planning. In one community, the hospital-donated office space is a critical lifeline to a family planning clinic serving more clients with less public funding. In another community, the main public hospital is increasingly relying on the county's indigent care program and accumulating a deficit as it continues to provide care for all women in need. Planned Parenthood affiliates in more affluent communities have offset funding cuts with private donations, but that hasn't been possible for affiliates in impoverished or politically conservative areas — and it's unclear how sustainable the fundraising will be even in the more affluent communities. In communities with a large population of migrants who are ineligible for the WHP, the challenge is even greater.

Ostensibly, the purpose of the law was to defund Planned Parenthood in an attempt to limit access to abortion, even though federal and state funding cannot be used for abortion care anyway. Instead, these policies are limiting women's access to a range of preventive reproductive health services and screenings. Disadvantaged women must choose between obtaining contraception and meeting other immediate economic needs. And, as one of our interviewees pointed out, providers are put in the position of "trying to decide, out of the most vulnerable, who is the most, most vulnerable." Moreover, the impact of these policies is not limited to Planned Parenthood; other organizations have had to close clinics, reduce hours, and lay off dedicated, experienced staff members. We are witnessing the dismantling of a safety net that took decades to build and could not easily be recreated even if funding were restored soon.

Time will reveal the full effects of these budget cuts on the rates of unintended pregnancies and induced abortions and on state and federal health care costs. Already, the legislation has created circumstances that force clinics and women in Texas to make sacrifices that jeopardize reproductive health and well-being. This unfortunate situation does offer an opportunity to compare outcomes such as contraceptive use, unintended pregnancy, and abortion in Texas and other states, such as California, that have less restrictive family planning policies. Such comparisons could provide important information about the impact of these policies. Debates about funding in Congress and in other states should consider the results of such research and take a hard look at the implications for women, families, and communities of restricting access to contraception.

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Health Care Reform and the Dynamics of Insurance Coverage — Lessons from Massachusetts

John A. Graves, Ph.D., and Katherine Swartz, Ph.D.

As the blueprint for the Affordable Care Act (ACA), the 2006 Massachusetts health care reforms are useful for projecting the potential effect of national health care reform on insurance coverage throughout the United States. In Massachusetts, reforms have yielded gains in insurance coverage. It is estimated that between 2006 and 2009, the proportion of low-income Massachusetts adults who lacked insurance coverage decreased by one sixth, while the proportion in similar states barely changed — a substantial achievement by any measure.[1]

One aspect of the Massachusetts reforms that has not been evaluated, however, is their effect on various groups of uninsured people — in particular, those who have short spells without insurance versus those who remain uninsured longer. This distinction is important: since 2007, Massachusetts and the federal government have together spent more than $700 million annually

on subsidies and expanded public programs. The tally will rise considerably when similar health care reforms are implemented nationwide starting in 2014, so it's helpful to establish whether the expenditures primarily benefited the long-term uninsured who had difficulty obtaining coverage before the reforms were implemented.

Also important is determining whether the lack of coverage in Massachusetts was an acute or a chronic condition, since policy levers for targeting the short- and long-term uninsured differ. For example, if most people who become uninsured while a mandate is in effect are without coverage only briefly, then perhaps available premium subsidies should be more widely publicized and programs providing transitional coverage should be designed. In contrast, if new uninsured spells are long-lasting, then the eligibility rules and subsidy amounts for the assistance program should be reassessed. In light of the current economic malaise, it also is critical to determine whether health care reforms sufficiently protected Massachusetts residents from having long-term coverage gaps during and after the 2008–2009 recession. If not, then other approaches for extending coverage might be required at the national level. Examples include the Massachusetts Medical Security Plan, which serves low- and moderate-income residents who receive unemployment benefits, and the COBRA subsidies of 2009–2010, which covered 65% of the cost of transitional coverage through a former employer for people who lost their jobs.

