



Studying Expansion of Coverage and Access to Care in Three States

An evaluation of the impacts of state health reform initiatives in Illinois, Massachusetts, and New York

SUMMARY

Researchers at the [Urban Institute's Health Policy Center](#) evaluated the impact of state health reform in Massachusetts, New York, and Illinois from 2008 to 2011. All three states had taken significant steps to expand health insurance coverage among residents, boost their access to and use of health care, and limit their out-of-pocket health costs.

The researchers drew on three national surveys for their analysis: the National Health Interview Survey, the Current Population Survey, and the American Community Survey. In journal articles and policy briefs, they focused most strongly on Massachusetts, and—at the suggestion of reviewers—omitted Illinois, where the expansion was narrower and they did not find significant changes.

The project occurred under *State Health Access Reform Evaluation (SHARE)*, a \$10.5 million national program of the Robert Wood Johnson Foundation (RWJF) that tracks the affordability, sustainability, and administrative efficiency of state coverage reforms; it was launched in 2006. (See [Program Results Report](#) for more information on the goals and strategies of the program and links to other Program Results Reports on its projects.¹)

Sharon K. Long, PhD—a senior fellow and economist with the Health Policy Center at the Urban Institute—directed the project.

¹ A separate project examined the Massachusetts experience as part of an analysis of health reform that also included Maine (Grant ID#s 64216 and 68845). More information is available [online](#).

Key Findings

In journal articles and policy briefs, the researchers reported these key findings:

- In the two years after comprehensive health reform took effect in Massachusetts (2007 and 2008), insurance coverage and access to health care rose among low-income adults (*Health Services Research*²):
 - The share with health insurance expanded by 4 to 6 percentage points—from 82 percent in the pre-reform period.
 - The share with needed care that went unmet because of cost fell by 6.7 to 10.3 percentage points.
- In the two years after more limited health reform took effect in New York (2003 and 2004), insurance coverage expanded by 3 to 5 percentage points—up from 68 percent in the prior two years—but access to care and use of care did not expand (*Health Services Research*³).
- The share of uninsured children in Massachusetts dropped by half in the first two years after health reform, giving the state the lowest such share in the nation (*Health Affairs*, 2010⁴). The share of young adults aged 19 to 26 without insurance also dropped significantly (from 21.1 percent before reform to 8.2 percent after) (*SHARE policy brief*⁵).

Key Conclusion

- Comprehensive reform efforts can better address gaps in insurance coverage and access to health care than narrower approaches. Given that national health reform incorporates many of the elements of Massachusetts initiative, the potential for significant gains in insurance coverage and access to and use of care is significant.

Funding

RWJF supported this project from May 2008 to June 2011 with a grant of \$320,885.⁶

² Long SK and Stockley K. “The Impacts of State Health Reform Initiatives on Adults in New York and Massachusetts.” *Health Services Research*, 46(1,II): 365–387, 2011. Available [online](#).

³ Ibid.

⁴ Long SK, Kenney G and Luque A. “Health Reform in Massachusetts Cuts the Uninsurance Rate for Children in Half.” *Health Affairs*, 29(6): 1242–1247, 2010. Available [online](#).

⁵ Long S, Yemane A and Stockley K. “The Importance of Young Adult Provisions in Massachusetts Health Reform.” State Health Access Reform Evaluation policy brief, August 2010. Available [online](#). This brief is drawn from a longer paper published in the *American Economic Review: Papers and Proceedings*, 100(2): 297–302, 2010. Available for a fee [online](#).

⁶ Grant ID# 64315.

CONTEXT

Massachusetts, New York, and Illinois all took significant steps in the 2000s to expand access to health insurance:

