

Closing the Coverage Gaps:

Reducing Health Insurance Disparities in Massachusetts

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I. BACKGROUND

Health insurance is the key that unlocks access to the U.S. health care system. Lacking health insurance is harmful and costly—to individuals, to health care providers, and to the entire community. People without insurance are far more likely than others not to have a usual source of health care and to postpone or go without needed care.¹ Not having insurance adversely affects health, most significantly for people who have chronic or acute conditions, and being uninsured has been associated with an increased risk of death, particularly among near-elderly adults.² Being uninsured, whether long- or short-term, also causes financial stress for individuals and families, who may use up their savings and accumulate medical debt;³ it also imposes costs on providers, governments, and society at large.⁴

Having insurance does not cure all access challenges. Access to care may be hindered if people are underinsured, which can make health care cost-prohibitive due to excessive out-of-pocket expenses.⁵ Access is also limited by discrimination (both overt and unconscious) based on race and ethnicity, languages spoken, age, disability, sexual orientation, and/or gender identity. Geography might be an access barrier for some, or provider shortages in an area for others. Health insurance is just one factor governing health care access, but it is an important one.

HISTORICAL CONTEXT AND BASIC COVERAGE FRAMEWORK IN MASSACHUSETTS

Over several decades, going back at least to the Medical Security Act in 1988,⁶ Massachusetts has been exemplary in developing policies to cover its residents, using both public programs and the private insurance market.⁷ Over time, coverage has been made more accessible to people receiving unemployment benefits, people with disabilities, and pregnant people and new mothers. Major reforms in 1996–97 included significant eligibility expansions to Medicaid (renamed MassHealth in 1997 and incorporating the new Children’s Health Insurance Program, or CHIP) and reforms in commercial insurance markets.

The new millennium saw the major reforms that brought Massachusetts to its present level of health insurance coverage. In 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care⁸ further expanded MassHealth eligibility, created the Health Connector marketplace and the Commonwealth Care program of subsidized coverage, merged the small group and individual insurance markets, and established mandates for certain employers to offer insurance and for most individuals to obtain coverage. Many of the features of the 2006 Massachusetts health care reform law served as a blueprint for the federal Affordable Care Act (ACA), passed in 2010, with most of its coverage provisions coming into effect in 2014. With the implementation of the ACA—including the introduction of federal tax subsidies for individuals to purchase insurance through the Health Connector and the recasting of Commonwealth Care as ConnectorCare in this new policy context—the pieces that make up the current coverage landscape in Massachusetts were in place.

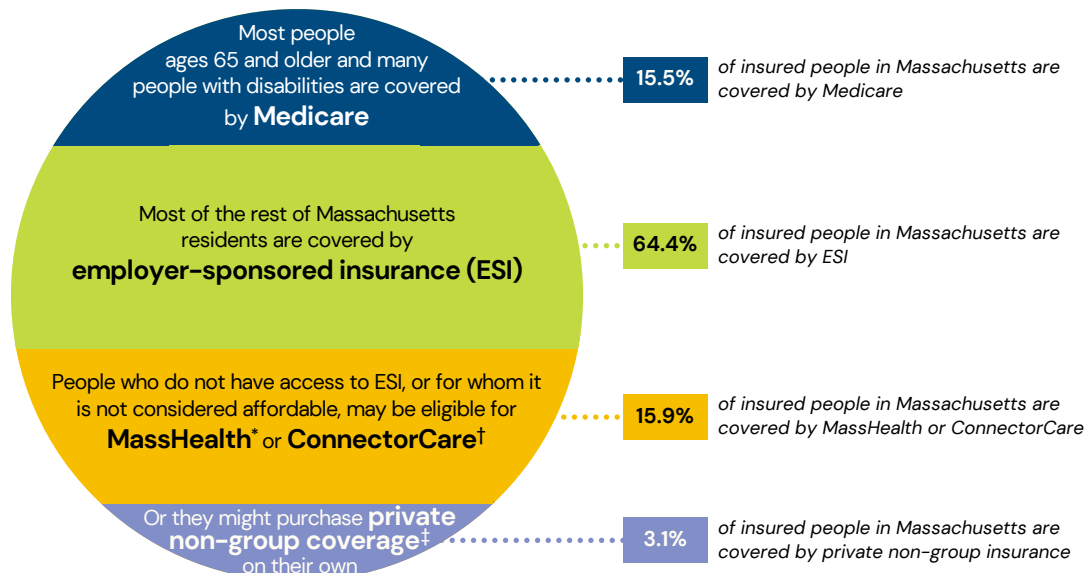
The **Massachusetts Health Connector** is a virtual marketplace where state residents may compare and purchase individual (nonemployer) commercial insurance. The Health Connector applies premium and cost sharing subsidies to health plans for those who qualify. **Commonwealth Care** was created in 2006 to make subsidized coverage available to people whose income exceeded eligibility levels for MassHealth but was still relatively modest, and who did not have access to subsidized employer coverage.

