CHAPTER 3

Health Care Access

Health insurance status is a key factor affecting access to health care. Adults who do not have health insurance are more likely to have poor health and chronic diseases than those with health insurance. They are also less likely to obtain important health care services including preventive care, primary care, and tertiary care, and more likely to delay getting needed medical attention for illness or injury.[1,2]

On April 12, 2006, Massachusetts enacted legislation that would provide nearly universal health care coverage to state residents. All residents were required to purchase health insurance, through either private insurers or the newly created Commonwealth Care Program, by July 1, 2007 or face a financial penalty. By March 2009, 406,000 more Massachusetts residents had health insurance than before health care reform.[3]

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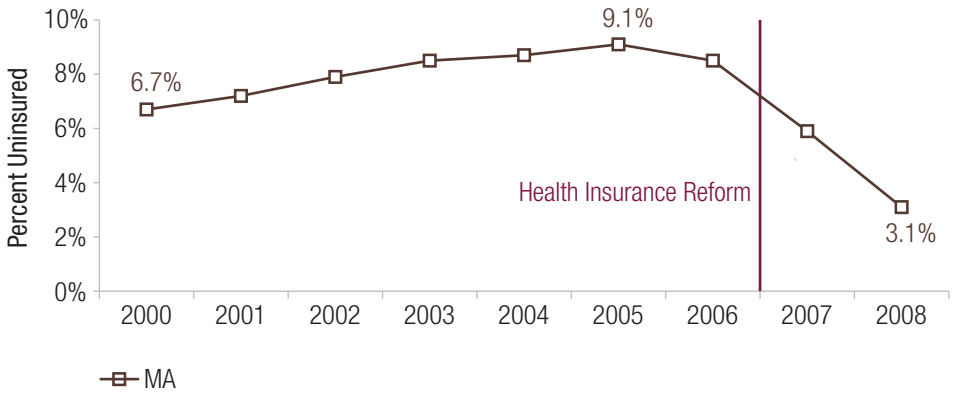
Figure 3.1 **Uninsured Adults 18-64**



Source: MDPH BRFSS 2000-2008.
*The trend is statistically significant ($p \leq 0.05$). This chart shows two-year moving averages.

Figure 3.2 **Components of the Landmark Health Care Reform Law**

Health care reform – often referred to as Chapter 58 – was signed into law on April 12, 2006, mandating in part:
• Adults required to purchase health insurance by July 1, 2007 or face a penalty.
• Employers with 11 or more employees required to offer health insurance.
• Commonwealth Connector created to "connect" individuals to insurance by offering affordable, quality insurance products.
• Commonwealth Care Program created as a low-cost insurance alternative for low-income families and individuals.
• Dental coverage for MassHealth adults and certain income-eligible members of Commonwealth Care.

Source: MA Health Connector, Health Care Access and Affordability Conference Committee Report.

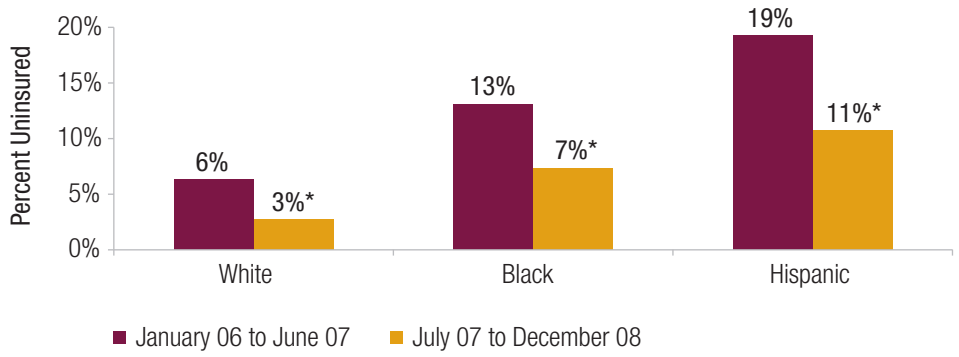
Health Insurance Status

In the period since Health Care Reform, Massachusetts shows a large reduction in the rates of uninsured residents. The percentage of uninsured adults dropped significantly from 9% in 2005 – the year prior to Health Care Reform legislation – to 3% in 2008, which is an initial indicator of success for Health Care Reform (Figure 3.1).

Though the number of Blacks and Hispanics with health insurance increased after Health Care Reform, a substantial gap in health insurance coverage remained between these groups and White residents. In the eighteen months following Health Care Reform, only 3% of White adults aged 18-64 reported a lack of health insurance, as compared to 13% of Black adults and 19% of Hispanic adults (Figure 3.3).

