance coverage alone does not appear to be sufficient to significantly 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



Diabetes

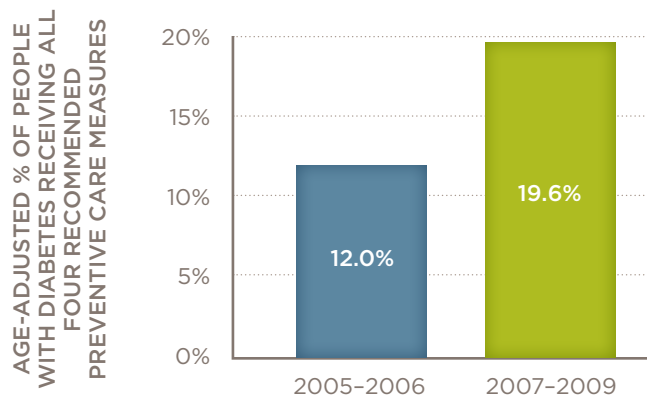
In the three-year period following the implementation of Chapter 58, the proportion of individuals with diabetes receiving recommended preventive care* increased significantly from 12% to 19.6% (Figure 4).

**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)*

Asthma

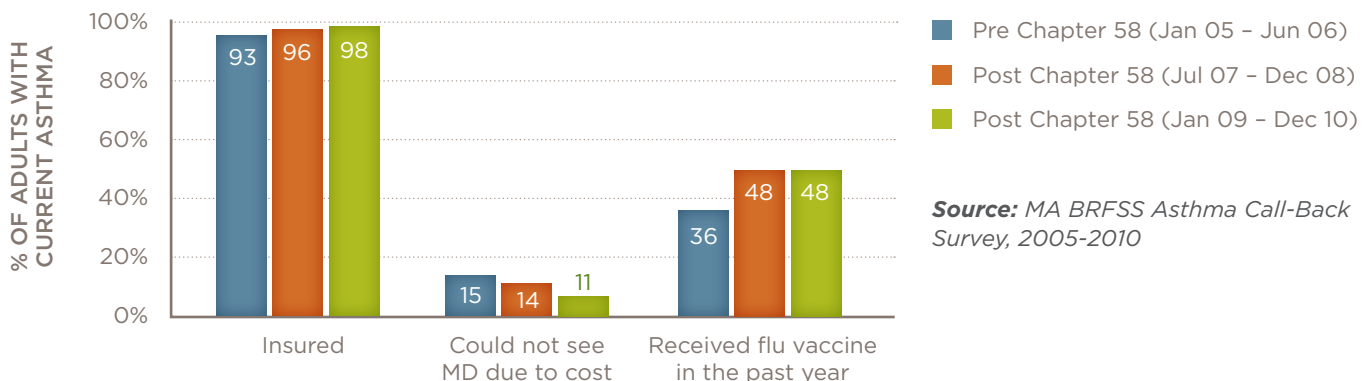
After the implementation of MA's Chapter 58, fewer residents challenged by asthma reported cost as a barrier to seeing a physician. Concurrently, there was a statistically significant increase in delivery of recommended annual flu shots to asthma patients, 48% after Chapter 58 vs. 36% before (Figure 5).