RECENT TRENDS IN INSURANCE COVERAGE

The coverage initiatives described above have borne results. The share of Massachusetts residents without health insurance fell sharply following enactment of the 2006 reform law.⁹ The state’s uninsurance rate stood at 3.9 percent by 2008, according to the Census Bureau’s American Community Survey (ACS).^{10,11} Uninsurance continued to decline over the next decade, reflecting both the ongoing implementation of state reforms and the implementation of national reforms under the ACA. By 2019, the Massachusetts uninsurance rate was at 3.0 percent, the lowest rate in the nation, representing about 204,000 uninsured residents.¹² With the COVID-19 pandemic and policy responses designed to mitigate its impact on health insurance coverage, uninsurance declined again, falling from 3.0 percent to 2.5 percent between 2019 and 2021.¹³ However, this may be a fleeting change reflecting a temporary freeze on MassHealth disenrollment during the COVID-19 federal public health emergency, and the uninsurance rate may rebound at least partially toward pre-pandemic levels as the state begins reviewing member eligibility now that the federal continuous coverage rules enacted during COVID-19 have ended.^{14,15}

Expansion of public coverage programs in Massachusetts has not drawn significant numbers of people off private coverage.¹⁶ In 2019, two thirds of insured people in the Commonwealth had coverage through an employer or from a private plan purchased independently or through the Health Connector, as shown in Figure 1.

FIGURE 1. HEALTH COVERAGE LANDSCAPE AMONG ALL INSURED RESIDENTS IN MASSACHUSETTS, 2019



Source: 2019 Massachusetts Health Insurance Survey (MHIS).

Coverage types are mutually exclusive for the purpose of this chart, based on this reporting hierarchy: ESI, Medicare, Private non-group, MassHealth/ConnectorCare. Chart does not include 1.2% reported in “Other” coverage category. Percentages do not add up to 100 due to rounding.

* MassHealth eligibility: Children up to 300% of the federal poverty level (FPL) and adults up to 138% FPL (with variation).

† ConnectorCare eligibility: Adults up to 300% FPL.

‡ Includes coverage with tax credit subsidies via the Health Connector and unsubsidized coverage.

The uninsured percentage in Massachusetts is admirably low, but it still represents a sizable number of people—about 204,000 in 2019. And that number is not the entire story, because it is based on a survey question that asked people whether they had insurance at that moment. A state survey the same year revealed that 7.3 percent, or about 503,000 people, had been without health insurance sometime in the past 12 months.¹⁷ Even a temporary gap in coverage increases the risk of not being able to get and pay for health care at rates similar to those experienced by people who are uninsured for a full year.¹⁸ These short coverage gaps reduce the ability of individuals and families to keep up to date with scheduled health care services.¹⁹ To these people, Massachusetts’ exemplary performance expanding coverage provides little solace.

While the overall uninsured rate at a given point in time is low in Massachusetts, not all groups benefit equally. People with certain characteristics—people who are Black or Hispanic, who have lower incomes, who are male²⁰—experience significantly higher rates of uninsurance than the state population overall. These groups are therefore more likely to experience the access barriers and financial insecurity associated with being uninsured. Inequities in coverage exacerbate longstanding racial and ethnic disparities in health outcomes and must be addressed as part of a broader effort to address structural racism and improve health equity.

BOX 1. A NOTE ABOUT DATA

In this report, we focus on the characteristics of Massachusetts residents who were uninsured in the years just before the COVID-19 pandemic, with an emphasis on federal survey data collected between 2017 and 2019 and the barriers to coverage uninsured people faced during that period.²¹ Though data from federal and state surveys are available for 2021, we were concerned that changes in the composition of the uninsured population and coverage barriers between 2019 and 2021 primarily reflect short-term impacts of and policy responses to the pandemic. We relied on data for the pre-pandemic periods as we believe that the experiences of residents who were uninsured before the pandemic will be more consistent with the experiences of the post-pandemic uninsured population.

II. PURPOSE OF THE PROJECT

The purpose of this project is to begin charting the course to closing the coverage gaps in Massachusetts, with a particular focus on creating a more racially and ethnically equitable system of coverage. Because coverage may come from many sources and people without insurance are diverse, it is likely that multiple strategies will be required to close the remaining gaps in coverage. This report identifies potential pathways to closing remaining gaps in coverage by:

- **Describing the uninsured population.** Section IV describes the people in Massachusetts without health insurance, including detailed demographics, employment and economic characteristics, and health status. These characteristics are used to estimate who among the uninsured population may be eligible for existing coverage.
- **Identifying barriers to coverage.** There are many reasons why people are not insured. Section V describes the barriers to coverage that uninsured people in Massachusetts face, including affordability, transitions across programs, administrative complexity, and immigration, language, and cultural barriers.
- **Proposing policy options for overcoming specific barriers.** Section VI uses the information from the preceding sections to derive a menu of policy options that address the specific challenges in Massachusetts. These proposals are meant to inform a statewide conversation about the best approaches for reducing the number of people without insurance and addressing longstanding disparities in health insurance coverage.

