

COVERAGE AND ACCESS REMAIN STRONG, BUT COSTS ARE STILL A CONCERN: SUMMARY OF THE 2012 MASSACHUSETTS HEALTH REFORM SURVEY

MARCH 2014

The Massachusetts health care reform law of 2006 set in motion a number of important changes to the health care system, and there is great interest, in the state and across the country, in how these changes have affected Massachusetts residents, businesses, health care providers, and others. Since 2006, the Massachusetts Health Reform Survey (MHRS) has been an important means of monitoring and understanding the impact of the state's coverage reforms on Massachusetts residents. This report summarizes the most recent MHRS, conducted in the fall of 2012 just after passage of Chapter 224, the state's most comprehensive cost-containment law. This round of the survey provides both a means for continuing to monitor the efforts in Massachusetts to sustain the coverage and access gains achieved through the 2006 health reform law and an important new baseline against which to assess the impact of the state's aggressive efforts to improve the affordability of care and reduce health care spending.

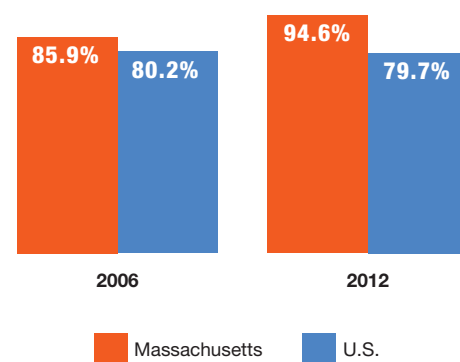
The 2012 MHRS brings both good news and signs that warrant concern. As with previous versions of the MHRS, the results of the 2012 survey provide promising evidence that the insurance provisions of the Affordable Care Act, which were modeled after the 2006 Massachusetts law, will improve coverage and access across the nation. However, the 2012 survey also shows that health care costs continue to be a burden for many individuals and families in Massachusetts. The persistence of such problems, several years into an era of near-universal coverage, amplifies the importance of the state's current policy focus on affordability and cost containment.

To view all publications on the 2012 MHRS, go to: <http://bluecrossmafoundation.org/publication/2012-massachusetts-health-reform-survey>

COVERAGE

Massachusetts continues to have the highest rate of insurance coverage for non-elderly adults of any state, 94.6 percent. This is a significant improvement over 2006, when 85.9 percent of non-elderly adults had insurance,¹ and much higher than the current national level of 79.7 percent.² In addition, gaps in coverage have lessened: 88 percent of adults in Massachusetts reported being covered for the entire year, much higher than the national level of less than 75 percent. This means that one in four adults in the nation experienced a gap in coverage during the previous 12 months, more than twice the frequency in Massachusetts.³ The proportion of people in Massachusetts who are "persistently uninsured"⁴ has been cut by nearly three-quarters, falling from 9.3 percent in 2006 to 2.7 percent in 2012.

PERCENTAGE OF NON-ELDERLY ADULTS WITH HEALTH INSURANCE



The primary source of coverage for non-elderly adults in Massachusetts in 2012 was employers, with 63.6 percent having employer-sponsored insurance, an increase of

three percentage points since reform. Comparable national data show a significant overall decline in the proportion of the population insured through employers over the same period. In 2006, 64.9 percent of the non-elderly adult population had employer-sponsored coverage nationally, declining more than five percentage points to 59.6 percent in 2012.⁵

In 2012, a sizable portion of the Massachusetts population — 31.1 percent — obtained coverage through public programs (i.e., MassHealth and Commonwealth Care). This proportion has increased slightly in recent years (although the increase was not statistically significant), most likely as a result of the downturn in the economy that led to increased unemployment.

These findings from Massachusetts have implications for the national rollout of the ACA, demonstrating that an individual mandate, combined with expansions of Medicaid and subsidized coverage, can be effective in boosting overall coverage. In addition, they suggest that employer-sponsored coverage need not decline, even as some employers face new responsibilities to provide health insurance to their workers or else pay assessments.