Prior to Health Care Reform implementation, certain subgroups consistently reported lower rates of health care access and utilization. Young

Figure 3.3 **Uninsured Adults by Race and Ethnicity**

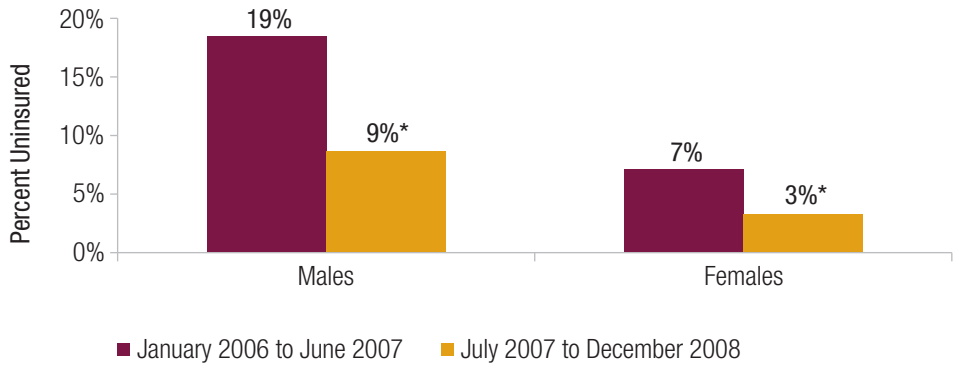


Source: MDPH BRFSS 2006-2008.
*Statistically significant ($p \leq 0.05$).

adults aged 18-34, males, and minority adults have been chronically under-insured and underserved in terms of health care (Figures 3.4 and 3.9)

Significant numbers of young adults aged 18-34 obtained health insurance after Health Care Reform. Among young males, the rates of uninsured fell from 19% to 9%. Among young females, the rates of uninsured fell from 7% to 3%.

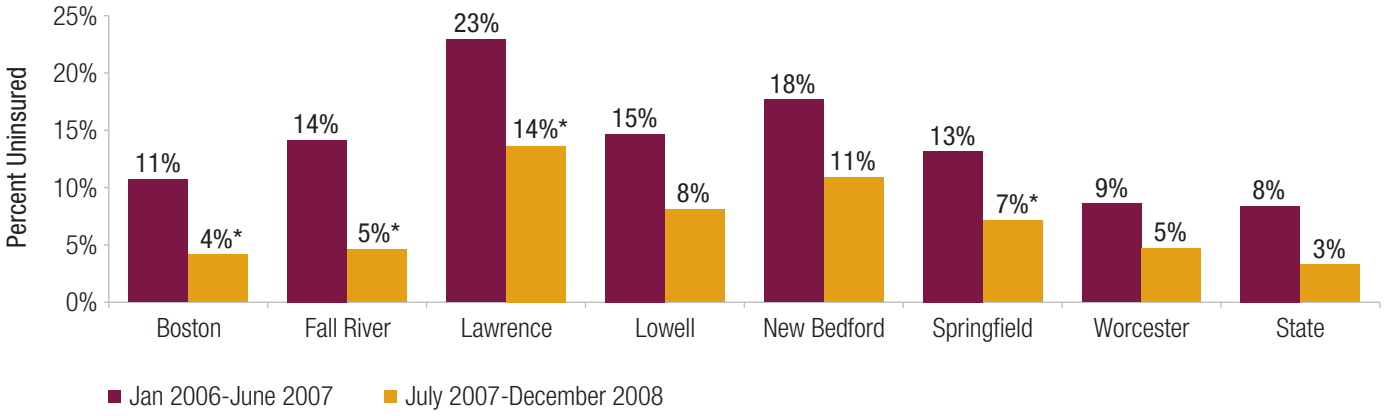
Figure 3.4 **Uninsured Young Males and Females Ages 18-34**



Source: MDPH BRFSS 2006-2008.
*Statistically significant ($p \leq 0.05$).

There are also geographic differences in the rates of those uninsured. Cities with larger numbers of minority adults – such as Lawrence, Lowell, and New Bedford – have a significantly higher percentage of uninsured adults compared with the state as a whole, and these disparities have persisted over time. Other large cities, such as Boston and Fall River had large reductions in the rates of uninsured residents (Figure 3.5). Boston's uninsured rate fell 82% and Fall River's fell 76%. Both cities uninsured rates are now approximately the same as that of the state. New Bedford and Lawrence experienced relatively smaller declines (55% and 40%, respectively).