The hope is that this report will spark a serious discussion—supported by data, research, and analysis—of realistic approaches to closing the remaining coverage gaps in Massachusetts and removing structural barriers that result in racial and ethnic disparities in health insurance coverage.

III. METHODOLOGY

We conducted a systematic review and synthesis of existing research and data on the characteristics of uninsured Massachusetts residents and the barriers they face in obtaining coverage, including differences in the barriers faced by different racial and ethnic groups. We used the following methods:

- A review of the research literature on the remaining uninsured population in Massachusetts
- Analysis of pooled 2017–2019 data from the American Community Survey (ACS), Current Population Survey (CPS), and Behavioral Risk Factor Surveillance System (BRFSS) to provide updated information and fill knowledge gaps
- Microsimulation modeling to estimate uninsured nonelderly residents' eligibility for public or subsidized coverage options
- Interviews with Massachusetts health insurance navigator organizations and other stakeholders who connect uninsured people with coverage and health care services in the Commonwealth

This mixed-methods analysis provided a more complete picture of remaining barriers to coverage than would have been possible using any single approach. It also helped us assess whether findings from previous research reflect the barriers uninsured residents currently experience.

The results from this synthesis informed our efforts to identify potential policy and programmatic options for making further progress toward universal coverage and reducing racial and ethnic disparities in uninsurance. This included:

- A review of literature to catalog the range of existing policies and programs across the nation used to address the barriers to coverage we identified
- A landscape scan of additional policies and programs under consideration at the local, state, and national levels

We describe our methodology for each component of this report further in a separate [methodology report](#).

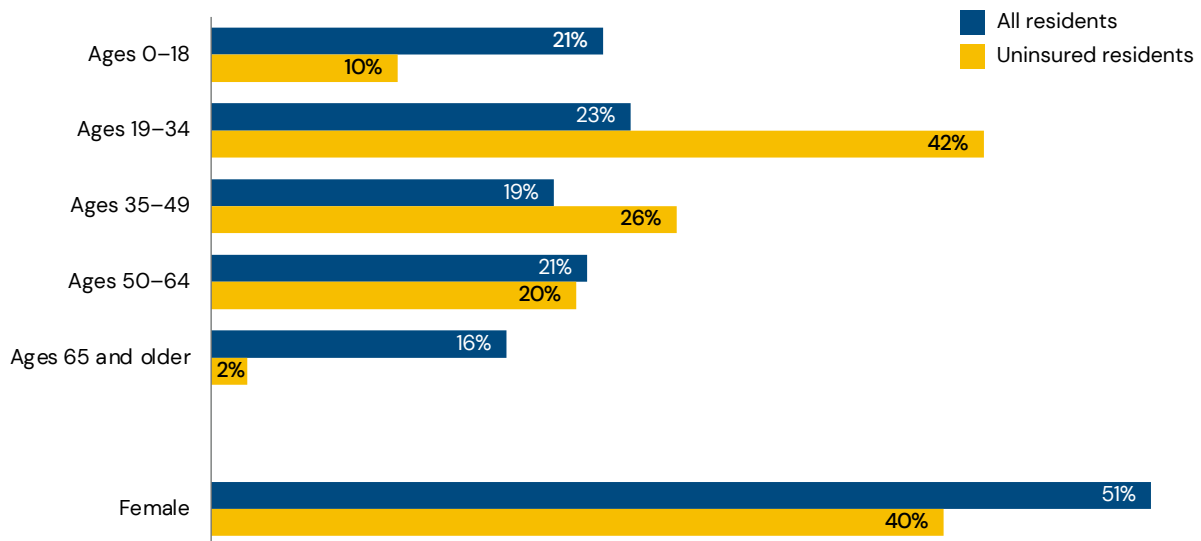
IV. OVERVIEW OF THE CHARACTERISTICS OF UNINSURED MASSACHUSETTS RESIDENTS

DEMOGRAPHIC CHARACTERISTICS

It is well documented that Massachusetts residents who currently face, or whose communities have historically faced, racial and ethnic discrimination, economic disadvantages, and/or gaps in eligibility for public or subsidized coverage are at elevated risk of being uninsured.²² Uninsurance is also relatively higher for younger adults, and especially young men, who may be less likely than other adults to think they need coverage. Our analysis of 2017–2019 ACS data supports those findings:

