EDITORIALS

Massachusetts Health Disparities: Key Lessons for the Nation

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In September, 2010 the US Census Bureau announced the number of uninsured persons in the USA had risen to the highest ever recorded at 50.7 million. How much of a dent the Patient Protection and Affordable Care Act (Pub. L. 111-148, PPACA, commonly known as national health insurance reform) will make on this crisis remains an ongoing question. While modeling estimates suggest that up to 32 million may gain coverage, many look to the Massachusetts health reform efforts begun in 2006 as a more real world experience of what may actually happen at the national level. Similarities between both plans include Medicaid expansions, subsidies for low income persons to obtain private coverage, business tax credits, individual and business mandates. Analyses using distinct datasets have shown that after the Massachusetts law was enacted, coverage in the state increased by approximately six percentage points.¹ However, these are unadjusted pre-post comparisons. How of much of that change can be specifically attributed to the legislation has remained unclear.

In this issue of JGIM² Zhu et al. try to tackle that question. In the analysis the authors adjust BRFSS coverage data for potential changes in important predictors of coverage. They employ a technique in health policy research where actual randomized experiments are rarely possible. They use a quasi-experimental approach to compare changes in coverage in Massachusetts to those of nearby states having baseline coverage rates well above the national average but where large scale health reforms were not enacted. They show that after adjusting for other important predictors of coverage, the gains seen in Massachusetts were not evident in other states. These findings strongly suggest that national health reform will improve coverage.

However, it is important to note the large differences in baseline proportion uninsured, 17% in the nation versus 7% in Massachusetts. Thus, in the adjusted analysis the absolute improvement in coverage experienced in Massachusetts was only three percentage points. Whether the PPACA will improve coverage by a few percentage points or decrease the proportion uninsured by at least half as predicted by modeling is not clear. In addition, as Zhu et al. show, without more fundamental changes in the health care system, the simple provision of an insurance card will do little to improve other important measures of access to care. The shortage of primary care providers and lack of major initiatives to address this problem

remain a major concern both for Massachusetts and the nation, particularly in rural and medically underserved areas.

Another major area of policy interest has been how vulnerable populations will fare under health reform. Zhu et al. show that while health reform did improve coverage for racial/ethnic minorities and low income persons, after adjusting for covariates, disparities in access were not narrowed. Further, as repeatedly documented, increased coverage by itself will not necessarily lead to increased access to quality health care among populations facing a myriad of additional social and cultural barriers.³ In contrast to these findings, unadjusted data from the Massachusetts Health Reform Survey suggest that by 2009, there was a narrowing of the insurance gap.¹ Yet even in that survey, racial/ethnic minorities continued to report more emergency department visits for non-emergent conditions and lower quality of care than non-Hispanic whites.

Some early lessons are clear. First, do not dismantle the safety net. Under reform, Federally Qualified Community Health Centers in Massachusetts fared reasonably well due to slightly higher and faster reimbursements than the prior uncompensated care pool. However, many safety net hospital systems and in particular the two largest, Boston Medical Center (BMC) and Cambridge Health Alliance (CHA), saw dramatic decreases in funding as a result of the reform.⁴ These included decreases in disproportionate share hospital (DSH) payments, reductions of approximately one-quarter in Medicaid payments, and losses of more than one-third of the funding they used to receive as part of the uncompensated care pool.

Second is not to forget about health disparities as a separate but critical component of reform. The PPACA contains a large number of provisions to specifically address disparities.⁵ Similarly, the Massachusetts legislation called for the creation of a Health Disparities Council to develop recommendations on minority health, including disparities in disease rates among communities of color, social determinants of health, and workforce diversity. Due to leadership changes and subsequent logistical challenges, progress has been slower than expected. Only recently have robust efforts begun to maximize the potential of this Council. Further, the recession virtually eliminated any discretionary funds or budgetary resources that might have been used to develop legislation and grant programs in this area.

Lastly, as discussed by Zhu et al., the legislation included some important "pay-for-performance" disparities goals. However, challenges in administering these provisions, budgetary constraints and some pushback by stakeholders (on appropriate metrics and measures) have resulted in placing these aspects of the legislation on temporary hold. Hopefully, research like this will reinvigorate efforts in Massachusetts

to move ahead with these meaningful planned disparities initiatives.

So what can we expect nationally based on the Massachusetts experience? While the PPACA will lead to improvements in coverage, the magnitude remains unclear. In addition, without more systematic changes in health care delivery, and especially without a strong focus on strengthening the primary care infrastructure, the provision of an insurance card alone will do little to improve access. Also, narrowing of disparities will require maintenance of a robust safety net and attention to ensure important disparities provisions are fully funded and carried out as intended.

Last, is the issue of cost. The PPACA has been priced out by the Congressional Budget Office at slightly under a trillion dollars over the next ten years. Single payer advocates argue we could have covered many more, in a much more equitable fashion, for much less cost had we chosen to pursue an enhanced "Medicare-for-all" approach to health reform.

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