

**A COMMENT ON**  
**“THE MASSACHUSETTS HEALTH PLAN:**  
**MUCH PAIN, LITTLE GAIN”**

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The Cato Institute recently released a study of health reform in Massachusetts by Aaron Yelowitz and Michael F. Cannon (hereafter YC), entitled “The Massachusetts Health Plan: Much Pain, Little Gain.”<sup>1</sup> That study, which relies on the Current Population Survey (CPS), reports fewer gains in health insurance coverage and higher costs than have been reported by earlier studies. As the Urban Institute has done a substantial amount of research on health reform in Massachusetts, we have received a number of requests to reconcile the findings on health insurance coverage from the study by YC with the findings from earlier work.<sup>2</sup> This paper is a response to those requests. In commenting on the YC study, the focus here is on the data and analyses presented in support of the following conclusions:

- The individual mandate has induced uninsured residents in Massachusetts to conceal their true insurance status, leading to increasing levels of nonresponse on health insurance questions under health reform.
- Because of an increase in survey nonresponse on insurance coverage,
  - available survey data understate the current levels of uninsurance in Massachusetts, and
  - prior studies have overstated the impacts of the Commonwealth’s health reform initiative on health insurance coverage.
- Public coverage has “crowded out” private coverage among the lowest income families in Massachusetts.
- Health reform has done little to improve health status.
- Health reform has made Massachusetts a less attractive place for individuals, particularly young people, to relocate.

Contrary to what YC report, we find no evidence of an increase in nonresponse on the health insurance questions in the CPS and, thus, no support for YC’s conclusion that available survey data understate the current levels of uninsurance in Massachusetts and no support for the conclusion that prior studies have overstated the impacts of health reform. We also find no evidence that public coverage has crowded out employer-sponsored insurance coverage for higher income families, the appropriate focus for an analysis of crowd-out. Finally, we find reason to question YC’s findings related to health status and in-migration given the limitations of the data and methods used. The remainder of the paper discusses these issues in more detail.

## ***What Do We Know about Health Insurance Coverage in Massachusetts?***

Every major national survey—the CPS, the American Community Survey (ACS), and the National Health Interview Survey (NHIS)—puts the uninsurance rate in Massachusetts at the lowest in the nation. Consistent with that, our studies estimating the impacts of health reform in Massachusetts on insurance coverage show large and significant drops in uninsurance.<sup>3</sup> Similarly, administrative data on insurance coverage in the state, including data on private coverage enrollment from commercial health plans, show large gains in coverage.<sup>4</sup> Even the Cato report supports that basic finding, showing a drop in the uninsurance rate of nearly 70 percent for adults under health reform.<sup>5</sup>

### ***An Assessment of the New Analyses by Yelowitz and Cannon on Insurance Coverage***

The Cato report argues that prior estimates of the impact of health reform on insurance coverage overstate the gains because of an increase in reporting errors in the CPS since health reform in Massachusetts. YC argue that an increase in nonresponse on health insurance questions in the CPS by Massachusetts residents reflects uninsured individuals' fear of reporting that they do not have coverage given the individual mandate that was introduced as part of the health reform initiative in the state. (The individual mandate requires adults in the state who have access to affordable coverage to obtain health insurance or pay a penalty.) When my colleagues and I run those same tabulations on the CPS, we find no evidence of a systematic decline in the response rate for insurance coverage in Massachusetts over time. Our tabulations show the share of nonelderly adults with missing data on health insurance coverage was 15.5 percent in 2005, 17.1 percent in 2006, 14.4 percent in 2007 and 15.7 percent in 2008 in Massachusetts.<sup>6, 7</sup>

Much of the missing data on insurance coverage in the CPS is not because individuals have refused to answer the insurance questions but instead it is because individuals refused to respond to all, or nearly all, of the Annual Social and Economic (ASEC) supplement to the CPS. The ASEC supplement appends additional questions to the end of the core CPS questionnaire once each

year to gather information on a range of issues, including insurance coverage.<sup>8</sup> Focusing on those who responded to the ASEC supplement but refused to respond to the health insurance questions, we find the share of cases with missing data appears to have dropped over time in Massachusetts: at 6.3, 7.0, 4.8 and 5.0 percent, respectively, in 2005, 2006, 2007 and 2008. The share of cases with missing data was more stable in all the other states (at 5.2, 5.7, 5.1 and 4.8 percent over the period), but also appears to have dropped in the other New England states (at 5.7, 6.6, 5.1 and 4.8 percent over the period).<sup>9</sup> We find no significant difference in missing data on health insurance coverage over the 2005–2008 period in Massachusetts relative to the other New England states and a significant *decline* in Massachusetts relative to all the other states. Thus, there appears to be no basis for YC's adjustment to the overall estimate of the impact of health reform in Massachusetts because of increasing nonresponse on health insurance questions.<sup>10</sup>

