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Massachusetts Health Reform: Impact on Women's Health

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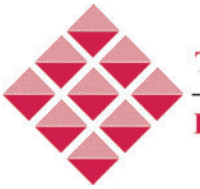

The Massachusetts Health Policy Forum

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THE CONNORS CENTER FOR WOMEN'S HEALTH AND GENDER BIOLOGY

The Connors Center is committed to improving the health of women and transforming their care through leading-edge research on women's health and sex and gender-based differences, and the application of this knowledge to the delivery of care. The Connors Center leads in the development of innovative interdisciplinary clinical, research, education, policy and global health leadership initiatives. The **Women's Health Policy and Advocacy Program** was established to promote the Connors Center's goal of informing policy to improve women's health. The mission of the program is to improve policy at all levels – local, state and national – to promote the highest standard of health and health care for all women.

THE MASSACHUSETTS HEALTH POLICY FORUM

The Massachusetts Health Policy Forum is a non-profit, nonpartisan organization dedicated to improving the health care system in the Commonwealth by convening forums and presenting the highest quality research to legislators, stakeholders and the public. The Forum was created to bring public and private health care leaders together to engage in focused discussion on critical health policy challenges facing the Commonwealth of Massachusetts. The mission of the Forum is to provide the highest quality information and analysis to leaders and stakeholders. The Forum provides an opportunity to identify and clarify health policy problems and to discuss a range of potential solutions.

EXECUTIVE SUMMARY

Even before health reform, women in Massachusetts enjoyed relatively good access to health care compared to women in many other states, with higher rates of insurance coverage, a long list of mandated benefits covering essential women's health services, and strong consumer protections. Chapter 58 did not try to address every issue relating to health care access, quality or cost; its primary goal was to increase the number of residents with health insurance. That goal has been achieved for women and men, with efforts to cover uninsured residents continuing today. A substantial number of women who remain uninsured appear to be eligible for subsidized coverage through MassHealth or Commonwealth Care, indicating a need for targeted outreach and enrollment programs.

Along most measures, access to care has also improved, although some women remain at risk for gaps in access to specific services. Reasons for this are varied, and include health system problems that pre-date reform, logistical challenges that have been magnified since 2006, and gender-related issues that disproportionately impact women.

A theme that emerges across a range of demographic profiles and sources of coverage relates to navigating the health care system. Cumbersome administrative requirements, frequent transitions in coverage, and changes in the locus of care have had a negative impact on coverage and access for many women. Often the reasons for coverage transitions are gender-related; low-income women, immigrants, and young adults are particularly affected. Women with problems accessing care remain in need of specific monitoring and services.

High health costs remain a challenge as well. A substantial number of women in all income groups report high out-of-pocket costs, problems paying medical bills, and ongoing medical debt. The affordability standard for exemption from the individual mandate may not reflect the true costs of health care, as it takes into account only the cost of premiums and excludes out-of-pocket costs.

Affordability may be a particular problem for certain groups of women, including low-income women; near-elderly women who are subject to age rating and are more likely to need extensive medical care with high associated costs; and younger women who have serious medical issues. The challenge of rising health costs pre-dates health care reform and is not limited to Massachusetts; however, the state's success in expanding coverage may have intensified affordability problems among women.

Data collection is a key challenge for women's health researchers. Most research on Massachusetts health reform stratifies just a handful of measures by sex, although other population characteristics such as age, income, race and ethnicity, and health status are routinely analyzed. Both survey and focus group results are suggested to fully understand the individual experiences of patients and providers since implementation of Massachusetts health reform. Given women's vulnerable yet critically important relationship with the health care system, a concerted effort to monitor and make available information on their health coverage, access, and affordability is vital to ensuring the best possible outcomes from health care reform.

A number of opportunities remain as health reform builds on the success of coverage expansions and moves toward cost containment and delivery system reform. First, data suggest that Hispanic women remain at a disadvantage in coverage and access versus other racial and ethnic groups. Massachusetts has achieved notable advances in reducing disparities in coverage and access overall, but there is a need for additional research as well as targeted intervention aimed at improving access to care among this population. Second, primary care shortages were exacerbated by coverage expansions in Chapter 58. Strategies to address this problem are included in the state's 2008 health reform law, but must take into account gender-related factors affecting women as physicians as well as patients. Last, while health reform was not designed to target every population with unique health needs, there is an opportunity for future policy attention aimed to improve support for caregivers and address gaps in care among incarcerated women.

Women have greater utilization of health care resources, specific and unique reproductive and lifelong health needs, and serve essential roles as managers of family health. Given the state's national leadership in health policy, it's important for Massachusetts to explicitly acknowledge and prioritize the advancement of women's health as an integral element of health care reform.

KEY FINDINGS

- **MA health reform has substantially improved health coverage for women of all demographic profiles.** About two-thirds of newly insured women are covered by publicly-subsidized programs (MassHealth and Commonwealth Care). Minimum Creditable Coverage requirements include a wide range of essential women's health services.

- **Access to care has also improved, although some women remain at risk for gaps in access to specific services:**
  - Young women and low-income women still face some barriers to accessing contraceptives.
  - Hispanic women have poorer access to some services, including dental care.
  - Immigrant women have fewer benefits and less stable coverage.

- **Costs remain a problem for many women in all income and demographic groups.** Commonwealth Choice premiums may be high for some women, particularly near-elderly women, who are subject to age rating, and women with moderate incomes.

- **Frequent transitions in coverage and access create access gaps for many women,** who are more likely to cycle through eligibility for coverage programs and often serve as managers of family health.

- **There is significant opportunity to better understand the impact of Massachusetts health reform on women's health.** Until now, most research stratified just a handful of measures by sex. Routine assessment of women's access, coverage and costs recognizes the central role women have in advancing family and community health.

INTRODUCTION

Massachusetts' landmark health reform has achieved the goal of near-universal health insurance coverage and is a model for national health care reform. While the state's approach has been broadly scrutinized, limited research exists on the impact of Massachusetts health reform on women's health. The state's 2006 reform law, Chapter 58, was designed to increase insurance coverage and improve access to affordable, quality care. Additional issues affecting women's health, such as frequent transitions in coverage, were not the target of Chapter 58 but are magnified by health reform, have a differential impact on women, or remain opportunities for future policy intervention. Women in Massachusetts have historically enjoyed extensive access to essential health services; understanding health reform in the broader context of women's health is vital to realizing additional opportunities for improvement and addressing ongoing and new challenges.

Health reform is a women's health priority.[1] Women utilize more medical services than men throughout their lives and have higher annual health care expenses.[2,3] Because women tend to have lower incomes, they are more likely to face challenges affording and accessing care.[4] Women are more likely to transition in and out of the workforce, more likely to be employed on a part-time basis, and are more likely to be covered as a dependent through a spouse's insurance, leaving them vulnerable to changes in health insurance status and gaps in coverage.[5] Older women are more likely than men to have multiple chronic illnesses with high associated costs, and difficulties coordinating care from various providers.[6] Women more often serve as the managers of family health, and as caregivers for their families and friends,[7] which may lead to higher rates of chronic disease.[8]

Until now, there has not been a comprehensive assessment of women's experiences with Massachusetts health reform. Most research on Massachusetts' approach stratifies data by income, age, health status, race and ethnicity, but rarely by gender, despite women being vulnerable health care consumers. **Appendix A** describes the few studies measuring women's experiences to date; these are also listed in the Massachusetts Women's Health Data Matrix.[i] Notably, a new report from the Blue Cross Blue Shield Foundation of Massachusetts examines coverage, access and affordability among women using data from the 2009 Massachusetts Health Reform Survey.[9] The Foundation's report was produced as a companion to this issue brief and should be read concurrently for a complete view of data and analysis available to date.

Evaluating Massachusetts health reform from a women's health perspective yields insight on coverage expansions for many of the state's most vulnerable residents, and provides timely information to inform health policy and clinical care in the rapidly unfolding landscape of national health reform. The goal of this brief is to assess how women in Massachusetts are faring after health care reform, and to highlight remaining challenges. To do that, we review the background, context and details of health reform relevant to women's health. We then examine improvements and challenges in coverage and access, including benefits that are vital for women and access to essential health services. Next we consider the affordability of health insurance and medical care. Last, we focus on issues not explicitly addressed by Chapter 58, including

[i] The Massachusetts Women's Health Research Data Matrix is an evolving compilation of data sources available from state agencies, research organizations, and advocates. Contributions are welcome and should be submitted to the Women's Health Policy and Advocacy Program at the Connors Center for Women's Health and Gender Biology, Brigham and Women's Hospital. Please see www.brighamandwomens.org/womenspolicy for updates.

implications for future reform efforts in the state. Our goal is to set a baseline for ongoing monitoring of the effects of Massachusetts health reform on women, in order to achieve the best possible outcomes for all residents of the Commonwealth.