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



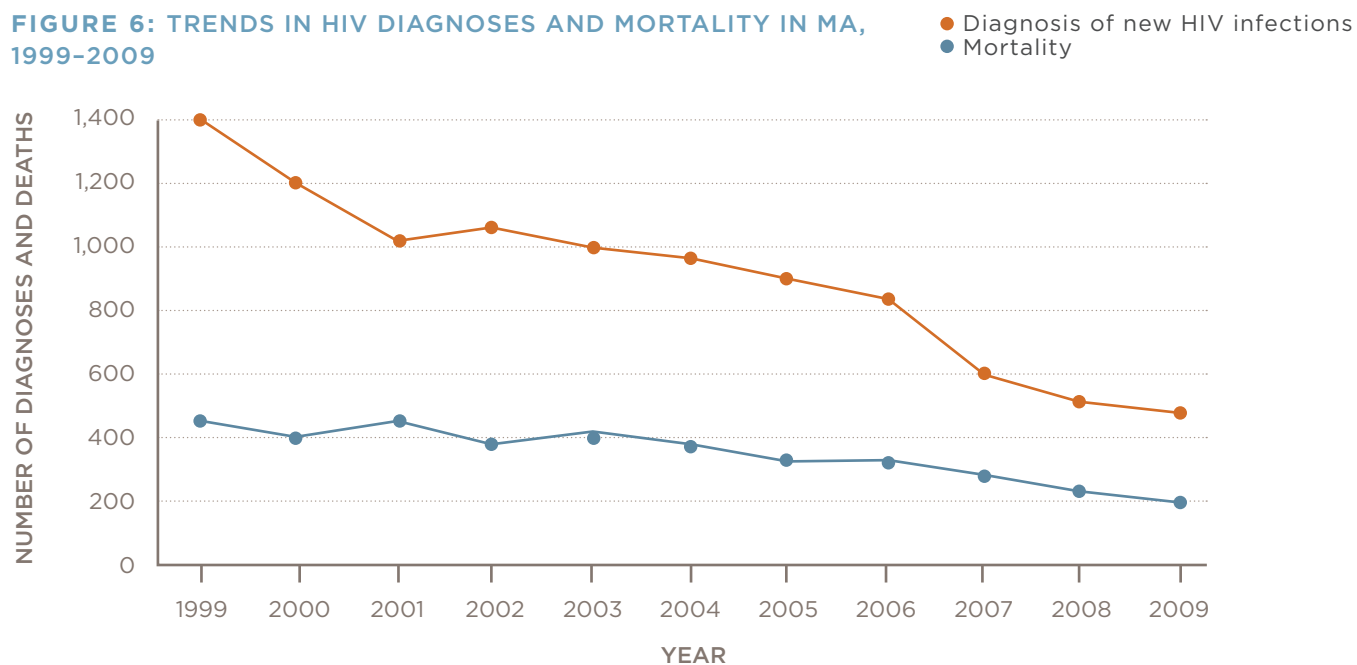
Source: MA BRFSS, 2005-2009

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



Source: MA BRFSS Asthma Call-Back Survey, 2005-2010



FIGURE 6: TRENDS IN HIV DIAGNOSES AND MORTALITY IN MA, 1999-2009

Note: Number of diagnoses reflects 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

HIV

New HIV diagnosis rates in MA, already trending downward, displayed a further sharp drop of 25% over the three years following Chapter 58 (Figure 6), 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.^{8,9}



Preventable hospitalizations

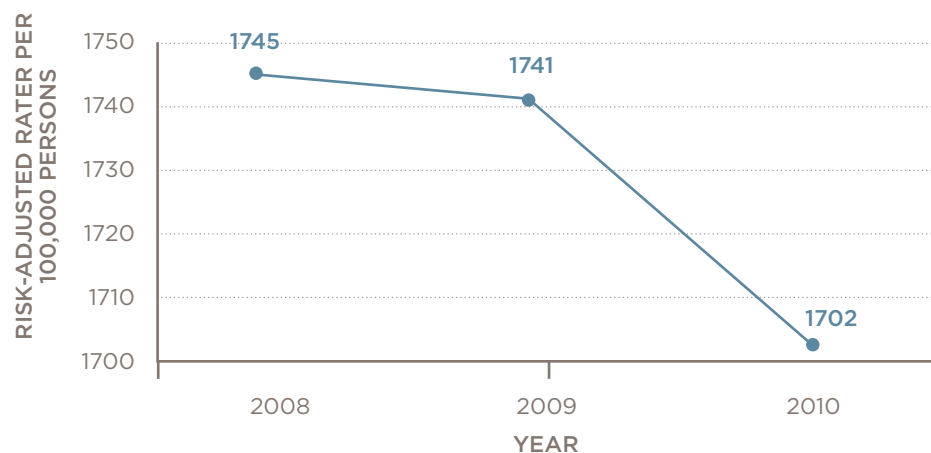
Preliminary data show that post-Chapter 58, preventable hospitalizations have shown an overall decline, but not for all causes (Figure 7).