YC extrapolate from missing-data problems in the CPS to other surveys to argue that all surveys overstate insurance coverage in Massachusetts. Nonresponse varies considerably across surveys. In contrast to the nearly 16 percent missing data on the health insurance questions in the CPS in 2008, health insurance was missing for about 4 percent of cases in the ACS in 2008 and 1 to 2 percent in the state's Massachusetts Health Insurance Survey (MHIS) in 2008 and 2009.<sup>11</sup>

*Health Reform and Crowd-Out.* YC also report evidence that public coverage has “crowded out” private coverage (employer-sponsored insurance [ESI] coverage and nongroup coverage combined) under health reform for Massachusetts families with incomes less than 150 percent of the federal poverty level. Studies of crowd-out typically focus on public coverage substituting for ESI coverage, not public coverage substituting for nongroup coverage, as in the YC work. It is not typically considered a program failure in either Medicaid or the Children's Health Insurance Program (CHIP) if individuals who have been purchasing private coverage on their own in the individual market, which often provides limited coverage and is very expensive, switch to public coverage. The anti-crowd-out provisions in Massachusetts's

programs, as in other states, are intended to prevent switching from ESI coverage to public coverage, not switching from nongroup coverage to public coverage. YC's work errs in focusing on all private coverage (ESI and nongroup) combined.

Estimating models focusing exclusively on ESI coverage, we find no evidence of the crowding out of ESI coverage among adults (regardless of their income level) or higher income children. For children with family income less than 150 percent of the federal poverty level, some of the models we estimate show a significant drop in ESI coverage while others show no such drop.<sup>12 13 14</sup>

Even if there were crowd-out among the lowest income children, that would not be a bad thing. Neither the Medicaid program nor the Medicare program includes anti-crowd-out provisions, precisely because society considers insurance coverage too important for children and elders to be at the mercy of family budgets. If the outreach surrounding health reform in Massachusetts brought more of the lowest income children into the Medicaid program, a program that they were eligible for prior to health reform, this would be completely consistent with national Medicaid and CHIP policy. It is crowd-out among higher-income families and individuals who have the resources to afford health insurance coverage on their own that is of policy concern. In our work, as in the work by YC, there is no evidence of crowd-out among either higher-income adults or children.

Finally, YC argue that the CPS provides the best estimate of point-in-time insurance coverage in Massachusetts. This position ignores the fact that the CPS health insurance questions ask about coverage over the prior calendar year and, as has been documented in an extensive literature, are subject to severe reporting error.<sup>15</sup> Most researchers would likely use the American Community Survey (ACS), with its much larger sample sizes and questions on current insurance coverage,<sup>16</sup> or the Massachusetts state survey (MHIS), which also asks about current insurance coverage and provides a more complete assessment of the range of coverage options in the state than does the ACS.<sup>17</sup> (The Urban Institute directs the MHIS.) That is not to say that those surveys are perfect. All surveys are subject to

error. The estimates of the uninsurance rate in Massachusetts are low in both the ACS and MHIS, with the ACS at 4.2 percent on average for 2008 (with a 95 percent confidence interval of 3.9 to 4.5 percent), while the MHIS was at 2.6 percent (with a 95 percent confidence interval of 1.8 to 3.4 percent) in spring 2008.<sup>18</sup>

Despite the limitations of the CPS, it is an important resource for examining the impacts of health reform on health insurance coverage. The CPS provides data over time (both prior to and following health reform) and allows for a comparison of changes over time in Massachusetts under health reform to changes in other states.

### ***Additional Technical Notes on Study Methods***

Beyond the estimates related to insurance coverage, YC tackle a host of other issues. We have not attempted to replicate their analyses on those issues here, but would note two areas of some concern.

*Assessing Health Status Using the CPS.* YC use the CPS to assess the impacts of health reform on health status, reporting little improvement in health status across the population. Just as the CPS is not the best source of data for an estimate of current insurance coverage in the state, it is not the best source of data for assessing health status. A discussion of the challenges of addressing the impacts of health reform on health status is beyond the scope of this note, except to say the single measure available in the CPS, self-reported health status, is a very generic measure of overall health to use in comparing cross-sectional samples of the population over time. Furthermore, one would expect any gains in health under health reform to be largely concentrated among the small share of residents who obtained coverage under health reform and to accrue over time as they accessed health care. As many of the uninsured were young and healthy, the expected gains in health status for many would be long-term gains. YC's analysis attempts to measure increases in health status within a short period of time for a small subset of the population by estimating changes in health status among the *full* Massachusetts population. It is not surprising that they find little consistency in the estimates of the impact of health reform on

health status with this approach.<sup>19</sup> In our work, we have focused on intermediate measures of health care access and use, for which we find strong evidence of increased access under health reform in Massachusetts.<sup>20</sup>

