

# WHAT WE KNOW ABOUT HEALTH REFORM IN MASSACHUSETTS

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## Introduction

In 2006, Massachusetts passed comprehensive health reform. Given inherent interest in the reform and its similarity to the Affordable Care Act (ACA), numerous studies have documented its effect on a variety of outcomes, from insurance coverage to employment. The sheer number of these studies can make it difficult to keep track of what is known – and what is not. Moreover, little research has focused on the employment outcomes of 55-64 year olds, a group that increasingly needs to work longer. Thus, this *brief* summarizes the literature on the Massachusetts Reform before examining how labor market outcomes have changed for 55-64 year olds.

The discussion is organized as follows. The first section describes the Massachusetts Reform and its relationship to the ACA. The second section summarizes research on the Reform with an eye on: 1) insurance coverage; 2) the provision of health services; 3) health outcomes; and 4) labor market effects. The third section uses *Current Population Survey* data to examine any changes in the labor supply and employment of 55-64 year olds. The final section concludes that the Massachusetts Reform seems to have achieved many of its goals without triggering higher unemployment and without “crowding-out”

employer-sponsored insurance. A couple of issues of concern remain, including costs and a slight decline in labor force participation among 55-64 year olds. However, to the extent that the Massachusetts Reform is being used as a “crystal ball” for the ACA, this *brief* suggests the message is largely positive.

## Massachusetts’ Health Reform

The Massachusetts Health Reform was billed as “An Act Providing Access to Affordable, Quality, Accountable Health Care,”<sup>1</sup> with the main goal of expanding access to health insurance and health care. Table 1 (on the next page) provides key details on the four broad components of the Reform.

Much of the recent interest in the Massachusetts Reform is due to its similarity to the ACA. The Massachusetts Reform was the basis for the ACA, and the ACA contains all of the components described in Table 1. As such, understanding the effects of the Massachusetts Reform is a good place to start in understanding the ACA’s potential impact.<sup>2</sup>

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TABLE 1. KEY FEATURES OF MASSACHUSETTS' HEALTH REFORM

Component	Specific elements
Individual mandate	<ul style="list-style-type: none"> <li>Mandated that individuals aged 17 and over attain coverage or pay penalty.</li> <li>Exempted from penalty those with incomes &lt;150 percent of Federal Poverty Line (FPL).</li> </ul>
Employer mandate	<ul style="list-style-type: none"> <li>Required employers with more than 10 full-time equivalent employees to demonstrate a "fair and reasonable" contribution to employee coverage.<sup>3</sup></li> </ul>
Reforms to non-group and small-group insurance markets	<ul style="list-style-type: none"> <li>Created the Health Connector, which makes private plans available to individuals, families, and employers with 50 and fewer employees.</li> <li>Standardized private plan benefit levels.</li> </ul>
Government expansion and subsidies	<ul style="list-style-type: none"> <li>Expanded Medicaid benefits to children whose parents earn up to 300 percent of FPL.</li> <li>Created Commonwealth Care,<sup>4</sup> a subsidized plan, for adults at 100-300 percent of FPL.</li> </ul>

Sources: Massachusetts Acts of 2006; Holahan and Blumberg (2006); and Blue Cross Blue Shield of MA Foundation (2014).

## What We Know from the Literature

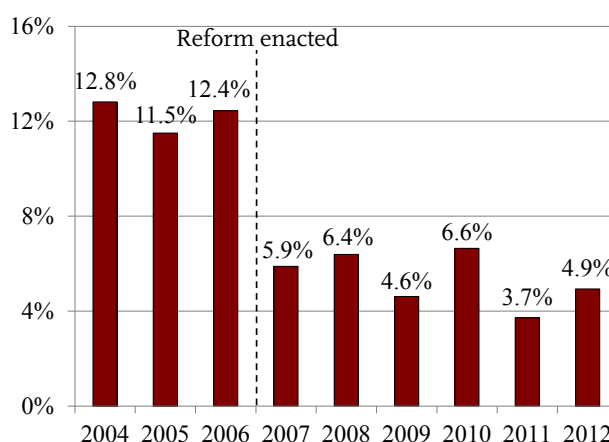
This section summarizes previous studies on the Massachusetts Reform with an eye on: 1) insurance coverage; 2) the provision of health services; 3) health outcomes; and 4) labor market effects.