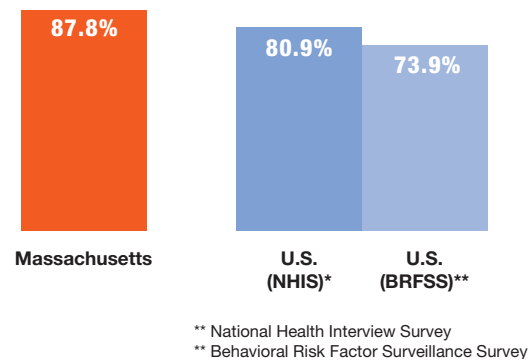
QUALITY AND ACCESS

The survey indicates that respondents are generally satisfied with their health care coverage. About two-thirds rated their health insurance coverage as very good or excellent on the range of services, choice of providers, and quality of care. Among those who used care in the past 12 months, nearly three-quarters rated the quality of care very good or excellent, up more than 10 percentage points from pre-reform.

Access to care, overall, also is very good. Nearly nine in 10 respondents reported having a place, other than the emergency room, that they usually go to when they are sick or need advice about their health. This is higher than national estimates for this measure, which ranged from 73.9 percent⁶ to 80.9 percent.⁷

Use of physician services is higher in Massachusetts than it is nationally. Eight in 10 non-elderly adults reported having had a doctor visit in the past 12 months, compared with 63 percent nationally,⁸ and three-quarters

PERCENTAGE OF NON-ELDERLY ADULTS REPORTING A USUAL SOURCE OF HEALTH CARE, 2012



of Massachusetts residents reported having had a preventive care visit. This gap may in part reflect the lower rates of insurance in other parts of the country. Access to dental care visits was also higher in 2012 than in 2006, increasing from 66.2 to 70.3 percent reporting a dental visit in the past year. Dental access also seems to be better in Massachusetts than the national average, with national surveys showing 62.4 percent of non-elderly adults in 2006 and 61.6 percent in 2011 reporting a dental visit in the past year.⁹

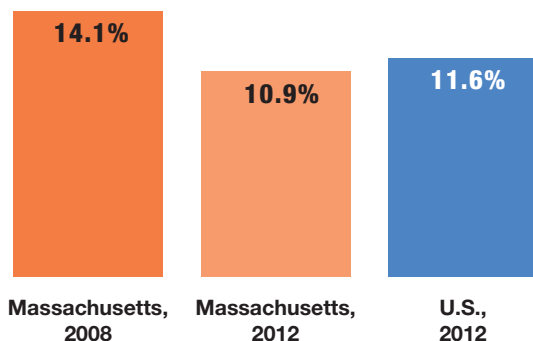
A smaller percentage of respondents used an emergency department (ED) in 2012 compared with 2006, a trend that, significantly, also applied to the use of EDs for those with chronic health conditions, suggesting a slight improvement in the provision of care to manage chronic conditions in more appropriate settings. Other access-to-care measures are at roughly the same level for people with chronic conditions as for the entire population.

The use of alternatives to physicians — nurse practitioners, physician assistants, midwives — appears to be on the rise, suggesting perhaps that delivery systems are attempting to organize care with greater cost efficiency in mind.

Since 2008, the first year for which these measures were taken, there have been some improvements in the ability of adults to obtain care. In 2012, fewer non-elderly adults were told by a doctor's office that it was not accepting new patients — with 13.0 percent reporting this problem in 2012, down from 16.4 percent in 2008.¹⁰ However, this rate is slightly higher than the national average of 11.2 percent.¹¹

Fewer reported problems getting primary care, with 10.9 percent reporting this problem in 2012, down from 14.1 percent in 2008.¹² This problem is less common in Massachusetts than nationally, where 11.6 percent reported problems getting primary care in 2012.¹³

PERCENTAGE OF NON-ELDERLY ADULTS REPORTING A PROBLEM GETTING PRIMARY CARE



In terms of the ability to get an appointment in a timely fashion, more than three-quarters (78.0 percent) reported they could always or usually get an appointment with a general doctor as soon as they thought they needed it, and nearly 70 percent always or usually could get an appointment with a specialist as soon as they thought they needed it.