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% (Figure 8). 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.

Long-term outcomes

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.

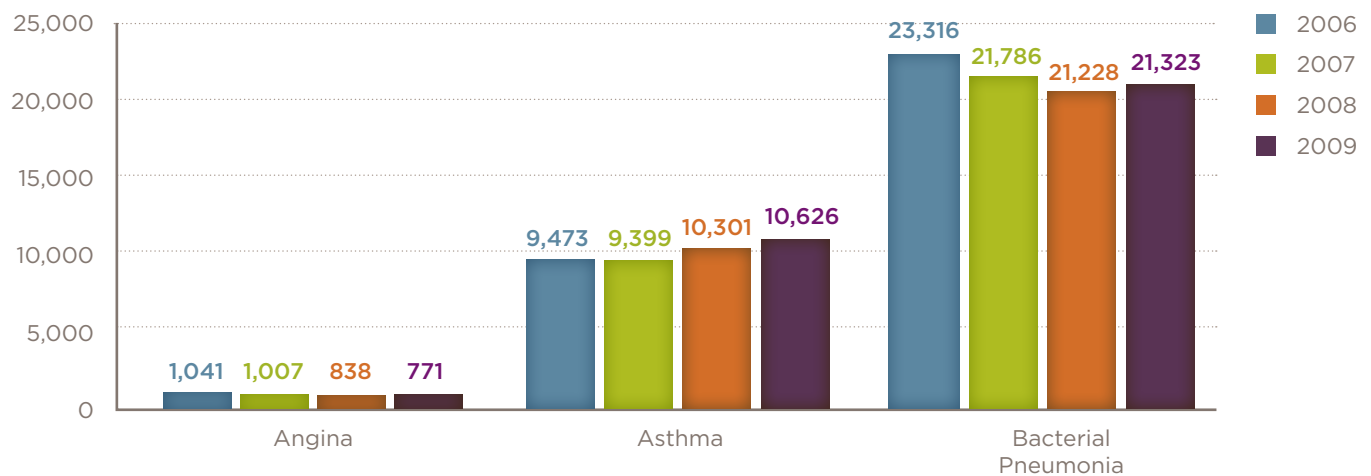
FIGURE 7: PREVENTABLE HOSPITALIZATIONS, MASSACHUSETTS 2008-2010



Notes: Risk-adjusted rate per 100,000 persons. Years shown are fiscal 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 <http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2012/preventable-hospitalizations-appendix-a.xls> November 2013



FIGURE 8. SELECTED PREVENTABLE HOSPITAL ADMISSIONS IN MA, 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>

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 significant percentage (3%) of the population remained uninsured and a notable proportion (unquantified but recounted qualitatively) continued to experience challenges to accessing care. Some of these reasons are explicated below and have implications for public health.

Cultural and systems challenges

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 benefits. Many residents who gained insurance benefits faced economic challenges to 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 encountered challenges with the reenrollment process.

Cuts to funding and program support

In the midst of Chapter 58 implementation, an economic recession hit, resulting in overall cuts to the state budget and the line item for the MA Department of Public Health.



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.

Administrative systems

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.

Confidentiality issues

The need to seek insurance reimbursement creates a barrier for those seeking confidential treatment for sensitive issues (e.g., STDs, HIV, family planning, and mental and behavioral health) due to the automatic generation of explanation of benefits (EOB) documentation to policy holders. Previously, under certain conditions, subcontractors used state funding to provide these services confidentially 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

Demand increased

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 (see Table 1).¹² Of note, Table 1 illustrates that even with changes in payer mix, private insurance was not crowded out of the Federally Qualified 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 (see Table 2).

“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

Patients	Calendar Year				
	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

Abbreviation: CHIP (Children’s Health Insurance Program)

Notes: Percentages may not total 100 because of rounding.
Commonwealth Care = health insurance exchange equivalent.