Women and Health Reform in Massachusetts - Background and Context

Massachusetts has a long history of expanding access to health care, as reflected in high levels of coverage and access among women even before health care reform. For example, in 2004, just 10 percent of non-elderly women in Massachusetts were uninsured compared to 18 percent of women across the country.[10] Rates of cholesterol screening, first trimester prenatal care, and mammography screening were higher among women in Massachusetts compared to the national average.[11] Massachusetts women also had lower rates of maternal mortality, death from coronary heart disease, and diabetes than the U.S. overall.[12]

As is the case nationally, women in Massachusetts have historically been insured at higher rates than men. This is primarily due to categorical eligibility for Medicaid, which includes pregnant women, and this advantage remains today. Additionally, even before health reform was enacted in 2006, Massachusetts required insurers to cover a robust list of benefits encompassing many essential services for women, including maternity services, minimum maternity stay, contraceptive services,[ii] mammograms, cytologic screening, mental health care, home health services, preventive care for children, and infertility care.[13] In contrast, in many other states, insurers offer "bare bones" policies excluding such services, leaving many women without access to vitally important care. Massachusetts also has protections in its insurance laws that many states do not have, including prohibiting gender to be used as a basis for rating for health insurance.

Despite these advantages, prior to health reform's passage in 2006, women fared worse than men in the state on key measures affecting health status and access to care. Between 2001 and 2005, median annual earnings for women were approximately three-quarters of median annual earnings for men. Women also headed 72 percent of Massachusetts families living below the poverty level.[14] During the same period, twice as many women as men in the state had health coverage as dependents, leaving them vulnerable to losing insurance due to changes in family status.[15] Just 44 percent of women were covered under their own job-based insurance, compared to 59 percent of men.[16] Similarly, women in the state reported poorer mental health than men, [17] and filled an average of 50 percent more prescriptions each year.[18] Racial and ethnic minorities, immigrants, and young women in Massachusetts have historically faced barriers to obtaining health coverage and timely and appropriate medical services.[19]

Massachusetts health reform was not designed to remedy economic differences between women and men or address gender disparities in health status, yet these indicators are relevant to health coverage, affordability, and access to care. Chapter 58 created a system of "shared responsibility" among health care stakeholders and a web of public and private health insurance options for residents. While the model has produced the highest rates of health coverage in the

[ii] The contraception mandate does not apply to churches or church-controlled entities. In addition, these mandates do not apply to self-funded health plans.

nation, there remains the burden of navigating an increasingly complex system, particularly for women with low incomes who often transition through a network of publicly funded programs to access care. Eliminating racial and ethnic disparities is a stated goal of Massachusetts' approach, but it does not explicitly recognize women's health as a key to improving the health of families and communities.

Sources of Data

Research on the intersection of Massachusetts health reform with women's health and access to care is limited. Some data are found in state and national surveys estimating rates and distribution of health insurance coverage and measuring access to care,[20] and reports from state agencies including the Commonwealth Health Insurance Connector Authority (Connector) and the Massachusetts Division of Health Care Finance and Policy.[21] Several organizations – including the Center for Women's Health and Human Rights at Suffolk University, Ibis Reproductive Health in collaboration with the Massachusetts Department of Public Health Family Planning Program, and the Connors Center for Women's Health and Gender Biology at Brigham and Women's Hospital – have engaged in specific research on key aspects of women's health policy in Massachusetts since reform, including affordability and access to preventive screenings and reproductive health services.[22] Their work contributed significantly to parts of this report. Last, the new report from the Blue Cross Blue Shield of Massachusetts Foundation is a major resource.[23] For a fuller description of data sources used in the issue brief, please see **Appendix A.** For a complete list of available data sources and research that can be stratified by sex, please see the **Massachusetts Women's Health Research Data Matrix**.[24]

IMPROVEMENTS AND CHALLENGES IN COVERAGE AND ACCESS

Health insurance is critical to women's access to care. Women without health coverage are less likely to obtain needed preventive, primary care, and specialty services, receive poorer-quality care, and have poorer health outcomes than women with insurance.[25] Health insurance is also linked to economic opportunity, improving annual earnings and increasing educational achievement.[26] Nationally, an estimated 45,000 excess deaths occur annually due to lack of health insurance, in addition to unnecessary pain and disability suffered by those unable to access care.[27]

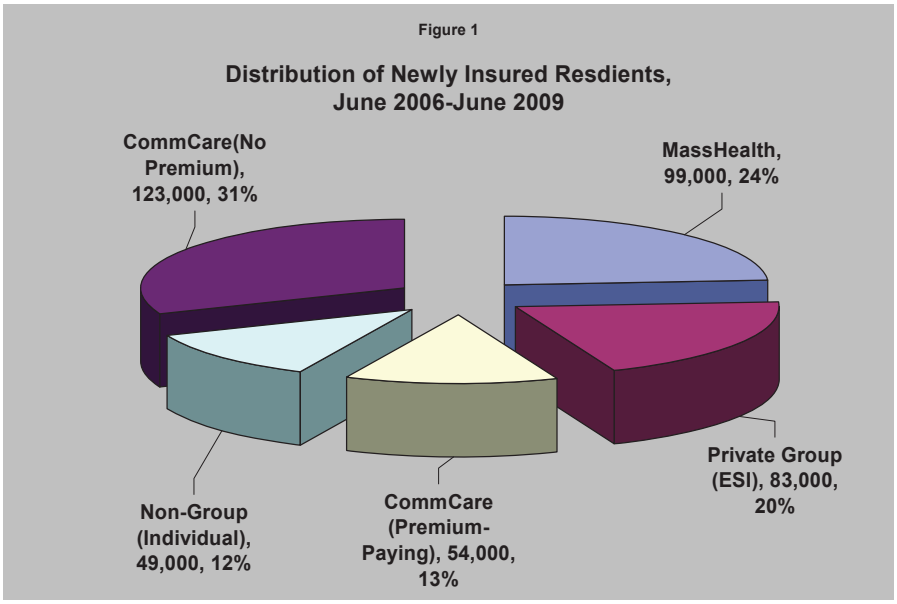
Among women in Massachusetts, health insurance coverage has improved significantly since health care reform.[28] Access to care has also improved, although some problems remain.[29, 30] Certain issues that were beyond the scope of Chapter 58, such as primary care shortages, are addressed to some degree in Massachusetts' 2008 health reform law (Chapter 305).[31] In a few areas, health reform has exacerbated or created new barriers for women accessing health care. Health coverage, access and affordability are also affected by the economy, and it is important to consider the impact of the recession on such indicators.[32]

In Massachusetts, as in other states, health coverage is available through a variety of private and publicly funded sources. The state's landmark 2006 health reform law, *An Act Providing Access to Affordable, Quality, Accountable Health Care*, mandated that individuals carry a minimum level of health insurance coverage. Larger employers that do not offer health insurance to employees are required to pay a small fine. Chapter 58 also combined the individual and small group market and made insurance options available through a health insurance exchange (the Connector). A first step toward cost containment was taken with the 2008 health reform law, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care*, aimed at increasing value and quality in the health care system. Significant reform of the payment and health care delivery system is currently under consideration.

Improvements in Coverage Since Reform

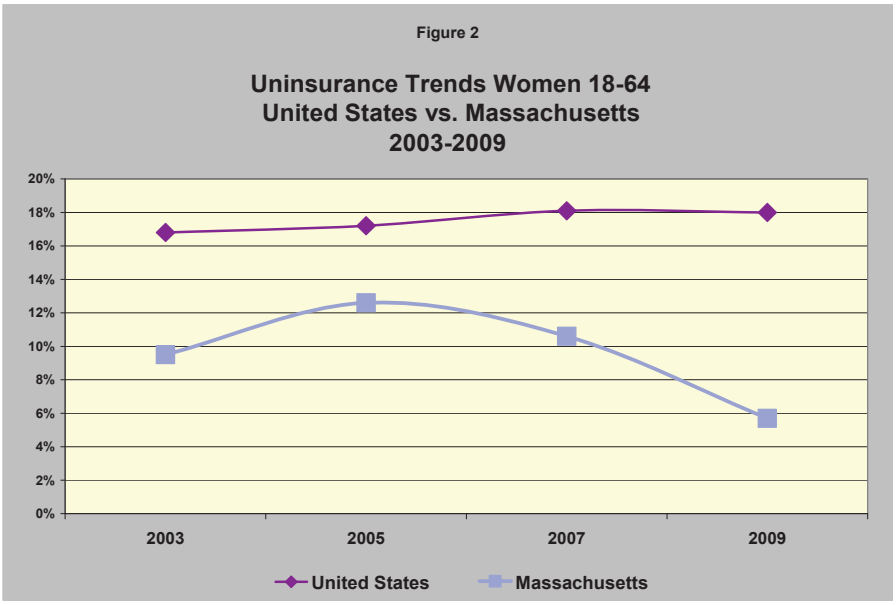
Overall, since health reform, the number of uninsured residents has decreased significantly, with about 364,000 people gaining health coverage as of September 2009.[33] The majority of newly insured residents (68 percent) obtained subsidized health insurance through MassHealth or Commonwealth Care. The remainder (32 percent) obtained coverage through private employer-sponsored or individual plans.[34] **(Figure 1)**

Prior to health reform, women were uninsured at lower rates than men (10 percent vs. 16 percent),[35] primarily due to their greater eligibility for MassHealth. While gains in health coverage have particularly helped men, men still comprise a larger share of uninsured residents.[36]



Source: Massachusetts Division of Health Care Finance and Policy.