### Insurance Coverage

The impetus for the Massachusetts Reform was to increase access to health insurance. In this goal, the Reform has been largely successful. Because individuals aged 65 and over have access to Medicare and children often have access to Medicaid, policymakers frequently focus on non-elderly adults (aged 19-64) when examining insurance coverage. Figure 1 shows that the uninsurance rate in 2012 was less than half its 2006 level. Since the Reform and through the recession, Massachusetts's non-elderly uninsurance rate has been well below the national level; in 2012, it was 4.9 percent compared to 21.2 percent nationally.<sup>5</sup>

Yet, some Massachusetts residents remain uncovered. Although low-income adults and minorities saw the largest absolute increase in coverage after the Reform, they also remained most likely to be uninsured. In 2011, individuals with income below 300 percent of poverty comprised 78 percent of all uninsured individuals despite representing less than 50 percent of the population. Another vulnerable group consists of Hispanics, who are more than twice as likely to be uninsured as white, non-Hispanics.<sup>6</sup>

FIGURE 1. PERCENT UNINSURED FOR MASSACHUSETTS RESIDENTS AGE 19-64, 2004-2012



Source: Author's calculations from University of Minnesota, Integrated Public Microdata Series, Current Population Survey (IPUMS CPS), 2004-2013.

The major concern of such a rapid expansion of coverage is costs. By 2009, it was clear that costs were becoming an issue; employer-sponsored insurance premiums were increasing by more than the national average<sup>7</sup> and the state's health spending was projected to double over just a ten-year span.<sup>8</sup> In fact, high insurance premiums are one reason some individuals remain uninsured: nearly half of the uninsured in Massachusetts who had access to an employer plan chose not to enroll because of costs.<sup>9</sup> In this environ-

ment, Massachusetts was forced to turn its attention to costs. This effort seems to have had some success. From 2009-2012, Massachusetts' health care expenditures grew at a slower rate than the state's economy (3.1 vs. 3.7 percent) and at the same rate as U.S. health expenditures (3.1 percent).<sup>10</sup>

### *Provision of Health Services*

The purpose of expanding health insurance coverage is to allow increased access to health care services and ultimately better health. Authors analyzing the *Massachusetts Health Reform Survey* found, from 2006-2010, significant increases in the share of non-elderly individuals with a usual source of care as well as having preventive and specialist visits.<sup>11</sup> Although some erosion occurred between 2010 and 2012, access remains greater than before the Reform. Furthermore, a higher share of care recipients reported receiving good or quality care in 2012 than in 2006.<sup>12</sup>

One possible counter to this trend occurred for a group less affected by the reforms: individuals over age 65 generally covered by Medicare. One study suggested that these individuals saw a decline in primary care visits, with one view being that they were "crowded-out" by the newly insured.<sup>13</sup> However, another study disputes this result, claiming it is unclear whether the decline is due to the reforms.<sup>14</sup>

One special area of interest following the ACA's passage is emergency room usage; some have expected emergency room visits to decrease, because insured people could use primary care physicians for minor issues. On this point, the evidence in Massachusetts is mixed. A comprehensive study of all emergency room admissions found an increase in volume,<sup>15</sup> but the number of low-severity visits showed a slight decline<sup>16</sup> as did the number of visits by children.<sup>17</sup> In a similar vein, a study of inpatient hospital admissions found that preventable admissions declined, perhaps signifying an increased role of prevention or primary care.<sup>18</sup>

### *Health Outcomes*

Increasing insurance coverage and increasing access to health care are a means to an end: better health. Several studies have relied on self-reported health status and have concluded that Massachusetts residents are healthier following the Reform. Using data from the Behavioral Risk Factor Surveillance System, one study found that, among non-elderly individuals, Massachusetts residents reported better levels and trends

of general, physical, and mental health than other New England residents post-reform.<sup>19</sup> Another study examined responses from the *Massachusetts Health Reform Survey* and found that the share of non-elderly adults reporting good or excellent health increased from 59.7 percent in 2006 to 64.9 percent in 2010.<sup>20</sup> Finally, some evidence indicates improved health outcomes for children, with one study reporting a 10-percent increase in the probability that a child's health was described as "excellent."<sup>21</sup> As with any self-reported data, care must be taken in over-interpreting these results. However, data based on mortality appear to yield a similar conclusion that residents are getting healthier. A recent study found that, following the Reform, the mortality rate in Massachusetts dropped relative to similar locations for 20-64 year-olds.<sup>22</sup>