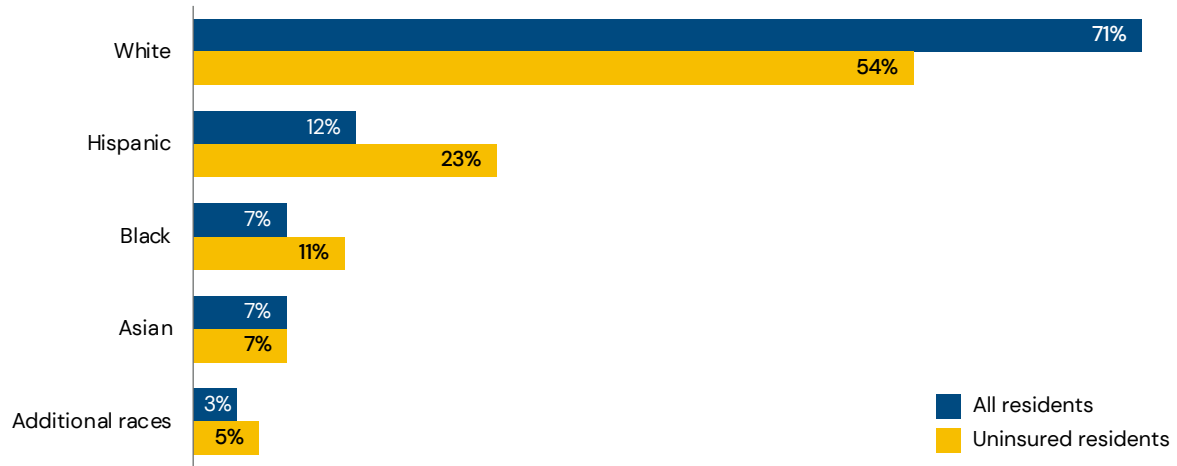
- **Age and sex:** Adults ages 19 to 64 have long had the highest uninsurance rates of any age group in the Commonwealth, predating the state’s 2006 reform law.²³ That is particularly true for young adults ages 19 to 34, who make up 23 of Massachusetts residents but 42 percent of the uninsured (Figure 2). Uninsurance is less common among children under 19, who have broader eligibility for MassHealth, and elderly adults ages 65 and older, nearly all of whom are eligible for Medicare. Nonelderly men (not shown in Figure 2) account for a disproportionate share of uninsured residents.
- **Race and ethnicity:** Consistent with earlier studies, we found significantly higher levels of uninsurance among Hispanic residents and non-Hispanic Black residents relative to non-Hispanic White residents. Hispanic residents, in particular, are much more likely to be uninsured, constituting 23 percent of the uninsured population but only 12 percent of all residents in the state (Figure 3). In contrast, non-Hispanic White residents represent 54 percent of the uninsured, even though they make up 71 percent of the total state population. Notably, Asian residents represent 7 percent of the total state population and 7 percent of the uninsured population in Massachusetts.

FIGURE 2. AGE AND SEX OF MASSACHUSETTS RESIDENTS, OVERALL AND AMONG UNINSURED RESIDENTS, 2017–2019



Source: Urban Institute analysis of pooled 2017–2019 American Community Survey data from IPUMS USA.

FIGURE 3. RACE AND ETHNICITY OF MASSACHUSETTS RESIDENTS, OVERALL AND AMONG UNINSURED RESIDENTS, 2017–2019

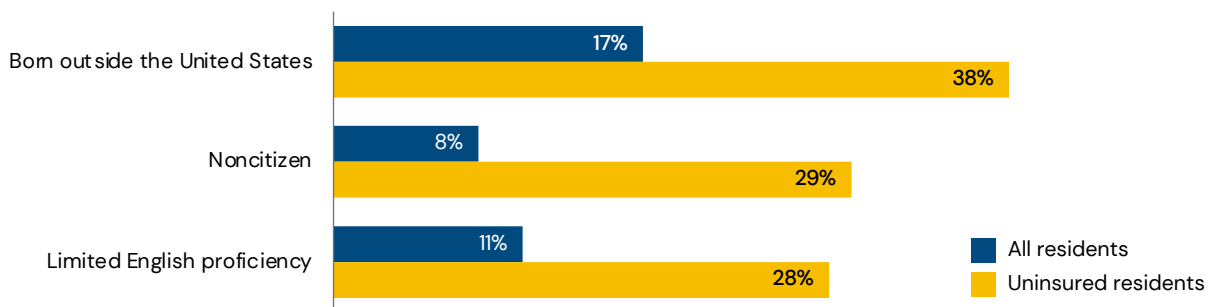


Source: Urban Institute analysis of pooled 2017–2019 American Community Survey data from IPUMS USA.

Notes: Additional races include Native Hawaiian or Pacific Islander, American Indian/Alaska Native, some other race, or more than one race. The categories for White, Black, Asian, and additional races refer to individuals who do not identify as Hispanic.