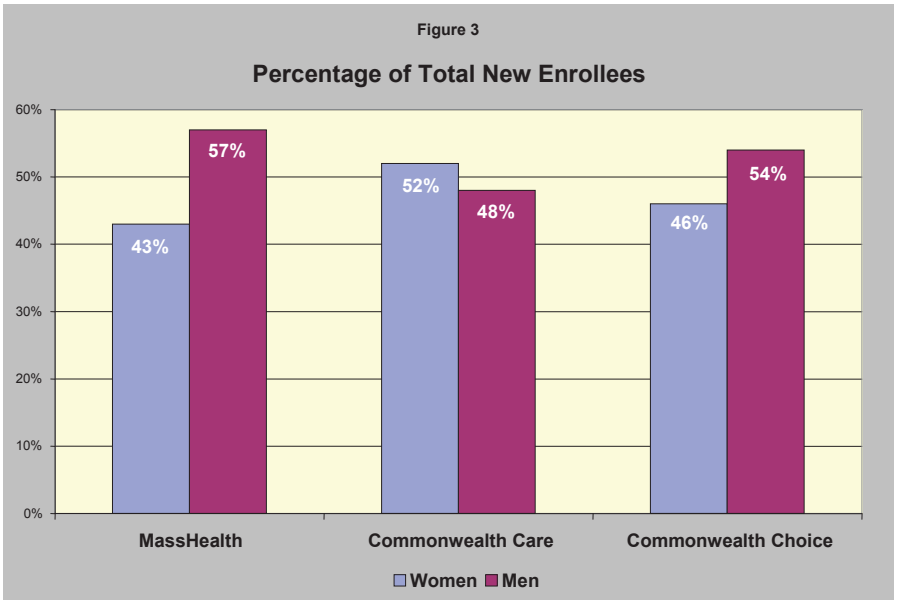
Among women in the state, significant coverage gains were experienced by all subgroups examined in the Massachusetts Health Reform Survey, including those with lower incomes, women of minority race or ethnicity, non-elderly women ages 50 – 64, and women without dependent children.[37] Compared with women nationally, the uninsurance rate in Massachusetts has dropped sharply since health care reform while the rate nationally has increased.[38] **(Figure 2)** The largest gains among women were in publicly subsidized coverage rather than privately funded health plans.



Source: Current Population Survey, 2003-2009. [iii]

[iii] CPS estimates are generally higher than other survey estimates, including the Massachusetts Health Insurance Survey. An explanation of differences in survey estimates is available at /www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/his_policy_brief_estimates_oct-2009.pdf

Since 2006, more men than women have enrolled in MassHealth – 57 percent male vs 43 percent (about 44,900 men and 33,800 women). **(Figure 3)** However, women comprised 76 percent of *total* MassHealth enrollees in 2009.[39] Enrollment in Commonwealth Care plans is more evenly split between the sexes, with 52 percent women vs 48 percent men.[40] For Commonwealth Choice plans, the share of male subscribers (54 percent) exceeds the share of female subscribers (46 percent).[41] Four years after implementation of health reform, *total enrollment* in subsidized health plans (MassHealth and Commonwealth Care) remains higher for women than for men.



Source: Massachusetts Division of Health Care Finance and Policy

Despite sizeable gains in publicly subsidized coverage, employment remains the most common source of health coverage in Massachusetts, with 74 percent of non-elderly residents covered by employer-sponsored insurance (ESI) in 2009.[42] Women in Massachusetts with ESI are more likely than men to be covered as a dependant on someone else's policy rather than having coverage in their own name.[43] However, Massachusetts women are less likely than women nationally to have dependent coverage.[44]

In addition to favorable rates of health coverage, Massachusetts has strong consumer protections governing health plans which pre-date health reform. No private health insurer in Massachusetts can deny coverage based on gender, age, occupation, health status, or actual or expected health condition. Moreover, gender rating is prohibited.[45,46] While state law allows insurers to use pre-existing conditions waiting periods of up to six months, none of the major private health insurance carriers impose such exclusions.[47,48] Massachusetts law also prohibits insurers from designating pregnancy or domestic violence as pre-existing conditions.[49] These regulations apply to publicly-subsidized and commercial health plans; self-insured plans, such as those often established by large employers, are exempt from such regulations by federal law (ERISA[50]), although many voluntarily comply.

Policy Implications. Massachusetts began implementing journey with health reform in a relatively strong position compared to other U.S. states, with higher rates of insurance coverage and strong consumer protections for women. These conditions likely contributed to rapid coverage gains among women and men. Subsidized plans are absorbing the largest share of those who were previously uninsured, exasperating state budget concerns.

Covered Benefits

Even prior to health reform, Massachusetts insurers were required to cover a broad range of health services important for women, including maternity care, minimum maternity stay, contraceptive services, mammograms, cytologic screening, mental health care, home health services, and infertility care. (For the full list, see **Appendix C**) Charged with developing "Minimum Creditable Coverage" standards (MCC) for the individual mandate, the Connector Board incorporated all 26 existing benefit mandates, requiring most residents to have coverage for a wide range of essential women's health care.

To keep premium rates low for young adults, a population that has historically been disproportionately uninsured, Student Health Plans (SHPs) and Young Adult Plans (YAPs) are exempt from MCC standards yet still satisfy the individual mandate.[iv] This has a disproportionately adverse impact on young women. Although plan benefits vary, some SHPs cover low cost services but not more expensive care. SHPs include coverage for primary and preventive care, hospitalization, surgical services, ambulatory and emergency services, and mental health, but are not required to cover prescription drugs, and can have annual caps on total payment for benefits[v] (generally $50,000 per year).[51] Similarly, YAPs, designed specifically for 18 – 26 year olds, are, by legislative mandate, exempt from some MCC requirements such as prescription drug coverage, in an effort to contain premium costs.

Policy Implications. Benefit mandates already in place covering a wide range of preventive and acute care services undoubtedly facilitated the comprehensive benefit package in MCC regulations. At the same time, young women enrolled in some YAPs and SHPs are not covered for the same set of services, as those plans are biased to cover low cost medical care and not necessarily more expensive care. This leaves young adults enrolled in these plans with exposure for high health care expenses in cases of serious illness. (See Malika's Story, **Appendix D**)

Access to Essential Women's Health Services

Massachusetts' coverage expansions have improved women's access to care, including gains in the share of women with a doctor visit for general and preventive care, and reductions in unmet need for care.[52] Newly insured women also cite reduced stigma and other emotional and psychological benefits of having insurance.[53] At the same time, for some women, challenges remain in the wake of health reform in access to specific health services.

[iv] SHPs do have to comply with underlying mandated benefits.
[v] On April 13, 2010, Governor Patrick announced a new health plan option for students enrolled in community and state colleges that removes caps on certain services and lifts benefit maximums.

Reproductive health and preventive services including breast and cervical cancer screening are vital to women's health. Monitoring women's access to specific services after health reform allows identification of any remaining gaps, providing a roadmap for future efforts to improve coverage and/or the delivery of care.

Reproductive Health

Prior to health reform, many low-income women accessed contraception and other reproductive health services through family planning clinics and community health centers. Among women now covered through Commonwealth Care, most report they continue to have relatively easy access to reproductive health services since becoming insured.[54] Family planning clinic providers agree that health reform has increased access to contraception, with newly-covered women more likely to seek out services. However, with expanded coverage, some new barriers to contraceptive access have developed.[55]

Specifically, some low-income women report that changes in the way they access contraceptive services since health reform have created new hurdles.[56] Certain traditional providers of reproductive health care, including family planning or community health centers, are not covered under private health plans.[57] Since becoming insured, women receive prescriptions to take to a pharmacy as opposed to receiving contraceptive supplies directly from their family planning clinic.[58] Some newly insured women do not understand how to use a prescription, and their pharmacists do not understand Commonwealth Care plans.[59] As a result, women must return to family planning clinics for assistance.[60]

Similarly, young women participating in a recent focus group reported a strong sense of security from being insured, but identified a number of health system factors that impact their access to contraception.[61] For those enrolled in MassHealth and Commonwealth Care plans, the low cost of prescription contraceptives and the range of contraceptive services are highly valued.[62] At the same time, frequent administrative changes are challenging and sometimes translate to higher prescription drug costs without warning.[63] For young adults enrolled in YAPs and SHPs without a prescription drug benefit, barriers to obtaining prescription contraceptives are more significant and are resulting in gaps in contraceptive use.[64]

Confusing information and administrative issues also impact access to contraceptive and other services. A recent analysis of the Commonwealth Care website found that information pertaining to specific types of contraceptive services was often difficult to access.[65] Additionally, cost for contraceptive services varied by plan and abortion coverage was often unclear.[66] Family planning agencies and providers have reported problems with billing and contracting with Commonwealth Care plans.[67] Low-income women have reported difficulty maintaining coverage, are often dropped without understanding why, and due to frequent moves or other life changes, do not receive requests for or struggle to provide the documentation needed to maintain coverage.[68] Among women whose eligibility fluctuates, there is little understanding as to why they are transitioned between different plans.[69] For young women who have frequent changes in address, the need to re-certify eligibility for benefits through paperwork sent by mail has affected their continuous use of contraceptives.[70]

Notably, cost does not appear to be a major barrier to low-income women's access to contraceptives after health reform. While a minority of women who use many medications in addition to contraception find cost to be a barrier, most low-income women report that their out-of-pocket costs for contraceptives are not prohibitive.[71] For younger women, the cost associated with various contraceptive methods is a factor influencing method choice.[72]