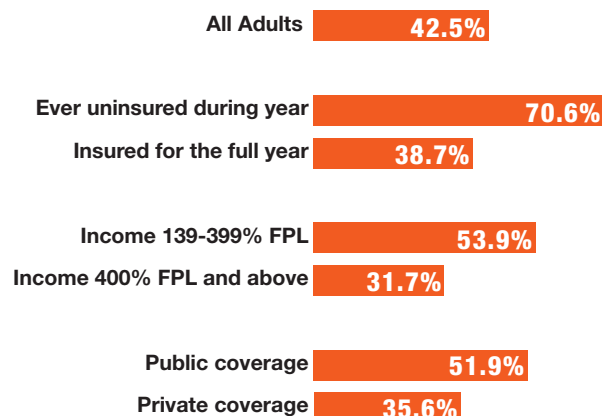
AFFORDABILITY

While some more recent data suggest that overall health care cost trends are moderating in Massachusetts,¹⁴ the MHRS indicates that many individuals are feeling costs acutely. More than 40 percent of non-elderly adults reported that health care costs had been a problem for them and their families over the previous year, including 37.1 percent who experienced problems with health care spending and 16.4 percent who reported going without needed care because of cost.

Those without insurance were particularly vulnerable to the burden of health care costs, with 70.6 percent of those ever uninsured during the past year reporting that health care costs had been a problem and more than a third (35.0 percent) reporting going without needed care because of costs.

However, health insurance coverage did not eliminate cost concerns: 38.7 percent of those who were insured for the

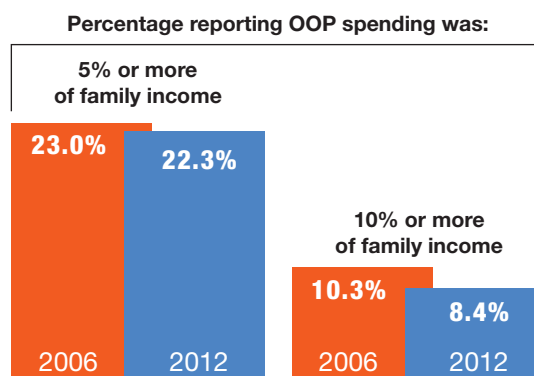
PERCENTAGE OF NON-ELDERLY MASSACHUSETTS ADULTS REPORTING THAT HEALTH CARE COSTS WERE A PROBLEM IN PAST YEAR



full year reported that they had problems with health care spending. These problems were most acute for people with lower incomes, particularly those with incomes between 138 and 400 percent of the federal poverty level (FPL); more than half of people at this income level reported such problems. Also, roughly half of those with public coverage report problems with health care costs.

Although more people had health insurance in 2012 than in 2006, the financial burden of needing and using health care services was almost identical in 2012 to pre-reform levels. More than one in five (22.3 percent) respondents reported out-of-pocket health care spending of at least 5 percent of gross family income, and nearly one in 10 (8.4 percent) had out-of-pocket expenses of at least 10 percent of income.¹⁵