- Nativity and citizenship status:** Nearly 4 in 10 uninsured residents were born outside the United States, and about 3 in 10 are not U.S. citizens (Figure 4). Residents who are not U.S. citizens have much higher uninsurance rates than U.S.-born and naturalized citizens,²⁴ in part because they are less likely to be employed in jobs that provide them with health insurance.²⁵ In addition, residents who are not lawfully present in the United States are ineligible for coverage through the Health Connector, and eligibility for MassHealth for people who are not U.S. citizens depends on whether they have a qualified immigration status and, for some groups, whether they have held that status for at least five years.²⁶ The nativity and citizenship statuses of uninsured residents vary widely by race and ethnicity (see Box 2).
- English proficiency:** Many uninsured adults have limited English proficiency (LEP), which can impede their ability to navigate the MassHealth or Health Connector enrollment process (Figure 4). Those who live in LEP households (i.e., where no one ages 14 and older speaks English very well) may have the most difficulty enrolling without translation assistance.

FIGURE 4. NATIVITY, CITIZENSHIP STATUS, AND ENGLISH PROFICIENCY OF MASSACHUSETTS RESIDENTS, OVERALL AND AMONG UNINSURED RESIDENTS, 2017–2019



Source: Urban Institute analysis of pooled 2017–2019 American Community Survey data from IPUMS USA.

Notes: Residents who were born in Puerto Rico or other U.S. territories or born abroad to U.S. citizen parents are considered to be born in the United States. Estimates for limited English proficiency are limited to adults ages 19 and older and include those who speak another language at home and do not speak English very well.

- **Household and family composition:** Though few uninsured adults live alone, most are unmarried and do not have dependent children under 19 who live with them,²⁷ thus limiting their paths to private coverage (e.g., via a spouse’s employment) and making them less likely to enroll in public coverage for which they may be eligible (e.g., because parents are more likely to enroll jointly with eligible children).²⁸

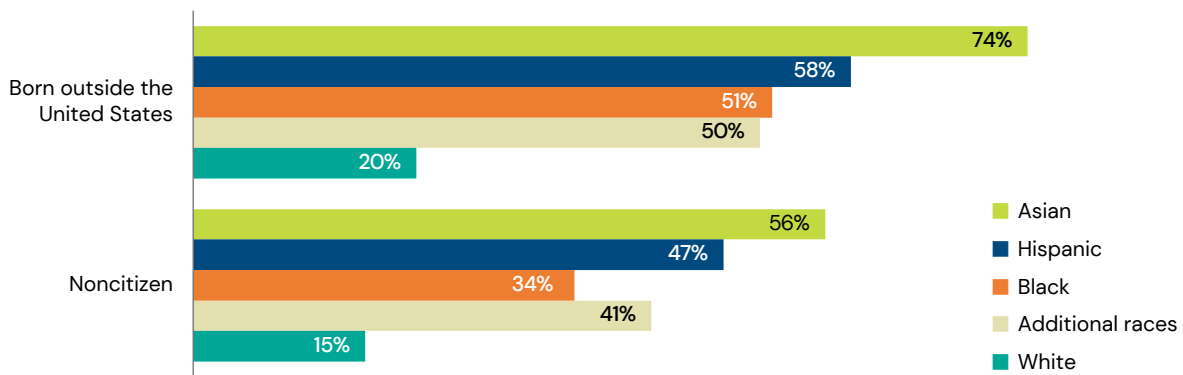
BOX 2. RACIAL AND ETHNIC COVERAGE DISPARITIES AND THEIR INTERSECTION WITH NATIVITY, CITIZENSHIP, AND OTHER CHARACTERISTICS

Coverage disparities by race and ethnicity have persisted for more than a decade, reflecting the consequences of structural racism—longstanding systemic barriers embedded in laws, policies, practices, and entrenched norms that have limited employment and economic opportunities for Hispanic residents and non-Hispanic Black residents in particular.²⁹ Non-Hispanic White residents are more likely to be continuously insured than residents who are Hispanic or who are non-Hispanic and Black or additional races, both overall and often within the same income groups.³⁰ Our analysis of the 2017–2019 ACS sheds new light on additional characteristics beyond income that intersect with racial and ethnic disparities, including nativity and citizenship status.

One in 5 uninsured non-Hispanic White residents were born outside the United States; by contrast, among uninsured residents who are Hispanic or who are non-Hispanic and Black, Asian, and additional non-White races or multiple races, at least half were born outside the United States. For the Asian uninsured population, almost three in four were born outside of the United States (Figure 5).³¹ Even larger shares of each group live in households with at least one foreign-born person.³² Coverage disparities overlap with differences by race and ethnicity in citizenship status. Hispanic residents and non-Hispanic Black residents are more than four times as likely as non-Hispanic White residents to not be U.S. citizens, a group with some of the highest uninsurance rates in the state.³³