Abortion was not a political issue in enacting health reform. Massachusetts is one of 17 states funding medically necessary abortion for Medicaid recipients in all or most circumstances (not limited to rape, incest, or endangerment of the mother's life).[73] Access to abortion has been facilitated by the state's generally pro-choice political environment, limited number of religious health care providers, lack of sectarian health plans, and small number of Catholic hospitals. A recent study found that the total number of abortions performed in Massachusetts between 2006 and 2008 declined by 1.5 percent, despite thousands of women having new coverage for this service.[74] This decline continues a steady overall downward trend in the abortion rate preceding 2006.[75]

> Policy Implications. Expanded access to contraceptives has been accompanied by an increase in administrative and logistical challenges for some women. Access to familiar providers and administrative simplicity remain areas of particular concern, suggesting that many women would benefit from services to help them navigate the health care system. For young women enrolled in plans without a prescription drug benefit, access to contraceptives remains a challenge. As women in their 20s account for over half of all unintended pregnancies,[76] facilitating access to contraceptives for young adults is essential. It is not known whether the decline in Massachusetts' abortion rate since 2006 is related to expanded contraceptive access, as complex social and political factors also influence decisions regarding abortion.[77]

Dental Care

Access to dental services among women in Massachusetts has improved since 2006, with an increase in the share of non-elderly adult women reporting a dental visit in the past 12 months.[78] Similarly, there has been a decrease in the share of women who did not get dental care because of costs.[79] At the same time, racial and ethnic disparities remain.[80] For women and men, dental health can affect a variety of physical and social functions, including nutrition, digestion, speech, social mobility, employability and quality of life.[81] Poor oral health is linked to diabetes, heart disease, respiratory disease and stroke.[82]

Insurance coverage of dental services for low-income residents has varied over time. Between 2002 and 2006, Massachusetts reduced dental benefits for adult MassHealth enrollees, approximately 75 percent of whom were women. With health reform, the state restored dental coverage for adults enrolled in MassHealth and provided benefits without cost-sharing to Commonwealth Care enrollees with incomes under 100 percent Federal Poverty Level (FPL).[83,84] Enrollees with incomes over 100 percent FPL do not receive dental benefits through their health plans, and dental benefits are not required to demonstrate Minimum Creditable Coverage.

Among minority women, the share of those who did not get needed dental care for any reason in the past 12 months dropped significantly between 2006 and 2009. There was an even greater decrease in the share of minority women who did not get needed dental care due to costs.

However, in 2008, the percentage of minority women in Massachusetts without a dental check-up was 80 percent higher than the percentage of white women.[85] The disparity between white women and minority women in unmet access to dental services is the highest among the 50 states.[86]

> Policy Implications. Significant improvements in the share of women accessing dental care since 2006, particularly after a period of cuts in benefits among MassHealth enrollees, suggests that dental benefits are a particularly acute need among low-income women. It is not known whether sharp disparities between minority and white women are related to coverage for dental services or attributable to factors unrelated to health reform. The lack of dental benefits in many private and publicly-subsidized health plans, coupled with evidence of disparities, suggests a need for additional focus on these vitally important services.

Primary Care

Women use more primary care than men throughout their lives. In 2009, women in Massachusetts across a range of demographic characteristics reported difficulty finding a provider who was accepting new patients or accepting patients with their type of health coverage.[87]

Several medical specialties that are vitally important for women's health met the criteria for severe labor market conditions in Massachusetts in 2009, including Family Medicine, Internal Medicine, and Obstetrics and Gynecology (Ob/Gyn).[88] Ob/Gyn is on the list for the first time since the Massachusetts Medical Society began its Physician Workforce Study in 2002.[89] As a result, women with new health coverage are entering a marketplace with decreasing numbers of primary care physicians accepting new patients. **(Table 1)** The emerging critical shortage of Ob/Gyn physicians is significant in that many women use Ob/Gyn doctors as their main source of primary care.[90] For many specialties, the tightening physician labor market in Massachusetts over the past two to four years mirrors national trends.[91]

Table 1
Massachusetts Primary Care Providers Accepting New Patients [92]

Service	Percent in 2008	Percent in 2009
Family Medicine	65	60
Internal Medicine	52	44
Obstetrics and Gynecology	92	81

Even for women with a primary care provider, wait times for appointments are exceedingly long across the state. In 2009, wait times for Internal Medicine and Family Medicine appointments for new patients averaged 44 days, while Ob/Gyn wait times average 46 days. In Boston, the numbers are more staggering: estimated wait times for Ob/Gyn appointments averaged 70 days in 2009, up from 45 days in 2004. Family practice wait times are also higher in Boston, at 63 days in 2009. [93] One study concluded that the average wait times in Boston are by far the highest in the country compared to other major U.S. metropolitan areas.[94]

Recognizing the challenges in expanding access in a tight primary care market, Massachusetts' 2008 health reform law takes steps to increase the number of primary care providers in the state. Among the strategies authorized are:

- Increasing the class size of University of Massachusetts Medical School, with an enhanced tuition incentive for students who commit to working in primary care for four years in Massachusetts;
- Establishment of a Massachusetts Primary Care Recruitment Center to attract primary care providers to rural and underserved areas, including a new loan forgiveness grant for residents and nurses in primary care;
- Expansion of the role of physician assistants and nurse practitioners, including requiring insurance companies to recognize them as primary care providers; and
- Creation of a loan forgiveness/incentive program to increase the nursing workforce and encourage nurses to pursue primary care.

> Policy Implications. Massachusetts' coverage expansions did not *cause* primary care shortages; they exacerbated and highlighted an existing problem in the health care system. Massachusetts began addressing delivery system issues, including primary care shortages, in its 2008 health reform law. Recruiting and training additional primary care physicians are threshold steps, but retention is an equally important strategy for improving access to primary care. Women comprise the majority of new primary care physicians,[95] tend to work fewer hours,[96] and express a desire for work/family balance that is inconsistent with the traditional demands of primary care practice.[97] This suggests that strategies to expand the primary care workforce and create new models of care delivery should include efforts to address the needs of women as providers as well as patients.

Mental Health Care

Massachusetts has long-standing mental health parity legislation that pre-dates health reform. Regulations require private insurers providing mental health benefits to cover diagnosis and treatment of specified, "biologically-based" mental health disorders[98] to the same extent they cover physical disorders, in addition to covering minimum inpatient and outpatient benefits for unspecified disorders.[vi] Massachusetts' mental health parity law particularly benefits women by specifically naming several disorders that disproportionately affect women, including depressive disorder and eating disorders. [99,100]

[vi] ERISA exempts self-insured plans from state mental health regulations; however, if a self-insured plan elects to cover mental health, they must provide parity. MassHealth plans are also exempt from the mental health parity law.

Policy Implications. Mental health benefits are critical for women, who are more likely to experience poor mental health than men, and face gender-related risk factors that influence the development of mental illness.[101,102] Mental illness is also linked to higher rates of physical illness.[103] In Massachusetts, coverage of mental health services for women remains broad after health reform. However, the lack of research on access to mental health services after reform leaves it unclear whether broad coverage is translating into access to needed care. In addition to data stratified by sex, data are needed along measures of income, race, and geography, as these factors also impact access to care.

Preventive Health Screenings

Women with health insurance are more likely to receive essential preventive screenings such as Pap tests and mammograms.[104] An ongoing study – Public Health Approach to Screening and Lifestyle Intervention in Uninsured Women (ASIST 2010) – is comparing women's access to specific preventive services before and after Massachusetts health reform. The study, funded by the U.S. Department of Health and Human Services Office of Women's Health, is a collaborative of Brigham and Women's Hospital, the Massachusetts Department of Public Health, the Connector Authority, Neighborhood Health Plan and several Massachusetts community health center partners.[vii]

ASIST 2010's major goal is to examine how health reform in Massachusetts has affected non-elderly (40 - 64), low-income women's utilization of breast and cervical cancer screenings and cardiovascular disease screenings (such as blood pressure and lipid panel). The study is also examining the impact of the "Healthy Heart" cardiovascular lifestyle intervention and the importance of access to patient navigators on screening utilization and health outcomes.

To understand changes in utilization patterns after health care reform, ASIST 2010 is following a cohort of women who formerly participated in the Women's Health Network (WHN), a program offering reimbursement to participating facilities for screening services for uninsured and under-insured women ages 40 - 64. Because many WHN participants obtained health coverage through MassHealth and Commonwealth Care after health reform, WHN now focuses on patient navigation (connecting women to needed health services, providers and social services), case management and risk factor management. To understand the impact health reform had on screening utilization, ASIST researchers are comparing insurance utilization data for this cohort of women from pre-reform and post reform periods. Results from the study will be available in 2011.

Policy Implications. Preventive services such as breast and cervical cancer screenings and cardiovascular disease management are vitally important to women, particularly those over 40 years of age who are at higher risk. Where such services were formerly available to low-income women through safety net programs, it is crucial to monitor whether access is affected by coverage obtained through health reform. In Massachusetts such data will be available by 2011.