Source: Ku et al., 2011

TABLE 2: REASONS CARE SOUGHT FROM SAFETY NET FACILITY IN MA

Reason ^a	Safety net-Covered Adults, % ^b
Convenient	79.3
Affordable	73.8
Availability of services other than medical care	52.0
Problem getting an appointment at a non-safety net facility	25.2
Staff able to speak patient’s primary language	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



Financial challenges emerged

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

- Been chronically underfunded due to insufficient reimbursement from MA's Health Safety Net (HSN) Fund that compensates safety net providers for services they provide to the uninsured and underinsured;
- Received rates from Medicaid and state sponsored plans that inadequately reimburse for care and do not adequately address health care inflation;
- Absorbed increased administrative burdens for provision of outreach and enrollment services; and
- Needed to offer higher salaries to attract and retain clinicians to address growth.

On the whole, due to increases in CHC's insurance-related revenue largely due to growth in patient volume and visits, health care cost inflation, and planned Medicaid rate increases, CHCs experienced relatively parallel increases in revenue and cost under Chapter 58. At the same time, to meet rising demand, CHCs managed to expand services, make capital improvements, and increase their supply of clinical staff. However, safety net hospitals faced more severe financial struggles where costs outpaced revenue due to inadequate Medicaid hospital reimbursement rates.

Rising costs, decreased funding, and limited reimbursement, along with the marked increase in patient volume and utilization, have put an increased strain on some safety net providers. Policy makers should consider the MA experience and the need for adequate resources to maintain clinical safety net services.

VII. EFFORTS TO RECRUIT PHYSICIANS AND EXPAND THE USE OF COMMUNITY HEALTH WORKERS ARE SUCCEEDING

Although long waits for appointments and difficulty finding primary care providers accepting new patients have been reported by both insured and uninsured individuals,¹³⁻¹⁵ the shortage in primary care clinicians pre-dated the implementation of Chapter 58 in MA and is ubiquitous across the country. To address this, MA launched both physician recruitment and loan repayment programs that have succeeded in boosting the CHC primary care workforce. In addition, use of community health workers (CHWs) has expanded to serve outreach, navigation, and coordination roles.

Clinician workforce shortages must be monitored, with measures put in place to prevent them and address them if they arise. A geographically specific plan for increasing access to primary care providers needs to be carefully developed. Community health workers should be trained and deployed to supplement the health care workforce.

VIII. IMPORTANT PUBLIC HEALTH PRIORITIES WERE REALIZED UNDER CHAPTER 58

During the process leading up to the passage of Chapter 58, public health advocates were active supporters of health care reform and understood the value of expanding insurance access in promoting health, preventing disease, and reducing health disparities. However, public health was not a focus of the health care reform conversation as the legislation focused upon expansion of health insurance access. While a coordinated public health voice was not strong during the formation of Chapter 58, the involvement of public health leaders yielded some important public health victories.

