

The effects of Massachusetts health reform on access to care and disparities

Project Summary

Lack of health insurance is associated with increased mortality, and is a prime source of racial and ethnic health disparities. When individuals have insurance, they are more likely to have a usual source of care and to utilize care, which can prevent unnecessary and costly hospitalizations, and ultimately, improve health. The US government has now passed health reform legislation; data are urgently needed to understand whether it will translate into actual improvements in access to medical care, and ultimately, improve outcomes. Massachusetts (MA) is the setting of a landmark experiment in health reform, and national reform efforts view MA as a model. We posit that data on the effects of the MA health reform on access to care can inform the design and implementation of health reform nationally. MA has lowered the percent of uninsured residents to the lowest uninsurance rate in the US (2.6%), thus providing a unique opportunity to evaluate whether a major coverage expansion has improved access to care and health status, and reduced disparities, across a spectrum of conditions. Most previously uninsured patients in MA now have a portable insurance card, rather than being tied to safety-net institutions where they previously received "Free Care." Newly-insured patients may have **expanded access to outpatient care and referral-sensitive procedures** (non-emergent procedures where lack of a referral can be a barrier to obtaining the procedure; e.g. joint replacement), potentially leading to improved health outcomes and reduced disparities.

Prior studies of MA reform's impact on access to and use of health care have relied on population surveys, rather than utilization or outcome data documenting actual use of care. While assessment of outpatient utilization is not feasible due to a lack of all-payer outpatient data, changes in access to outpatient care under the reform can be examined indirectly, using all-payer inpatient discharge data to examine changes in **ambulatory care sensitive (ACS) hospital admissions**, hospitalizations which are felt to be preventable by access to ambulatory care within the weeks before admission. Admissions for ACS conditions have become an established tool for health services researchers to measure access to outpatient medical care, particularly for vulnerable populations (who are often difficult to reach through other research designs). The Agency for Health Care Research and Quality (AHRQ) has used ACS conditions as the basis for one of its set of key Quality Indicators and this has been endorsed by the National Quality Forum. **30-day hospital readmissions** are another indirect measure of access to outpatient care, as post-hospital discharge follow-up outpatient care is critical to avoiding re-hospitalizations. We propose to use state inpatient discharge administrative data on adults age 21-64 (e.g. those not covered by Medicare) from four states, including MA, which have nearly-complete race and ethnicity indicators, sizable minority populations, and diagnosis and cost data for each admission. We will analyze data from 2004-2010, encompassing the years before and after 2006 MA health reform implementation. All analyses will control for potential confounders such as unemployment, poverty, regional variation in health resources (e.g. physician supply), and baseline insurance rates among states.