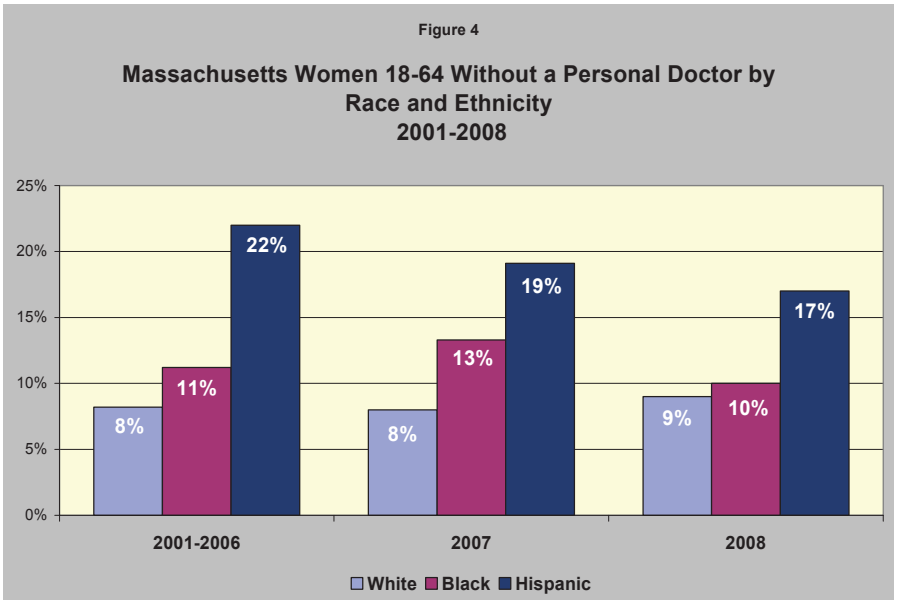
[vii] ASIST 2010 CHC Partners include: The Joseph Smith Community Health Center, the Mattapan Community Health Center, North Shore Medical Center, the Salem Family Health Center and the Lynn Community Health Center.

Access among Racial and Ethnic Minorities

Eliminating health disparities is an explicit goal of Massachusetts health reform. Analysis of the 2009 Massachusetts Health Reform Survey shows significant improvement among minority women in coverage, access and affordability. Strong improvements were seen in the share of minority women reporting preventive and general doctor visits over the past 12 months, with a corresponding decrease in the share of minority women who did not get needed care due to cost.[105] Rates of insurance coverage are almost the same for white and minority women; no other state has achieved a comparable result.

Data from the ASIST 2010 project suggest that Hispanic women ages 18 – 64 are better connected to care than before health reform, but fare worse than other racial and ethnic groups. ASIST 2010 uses data from the Behavioral Risk Factors Surveillance System Survey (BRFSS) – an annual, nationwide telephone survey tracking trends in health status, access, disparities, and risk factors.[106] Connection to care is measured by asking respondents whether they have one person they think of as their personal doctor or health care provider, and how long it has been since their last visit to a doctor for a routine checkup.[107]

Comparing responses from the period just before health reform (2001-2006) – a time of high unemployment and expanded Medicaid – with 2007 and 2008, researchers found that the share of women without a personal doctor decreased among black and Hispanic residents. Hispanic women were less likely to have a personal physician in 2008 than white women, but the gap between these groups has narrowed since health care reform. **(Figure 4)**



Source: Behavioral Risk Factor Surveillance System, 2001-2008.

Policy Implications. Health reform has significantly reduced disparities in coverage, access and affordability between racial and ethnic minority women and white women. Disparities remain between Hispanic women and those in other racial and ethnic groups, although data suggest that gaps in access are narrowing. There is a need for targeted intervention aimed at improving access to care among this population.

Access among Immigrants

Access to health insurance and adequate health care were major issues for immigrant women before health care reform, and remain so today. Eligibility for MassHealth is established by federal law, and excludes undocumented aliens and legal permanent residents (LPRs) with fewer than five years of residency. Commonwealth Care and Commonwealth Choice similarly base eligibility on citizenship status. In 2009, a new program called Commonwealth Bridge was created to provide coverage for almost 30,000 LPRs who had previously received subsidized coverage through Commonwealth Care but lost eligibility as a result of state budget constraints. Massachusetts is one of only a handful of states to provide coverage for this population.

Barriers to health care access due to limited English language proficiency continue after health care reform. Some providers believe that the individual mandate has magnified this problem, as undocumented women do not understand its requirements and believe that lack of health coverage will lead to deportation.[108] As a result, some women have ceased seeking medical care.[109] In addition, non-English-speaking residents report confusion finding appropriate coverage among the range of available programs.[110]

Other barriers are the result of coverage transitions experienced by low-income immigrant women. Unlike Commonwealth Care, Commonwealth Care Bridge does not cover dental, vision, hospice or skilled nursing care,[111] and co-pays for some services, like brand name prescription drugs, have risen dramatically.[112] Additionally, because Commonwealth Bridge has a smaller provider network, many members were required to find new primary care doctors.[113] Some immigrant women without any source of health coverage continue to rely on emergency rooms as their primary source of care or are foregoing needed care.

> Policy Implications. There is little data on the specific impact of health reform on immigrant women. Challenges accessing health care are endemic among this population. Health policy research could help to establish the benefits of providing continuous, comprehensive health coverage, particularly in an era of fiscal restraint. In the interim, assistance navigating health insurance options as well as the delivery system would benefit immigrant women.

Despite strong gains in health care coverage, costs remain a challenge for many women since health care reform, including those with incomes over 300 percent FPL and many with employer-sponsored coverage.[114] This is in part a reflection of the high cost of medical care in Massachusetts.[115] Some women report paying new premiums, deductibles and co-pays as a result of health reform, while others report paying less out-of-pocket now than they previously did.[116]

The 2009 Massachusetts Health Reform Survey found no significant change since 2006 in the share of women spending five percent or more of family income on out-of-pocket health care costs, nor has there been a decrease in the share of women reporting problems paying medical bills or paying medical debt over time.[117] At the same time, the share of women with unmet need due to cost *has* substantially decreased.[118]

Certain women enrolled in plans offered through the Health Connector are at particular risk for problems affording health coverage and accessing care due to cost. [119] These include:

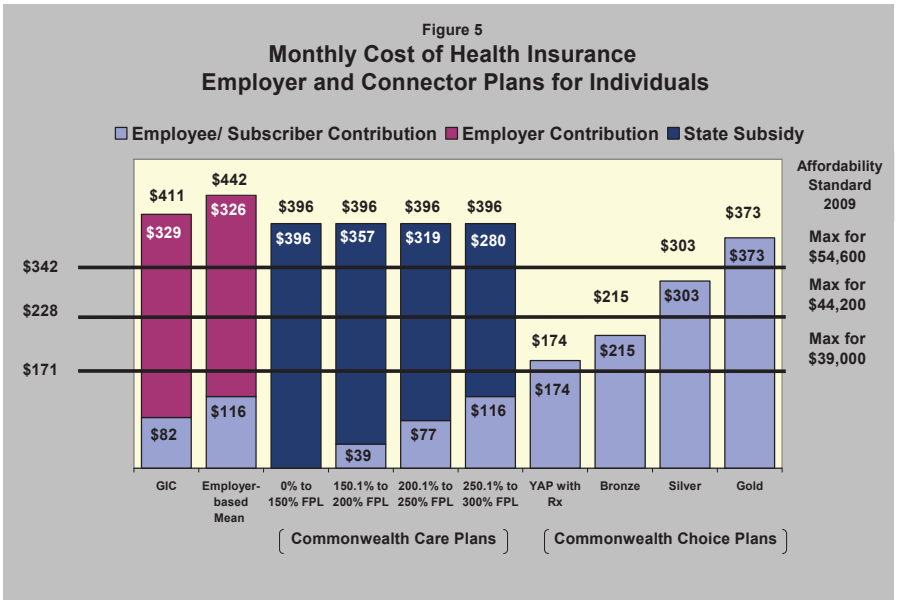
- Moderate-income women who do not qualify for subsidized coverage through Commonwealth Care and have difficulty affording Commonwealth Choice premiums;
- Women choosing low-premium Commonwealth Choice plans with high deductibles and co-payments who don't understand cost-sharing requirements;
- Women enrolled in Young Adult Plans that have limited coverage for certain services;
- Women who previously received care through Massachusetts' Uncompensated Care Pool who now have cost-sharing for services they previously received for free.

Affordability of Health Coverage

Although health reform resulted in affordable health coverage for many residents, some women may have difficulty paying for health insurance – particularly those with moderate incomes not covered by ESI.

Commonwealth Care

Health plans offered through Commonwealth Care are subsidized by the state at varying rates according to income. Cost-sharing is divided into four categories: individuals with incomes up to 150 percent of FPL pay no premiums; those with income over 150 percent of the FPL pay premiums on a sliding scale basis. **(Figure 5)** Commonwealth Care plans are only offered to individuals; children from families with incomes under 300 percent FPL are eligible for coverage through MassHealth.