### *Labor Market Effects*

One fear following the Massachusetts Reform, and reiterated on the national stage, was decreased labor supply – making it easier to get health insurance not tied to employment might cause some individuals to stop working. Another concern was that employers would cut back on employees or hours to avoid the requirement to offer health care, which is based on the number of full-time equivalent workers. A comprehensive study of individuals 16 and over using 2001-2010 *Current Population Survey* (CPS) data compared Massachusetts to four other states and found that the level of employment relative to the working-age population (i.e., the employment rate) followed a generally similar pattern. The same study found that Massachusetts did not see relative increases in the share of workers working part-time.<sup>23</sup>

Regarding the provision of health insurance, another concern was that employer-sponsored insurance would be crowded out by public insurance, as employers simply dropped coverage and paid the \$295 fine per employee. In fact, the percentage of employers offering coverage actually increased after the Reform.<sup>24</sup>

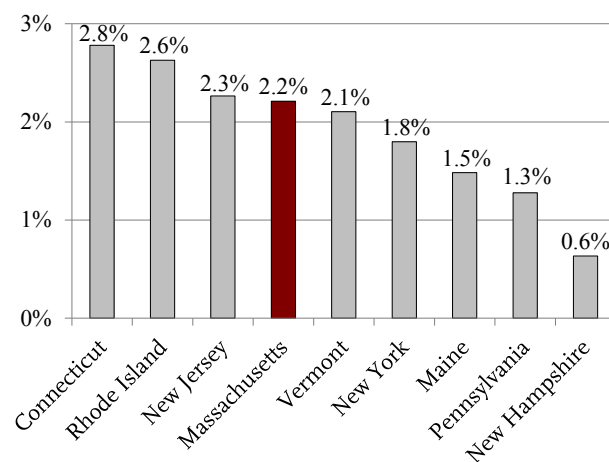
Thus, a wealth of research on the Reform suggests that insurance coverage and access to health care have increased, that health outcomes appear to be improving, and that the worst fears about employment have not come to pass in Massachusetts. Costs, however, remain an issue. Despite this wealth of research, to date, no study has focused on a group whose employment may be especially affected by the reforms: 55-64 year olds. Because the employment behavior of that group is of special relevance to issues of retirement, the *brief* turns now to this group.

## Labor Force Outcomes for 55-64 Year Olds

To explore labor market outcomes for 55-64 year olds, using CPS data, the analysis compares Massachusetts to several nearby states to see if the Reform resulted in: 1) an abnormal increase in unemployment; or 2) abnormally high departures from the labor force among older workers. The first result would occur if employers found it more costly to hire older workers in the post-Reform world due to added insurance costs and the second if older workers were able to retire earlier and lean on either the Health Connector or subsidized plans for coverage.<sup>25</sup> Among individuals age 55-64, the sample consists of males only, because females are more likely to rely on a spousal employer-sponsored health benefit and less likely to be in the labor force. Given these facts, it seems that males would be more likely to feel the effects of the reform.

Figure 2 shows the percentage-point increase in the unemployment rate for males aged 55-64 between 2000-2005 and 2007-2012.<sup>26</sup> The figure clearly illustrates that the first concern discussed above has not come to pass; the unemployment rate in Massachusetts increased due to the Great Recession in a manner consistent with the surrounding states. Indeed, the national increase (excluding Massachusetts) was 2.1 percentage points, almost identical to the 2.2-percentage-point increase in Massachusetts.