- Massachusetts passed a comprehensive health care reform law in 2006 designed to move the state to near-universal insurance coverage. The law:
 - Expanded eligibility for the state’s Medicaid program (MassHealth), opening enrollment to all children with family incomes up to 300 percent of the federal poverty level.
 - Broadened coverage for young adults, who are much less likely than older adults to have insurance. The law extended eligibility for coverage as a dependent (typically under a parent’s health plan) from age 19 to age 26. It also created young adult plans—less costly, with limited-benefit options for those who do not have access to employer-sponsored coverage.
 - Eliminated enrollment caps for Medicaid coverage for long-term unemployed adults, disabled working adults, persons with HIV, and others.
 - Provided sliding-scale subsidies for health insurance (Commonwealth Care) for adults with family incomes up to 300 percent federal poverty level.
 - Created the Commonwealth Health Insurance Connector Authority and the CommChoice program, to link individuals without access to employer coverage and firms with fewer than 51 workers to health plans.
 - Merged small-group and non-group insurance markets, to reduce the cost of premiums for small businesses and individuals.
 - Imposed an individual mandate requiring adults to have health insurance if they have access to an affordable health plan, or to pay a tax penalty.
 - Required employers with more than 10 employees to make a “fair and reasonable” contribution toward their workers’ health insurance or pay an assessment.
- New York passed the Health Care Reform Act of 2000, which created two new programs to expand insurance coverage:
 - Family Health Plus provides coverage to low-income adults aged 19 to 64 who do not have insurance and who have incomes too high to qualify for Medicaid. Parents with incomes up to 150 percent of the federal poverty level and childless adults with incomes up to 100 percent of the poverty level are eligible.
 - Healthy New York reduces the cost of private insurance for small employers, sole proprietors, and workers earning less than 250 percent of the federal poverty level whose employers do not offer insurance. Plans covered by Healthy New York

may have fewer benefits than the state normally requires, and higher out-of-pocket costs, and enrollees must participate in health maintenance organizations.

- Illinois built on a 2002 Medicaid waiver to expand eligibility for public insurance coverage or premium subsidies for low-income families. The state also raised eligibility levels for the State Children’s Insurance Program (SCHIP) from 185 percent to 200 percent of the federal poverty level.

In 2006, Illinois launched All Kids, coverage available to all uninsured children without regard to income, health status, or citizenship, with premiums scaled to family income. All Kids is among the nation’s first universal health insurance programs for children. The evaluation of the All Kids program was not part of this project.

RWJF’s Interest in This Area

A long-running RWJF program that has focused on the states’ activities in expanding insurance coverage to the uninsured is *State Coverage Initiatives* (1991 to 2013). This \$52.5 million program provides funding and technical assistance to help 28 states develop health care financing and delivery mechanisms to expand coverage to the uninsured. Since the enactment of the federal Affordable Care Act (ACA) in 2010, the program is also helping states implement health reform. Most participating states have adopted at least one of these interventions:

- Reform of the small group health insurance market, including regulations limiting the ability of insurers to exclude certain groups or individuals, or to charge them different rates
- Health insurance purchasing alliances, which allow small groups to pool resources to negotiate lower rates and cut administrative costs
- Expanded public insurance options, such as broader eligibility for Medicaid

Another RWJF program in this area is *State Health Access Reform Evaluation (SHARE)*, a \$10.5 million national program that tracks the affordability, sustainability, and administrative efficiency of state coverage reforms. It began in November 2006 and runs until mid-January 2014. From 2006 through mid-2010, the focus was on state policy. Starting in September 2010, the program shifted to concentrate on health reform issues as they relate to state implementation of the ACA.

The SHARE national program office is at the State Health Access Data Assistance Center at the University of Minnesota’s School of Public Health. (See [Program Results Report](#) for more information on the goals and strategies of the program and links to other Program Results Reports on its projects.) The project described in this report was funded under SHARE.

THE PROJECT

From 2008 to 2011, researchers at the [Urban Institute's Health Policy Center](#) assessed the impact of health reform initiatives in Massachusetts, New York, and Illinois on residents' insurance coverage, access to and use of health care, and out-of-pocket health costs.

The researchers tapped three major national surveys for their analyses:

- National Health Interview Survey (1999–2008), conducted annually by the Centers for Disease Control and Prevention (CDC). This survey includes questions on respondents' health, health insurance coverage, and access to and use of health care.
- Current Population Survey (2005–2009), conducted monthly by the U.S. Bureau of Labor Statistics and the U.S. Census Bureau. This nationally representative household survey collects labor market information, including on respondents' health insurance status.
- American Community Survey, conducted annually by the U.S. Census Bureau. This survey collects information on respondents' economic, social, demographic, and housing characteristics, and began asking about health insurance status in 2008.

Publishing the Findings

Researchers published their findings in four journal articles and three policy briefs (see the [Bibliography](#)). The researchers focused only on Massachusetts and New York in these publications, as the Illinois expansion was fairly narrow and did not lead to significant changes in insurance coverage, and reviewers urged them to remove information on that state to simplify the analysis.