Differences in other socioeconomic characteristics have implications for policy and programmatic changes that aim to close racial and ethnic health care coverage disparities as well. For instance, employment rates vary widely for uninsured adults, with the highest rates found among Hispanic adults and the lowest among non-Hispanic Asian adults, who are disproportionately more likely to be of retirement age or students.³⁴ Policies expanding access to employer-based coverage will therefore have different effects on these groups. The impact of new, income-targeted health reforms will also vary within racial and ethnic groups. For instance, uninsured non-Hispanic Asian adults are the most highly stratified group by income and educational attainment, reflecting the wide range of socioeconomic circumstances within the Asian population.³⁵

FIGURE 5. NATIVITY AND CITIZENSHIP STATUS OF UNINSURED MASSACHUSETTS RESIDENTS, BY RACE AND ETHNICITY, 2017–2019



Source: Urban Institute analysis of pooled 2017–2019 American Community Survey data from IPUMS USA.

Notes: Additional races include Native Hawaiian or Pacific Islander, American Indian/Alaska Native, some other race, or more than one race. The categories for White, Black, Asian, and additional races refer to individuals who do not identify as Hispanic. Residents who were born in Puerto Rico or other U.S. territories or born abroad to U.S. citizen parents are considered to be born in the United States.

GEOGRAPHIC CHARACTERISTICS

Relative to the overall state population, uninsured residents were slightly more likely to live in Suffolk County and less likely to live in Bristol, Plymouth, and Norfolk Counties in 2017–2019.³⁶ Otherwise, the distribution of uninsured residents across counties roughly matched that of the overall population.

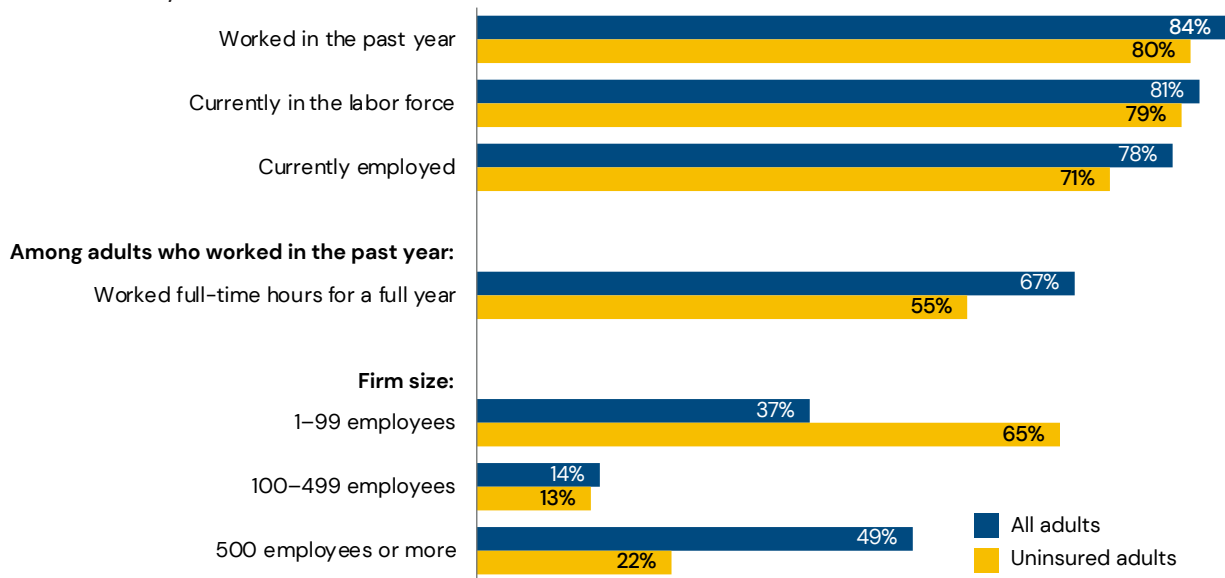
This relatively even distribution conceals wide variation in uninsurance rates at the community level. Uninsurance hot-spot communities, defined as communities with the highest uninsurance rates in the state, are found in every region of the state, and these communities tend to have high poverty rates and housing cost burdens, low average incomes, and persistently high uninsurance rates over time.³⁷ About half of uninsurance hot spots with the highest concentration of uninsured residents are in the Boston region. Communities with high levels of tourism and seasonal employment, such as those in Nantucket, Dukes, Barnstable, and Berkshire Counties, also face notably higher uninsurance rates, possibly related to limited access to employer-sponsored insurance (ESI); however, because these communities contain a small share of the state’s overall population, they also account for a relatively small portion of the state’s uninsured population.³⁸

SOCIOECONOMIC CHARACTERISTICS

Though most Massachusetts residents obtain their health insurance coverage through an employer,³⁹ the socioeconomic characteristics of uninsured residents likely limit their incomes and their access to ESI, making it more difficult for them to afford coverage.