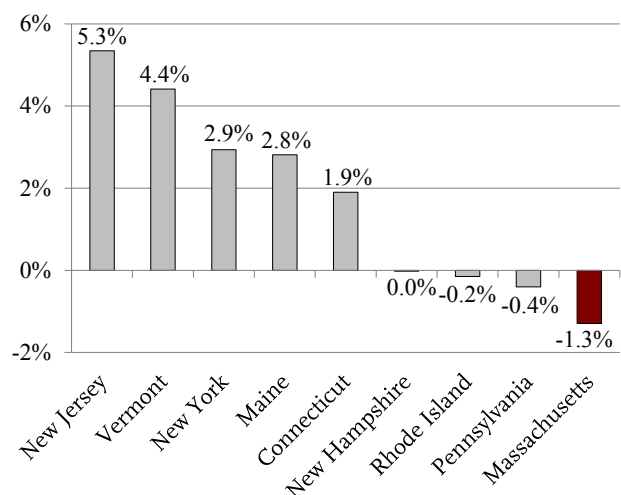
FIGURE 2. PERCENTAGE-POINT CHANGE IN UNEMPLOYMENT FOR MALES AGE 55-64, 2000-2005 TO 2007-2012



Source: Author's calculations from IPUMS CPS, 2000-2012.

Figure 3 shows the percentage-point change in the share of workers participating in the labor force (defined as working or actively searching for work). The figure shows that Massachusetts has seen the largest decrease in labor force participation of any of the comparison states (most states saw an increase). Indeed, nationwide labor force participation (excluding Massachusetts) increased by 1.7 percentage points among 55-64 year old males, compared to the 1.3-percentage-point decrease in Massachusetts.<sup>27</sup> This result suggests that the Massachusetts Reform may have enabled some males to leave the labor force early.

FIGURE 3. PERCENTAGE-POINT CHANGE IN LABOR FORCE PARTICIPATION FOR MALES AGE 55-64, 2000-2005 TO 2007-2012



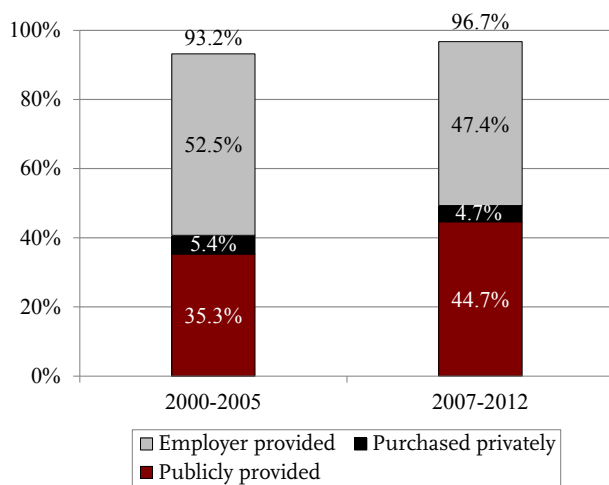
Source: Author's calculations from IPUMS CPS, 2000-2012.

It is worth noting that the Congressional Budget Office (CBO) estimated a 1.5-2.0 percent reduction in hours worked due to the Affordable Care Act.<sup>28</sup> Although the CBO's estimate represents all workers and looks at hours worked, not labor force participation, the magnitude of the decline in labor supply estimated by the CBO is consistent with the estimates shown in Figure 3.

Given the reduction in labor force participation, it is natural to wonder whether individuals outside of the labor force are more likely to be covered by employer retiree health benefits or by public insurance or insurance purchased from the Health Connector.

Figure 4 examines coverage for 55-64 year old males not participating in the labor force and illustrates two facts. First, insurance coverage increased from 93.2 percent before the Reform to 96.7 percent after it. Second, the percent of workers covered by publicly-provided insurance increased from 35.3 to 44.7 percent.<sup>29</sup> Both these findings are consistent with the idea that some older males in Massachusetts were able to leave the labor force early because they were more likely to obtain health insurance outside of their employer, often from a public source. This response is one form of the reduction in “job lock” frequently discussed in the popular press.

FIGURE 4. INSURANCE COVERAGE BY SOURCE OF INSURANCE FOR MALES AGE 55-64 NOT PARTICIPATING IN THE LABOR FORCE, 2000-2005 AND 2007-2012



Source: Author's calculations from IPUMS CPS, 2000-2012.

## Conclusion

A review of the literature on the Massachusetts Health Reform suggests thus far it has mainly been a success: uninsurance is down, access to health care is up, self-reported health has shown improvements, and unemployment does not seem to have increased. The main drawback of the Reform seems to be costs – Massachusetts has the highest average employee contributions of any state<sup>30</sup> and there is evidence that some individuals remained uninsured because their employer plans are expensive. Still, this situation has not prevented Massachusetts from having by far the lowest uninsurance rate in the country. More research is needed to determine if lower labor force participation among older workers is due to the Reform and, if so, if it is even a bad thing – if unhealthy workers are able to leave their strenuous jobs early, it may not be a negative outcome. In any case, to those using the Massachusetts Reforms as a “crystal ball” for the ACA, the view seems to be mostly positive.