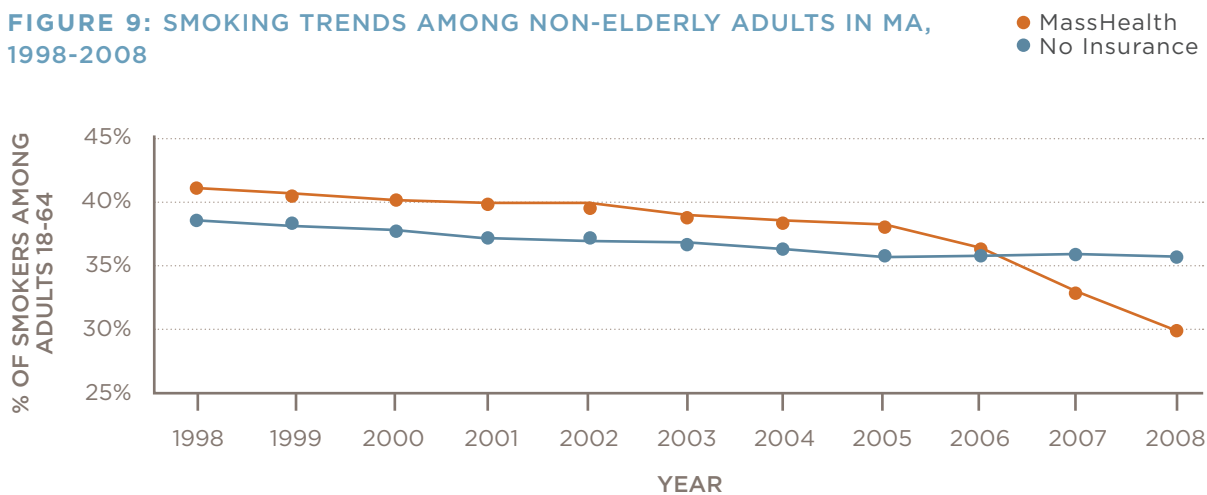


Smoking cessation Medicaid benefit

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 benefit contributed to a striking 26% drop in smoking prevalence among this group (Figure 9 and Table 3).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: SMOKING TRENDS AMONG NON-ELDERLY ADULTS IN MA, 1998-2008



Source: Land, et al. 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% [vs. 16% of total MA population]	28%
Successful Quit Attempts	6.6%	18.9%

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



Community health worker certification

Patient navigation by non-traditional providers has benefits beyond enrolling in insurance plans; these trusted advisors equip the newly insured to maximize the benefits 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 to the development of a certification process. This process set the stage for policy change by legitimizing and recognizing patient navigation as an immediate role that CHWs can fulfill in promoting health and that a larger role in the health care system can also be achieved.

“There was concern at the state level that there were going to be high-risk eligible clients — who because they were disconnected from health care delivery previously — [would] not even know they were eligible for health insurance. One successful way to reach them was by tapping the experience and skill of the community health workers and other grant-funded employees with client contact. CHWs often interacted with those community members who were disconnected from health care. They knew who they were and how to reach them.”

– STATE PUBLIC HEALTH LEADER

“It was clear that [the] expansion of coverage for low-income folks alone [would] not be enough to provide care; community health workers were going to be an essential ingredient in promoting equity.”

– STATE PUBLIC HEALTH LEADER

IX. CONTEXTUALIZING HEALTH CARE REFORM THROUGH A POPULATION HEALTH LENS

Since the passage of Chapter 58, there has been increased attention to population and community health status. Particularly with the 2012 passage of Chapter 224, there has been encouragement for managed care and accountable care organizations to consider the evidence that investing in prevention and health promotion initiatives have the potential to reduce health care costs and improve the quality of life for enrolled patients.

“We need to keep our eyes on the prize. For me, that’s improving the health of our communities. Medical care is an important piece, but not the answer.”

– STATE PUBLIC HEALTH LEADER



Coordinating the approach for longitudinal assessment of population health outcomes

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 efficacy 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 coverage, it will be important to not only measure health insurance access and care utilization, but also health behaviors, health outcomes, and accurate racial, ethnic, and economic data to address disparities. Obtaining and monitoring real-time data would enable meaningful and efficient strategy adjustments, as needed. Opportunities for collaboration and data sharing across state and local departments should be identified, and memoranda of understanding forged, in order to ensure that comprehensive data for evaluation of programs and policies show the impact of health care reform in national, state, and local contexts.

X. PUBLIC HEALTH HAS AN IMPORTANT ROLE IN SHAPING HEALTH CARE REFORM IMPLEMENTATION

Lessons learned in MA demonstrate the importance of ensuring that the voice of public health is included throughout the planning, implementation, and monitoring of state health care reform. Those involved indicated that this was not easy to do, but is critical if policy leaders are to understand that population health will not be achieved by insurance access alone. Building cross-sector partnerships early in the health care reform process and maintaining a formalized role that may include an ongoing advisory body are recommended. The ability to speak the insurance language and demonstrate the return on investment for prevention is essential to promoting public health approaches.

Getting a seat at the table and communicating the public health message

Public health leaders did not develop a coordinated approach with a defined visible role during the implementation of Chapter 58. Yet public health needs are essential to inject into health care reform processes.