OUT-OF-POCKET (OOP) HEALTH CARE SPENDING IN PAST 12 MONTHS RELATIVE TO FAMILY INCOME, MASSACHUSETTS



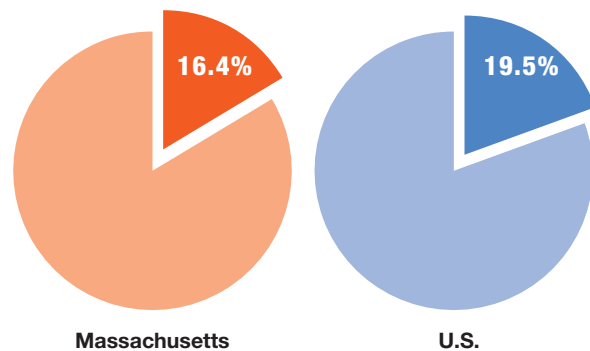
One reason the burden of health care costs has not diminished with rising levels of coverage is the continuing trend among employers to shift costs onto workers and their families. For example, employers may purchase insurance products that have lower premiums but higher out-of-pocket obligations for the insured workers, such as high-deductible plans. Enrollment in high-deductible plans has risen significantly in the state since 2006. Among all workers with employer-sponsored insurance, in 2012 25.1 percent were enrolled in a plan with a high deductible, defined as greater than \$1,000 per person, up from 10.3 percent in 2008 (the first year for which such results are available). An even greater proportion of employees of small firms were enrolled in plans with a high deductible, with more than a third (33.7 percent) enrolled in high-deductible plans. Despite this trend, Massachusetts continues to have a lower proportion of people with employer-sponsored insurance enrolled in high-deductible plans than the rest of the nation. In the U.S., 29.2 percent of persons under age 65 with employment-based private health insurance were enrolled in a high-deductible plan in 2012.¹⁶

The 2012 MHRS found that respondents face persistent financial challenges with health care costs in a number of other areas, despite very high rates of coverage. Only just over half (53.1 percent) of respondents rated their health insurance coverage as very good or excellent in providing financial protection against high medical bills, which is one of the central purposes of health insurance. Nearly one in five (17.9 percent) reported having had problems paying their medical bills in the previous 12 months, which is statistically unchanged from 2006. Similarly, one in five respondents (20.3 percent) reported having medical debt (i.e., bills they were paying off over time). Medical debt affected people across the income spectrum: the percent of lower-income adults¹⁷ reporting medical debt (22.0 percent) was not significantly different from that in the overall population. Lower-income respondents were much more likely to have high out-of-pocket medical expenses that exceeded 5-10 percent of income, depending on income level — an indicator of underinsurance.¹⁸ More than nine out of 10 (93.1 percent) of those who were identified as underinsured using this definition had family incomes

below 300 percent of FPL — suggesting, not surprisingly, that out-of-pocket expenses impose a far greater burden on lower-income people, even when they are insured for the entire year.

One-third (33.5 percent) of respondents reported not getting care that they needed in the past 12 months, with nearly half of those — or 16.4 percent of all adults — citing the cost of care as posing a barrier to obtaining needed care. This is slightly lower than the national experience, where roughly 20 percent of people reported going without needed doctor care due to cost.¹⁹

PERCENTAGE REPORTING NOT GETTING NEEDED CARE DUE TO COST, 2012



For the 25 percent of families who experienced financial problems as a result of the cost of health care, these problems necessitated difficult changes and choices in many other areas of their lives, including cutting back on other, non-health-related spending (89.0 percent); cutting back on or taking money from savings (77.0 percent); cutting back on health care use (57.2 percent); increasing work hours or taking on another job (39.2 percent); borrowing or taking on credit card debt (42.7 percent); and declaring bankruptcy (4.8 percent).

CONCLUSION

The results of the 2012 MHRS remind us that the goals of health care reform are not achieved simply by reducing the number of people who are counted as uninsured. Even with Massachusetts's best-in-the-nation level of coverage, many people in the state lack adequate financial protection and are burdened by health care costs. The cost pressures may in turn lead to decisions to forgo needed care if that

care would result in unmanageable out-of-pocket costs. Being underinsured has been found in other research to be nearly as much a barrier to health care as being without any coverage at all.²⁰

Requiring individuals to shoulder a greater portion of the cost of their care may slow the overall growth in health care spending, but in some cases, it may be at the expense of people's health and well-being. Also, there is a limit to how much of the costs can be shifted, as many consumers do not have the financial capacity to continue to shoulder more and more of the cost burden. This is why the cost-containment and affordability initiatives now under way in Massachusetts — which look to solutions beyond shifting of costs to consumers — are of critical importance to the long-term sustainability of the Common-

wealth's health care reforms. The activities set in motion by Chapter 224 — such as reengineering of delivery systems and emerging payment models linking payment to outcome rather than to volume — offer the potential for structural change that will remove unnecessary costs from the system, creating savings that all can share. While it is far from guaranteed that these initiatives in both the public and private sectors will succeed, they deserve continuing effort, close monitoring, and periodic adjustment to give them the best possible chance.