Figure 3.5 **Uninsured Adults – Selected Cities**



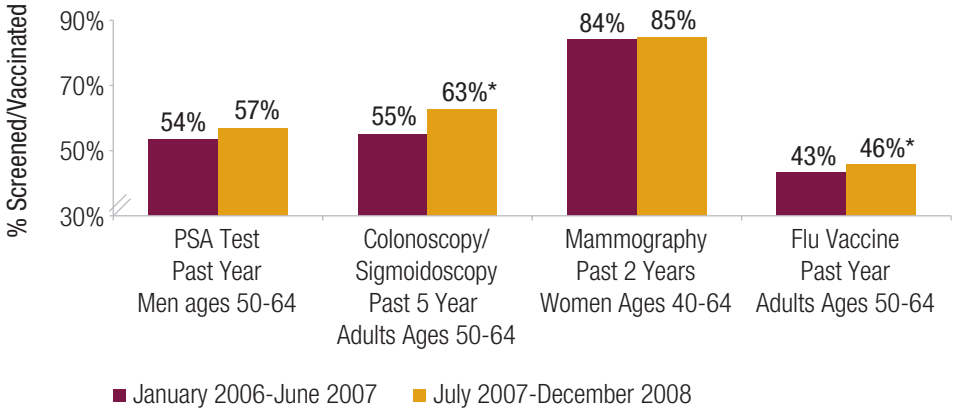
Source: MDPH BRFSS 2006-2008.
*Statistically significant ($p \leq 0.05$).

Though obtaining health insurance may make it more likely that residents will access health care, it does not guarantee access. It is important to look at other health indicators to evaluate access to health care. In addition to health insurance status, we tracked cancer screenings, flu immunizations, dental visits, and residents who reported having a Personal Health Care Provider (PHCP).

Preventive Screenings

Massachusetts has one of the best cancer screening rates in the United States, with 85% of women age 40 and older reporting that they have had a mammogram in the past two years in 2008 (compared to the national average of 76%) and 64% of people age 50 and older reporting that they

Figure 3.6 **Screenings and Flu Vaccinations – Adults <65**



Source: MDPH BRFSS 2006-2008.
*Statistically significant ($p \leq 0.05$).

have had a colonoscopy in the past five years (compared to the national average of 52%). Rates of prostate cancer screening and flu vaccination are also high in Massachusetts.

In the months following Health Care Reform, both the rates of colonoscopy and flu vaccination improved for survey respondents age 50-64. Though these initial findings are encouraging, the long-term effects of health reform on use of preventive services have yet to be measured.

Figure 3.6 shows an increase in both PSA screenings and mammographies. These small increases in PSA and mammography screenings in this period were not statistically significant.

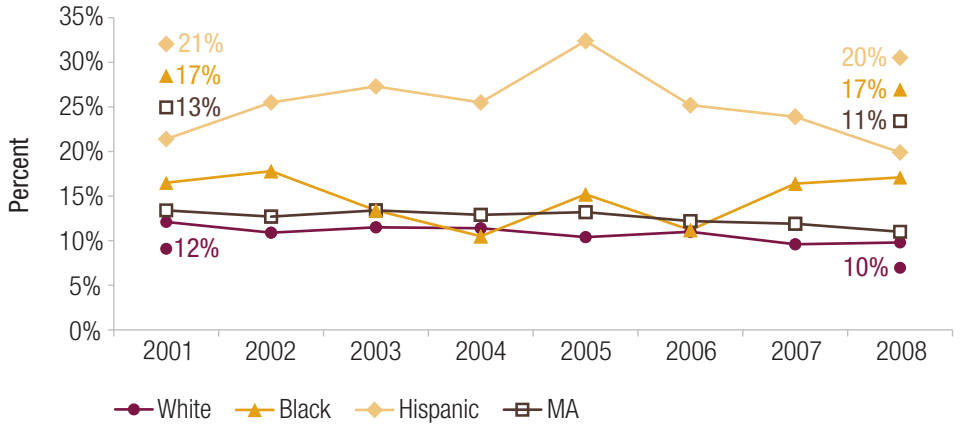
Residents Who Have a Doctor or Other Personal Health Care Provider

Residents who have a personal health care provider (PHCP) are more likely to access preventive and routine care in the most appropriate clinical settings than those who do not have a PHCP.

However, even though only 3% of adults are uninsured, 11% report that they do not have a personal health care provider (Figure 3.7). Since Health Care Reform was enacted, fewer White residents report that they do not have PCHPs, but high percentages of Black and Hispanic residents still report not having PCHPs.