“There was lots of political turmoil in Illinois at the time, and coverage was expanded and then cut, and we did not see any significant impact overall,” noted Long, the principal investigator.

The researchers conducted additional analysis in Massachusetts, and several articles and policy briefs focus specifically on that state. “We saw opportunities for analysis there because so much was happening,” explained Long.

The researchers also presented their findings in a webinar and at a number of conferences, including annual meetings of the American Economic Association and AcademyHealth.

FINDINGS

The researchers reported these findings in journal articles and policy briefs:

- **In the two years after health reform took effect in Massachusetts (2007 and 2008), insurance coverage and access to health care rose among low-income adults** (*Health Services Research*⁷). Among adults with family incomes below 300 percent of the federal poverty level:
 - The share with health insurance expanded by 4 to 6 percentage points—from 82 percent in the pre-reform period.
 - The share of needed care that went unmet because of cost fell by 6.7 to 10.3 percentage points from 26.3 percent.
 - The use of health care services increased—especially those provided by nurse practitioners, physician assistants, and midwives. However, some adults had difficulty getting office appointments, possibly reflecting rising demand for services as more people became insured.
- **In the two years after health reform took effect in New York (2003 and 2004), insurance coverage expanded, but access to care and use of care did not** (*Health Services Research*⁸). The share of residents with health insurance rose 3 to 5 percentage points—up from 68 percent in the prior two years before reform—but most measures of access to care did not expand, and measures of use of care tended to drop.
- **In an analysis of 10 studies on the impact of health reform in Massachusetts (SHARE policy brief⁹)**, the researchers concluded:
 - Insurance coverage for non-elderly adults expanded markedly. In 2006, various surveys put the uninsured rate at 10.2 percent to 13.6 percent. By 2009, estimates ranged from 5.2 percent to 5.9 percent.
 - Uninsurance rates in Massachusetts have been well below those in the nation since reform. National estimates hovered around 20 percent in 2006, and 20.6 percent to 22.3 percent in 2009.
 - Public insurance coverage did not supplant employer-sponsored coverage. In fact, Massachusetts employers said they were more likely to offer coverage in 2009, and enrollment in private plans grew by 28,000 from 2006 to 2010.

⁷ Long S and Stockley K. “The Impacts of State Health Reform Initiatives on Adults in New York and Massachusetts.”

⁸ Ibid.

⁹ Long S, Stockley K and Dahlen H. “National Reform: What Can We Learn From Evaluations of Massachusetts?” *State Health Access Reform Evaluation* policy brief. Minneapolis: University of Minnesota, June 2011. Available [online](#).

- Gains in access to and use of health care became more apparent over time. For example, more nonelderly adults reported a usual source of health care in 2009 than in 2007, and those adults also reported more outpatient visits and greater use of prescription drugs. However, one in five adults in 2009 had not received some type of needed care in the previous 12 months.
- Health care was more affordable in 2009 than before reform. However, affordability gains eroded over time.
- **The share of uninsured children in Massachusetts dropped by half in the first two years after health reform, giving the state the lowest such share in the nation (*Health Affairs*¹⁰):**
 - Some 1.8 percent of children (aged 0–18) were uninsured in 2007–08, compared with 4.6 percent in 2004–06.
 - The greatest gains in coverage occurred among children in lower-income families. Uninsurance rates for children in families with incomes at or below 300 percent of the federal poverty level fell to 3 percent, from 8.2 percent prior to reform.
- **The share of young adults aged 19 to 26 without insurance dropped significantly after health reform in Massachusetts (SHARE policy brief¹¹).** More than one in five young adults (21.1 percent) was uninsured in 2005–06, compared with 8.2 percent in 2007–08.
- **Most adults who remained uninsured had one or more characteristics that distinguished them from the insured population (SHARE policy brief¹²).** Uninsured residents were more likely to be:
 - Male, young, and single
 - Racial/ethnic minorities or immigrants
 - Unable to speak English well or very well
 - Living in a household in which no adult speaks English well or very well
 - Uninsured residents also had lower levels of education, employment, and family income, and more financial stress. Lower rates of insurance coverage were also concentrated in certain regions of the state.

¹⁰ Kenney GM, Long SK and Luque A. “Health Reform in Massachusetts Cut the Uninsurance Rate Among Children in Half.”