*Assessing In-migration Using the CPS.* YC use the CPS to assess in-migration in Massachusetts, attributing a drop in migration into Massachusetts over the study period (overall and among young adults) to health reform. In-migration is a complicated issue, with economic factors related to the recent recession likely to play a much more significant role than health insurance programs. However, if one were to evaluate changes in in-migration in Massachusetts, the ACS is the better data source, as it has a sample size 25 to 30 times that of the CPS and, unlike the CPS, includes people from communities in all areas of the United

States. A quick analysis of in-migration for nonelderly adults based on the ACS shows that in 2008 the in-migration rate was 3.4 percent in Massachusetts, as compared to 3.1 percent in the other New England states. In 2005, just prior to health reform, those rates were 3.1 percent for Massachusetts and 3.7 percent for the New England states. In contrast to YC's analysis of the CPS, the ACS shows an increase in in-migration in Massachusetts relative to the other New England states. (In-migration by young adults (ages 19 to 29) in Massachusetts was quite stable over the period at 7.7 percent in 2005, 7.5 percent in 2006, 7.6 percent in 2007 and 7.6 percent in 2008.) More work would be needed to determine the extent to which the increased in-migration reflects the impacts of health reform as opposed to the impacts of the severe economic recession.

## NOTES

<sup>1</sup> Aaron Yelowitz and Michael F. Cannon, "The Massachusetts Health Plan: Much Pain, Little Gain" (Washington, DC: Cato Institute, 2010), [http://www.cato.org/pub\\_display.php?pub\\_id=11115](http://www.cato.org/pub_display.php?pub_id=11115).

<sup>2</sup> See, for example, Sharon K. Long. "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year" *Health Affairs* 27, no. 4 (2008): w270-w284; Sharon K. Long, Karen Stockley, and Alshadye Yemane. "Another Look at the Impacts of Health Reform in Massachusetts: Evidence Using New Data and a Stronger Model" *American Economic Review* 99, no. 2 (2009): 508-511; and Sharon K. Long and Karen Stockley. "Health Reform in Massachusetts: An Update on Insurance Coverage and Support for Reform as of Fall 2008" (Washington, DC: The Urban Institute, 2009).

<sup>3</sup> Ibid.

<sup>4</sup> See, for example, Amy M. Lischko and Anand Gopalsami. "An Interim Report Card on Massachusetts Health Care Reform, Part 1: Increasing Access," Pioneer Institute White Paper, No. 29 (Boston, MA: Pioneer Institute, 2010); and Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," November 2009, [http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key\\_indicators\\_nov\\_09.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_nov_09.pdf).

<sup>5</sup> While YC provide little information on their data and methods, several apparent limitations of their analysis should be noted. First, YC do not appear to reweight their analysis sample to reflect the cases that they drop because of missing health insurance information. They also do not appear to adjust the standard errors in their analysis to reflect the complex design of the CPS. Failing to do the former likely introduces biases into their sample, while failing to do the latter may lead to claims of statistical significance when the estimates are not, in fact, significantly different from zero. Second, the New England states that are included in the comparison group include states that were making changes in their own health insurance systems over the same period. By selecting states that were initiating their own health reform efforts as the "counterfactual" for what would have happened in Massachusetts in the absence of health reform, YC's estimates of the impacts of health reform in Massachusetts are likely biased downward. In our work, we exclude states that have initiated their own health reform efforts from the comparison group. We also test the sensitivity of our findings to alternative comparison groups, something that YC do not appear to do.

<sup>6</sup> YC do not provide information on their methods or on the annual estimates underlying the percentage changes reported in their paper, making it impossible to determine why our estimates differ.

<sup>7</sup> Although the YC report and this work report annual estimates for Massachusetts based on the CPS, the Census Bureau recommends using three-year averages for state-level estimates. According to the Census Bureau: "The CPS ASEC is designed to collect statistically reliable estimates primarily at the national level and secondarily at the regional level. State estimates are considerably less reliable—that is, the sampling variability for state estimates is higher, and state estimates fluctuate more widely year-to-year than national estimates." See, Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-235, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, U.S. Government Printing Office, Washington, DC, 2008, p. 26.

<sup>8</sup> In the CPS, the full ASEC supplement was missing in Massachusetts for 9.1 percent of nonelderly adults in 2005, 9.9 percent in 2006, 9.7 percent in 2007, and 10.6 percent in 2008. This compares to 9.7, 9.8, 8.7 and 8.8 percent, respectively, in all of the other

states over the period. Thus, it would appear there was an increase in the share of respondents refusing to answer all or most of the ASEC questions over time in Massachusetts.