- **Educational attainment:** A majority of uninsured adults have not attended college. Only 1 in 5 uninsured adults has a four-year college degree, compared with more than 2 in 5 of all adults in the state.⁴⁰
- **Employment status and employer type:** Uninsured working-age adults are employed and in the labor force at only slightly lower rates than adults overall (Figure 6). Though most uninsured workers usually work a full-time schedule of 35 or more hours per week, they are less likely than other workers to have had year-round full-time employment. Uninsured workers are disproportionately employed in small firms and in industries that are more likely to offer lower wages and/or limited benefits, such as construction, accommodation and food services, and retail trade.⁴¹ Most uninsured workers do not have access to ESI through their jobs, as discussed further below.

FIGURE 6. EMPLOYMENT CHARACTERISTICS OF MASSACHUSETTS ADULTS AGES 19 TO 64, OVERALL AND AMONG UNINSURED ADULTS, 2017–2019

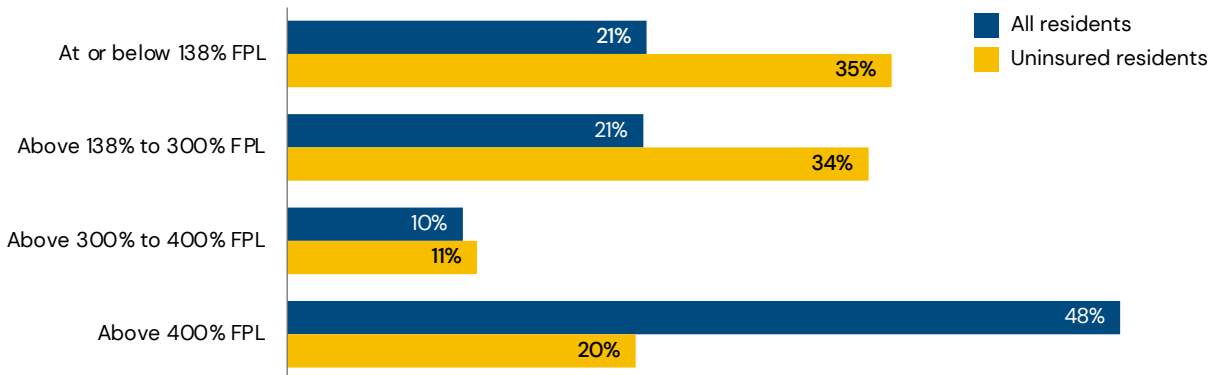


Source: Urban Institute analysis of pooled 2017–2019 American Community Survey (ACS) data from IPUMS USA and pooled 2017–2019 Current Population Survey Annual Social and Economic Supplement (CPS–ASEC) data reweighted to the characteristics of residents in Massachusetts in the ACS.

Notes: Adults in the labor force include those who are currently employed or unemployed (i.e., not working in the last week but actively looking for work in the last 4 weeks or being on temporary layoff). Current employment status is based on any work for pay at a job or business in the last week. Full-time hours are defined as usually working 35 or more hours per week. Full-year is defined as working 50 to 52 weeks. Firm size estimates are based on the CPS–ASEC data and exclude adults in group quarters.

- Family income:** The education and employment characteristics of uninsured adults contribute to their relatively lower incomes. Consistent with other surveys⁴² and tax filing data,⁴³ nearly 7 in 10 uninsured residents reported incomes at or below 138 percent of the federal poverty level (FPL) (\$17,200 for a single adult and \$29,400 for a family of three in 2019) or above 138 to 300 percent FPL (300% FPL is equal to \$37,500 for a single adult and \$64,000 for a family of three in 2019), the income eligibility thresholds for MassHealth and ConnectorCare coverage that apply to most adults without disabilities (Figure 7).

FIGURE 7. FAMILY INCOME AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL AMONG MASSACHUSETTS RESIDENTS, OVERALL AND AMONG UNINSURED RESIDENTS, 2017–2019



Source: Urban Institute analysis of pooled 2017–2019 American Community Survey data from IPUMS USA.

Notes: FPL is federal poverty level. Family is defined based on the health insurance unit developed by the State Health Access Data Assistance Center (SHADAC). Estimates exclude residents in group quarters.

- Housing costs and material hardship:** Given their lower incomes, uninsured residents must often dedicate a large share of their budgets to essential expenses such as food and housing, leaving fewer resources for health insurance premiums and out-of-pocket health care costs. Most uninsured residents live in rented homes, and more than 4 in 10 have a moderate or severe housing cost burden, in which they pay more than 30 percent of their household income toward housing costs or have no income.⁴⁴ Consistent with that finding, 1 in 5 uninsured adults reported problems paying their rent, mortgage, or utility bills in the past year, and roughly the same share reported difficulty affording food during that period, according to our analysis of 2017–2019 BRFSS data. These material hardships could also be exacerbated by the greater risk of incurring medical debt because of being uninsured.⁴⁵

Residents who have been uninsured for at least one year have socioeconomic characteristics that suggest they are more likely than residents with shorter uninsurance spells to have limited access to ESI, gaps in eligibility for public and subsidized coverage, and persistent affordability challenges (see Box 3).