Are differences among cities in the percentage of adults who do not have a personal health care provider related to the availability of health care providers? When we look at the rates per 100,000 population of physicians who provide primary health services (family practice/general medicine,

Figure 3.7 **Adults Without a Personal Health Care Provider**



Source: MDPH BRFSS 2001-2008.
This chart shows two-year moving averages.

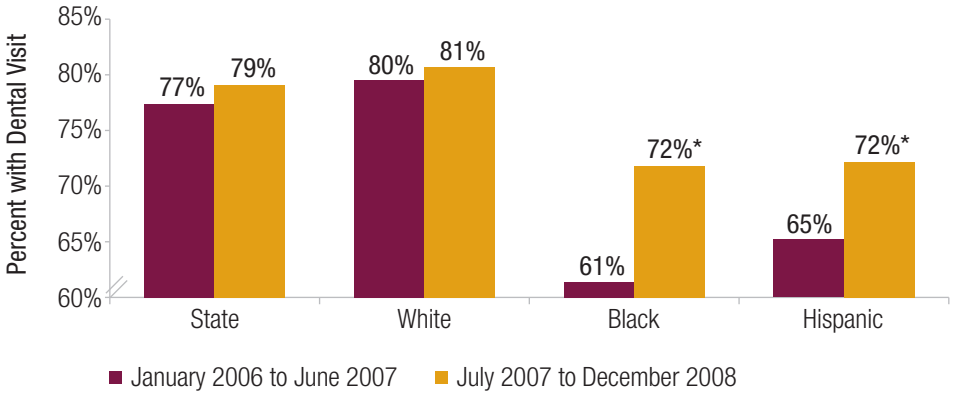
internal medicine, obstetrics, and gynecology, pediatrics/adolescent medicine) in the cities, no clear relationship between physician availability and having a PHCP emerges.[4] For example, Boston, which has the highest rate of physicians per 100,000 population, has a significantly higher percentage of those who do not have a PHCP than the state (18% v. 11%); while, Fall River, which has a relatively low rate of physicians, has a percentage similar to the state of those who do not have a PHCP.[5]

When determining how health care access can be improved in Massachusetts, identifying and addressing geographical differences such as these is critical.

Visits to a Dentist

Oral health plays an important role in general health, and is an important indicator of health care access and utilization. The percentage of adults who visited a dentist in the past year has increased slightly over time, reaching 78% in 2008. Population subgroups, including young males (18-34), Blacks, and Hispanics have experienced significant improvements as well. However, gaps in dental care persist. Both Black and Hispanic residents have a lower rate of dental visits than White residents (Figure 3.8).

Figure 3.8 **Dental Visits in the Past Year**



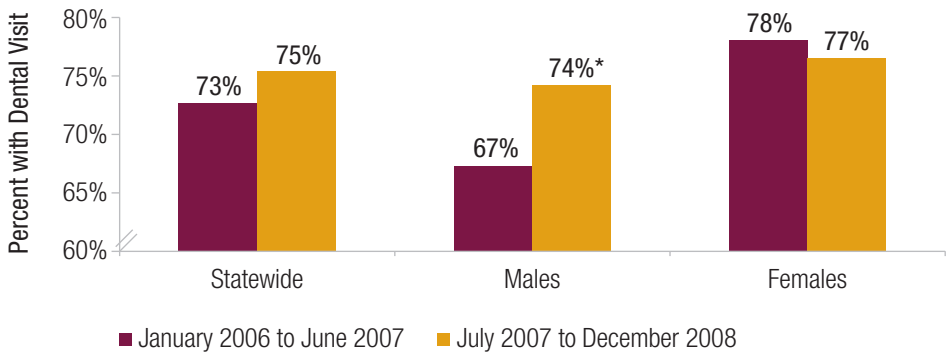
Source: MDPH BRFSS 2006-2008.
*Statistically significant ($p \leq 0.05$).

Rates of reporting a dental visit also vary across the state. Many large cities such as Boston, Springfield, and Worcester have similar rates of dental care (approximately 75%) as compared to the state rate of 78%. Other cities such as Fall River and New Bedford, however, report significantly lower rates of dental care (approximately 66%).

The period after implementation of Health Care Reform saw significant increases in the number of residents who visited a dentist. Since dental

care is an important part of general health, this represents anther positive impact of Health Care Reform.

Figure 3.9 **Dental Visit in the Past Year – Adults Ages 18-34**



Source: MDPH BRFSS 2006-2008.
*Statistically significant ($p \leq 0.05$).