<sup>9</sup> The decline in nonresponse for the health insurance questions in the CPS in Massachusetts and in all the other states suggests a competing hypothesis—an active public debate on health insurance coverage, as happened in Massachusetts and the nation, may have increased the saliency of the issue, leading to better reporting of insurance status over the last few years. It would be useful to look more closely at the issue of changes in reporting on health insurance coverage using a national survey that does not have the ASEC nonresponse issue. It seems likely that the NHIS would be a more useful data source for this analysis than the CPS.

<sup>10</sup> Note that if YC's assumption that uninsured individuals would be less willing to report that they were uninsured as a result of the individual mandate is correct, the soonest we might expect to see marked change in nonresponse in the CPS would be between the survey in 2009 (which collected data for 2008) and the survey in 2010 (which will collect data for 2009), since the individual mandate did not become effective until December 31, 2007.

<sup>11</sup> The 2008 ACS is the first year that the health insurance question was asked in that survey. There are discussions underway at the Census Bureau to refine the strategy used to identify missing data which would likely lead to a lower estimate of nonresponse in the ACS. Three factors that may contribute to the lower nonresponse rate on the health insurance questions in the MHIS relative to the CPS and ACS are (1) the reliance on an adult in the household who is knowledgeable about the health insurance coverage for other members of the household as the survey respondent, (2) a more complete listing of possible types of insurance coverage in the state as part of the health insurance questions, and (3) the placement of the health insurance questions early in the survey. See Kathleen T. Call, Michael Davern, and Lynn A. Blewett "Estimates of Health Insurance Coverage: Comparing State Surveys with the Current Population Survey." *Health Affairs*, 26, no. 1 (2007): 269-278.

<sup>12</sup> The models that show a drop in ESI coverage rely on all other New England states as the comparison group, as in the work by YC. When we exclude the three New England states that expanded eligibility for public coverage to adults over the study period (since research shows that an expansion of coverage to parents often leads to gains in coverage for their children), we find no evidence of crowd-out for any children in Massachusetts.

<sup>13</sup> One challenge with focusing on type of insurance coverage is that there is measurement error in how individuals categorize their insurance coverage in all surveys. In Massachusetts it not clear how respondents will report participation in CommCare, CommChoice or the premium assistance programs under MassHealth. Given these reporting problems, we have more confidence in estimates of the overall level of insurance coverage in Massachusetts from survey data than in the particular type of coverage.

<sup>14</sup> Another measure of crowd-out is provided by the state's periodic survey of employers, which shows an increase in the share of employers offering insurance coverage to their workers in Massachusetts since health reform began, while the employer offer rate has remained flat nationally over the period. See Massachusetts Division of Health Care Finance and Policy, "Analysis in Brief: Employers and Massachusetts Health Reform," (Boston, MA: Division of Health Care Finance and Policy, January 2010), [http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mes\\_aib\\_2009.doc](http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mes_aib_2009.doc).

<sup>15</sup> Specifically, the CPS asks about insurance coverage over the prior calendar year in March (mostly) of the following year. Both the nature of the questions (coverage over the entire prior year) and the timing of the question (up to 15 months later) lead to recall problems for survey respondents. There is a substantial literature that assesses the extent of those recall problems, with the most recent work suggesting that CPS health insurance responses appear to be a hybrid of point-in-time responses and prior-year responses. The Census Bureau provides a review of issues related to the quality of the CPS health insurance estimates in Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-236, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, U.S. Government Printing Office, Washington, DC, 2009, pp. 57-58. Also, see the materials on CPS at the State Health Access Data Assistance Center website: <http://www.shadac.org>.

<sup>16</sup> In fact, the Census Bureau stopped including state-level estimates of insurance coverage in its annual report on income, poverty and health insurance coverage based on the CPS ASEC in 2008, the first year state-level estimates were available from the ACS.

<sup>17</sup> Although YC report that the CPS but not the MHIS includes residences without telephones, they are incorrect. The MHIS, like the CPS, includes an address-based sample and so also captures households without landline telephones (i.e., households without any telephone and households that rely on wireless telephones).

<sup>18</sup> The ACS estimate reported here is slightly higher than that reported elsewhere since we exclude individuals in group quarters from the ACS sample to align the ACS estimate more closely to the estimate from the MHIS.

<sup>19</sup> Note the methodological issues outlined in Note 5 also apply to YC's analysis of health status.

<sup>20</sup> Sharon K. Long and Paul B. Masi "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs* 28, no. 4 (2009): w578-w587.

## About the Author and Acknowledgements

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