## Endnotes

- 1 Massachusetts Acts of 2006.
- 2 Aside from the obvious difference that the Massachusetts Reform was a state-level policy while the ACA is a national policy, other minor differences exist. For example, the individual exemption under the Massachusetts Reform is at a higher income level than the ACA; penalties in Massachusetts are more tapered for low-income individuals; and the ACA exempts larger firms from the employer mandate than does the Massachusetts Reform.
- 3 The fine for failure to comply was \$295. This mandate was repealed in 2013 so that it did not overlap with the federal mandate as part of the ACA.
- 4 Commonwealth Care will be eliminated at the end of June 2014 and replaced by either MassHealth (Medicaid) or a subsidized plan known as Connector-Care, depending on an individual's income.
- 5 It is worth noting that the uninsurance rate in Massachusetts was below the national average before health reform as well. For example, in 2006, the uninsurance rate in Massachusetts for 19-64 year olds was 12.4 percent compared to 19.7 percent nationally.
- 6 Blue Cross Blue Shield of Massachusetts Foundation (2014).
- 7 Cogan, Hubbard, and Kessler (2010). Graves and Gruber (2012) argue that the difference is not statistically significant.
- 8 Blue Cross Blue Shield of Massachusetts Foundation (2014).
- 9 Long, Goin, and Lynch (2013).
- 10 Massachusetts Health Policy Commission (2014).
- 11 Long, Stockley, and Dahlen (2012). Long and Masi (2009) reported similar findings using survey results through 2008.
- 12 Long and Fogel (2014).
- 13 Another view presented by the authors is that physicians were simply improving their efficiency (Bond and White 2013).
- 14 Gruber (2013).
- 15 Smulowitz et al. (2014). It is worth noting that in Oregon an experiment expanding Medicaid coverage to randomly selected, low-income individuals found an increase, albeit a statistically insignificant one, in emergency room admissions among that group (Baicker et al. 2013).
- 16 Smulowitz et al. (2011).
- 17 Miller (2012).
- 18 Kolstad and Kowalski (2012).
- 19 The differences were small, but statistically significant (Van Der Wees, Zaslavsky, and Ayanian 2013). Baicker et al. (2013) found that participants in the Oregon Medicaid experiment (see footnote 15) self-reported significantly better health and were significantly less likely to be diagnosed with depression, but did not show significant improvements in physical health.
- 20 Long, Stockley, and Dahlen (2012).
- 21 Miller (2012).
- 22 Sommers, Long, and Baicker (2014). The authors acknowledge that their study cannot demonstrate causality, i.e., if other factors changed in Massachusetts aside from the Health Reform, then lower mortality may be due to those factors and not the Reform.
- 23 The study found that "Delaware, Minnesota, Nebraska, and Wisconsin were the states identified as most similar to Massachusetts in employment over the 2004-2006 period based on cluster analysis" (Dubay, Long, and Lawton 2012). These states were the four comparison states used by the study.
- 24 For example, see Gabel, Whitmore, and Pickreign et al. (2008).



25 Gruber and Madrian (2004) discuss the likelihood that having a health plan option outside of employment increases the risk of early retirement, although not in the context of the Massachusetts Reform.

26 Six-year windows were chosen to ensure a large enough sample size for each state. 2006 is excluded because that is the year in which the reform occurred.

27 Dubai, Long, and Lawton's (2012) analysis of *employment* rates, cited earlier, differs from this *brief* for two main reasons: (1) their study examined a different set of comparison states and (2) they examined all workers over age 16.

28 Congressional Budget Office (2014).

29 It is worth noting that in the United States as a whole there was a similar, but slightly smaller increase in the share of older, out-of-the labor force workers receiving their insurance from public sources. This outcome is likely due to the effects of the recession.

30 Henry J. Kaiser Foundation (2014). While premiums in Massachusetts did grow faster after the reform, they were also higher than the national average before the reform.

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