“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 AUERBACH¹⁷



“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 that’s how I’d want [public health] to push the conversation. [Public health] has to be a part of the overall picture.”

– LOCAL PUBLIC HEALTH LEADER

Collaboration across public health silos is crucial to build and present a coordinated public health message to represent community and population health interests at the health care reform table. The message should focus on the public health mission and the importance of incorporating prevention and health promotion goals in the reform process, success stories from health care reform implementation, as well as on public health’s economic value in terms of return on investment to the health care system. The public health message is best delivered with a clear, coordinated vision, well-crafted proposals, and a strong, unified voice.

“Business and political negotiation ability ... is how public health can participate in these conversations in a way that’s analogous to what the hospital and insurer players are able to do. It’s the dominant language.”

– PUBLIC HEALTH ADVOCACY LEADER

Adapting public health’s structure and function to accommodate shifting roles

As clinically-oriented services shift to more traditional (public and private) primary care realms under health care reform, new emerging and expanding roles for the public health sector include opportunities to:

- **Be the chief health strategist** by convening and maintaining multi-sector coalitions engaging non-traditional partners to assume “greater accountability for the design and development of the overall strategic plan for improving health in communities”;¹⁸
- **Empower consumers** of enrollment benefits through education, outreach, care coordination, and navigation;
- **Educate and train clinicians** around medical issues with a population health impact;
- **Educate the public health workforce** so they understand how their programs can support health care reform goals and form closer alliances with the health care sector;



- **Rethink and reprioritize traditional public health functions**, such as immunizations, substance abuse services, and STD and TB clinics. Identify which functions can be shifted to clinical settings, and **communicate the need to maintain funding and support** for those services that should remain in the public health sphere;
- Identify and implement opportunities to **bridge the provision of clinical preventive services with public health efforts** to leverage opportunities to promote population health;
- **Provide resources, training, and the infrastructure** to public health departments and safety net providers needed to prepare for increases in patient volume and bill insurers for reimbursable services;
- **Identify, implement, and monitor** effective strategies to maximize quality of care, reduce cost, and improve health outcomes; and
- **Monitor and evaluate** the process and outcomes of health care reform efforts.

Establishment of a Prevention and Wellness Trust Fund

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 added (ROI) that public health efforts bring to a comprehensive reform effort, going beyond access and addressing population health to enhance effectiveness of health care reform efforts around the nation.

To accomplish these objectives: a robust safety net should be preserved; culturally appropriate enrollment strategies should be provided; the public health system should prepare its staff and systems to adjust to changes; data should inform achievement of the triple aim, especially improved population health; addressing disparities should be a centerpiece of health care reform efforts; and resources should be provided for community prevention efforts.

Lessons learned from the MA experience implementing the health care reforms mandated by Chapter 58 serve as instructive messages as states across the nation implement the ACA. As the nation embarks on health care reform, states can embrace the findings and recommendations of this research to inform their strategies and efforts, avoid pitfalls, and increase the likelihood of successfully expanding access and improving individual and community health.



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

	Similarities between CHAPTER 58 & ACA	Differences between CHAPTER 58 & ACA	
		Chapter 58	Affordable Care Act
Insurance Market Reforms	Systemic insurance market reforms require guaranteed issue, community rating, and coverage standards.	Systemic insurance market reforms also required affordability standards. Individual and small group markets were merged into a single risk pool. Dependent coverage was expanded to age 25 or two years after loss of dependent status.	Systemic insurance market reforms also required the elimination of lifetime limits. Preventive services were expanded in 2010. Dependent coverage was extended to age 26.
State-based Exchange	Health insurance marketplaces enable individuals and small businesses to compare and purchase private insurance that meets certain coverage and cost standards.	The Connector established a quasi-governmental health insurance marketplace which has been characterized as an “active purchaser” system. ¹	States have chosen type (clearinghouse or active purchaser), structure (operated by state, quasi-governmental, or non-profit), and level of federal involvement (state-based, state-federal partnership, or federally-facilitated) of their exchanges. They may change their decision later. ²
Subsidies for Private Coverage	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. ³	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.