Source: Massachusetts Division of Health Care Finance and Policy. [120]

Subscriber contributions to Commonwealth Care plans compare favorably to the median contribution made by employees covered by ESI. **(Figure 5)** Premiums for specific income categories as of March 2010 are shown in **Table 2**. While rates are low compared to commercial policies, some women find them prohibitive, particularly those who formerly received services without cost through Massachusetts' Uncompensated Care Pool.[121] However, while women obtaining care today through the Health Safety Net may have lower cost-sharing, they also do not have the same range of covered services as women enrolled in Commonwealth Care.[122]

Table 2
Commonwealth Care Insurance Premiums [123]

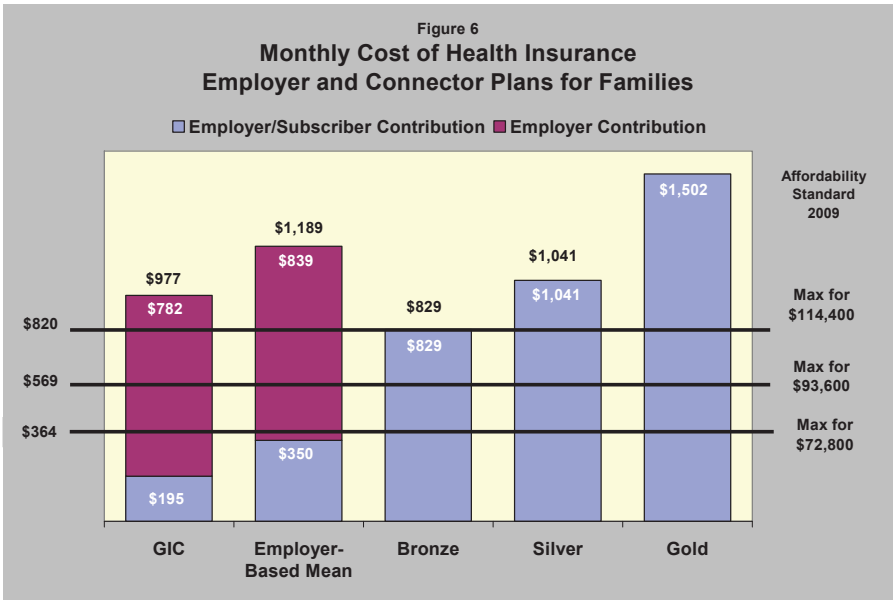
Income (2009)	Monthly Premium (as of March 2010)
Equal or less than $16,620	$0
$16,621-$21,672	$39
$21,673-$27,096	$77

Commonwealth Choice

Plans offered through Commonwealth Choice are not subsidized, and all enrollees pay premiums of varying amounts based on their choice of coverage (Young Adult Plan, Bronze, Silver or Gold). Commonwealth Choice plans have a range of deductibles, co-pays, and maximum benefits, although all plans offer a certain number of preventive care visits without a deductible. Commonwealth Choice plans were designed to be affordable, and carry the same risks as commercially available and employer-sponsored plans.

According to a recent analysis from the Massachusetts Division of Health Care Finance and Policy, all Commonwealth Choice products compare favorably to the median total cost of employer-based insurance. However, subscriber contributions for Commonwealth Choice plans are *higher* than the median employee contribution for private employer-based coverage for individuals and families. **(Figure 6)** Commonwealth Choice plans also may present unexpected

problems for moderate-income women who lack a practical understanding of actual costs, particularly when choosing low-premium, high-deductible health plans.[124] While men and women have signed up for Commonwealth Choice plans in relatively equal numbers, women's greater health care needs and expenses and overall lower incomes leave them particularly vulnerable to unpredictable out-of-pocket costs.[125]



Source: Massachusetts Division of Health Care Finance and Policy; *Health Care in Massachusetts: Key Indicators February 2010*

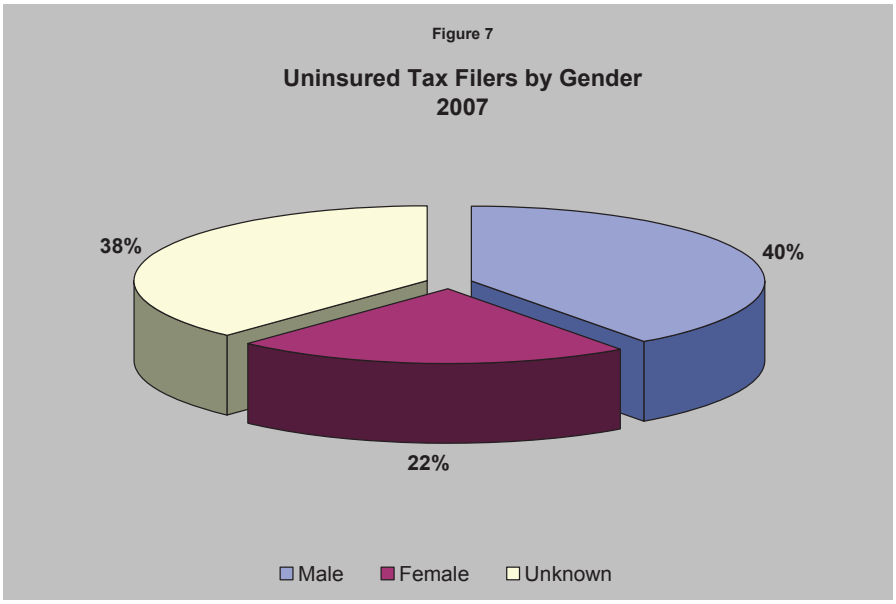
Inflation in health insurance remains an ongoing problem. Between January 2008 and December 2009, premiums for the lowest-cost Commonwealth Choice plans grew at an average annual rate of 6.3 percent.[126] Premiums for the highest-cost Commonwealth Choice Bronze plans averaged an annual growth rate of 9.0 percent over the same period. Although these rates are not as drastic as recent national premium increases, premiums are prohibitively expensive for some women, particularly those who are near-elderly and subject to age rating.[127]

Uninsured Women

Residents who cannot afford to pay for private insurance are specifically exempt from paying the fines imposed by Massachusetts' individual mandate. In 2008, 45,000 residents could not purchase affordable coverage and so were exempt. Another 135,000 residents had incomes below 150 percent of FPL and therefore did not have a penalty. The definition of affordability takes into account *only* the cost of health insurance premiums and excludes out-of-pocket costs such as co-pays and deductibles, which has led advocates and some legislators to argue that the affordability standard does not reflect the realistic costs of health care.[128,129]

A profile of women uninsured in 2009 is included in the Blue Cross Blue Shield of Massachusetts Foundation's new analysis of the Massachusetts Health Reform Survey.[130] That analysis concludes that women without insurance are disproportionately young, minority, and single.[131] Notably, a substantial majority of uninsured women report family incomes under 300 percent FPL and appear to be eligible for coverage through MassHealth or Commonwealth Care, indicating a need for targeted outreach and enrollment programs.[132]

The Department of Revenue certifies compliance with the individual mandate as part of annual income tax filings, and collects data on uninsured residents. Because tax forms do not include demographic data, it is difficult ascertain the share of residents exempt from the individual mandate for affordability reasons who are women. However, among uninsured tax filers in 2007 whose gender could be ascertained from other sources (62 percent of total uninsured filers), men outnumber women two to one.[133] **(Figure 7)**



Source: Massachusetts Department of Revenue [134]

Challenges Anticipating Out-of-Pocket Costs

Problems caused by the unpredictability of out-of-pocket costs can be substantial even for women with routine health needs, and are not unique to residents obtaining coverage through health reform. At the same time, the variety of Commonwealth Choice plans with varying premiums, deductibles, and co-pays makes selecting insurance confusing.[135] As shown in **Table 3,** estimates of total annual out-of-pocket expenses for common women's health services, including premiums, co-payments, deductibles, and co-insurance, vary significantly between the four levels of coverage available through Commonwealth Choice.[136] Benefits among these plans are standardized, highlighting the element of gamble inherent in selecting a plan.[137] For some services, total out-of-pocket costs are *higher* for women covered through lower-premium plans than for women with high-premium Gold Plans providing comprehensive coverage with no deductible and small co-pays. (See Ann's Story, **Appendix D**) The calculations in Table 3 are based on "extensive research into the average costs of particular treatments, painstaking untangling of the structures of various Commonwealth Choice plans, and complicated equations regarding how those costs would likely play out under the various plans."[138] Most consumers are unlikely to replicate these computations, yet the variation between coverage levels is significant and may affect an enrollee's ability to access care.[139]

Table 3
Out-of-Pocket Cost and Yearly Premiums for Four Commonwealth Choice Plans [140]

Total costs include annual premiums plus out-of-pocket expenses

	Young Adult Plan w/out Rx Coverage	Bronze Plan with Rx Coverage	Silver Plan with Rx Coverage	Gold Plan
Yearly Premiums	**$1,494**	**$2,588**	**$3,504**	**$5,234**
Services and Procedures	**Out-of-Pocket Expenses**			
Vaginal Delivery, No Complications	$2,840	$2,440	$500	$0
Vaginal Delivery, with Complications	$3,240	$2,840	$500	$0
C-Section No Complications	$3,900	$3,500	$500	$0
C-Section with Complications	$4,700	$4,300	$500	$0
Prenatal Care, No Complications	$1,275	$1,275	$315	$150
Breast Surgery- Mastectomy	$4,940	$4,540	$500	$0
Chemotherapy and Supportive Care for Ovarian Cancer	$5,000	$5,000	$500	$0
Hysterectomy	$3,600	$3,200	$500	$0
Uterine Fibroid Embolization	$300	$2,600	$500	$0
Emergency Contraception	$370	$370	$370	$0
1st Trimester Abortion	$1,230	$1,230	$500	$0
HPV Vaccine Series	$790	$790	$500	$30
Cryotheraphy	$270	$270	$270	$0

Policy Implications. Even after health reform, affordability remains a problem for many women across the spectrum of demographic and income groups. Premium costs for Commonwealth Choice enrollees are relatively high compared with subscriber and enrollee cost-sharing for ESI and Commonwealth Care plans, suggesting a need for close monitoring of affordability standards. Variation between expected costs and actual expenses for many common women's health services likely exists across the insurance system, yet evidence suggests that Commonwealth Choice enrollees are particularly vulnerable consumers. Finding ways to control the price and use of health care is essential to ensure women's access to affordable and comprehensive coverage.