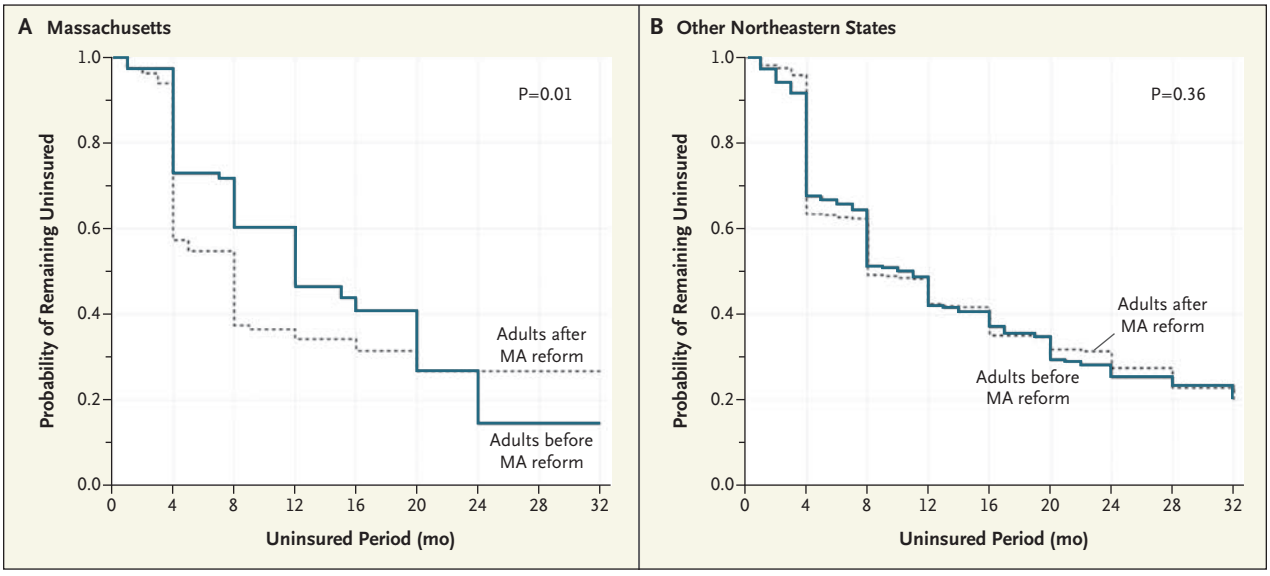
Finally, changes occurring in coverage dynamics in Massachusetts should be assessed because financing for uncompensated care in acute care hospitals will change under the ACA. As part of covering approximately 32 million currently uninsured people, the law mandates a reduction in Disproportionate Share Hospital (DSH) payments by an estimated $36 billion between 2010 and 2019,[2] with specific amounts determined by new DSH formulas that incorporate percentage decreases in the number of uninsured people within each state.[3] Recent evidence indicates that nearly 40% of uninsured adults and more than half of uninsured children are without insurance for spells of 4 months or less.[4] A large decrease in the number of uninsured people could therefore be concentrated among those with temporary gaps in coverage. Past research has also shown that long uninsured spells are associated with lower socioeconomic status, racial or ethnic minority status, and lower educational attainment.[5] If reforms similar to the ACA disproportionately reduce the incidence of short uninsured spells, then reductions in DSH payments under the new statutory formula could threaten the financial viability of acute care hospitals and exacerbate access problems among the chronically uninsured.

To better understand how uninsured spells may have changed in Massachusetts since health care reforms were implemented, we analyzed longitudinal data on monthly reports of insurance coverage between November 2003 and December 2011, which came from the Survey of Income and Program Participation (see graphs). We compared two samples of adults who had uninsured spells. One sample consisted of Massachusetts residents before and after the state's 2006 reforms, and the other consisted of adults in neighboring states in the Northeast Census region. Using nonparametric Kaplan–Meier methods, we estimated the duration, in months, of each person's uninsured spell. Only spells that began during the survey's period of observation were included.

Adults were categorized as belonging to the prereform group if their uninsured spell began before October 2006, the date when expanded enrollment in the Massachusetts Commonwealth Care program began for uninsured adults whose medical care had previously been paid for by the state's free care pool. Commonwealth Care offers subsidized insurance options for people with incomes up to three times the federal poverty level. Persons who became uninsured after October 2006 were considered to belong to the postreform group.

We found that the distribution of uninsured-spell durations in Massachusetts changed in important ways in the postreform period. Before reform, the median duration of an uninsured spell in Massachusetts was 12 months, and the duration at the 75th percentile was 24 months. This distribution was similar to the distribution of spells in the other northeastern states ($P=0.60$ by the log-rank test), where the median spell was also 12 months, and slightly more than one quarter of adults (25.2%) had spells lasting longer than 24 months.

Between October 2006 and December 2011, the distribution of spell lengths in the other northeastern states remained quite stable ($P=0.36$ for the change over time). In Massachusetts, however, there was a statistically significant downward shift in the duration of uninsured spells, concentrated primarily between the 25th and 75th percentiles ($P=0.01$ for



Duration of Uninsured Spells in Massachusetts and Northeastern United States, 2003–2011.

Data are from the Survey of Income and Program Participation (2004, 2008). The prereform period was defined as January 2004 through October 2006; the postreform period was defined as November 2006 through December 2011. The other northeastern states that were compared with Massachusetts included New York, Pennsylvania, New Jersey, Connecticut, Rhode Island, Maine, New Hampshire, and Vermont.

the time difference in curves; P=0.047 for the comparison with other states in the postreform period). In the postreform period in Massachusetts, half the spells concluded within 8 months, a 4-month decrease from the prereform period. However, the percentage of Massachusetts adults who were uninsured for longer than 24 months after the reform (26.7%) was nearly identical to the percentage of long-term uninsured in the other states (27.4%). One reason that reforms might not have helped people who were uninsured for long spells is that anyone eligible for employer-sponsored insurance is ineligible for Commonwealth Care, even if the person is exempt from the mandate to obtain coverage because his or her share of the employer-sponsored insurance is unaffordable.