	Similarities between CHAPTER 58 & ACA	Differences between CHAPTER 58 & ACA	
		Chapter 58	Affordable Care Act
SHOP (Small Business Health Options Program) Exchange Eligibility & Subsidies	Certain businesses are required to offer health insurance to their employees or face financial penalties.	<p>Businesses with 50 or fewer employees may offer health benefits 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.⁴</p> <p>Chapter 58 does not provide subsidies to small businesses.</p>	<p>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.</p> <p>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.</p>
Expansion of Public Coverage	Medicaid coverage was 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.	<p>Medicaid was broadly expanded to all individuals under age 65 with incomes up to 133% FPL (plus a 5% automatic income disregard) based on modified adjusted gross income.</p> <p>In 2012, the US Supreme Court decided that states have the option of whether or not to accept the expansion.</p>
Individual Coverage Requirement	Individuals must be enrolled in an insurance plan that meets minimum requirements or face a financial penalty. The minimum requirements are satisfied automatically by public insurance coverage.	<p>Minimum coverage requirements are known as minimum creditable coverage (MCC).</p> <p>The financial penalty is up to 50% of the lowest cost premium an individual would have qualified for through the Connector.</p> <p>In addition to public insurance coverage, MCC is also automatically satisfied by student health coverage and young adult plans held by eligible residents.</p>	<p>Enrollment in a qualifying health plan is required to avoid the individual responsibility payment.</p> <p>The financial penalty is the greater of the following two amounts: a flat dollar amount that increases at a fixed rate or a percentage of one's household income of 1%, 2%, and 2.5% in 2014, 2015, and 2016, respectively.</p> <p>Fully insured products sold to small employers and non-group insurance products sold to residents must include the EHB and expanded preventive services, with the exception of grandfathered plans.</p>



	Similarities between CHAPTER 58 & ACA	Differences between CHAPTER 58 & ACA	
		Chapter 58	Affordable Care Act
Employer Requirements	Certain employers must offer insurance coverage to their employees or face a financial penalty.	Employers with 11 or more employees are required to provide insurance or pay a “Fair Share” contribution of up to \$295 annually per employee. Employers are required to offer a “cafeteria plan” that permits workers to purchase health care with pre-tax dollars or face a “free-rider surcharge” if employees make excessive use of uncompensated care.	Employers with 50 or more full-time employees that do not offer coverage are required to pay a fee of \$2,000 per employee, excluding the first 30 employees if one of the employees gets a tax credit or cost sharing subsidy on the health insurance marketplace. Employers with over 200 employees must automatically enroll employees into plans offered by the employer. Employees may opt out of coverage.
Exemptions to Coverage Requirement	Some populations are exempted from the individual mandate, including those with religious objections and those certified as having economic hardships.	Other populations exempted: those who are without coverage for less than 90 days during the year.	Other populations exempted: those with incomes below the income-tax-filing threshold, undocumented immigrants, Native Americans, and those who are without coverage for less than three consecutive months during the year (the exemption applies only to the first gap in coverage).

Adapted from Kaiser Family Foundation’s “Massachusetts health care reform: Six years later” (2012), Patel, et al.’s “From MA to 1600 Pennsylvania Avenue: Aboard the Health Reform Express” (2010), Blavin, et al.’s “Massachusetts under the Affordable Care Act: Employer-related issues and policy options” (2012), and Blumberg, et al.’s “Reconciling the Massachusetts and federal individual mandates for health insurance: A comparison of policy options (2012).