The authors would like to thank the following individuals for their valuable insights and comments: Audrey Shelto, Kaitlyn Kenney-Walsh, Jessica LaRochelle, and Elisabeth Rodman from the BCBSMA Foundation and Nancy Turnbull from the Harvard School of Public Health.

ENDNOTES

- 1 Trends in this summary and the main report are regression-adjusted to control for changes over time in the characteristics (distributions of age, sex, race/ethnicity, citizenship, marital status, education, employment, firm size, chronic conditions, family income, and region) of the sample of adults surveyed.
- 2 National Health Interview Survey, 2012.
- 3 National Health Interview Survey, 2012.
- 4 “Persistently uninsured” is defined as being uninsured at the time of the survey and for at least the previous 12 months.
- 5 U.S. Census Bureau, Current Population Survey, 2007 and 2013 Annual Social and Economic Supplements.
- 6 Behavioral Risk Factor Surveillance Survey, 2012.
- 7 National Health Interview Survey, 2012.
- 8 National Health Interview Survey, 2012.
- 9 National Center for Health Statistics. *Health, United States, 2007* and *Health, United States, 2012*. Source data from National Health Interview Survey.
- 10 Note: this question was not asked in the pre-reform baseline survey, so results from 2006 are not available for this measure.
- 11 National Health Interview Survey, 2012.
- 12 Note: this question was not asked in the pre-reform baseline survey, so results from 2006 are not available for this measure.
- 13 National Health Interview Survey, 2012.
- 14 Liz Kowalczyk, “Mass. making progress in containing health costs.” *Boston Globe*, October 2, 2013, p. B5.
- 15 Because of limitations in how income information is collected in the survey, this result is for just those families with gross income less than 500 percent of the federal poverty level, a group that makes up about two-thirds of the survey sample.
- 16 National Health Interview Survey, 2012. Note: the national statistic is based on a narrower definition of “high deductible,” of at least \$1,250 per individual, meaning that the real difference between Massachusetts and the rest of the nation is likely even larger than that depicted here.
- 17 Lower-income is defined as those non-elderly adults with family income below 300% FPL.
- 18 An individual is defined as being underinsured if he or she had health insurance coverage for the full year and had high health care costs that were not covered by his or her health plan. The definition of “high” out-of-pocket health care costs used was developed by Cathy Schoen and colleagues and includes having out-of-pocket health care costs of 5.0 percent or more of family income for those with family income of less than 200 percent of the FPL or 10.0 percent or more of family income for individuals with family income above that level. The lower threshold for lower-income individuals is consistent with the cost-sharing provisions of the Children’s Health Insurance Program (CHIP). A complete assessment of the adequacy of insurance coverage requires detailed information on the coverage and cost-sharing provisions of the individual’s health insurance plan. Given the data available in the MHRS over time, the analysis is limited to a narrower focus that considers the individual’s out-of-pocket health care costs. High out-of-pocket costs provide a conservative, lower-bound estimate of underinsurance, as out-of-pocket costs capture inadequate insurance coverage only for those who had high health care costs in the last year. This measure of underinsurance does not include any of the individuals with similar health insurance coverage who did not have high health care costs during the year.
- 19 Behavioral Risk Factor Surveillance System, 2012.
- 20 Insured But Not Protected: How Many Adults Are Underinsured? Cathy Schoen, M.S., Michelle M. Doty, Ph.D., Sara R. Collins, Ph.D., and Alyssa L. Holmgren, Health Affairs Web Exclusive, June 14, 2005 W5-289-W5-302.