These findings have important implications for Massachusetts and for national health care reform. We have found that even under a mandate and with subsidies available for purchasing insurance through an exchange, the proportion of adults who became uninsured but then gained coverage within 3 months was nearly identical in the years before and the years after reform. One reason may be that people who lose Medicaid eligibility frequently have a gap in coverage between Medicaid and a Commonwealth Care plan, because private plans do not start coverage until the first day of the month following enrollment. The finding that the percentage of adults in the midst of uninsured spells of 24 months or longer was the same in Massachusetts after the reforms were implemented as it was in other states suggests that the eligibility rules for Commonwealth Care need to be revised for low-income people who have access to, but cannot afford, employer-sponsored coverage. A key implication for the ACA is that ensuring access to exchange tax credits for families with unaffordable employer-sponsored health insurance could prove to be critically important for covering the long-term uninsured.

As we show here, postreform decreases in the duration of uninsured spells in Massachusetts came primarily from a decrease in the proportion of uninsured spells lasting 4 to 20 months. Our findings suggest that a mandate and subsidized coverage work well for people who might otherwise remain uninsured for up to a year and a half. However, policies are needed to minimize gaps in coverage that might occur when people transition between Medicaid and subsidized plans or employer-sponsored coverage, and eligibility rules should be changed for low-income people who cannot afford an employer-sponsored plan.

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Cure for the Common Cold

David Watts, M.D.

Rumor has it that the medical profession suffers from too many cold and distant doctors. Studies have attempted to subject this notion to the scrutiny of science,[1,2] and although we could argue over their degree of success, we know it's true. We need only ask our patients in order to be regaled with stories confirming the accusation. Cold. Yet we didn't start out that way.

I was a member of a medical school admission committee for almost a decade. Through the chair in front of my desk streamed the intellectually elite and the altruistically driven. Academic prowess was a constant, but there was also an abiding sense of goodwill. By their third year of medical school, however, these aspiring physicians had changed.

No exception myself, I recall one Saturday deep into the wee hours in the ER at Houston's Ben Taub General Hospital, when, assigned in my third year at Baylor College of Medicine to work up an alcoholic hulk admitted for the umpteenth time to be dried out, I lost it. Sleep-deprived and confronted with what I perceived as a futile task, I broke into a yelling, spitting, seizure-like rage that shook the room, hurling shame and insult at what I saw as a mass of flesh on a gurney. I didn't know I had that in me.

Stepping back to take a deep breath, I bumped into someone standing in the shadows. It was the man's father, there to support his son. The moment turned, and my error flashed into view.

Hippocrates said that some patients get well only by the goodness of their physicians. The same is true today. Compliance with antihypertensive regimens, response to pain management, diabetes control — many diseases improve when patients feel connected to their doctors.[3]

That night in the ER, my goodness had gone missing. What had happened to the bright-eyed young man who had come to medical school? My self-diagnosis: my brain was off-kilter.

Dynamic studies of the brains of cab drivers who pore over maps cramming knowledge of London geography have shown enlargement of the right posterior hippocampus[4] — as if a brain hypertrophies as a muscle does, or plumps like the livers of force-fed geese. It's astonishing that beyond the flexibility of the electrochemical matrix, the very fabric of the brain is also plastic.

My brain, like those of many third-year students, had been plumped. Whether it was a biochemical or anatomical change I don't know, but what went missing was perspective, balance. We had so much science crammed into our brains that we had lost touch with humanistic practices and values. Without balance, we become vulnerable to distorted ideas — like the belief that we have the right to shower abuse on hopeless alcoholics or that we need to build walls against the vortex of human emotion surrounding suffering and death.

As it turns out, there is no reason to fear engagement. We are not destroyed when patients suffer or die, but rather deepened, becoming better able to open ourselves to the complex lives of the distressed and infirm the next time around. Over time, there comes a natural but mysterious adjustment toward equanimity, in which we can hold onto both worlds, that of safety and that of danger, simultaneously, without calamity. I call this phenomenon the "doubleness factor." My mentor had it, as have many seasoned physicians I've met along the way. Essential to the transition to this double state is assurance that we can survive within the crucible of danger and that the loss of personal safety is worth the risk. It means we have to rethink danger. The cure for the malady of distance is to enter danger and come back alive.

Can this ability be taught? The most boring lecture I ever attended was a lecture on compassion — and I'm passionate about the subject. The lecturer talked about eye contact, leaning forward, touching the patient's elbow at just the right moment. But these