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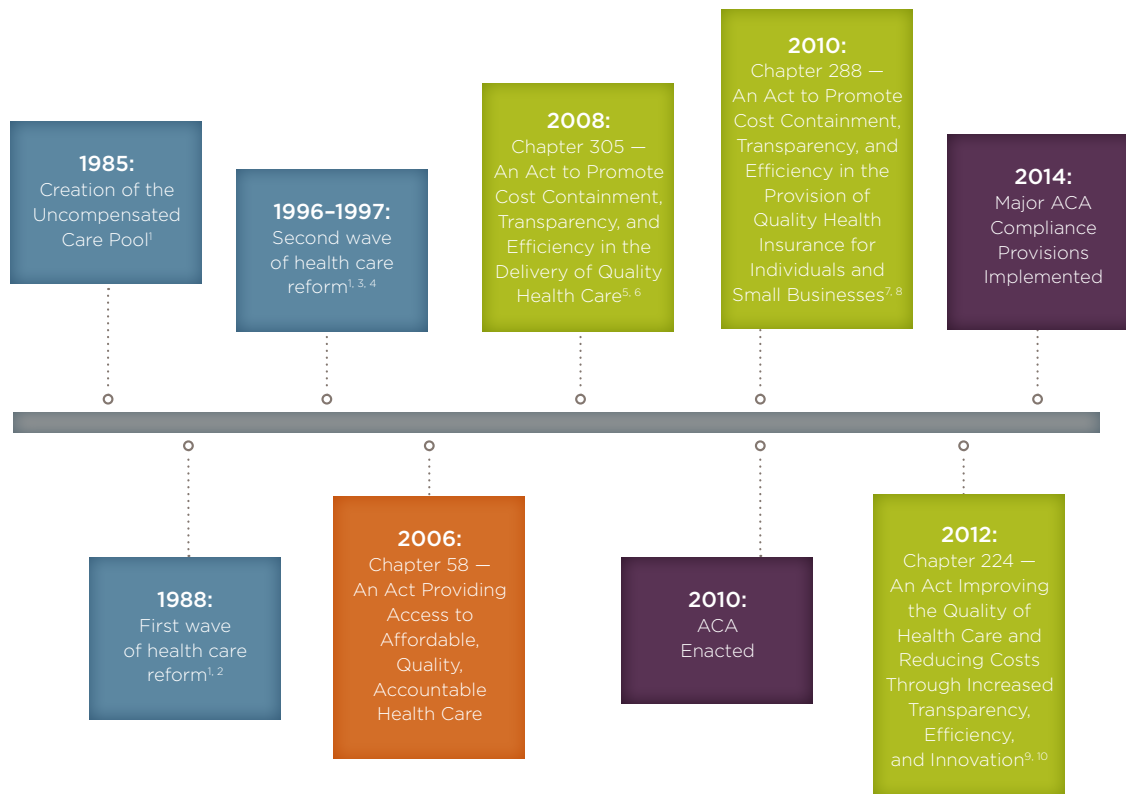
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Appendix B: Milestones of Health Care Reform in Massachusetts



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 Medical Security Plan. Passage of the Non-Group Health Insurance Reform Act.

⁵ <https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter305>

⁶ This legislation aimed to improve quality and contain costs through requiring electronic health records; streamlining insurer and provider billing and coding; recruitment and retention of primary care providers; instituting marketing restrictions on pharmaceutical companies; and commissioning various studies on cost containment and quality improvement measures.

⁷ <https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288>

⁸ This legislation aimed to improve quality and contain costs through creation of a group wellness pilot program; analyzing mandated insurance benefits; requiring health care providers to track and report quality information; requiring health insurance carriers to calculate and

report detailed financial information, including medical loss ratios; requiring hospitals to report all costs; establishing a single all-payer database; encouraging providers and payers to adopt a bundled payment system; reviewing small group insurance rating factors; requiring health plans to offer selective or tiered network plans; simplifying payer claims processing; establishing small business group purchasing cooperatives; promoting provider payment transparency; preventing certain carrier-provider contracting practices; and establishing a special commission on provider price reform.

⁹ <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

¹⁰ This legislation aimed to improve quality and contain costs through establishing a health care cost growth benchmark tied to the growth rate of the gross state product; requiring providers to report financial data; implementing consumer price transparency measures; requiring state approval for certain health care infrastructure changes (hospital mergers, construction of new health care facilities); changing Medicaid reimbursement rates; creating a new process for certifying Accountable Care Organizations; reforming medical malpractice; developing certification standards for patient-centered medical homes; and creating new funds for prevention.



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