Affordability for Young Women

Although Young Adult Plans and Student Health Plans have increased coverage among their targeted populations, they also carry affordability concerns. YAPs offer the lowest premiums of the four Commonwealth Choice categories but may have high deductibles and low maximum annual benefits.[viii] Young adults can also purchase Bronze, Silver or Gold coverage, which have no annual limits, but may choose a YAP because of lower premiums. However, a high deductable of $2,000 in addition to premium costs can consume a large part of a young adult's income. For example, a 25 year old woman earning $35,000 per year who purchases a YAP may

[viii] Insurers have reported to the Connector Board that no YAP member has yet exceeded his or her annual limit, indicating that this concern may be more theoretical than practical.

pay a $1,980 annual premium and still has a $2,000 deductible before her YAP begins paying expenses at 80 percent. YAPs generally have a $5,000 out-of-pocket cap.[141] [ix]

Like YAPs, Student Health Plans (SHPs) carry affordability concerns. SHPs cover physician office visits, physical therapy, diagnostic X-ray and laboratory services, and durable medical equipment; most also cover prescription drugs with benefits capped at or below $750 annually.[142] Almost half of all SHPs have a per-illness or injury maximum of $25,000, and many have yearly annual caps of $50,000.[143] (See Malika's Story, **Appendix D**) Few SHPs set maximum out-of-pocket expenses for consumers, although most plans created by the Connector Board do have such limits. Along with annual and per-illness maximums, some SHPs also have caps on individual services, such as a $5,000 cap on surgeon's fees, a $150 cap on ambulance services and a $1,500 cap on outpatient care.[144] Recently, a more comprehensive student health plan was introduced specifically for students in community and state colleges.[145]

Policy Implications. Insuring young adults is a significant goal of health reform; in 2009, women ages 18 – 25 comprised the largest share of uninsured women in the state. Coverage must be affordable for this population, yet low cost alone may not be sufficient to encourage young adults to purchase a health plan. For young women entering their childbearing years, ensuring access to comprehensive health care is vitally important, but striking a balance between affordability and broad benefit coverage is challenging, and may leave enrollees in young adult targeted plans at risk for substantial cost exposure. It is not known whether the potential for high out-of-pocket costs is a contributing factor to the high rate of uninsured young women. Research is needed to determine whether changing the balance of premium costs, coverage, and out-of-pocket expenses would increase the ranks of insured young women.

[ix] At least three visits to the doctor are exempt from the annual deductible.

REMAINING OPPORTUNITIES

Massachusetts health reform began with expanded health coverage, a reformed insurance market, and a new model of shared responsibility.[146] The state did not try to anticipate or address related cost, quality, and access issues at the time Chapter 58 was enacted.[147] Yet health reform has magnified certain concerns affecting women's health and access to care that impact women disproportionately or remain opportunities for the future policy intervention. Some of these issues – including frequent coverage transitions, the role of caregivers, and access among incarcerated women – are highlighted below.

Transitions in Coverage and Enrollment

The complexity and structure of health reform has raised new issues for some low-income women, as shifts in eligibility result in frequent transitions through various types of coverage.[148] Many of the reasons underlying enrollment transitions are related to gender. Women are more likely than men to have variable employment including part-time jobs,[149] and are less likely to be eligible for employer-sponsored benefits.[150] Women with variable employment also tend to have inconsistent income, which is a key factor in determining eligibility for MassHealth, Health Safety Net (HSN) and Commonwealth Care. Life events, such as finishing or starting college, leaving home, pregnancy, marriage, divorce and death of a spouse also affect a woman's eligibility and can lead to gaps that affect timely access to care. **(**See Christina's Story**, Appendix D)**

Research shows that a significant number of low-income Massachusetts residents transition between MassHealth, Commonwealth Care and the (HSN) every month.[151] Between January 2008 and April 2009, an average of 9,800 people per month transitioned *into* MassHealth from Commonwealth Care and HSN. An additional 9,400 individuals per month moved *from* MassHealth and the HSN onto Commonwealth Care.[152] Of those individuals, 17 percent of MassHealth beneficiaries and 16 percent of Commonwealth Care enrollees experienced a gap in coverage during their transition. This figure does not take into account the one- to three-month gap in coverage individuals typically experience when transitioning onto Commonwealth Care.[153,154] Women comprise the majority of non-elderly MassHealth enrollees, and a higher percentage of women than men have enrolled in Commonwealth Care, suggesting that the largest percentage of those transitioning between insurance programs and experiencing coverage gaps are women.

Some women indicate they do not receive understandable information about why they transition on and off different insurance types and what is required to maintain coverage.[155] This is mirrored by "closed case" trends in MassHealth and Commonwealth Care. A "closed case" occurs when an individual applies for MassHealth or Commonwealth Care and is not eligible or fails to provide needed information to determine eligibility. Between January 2008 and April 2009, 73 percent of MassHealth closed cases and 81 percent of Commonwealth Care closed cases were the result of failure to complete or return information or failure to provide required identification.[156] Only six percent of MassHealth and Commonwealth Care Cases were closed because of failure to pay a monthly premium.[157] The Massachusetts Medicaid Policy Institute (MMPI) notes that most individuals who lose coverage due to administrative problems are financially eligible for the program. That the majority of MassHealth and Commonwealth Care

cases were closed due to administrative reasons suggests many eligible individuals, the majority of whom are women, have difficulty understanding what is required to maintain eligibility for these programs.[158] [159]

For some women who formerly accessed health services at no cost as beneficiaries of Massachusetts' Uncompensated Care Pool, the logistical requirements of enrollment and frequent transitions in coverage have created gaps in their access to care.[160,161] Some describe Commonwealth Care's ongoing reporting and recertification requirements as confusing and cumbersome.[162] For some low-income women, transitioning insurance coverage has affected access to family planning and contraceptive services.[163]

> Policy Implications. Problems associated with frequent coverage transitions suggest that efforts to ensure continuity of coverage and improve administrative procedures are needed. Patient navigation assistance and targeted advocacy may help women to manage the bureaucracy of insurance coverage.

Caregivers

Nationally, 65 percent of people who become ill depend on family members and friends for support. The majority of caregivers are middle-aged women who often hold full-time or part-time jobs.[164] Balancing the responsibilities of care, work, and family exerts a strain on caregivers' resources and well-being.[165] One-third of caregivers report family income as low or moderately low,[166] and female caregivers are six times more likely to suffer symptoms of depressive and anxiety disorders.[167] Midlife women in the labor force who serve as caregivers often reduce hours to accommodate this role, but are more likely to leave the workforce entirely.[168]

In Massachusetts, where almost one in five residents is over 60 years old, informal caregivers play a crucial role in maintaining the health of the aging population. In 2007, 700,000 informal caregivers in Massachusetts provided nearly 760 million hours of care valued at $8.9 million.[169] Though the data for Massachusetts are not stratified by sex, national trends suggest that the majority of caregivers in the state are women.[170]

> Policy Implications. The role of caregiving in the health care system is outside the scope of Massachusetts health reform, yet caregivers provide vital health care services, often at the expense of their own economic and physical well-being. As Massachusetts begins to address delivery system reform, efforts to better integrate and coordinate home and community-based supports may help to reduce the burden of caregiving among women.

Incarcerated Women

Incarcerated women are among the sickest and least likely to have easy access to health insurance and care. Female inmates are three times more likely to report poor health than women in the general population.[171] They face higher rates of chronic illness and sexually transmitted diseases, have far worse mental health than the general public and have difficulty accessing care during and after incarceration.[172] There are between 650-800 female prisoners in Massachusetts at any given time.[173] Although incarcerated women constitute a small portion of the female population in Massachusetts, their experiences accessing care and poor health outcomes reflect problems with the state's public health insurance program and the prison health care system. Additionally, incarceration places a significant burden on pregnant and post-partum women; many women do not receive appropriate post-partum care and can be separated from their children after birth.

A 2008 study of Massachusetts incarcerated women found higher than normal rates of chronic disease such as Hepatitis C and asthma, depression and severe psychiatric illnesses and physical problems such as dental and gynecological problems.[174] Significantly, nearly 70 percent of these women were covered by MassHealth at some point in the five years preceding their incarceration and many had a primary care doctor during their childhood.[175] Although most were eligible for some subsidized care before (and after) incarceration, they did not obtain necessary medical care. This finding is mirrored by a Massachusetts Public Health Association report that found that incarnated individuals are much less likely than their non-incarcerated counterparts to receive care in the community. [176]

In addition to poorer health than the general public, incarcerated women also face significant barriers accessing care in the prison system. One report noted that wait time to see prison physicians was so long that some women did not receive needed care before transitioning out of the system.[177]

> Policy Implications. Incarcerated women are a disadvantaged population whose health needs are outside the scope of health reform. Documented challenges in accessing care suggest that future health reform efforts should address access inside the prison system and post-incarceration support, including the reproductive health needs of incarcerated women and high rates of chronic disease among female prisoners.

LESSONS FOR NATIONAL HEALTH REFORM

In the wake of health reform, women in Massachusetts have the highest rates of health insurance coverage in the nation. Access to care has also improved across all demographic groups. Affordability remains a problem, although this is very much a reflection of the state's high health care costs.