Effects of Health Care Reform

The goal of Health Care Reform is to improve the health of Massachusetts residents by providing wider access to health care and preventative services, and to control medical care costs with early diagnosis and treatment of illness.

Massachusetts has seen a number of improvements in health care access and utilization. A comparison of the 18 months prior to Health Care Reform and the 18 months following reform shows a 53% decrease in the number of uninsured adults aged 18-64 across the state. Large numbers of young males (aged 18-34) and Hispanics obtained health insurance, as did residents of seven large Massachusetts cities with large minority populations.

Health Care Reform also provided dental care for MassHealth members, (the state's Medicaid program) and dental coverage for some Commonwealth Care members. Utilization of preventive care services for those below Medicare age also increased in the months following Health Care Reform. Increases in both flu vaccination and colorectal screening were significant.

However, statewide, and for some population groups, the impact of health reform was not clear. We have seen no significant change in the numbers of residents with PHCPs. There was initial concern that increasing health care coverage without expanding the pool of Personal Health Care Providers might lead to "crowd out," where despite increased access, an insufficient number of health care providers would be available. In addition, some healthy young adults may not feel they need to have a personal doctor.

There are fewer racial and ethnicity gaps in health care access and utilization, but important differences remain. Disparities still exist by age. Hispanics rank last among the three population groups presented here. Young males (aged 18-34) and residents in certain cities have had less improvement than other groups in health care access and utilization.

The effects of Massachusetts Health Care Reform will continue to evolve in the years to come. Initial indications show promise, but we must focus on the longer-term impact of this policy change. In particular, we need to ensure that Health Care Reform is far-reaching and inclusive of all ages, communities, and populations that have fared less well in the past and continue to lag behind.

Policy Perspective: Health Care Access

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Massachusetts' landmark health reform law has resulted in significant improvements in access to health care for the people of the Commonwealth. There have been large gains in coverage, particularly for groups that have been traditionally more likely to be uninsured. Yet, the data show that important challenges remain. We still have much work to do in the areas of reducing racial and ethnic health disparities, enhancing the primary care workforce, and strengthening public health services. The state's budget crisis has threatened the progress that we have already made (the cutback in coverage of legal immigrants being the most glaring example) and will make it more difficult to address these issues. This means that we must work to maintain health reform's momentum.

Delivery system reform has moved to top of the state's political agenda, with an imperative to design a health system that provides quality, cost effective care. National health care reform may provide the state with additional tools to address these issues, but whether Congress will act is unclear at this time. In any case, the nation will surely be watching Massachusetts in its continued efforts to reform its health care system.

FIGURE NOTES

The source for all figures in this chapter is the Massachusetts Behavioral Risk Factor Surveillance System.

Figure 3.1: All percentages are age-adjusted to US 2000 standard population.

Figure 3.3: Percentages are not adjusted for age of other socio-demographic population differences. Asians are excluded from this analysis due to the small numbers of respondents and the high variability of the data.

Figure 3.5: The MDPH BRFSS oversamples the cities of Boston, Fall River, Lawrence, Lowell, New Bedford, Springfield, and Worcester in order to calculate city-specific rates. Lawrence, Lowell, and New Bedford have significantly higher percentages of uninsured than the State does in 2008 ($p \leq 0.05$). Percentages are not adjusted for age of other socio-demographic population differences.

Figure 3.7: All percentages are age-adjusted to US 2000 standard population.

Figure 3.8: Asians are excluded from this analysis due to the small numbers of respondents and the high variability of the data.

ENDNOTES

1 Self-assessed health status and selected behavioral risk factors among persons with and without health-care coverage – United States, 1994-1995. Morbidity and Mortality Weekly Report. 1998; 47(09):176-180.

2 Weissman JS and Epstein AM. The insurance gap: does it make a difference? Annu Rev Public Health. 1993;14: 243-270.

3 Massachusetts Division of Health Care Finance and Policy "Key Indicators Report". Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_aug_09.pdf. Accessed on September 30, 2009.

4 Board of Medicine licensed physicians, Physicians Registered and Working in Massachusetts, Massachusetts Community Health Information Profile (MassCHIP), Massachusetts Department of Public Health, v 3.0, r323, October 19, 2009.

5 Massachusetts Department of Public Health, Bureau of Health Information, Statistics, Research and Evaluation, Health Survey Program. A Profile of Health Among Massachusetts Adults in Selected Cities, 2008. http://www.mass.gov/Eeohhs2/docs/dph/behavioral_risk/cities_08.pdf. Accessed on January 11, 2010.