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Health and Access Improved after the 2006 Massachusetts Reforms that Paved the Way for Federal Health Reform

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In 2006, the Massachusetts legislature passed and Governor Mitt Romney signed into law a health care reform with subsidized health insurance coverage for low-income people, a health insurance exchange to help people not otherwise covered choose among available plans, an individual mandate requiring residents to obtain coverage if affordable, and an expansion of Medicaid to include children and long-term unemployed adults. The reform in Massachusetts turned out to be a blueprint for the Affordable Care reforms passed by Congress and signed by President Barack Obama in 2010. ObamaCare, as the federal reform law is sometimes called, is only now going into full effect, as debate continues to swirl about its provisions and its likely effects. No one can tell what the national reform's impact on Americans' health will turn out to be, but we can get an idea of possible benefits by looking at what is known so far about the aftermath of the earlier Massachusetts reforms.

Assessing the Impact of Health Reform in Massachusetts

Approximately 400,000 Massachusetts residents have obtained coverage since the 2006 reform – and 98% of state residents are now insured, the highest percentage of any state in the nation. Policymakers and health care providers are now focused on controlling rising health care costs, and it is in many ways too soon to tell, precisely, what the full impact of the reform on people's health will eventually be. Nevertheless, my colleagues and I have devised an approach to evaluate the impact of the Massachusetts health reforms on people's health status and use of health services in doctors' offices, clinics, and other walk-in health facilities. We look before and after the 2006 reforms and also compare Massachusetts developments to trends in the other New England states. How exactly did my colleagues and I do our research?

- Our data came from surveys done from 2001 through 2011 by the Behavioral Risk Factor Surveillance System. In this system, state health departments collaborate with the U.S. Centers for Disease Control and Prevention to track health conditions and behaviors, access to care, and the use of health care services for adults residing in households in each state.

- To analyze the data, we used what is called a quasi-experimental design. In circumstances where researchers cannot conduct lab-style experiments – in which some people are subjected to a reform or treatment, but not others – this advanced statistical approach does better than simply recording numbers before and after a policy change. For groups of Massachusetts and other New England people, we estimated predicted probabilities of particular health conditions, and examined changes in these probabilities before and after reform. We tracked and compared the overall populations in the various New England states, and also assessed changes for different income groups and for various racial and ethnic subsets of people.

Massachusetts Residents Reported Greater Improvements

In comparing health and the use of health services by Massachusetts people before and after 2006 – and comparing trends to those in the neighboring states – we found encouraging indicators that the Massachusetts health reform law made a positive difference.

- By small but significant margins, Massachusetts residents reported greater improvements after the 2006 reform in general health, physical health, and mental health.

- Access to health care also improved for Massachusetts residents compared to their neighbors – as indicated by statistically significant improvements for health insurance coverage, having a personal doctor, and not worrying about cost barriers to getting health care.

- Massachusetts residents reported comparatively significant increases in the use of important tests – such as Pap screening, colonoscopies, and cholesterol testing.

Reform Reduced Inequalities, but More Remains to be Done

Even before 2006, Massachusetts had a very high percentage of insured residents. But those still not covered were disproportionately low-income people, members of racial or ethnic minorities, or both. Our analysis suggests that gaps narrowed after reform, although disparities still exist.

- Analysis by income level shows that (compared with trends in the other states) the likelihood of having health insurance in Massachusetts increased from before to after reform by 6.1% for households earning less than 300% of the national poverty line, compared to 2.6% for those with incomes above that line.

- Massachusetts residents with lower incomes reported greater improvements in general wellbeing and physical and mental health. For use of tests, results were mixed.

- Analyses by race and ethnicity showed that in Massachusetts compared to the other New England states, Hispanic residents had the largest increase in probability of insurance coverage, with smaller gains for African Americans and whites. Slight improvements were noted for all groups on the health indicators. Hispanic residents of Massachusetts showed an increase in use of tests, compared to smaller increases for African Americans and whites.

In sum, our study shows that health reform in Massachusetts has been associated with increased access to care, improved health status, and greater use of vital preventive tests. As reformers intended, low- and moderate-income people have gained the most, even as all ethnic and racial groups made gains. Gaps certainly remain to be closed. And additional studies are needed to confirm our findings and see whether improvements are sustained. Still, our results suggest that very real improvements in health and access to important kinds of care may also be achieved following the nationwide implementation of the Affordable Care reforms modeled on the pioneering measures previously enacted in Massachusetts.

Read more in Philip J. Van der Wees, Alan M. Zaslavsky, and John Z. Ayanian, "Improvements in Health Status after Massachusetts Health Care Reform." *The Milbank Quarterly* 91, no. 4 (2013): 663-689.