¹¹ Long SK, Yemane A and Stockley K. “The Importance of Young Adult Provisions in Massachusetts Health Reform.”

¹² Long S, Phadera L and Lynch V. “Massachusetts Health Reform in 2008: Who Are the Remaining Uninsured Adults?” State Health Access Reform Evaluation policy brief. Minneapolis: University of Minnesota, August 2010. Available [online](#).

Conclusions

In journal articles and policy briefs, the researchers concluded:

- **Comprehensive reform efforts can better address gaps in insurance coverage and access to health care than narrower approaches.** Given that national health reform incorporates many of the elements of Massachusetts initiative, the potential for significant gains in insurance coverage and access to and use of care is significant.
- **Complex reform can be implemented quickly and effectively, and sustained in a weak economy.** The significant gains in insurance coverage in Massachusetts during the recession offer reason for optimism on national health reform.
- **Expanded insurance coverage, outreach to parents, and simplified enrollment can substantially reduce the number of uninsured children, particularly among the lowest-income families.** The Massachusetts experience also suggests that expanded coverage for parents has a spillover effect on their children.
- **Some adults remained uninsured despite expanded access, suggesting the need for initiatives targeted to specific populations and communities.** These include residents with low literacy or limited English proficiency, young adults, immigrants, and people in communities with lower rates of insurance.
- **Expanded insurance coverage does not necessarily ensure better access to care or more affordable care.** Massachusetts is considering strategies for controlling health care costs, such as alternatives to fee-for-service care, but strong federal leadership is essential to reforming the health care payment system.

LESSONS LEARNED

1. **Data for evaluating state-level health reform are limited.** Sample sizes of national surveys are often small, and they may not cover all questions of concern. In this project, cuts in the sample sizes of National Health Interview Surveys coincided with the post-reform study in Massachusetts limiting the statistical power of the analysis. Lags in the availability of data may also affect the timeliness of such analyses.
2. **Differences among surveys can make it difficult to collect consistent data on Medicaid and other health care programs.** For example, the Current Population Survey asks respondents about health insurance coverage during the prior year, while other surveys examine coverage at a specific point in time.

“Surveys sometimes rely on different field mechanisms and ask different questions in ways that make it hard to know whether there are real differences or just differences in the way something is measured or the time period over which it is measured,”
Long noted.

3. **Federal agencies need to improve national surveys to support analyzes of state efforts to reform health care, and to understand the implications of those efforts for national reform.** Strategies include:

- Investing in larger or more representative samples within states
- Expanding the content of surveys to include information related to health reform. For example, American Community Survey could include questions about access to health care, and its affordability.
- Ensuring that data are comparable across surveys
- Releasing data more quickly and in more accessible formats

Federal agencies have shown an interest in taking these steps, said Long. “There is an openness at the agencies as we prepare for national health reform. They are responding to lessons from trying to do state-level evaluations with national data. It is an improving world for state policy research.”

4. **Apply to the CDC’s National Center for Health Statistics for access to data from the National Health Interview Survey in advance, as gaining approval can take several months.** However, approval expires after 12 months, so do not submit an application too early either. (Project Director/Long)

AFTERWARD

With funding from the U.S. Department of Health and Human Services, Urban Institute researchers now are working with the Research Triangle Institute in North Carolina and the State Health Access Data Assistance Center to design an evaluation of Medicaid expansion under national health reform.

In addition, RWJF provided \$1.8 million in support to the Urban Institute to undertake a comprehensive monitoring and evaluation project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010.¹³ The project began in May 2011.¹⁴

It is part of a concerted effort by the RWJF to support 10 states—Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia—in the implementation of health reform. Through the *State Health Reform Assistance Network*, RWJF is also providing these states with technical assistance by outside experts and is funding consumer advocacy efforts. The Urban Institute’s monitoring and evaluation project is a key component in the overall effort.

¹³ Grant ID# 68780, which runs to May 2012.

¹⁴ Urban Institute has a pending renewal grant, ID# 69929, for \$2,035,161 until the end of May 2013.

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¹⁵ A portion of the funding for this article came from a separate RWJF grant (ID# 65624) to Genevieve M. Kenney, PhD. She also used that grant to produce “Gains for Children: Increased Participation in Medicaid and CHIP in 2009,” available [online](#).