There are several lessons for national health reform in Massachusetts' experience. First, changes in coverage and access are logistically challenging for many women, who often serve as managers of family health. Administrative simplicity and patient navigation support can help maximize participation in coverage programs. Second, coverage expansions may exacerbate existing shortages in primary care. As women use more primary care throughout their lives and comprise the greater share of new primary care trainees, this is a critically important women's health concern. Third, women are disproportionately affected by health care costs. Affordability standards based exclusively on premiums are unfair to women, who have higher out-of-pocket health expenses. Strategies that address cost containment while ensuring access to vital health services are essential for women and men. Last, stratifying data by sex is crucial to understand health reform's impact on women.

It should be noted that while abortion continues to play a divisive role in national health reform, this was not the case in Massachusetts.

Massachusetts has provided a roadmap for national efforts to expand coverage and improve access to care. As the state begins to acknowledge and prioritize women's health as an integral element of health reform, so must the U.S.

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Appendix A

Sources of Data on Massachusetts Health Reform and Women's Health

Suffolk University's Center for Women's Health and Human Rights' 2008 policy brief, **Women and Health Care Reform in Massachusetts**, [178] offered an early analysis of how the state's reform model might affect women of diverse ages and income statuses. Its conclusions regarding variation in out-of-pocket costs for different plans offered through Commonwealth Choice are the basis of what this report describes as the "affordability challenge." Material from the Center's 2007 report, **Barriers to Health Care for Women Who Have Been Incarcerated,** also appears in this document.

Three reports from Ibis Reproductive Health highlight the impact of Massachusetts health reform on women and reproductive health. The first, **Low-Income Women's Access to Contraception after Massachusetts Health Care Reform,** undertaken in conjunction with the Massachusetts Department of Public Health (MDPH) Family Planning Program, documents the perspectives and experiences of two groups before and after health care reform: low-income women seeking contraceptive services, and MPH-funded family planning agencies and clinics providing contraceptive services. The report also identifies potential new barriers to accessing contraception for low-income women under health care reform, and highlights gaps in knowledge. Findings from this project are highlighted throughout this issue brief.

A second project, the **Reproductive Empowerment and Decision Making for Young Adults (REaDY) Initiative**, is a coalition of multiple organizations and agencies within the Commonwealth. Ibis Reproductive Health leads the formative research component for REaDY which has generated two research reports. The first is a systematic review of the reproductive health coverage of young adult-targeted health plans, and the second reports findings from focus group discussions with young adults (aged 18-26) in different areas of Massachusetts. A survey of health service providers serving young adult populations in the Commonwealth is ongoing.

A third report, **Young Adults, Health Insurance and Access to Contraception in the Wake of Health Care Reform,** analyzes focus group discussion with young adults on YAPs and SHPs to understand the impact these insurance plans have on access to contraception and contraception counseling.

The **Public Health Approach to Screening and Lifestyle Intervention in Uninsured Women (ASIST 2010)** study is examining three aspects of women's health: (1) the impact of Massachusetts health reform on cancer and cardiovascular screening utilization among low-income women ages 40-64; (2) the impact of the "Healthy Heart" cardiovascular lifestyle intervention and (3) the importance of access to patient navigators on screening utilization and health outcomes. This study is a collaborative effort between the Connors Center for Women's Health and Gender Biology at Brigham and Women's Hospital, the Commonwealth Health Insurance Connector Authority, the Neighborhood Health Plan and several Massachusetts community health center partners. Results from this study will be available in 2011 and will offer new insights into the impact of Massachusetts' model on the health needs of women in this age group.[179]

To understand trends in the use of preventive services and unmet need for care in relation to health reform, ASIST 2010 is also examining data from the Massachusetts Behavioral Risk Factor Surveillance Survey (BRFSS). BRFSS is an annual telephone-based survey tracking health and behavioral risk factors, providing important information regarding access to and utilization of care by adults. BRFSS is sponsored by the U.S. Centers for Disease Control and Prevention and administered by each state's Department of Health. ASIST 2010 investigators are analyzing data from 1996-2008, a time range that included a period of pre-reform economic growth and a pre-reform period of economic recession. Data from prior to health reform will be compared to post-reform data to best understand the impact of Massachusetts health reform on access and screening trends. Researchers are particularly interested in disparities related to sex, socioeconomic status and race/ethnicity. Results will be available in late 2010.

Appendix B

Massachusetts Health Reform - The Basics of Chapter 58

- **The Individual Mandate**: all Massachusetts residents over the age of 18 and deemed able to afford health insurance are required by law to have health insurance that meets the Minimum Creditable Coverage standard. Residents who do not obtain coverage are subject to a state income tax penalty.

- **The Commonwealth Health Insurance Connector Authority (Connector Board):** The Connector Board is responsible for determining Minimum Creditable Coverage. The Connector Board also regulates Commonwealth Care and Choice plans and is responsible for negotiating with private health insurers for competitive Commonwealth Choice Plan prices.

- **Minimum Creditable Coverage (MCC):** is a set of baseline health benefits and insurance rules. MCC benefit requirements include:

  - Ambulatory patient services
  - Diagnostic imaging and screening
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Medical/surgical care, including preventive and primary care
  - Mental health and substance abuse
  - Prescription drugs
  - Radiation therapy and chemotherapy

  MCC insurance rules include:

  - Doctor visits for preventive care, without a deductible
  - A cap on annual deductibles of $2,000 for an individual and $4,000 for a family for services received in-network
  - For plans with up-front deductibles or co-insurance on core services, an annual maximum on out-of-pocket spending of no more than $5,000 for an individual and $10,000 for a family for services received in-network
  - No caps on total benefits for a particular illness or for a single year
  - No policy that covers only fixed dollar amount per day or stay in the hospital, with the patient responsible for all other charges
  - For policies that have a separate prescription drug deductible, it cannot exceed $250 for an individual or $500 for a family for services received in-network
  - No fixed-dollar cap on prescription drug benefits (starting in 2011)
  - Core medical services and a broad range of medical services for any dependents, if dependents are covered (starting in 2011)

- **Commonwealth Care:** Provides subsidized premiums for individuals with incomes between 100%-300% of FPL.

- **Commonwealth Choice**: Provides competitively priced individual plans for moderate to higher-income individuals. Plan levels include Young Adult plans and bronze, silver and gold coverage.

Appendix C

Benefits Mandated by Massachusetts Law

- Alcoholism rehabilitation
- Bone marrow transplants for treatment of breast cancer
- Cardiac rehabilitation
- Chiropractic services
- Clinical trials for treatment of cancer
- Contraceptive services
- Cytologic screening (Pap smear)
- Diabetes-related services and supplies
- Early intervention services
- Hearing screening for newborns
- Home health care
- Hormone replacement therapy (HRT)
- Hospice care
- Human leukocyte antigen testing (HLA)
- Infertility treatment
- Lead poisoning screening
- Low protein food products for inherited amino acid and organic acid diseases (PKU)
- Mammography
- Maternity health care (including minimum maternity stays)
- Mental health care
- Nonprescription enteral formulas
- Preventive care for children up to age six (including specific newborn testing)
- Off-label uses of prescription drugs to treat cancer
- Off-label uses of prescription drugs to treat HIV/AIDS
- Scalp hair prostheses for cancer patients
- Speech, hearing, and language

Malika's Story [180]

Malika is a student who became pregnant while covered through her university's student health plan (SHP). Although her SHP covers pregnancy, coverage is capped at $25,000 per injury or illness. Malika had a complicated delivery, which required ambulance transportation to a hospital better able to handle her high-risk care. Unfortunately, her plan has an individual service cap on ambulance transportation, leaving her responsible for $1,500 in out-of-pocket costs. The hospital charged $24,000 for Malika's care and $32,000 for her baby's care. Her health plan decided to count Malika and her baby's care as a single episode of illness, leaving her with $31,000 in additional out-of-pock costs. Her massive medical bills qualify her for the Health Safety Net; however, she is still responsible for paying a significant portion of the costs herself - $16,000.

"If the insurance barely helped me then what am I paying them for?"

Appendix D
Vignettes

Ann's Story [181]

Ann is 56 years old, divorced with two adult children. She makes $62,000 a year and a realtor for a small firm not required to offer health insurance. This year, Ann had an annual mammogram which detected an abnormal mass in her right breast. She was diagnosed with breast cancer and had a mastectomy. Ann's income qualifies her for a Commonwealth Choice plan. This chart highlights her out-of-pocket costs (premiums, deductibles and co pays) for one year under different Commonwealth Choice Plans.

Plan (with Rx)	Total Annual Cost
Bronze	$7,128
Silver	$4,004
Gold	$5,234

For Ann, the lowest premium plan has the highest out-of-pocket costs.

Christina's Story [182]

Christina is a 27 year old single woman earning 150% of the Federal Poverty Level ($16,245 a year) working as a waitress and is eligible for Commonwealth Care. Christina become pregnant and is now categorically eligible for Medicaid because her income is below 200% FPL. Christina must apply for Medicaid because eligibility for public insurance negates Commonwealth Care eligibility. While she waits for MassHealth eligibility, she in insured by MassHealth Prenatal, a short-term program designed to cover pregnant women while they wait for MassHealth approval. After birth, she must re-apply to Commonwealth Care because her income makes her MassHealth ineligible (mothers with Medicaid eligible children can remain beneficiaries if they make 133% or less of the FPL).

In one year, Christina has applied to three insurance plans and transitioned between plans four times.

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