BOX 3. DIFFERENCES BETWEEN THE LONG-TERM UNINSURED AND THOSE WITH TEMPORARY COVERAGE GAPS

Studies of tax filing data have found that uninsured tax filers are evenly split between those who are uninsured for less than a year and those who are uninsured all year,⁴⁶ about 4 in 10 of whom are without coverage for a period of two years or more.⁴⁷ Full-year uninsured tax filers are more likely than part-year uninsured filers to be ages 18 to 25 or ages 65 and older and to have incomes below 133 percent FPL, an indicator of gaps in access to dependent coverage, Medicare, and MassHealth, respectively. Pre-ACA survey data found that full-year uninsured nonelderly adults in Massachusetts were more likely than those uninsured only part of the year to be men, Hispanic, unmarried, to lack U.S. citizenship, and to lack a high school degree.⁴⁸

These earlier studies are largely consistent with our analysis of 2017–2019 CPS data, which found that persistently uninsured adults were more likely than intermittently uninsured adults to be men and to have lower educational attainment.⁴⁹ Persistently uninsured adults were also less likely to be employed, and those who worked were more likely to be employed in small firms and to lack an offer of ESI.⁵⁰

These findings and our interviews with stakeholders suggest the long-term uninsured population is disproportionately composed of groups facing ongoing challenges affording coverage: workers without access to affordable ESI; people with low and moderate incomes who are unaware they qualify for MassHealth or ConnectorCare or who cannot afford premiums for a Health Connector plan; undocumented immigrants who are not eligible for state programs as well as other people who are not U.S. citizens and either are not aware of, face barriers enrolling in, or avoid state programs; and residents who are experiencing homelessness. In contrast, people with shorter coverage gaps are often those with temporary difficulties applying for or renewing MassHealth or Health Connector coverage or who are seeking replacement coverage for ESI following a layoff.

HEALTH CHARACTERISTICS

As with previous research,⁵¹ we find mixed results when assessing the health status of uninsured adults using the 2017–2019 BRFSS data.⁵² Uninsured adults are less likely than insured adults to have a disability and to have been diagnosed with chronic health conditions but also are less likely to report being in excellent or very good health. However, limited health care access because of uninsurance could result in undiagnosed and untreated health problems.⁵³ Compared with insured adults, those without coverage face far greater challenges with health care access and affordability, use less care, and rely more heavily on the emergency department both overall and for nonemergency care.⁵⁴ Though many uninsured adults are healthy and may perceive less of a need for coverage, those who need care have greater difficulty getting it, which may worsen their health outcomes.

A LOOK BEHIND THE DATA

This report provides a data-rich profile of the remaining uninsured in Massachusetts. Understanding the data—on who the uninsured are and what the most common barriers to coverage are—is critical to getting to the root of the problem. This data illuminates the role of structural racism in contributing to disparities in insurance coverage, and it helps point to solutions to build a better, more equitable health care system.

However, it is equally important to listen to and learn from the experiences of people who have been uninsured. Their stories remind us of why it is so critical to act, and their voices give this issue detail and depth, which is missing from even the very best data. The Blue Cross Blue Shield of Massachusetts Foundation recently released a 3-minute video featuring four Massachusetts residents who describe their experiences without health insurance. To hear their stories, please view the video [here](#).

V. BARRIERS TO COVERAGE AMONG UNINSURED RESIDENTS

Though most uninsured residents want coverage (Box 4), they are usually excluded from the employer-based health insurance market (typically either because they do not work for employers who offer coverage or because they cannot afford it) and face obstacles to getting coverage through MassHealth and the Health Connector, which are driven by federal and state policies and processes. Our synthesis of research and data, simulation modeling, and stakeholder interviews identified an array of coverage barriers, including:

- Real and perceived gaps in eligibility for and access to affordable coverage
- Language barriers and other enrollment barriers affecting immigrant families
- Complexity of coverage options that makes navigating eligibility transitions difficult
- Administrative processes that cause gaps in coverage for people eligible for MassHealth and Health Connector coverage

BOX 4. MOST UNINSURED RESIDENTS WANT COVERAGE, BUT INCENTIVES TO GET COVERED LIKELY VARY BY AGE, HEALTH STATUS, AND INCOME

Massachusetts Health Insurance Survey (MHIS) data show that, although most uninsured residents want coverage, 1 in 6 residents who were uninsured in 2019 said they did not need it.⁵⁵ Many uninsured residents are younger and healthier, including young men with lower risk aversion and with expectations of low health care costs. Our interviews with stakeholders highlighted examples of uninsured residents waiting to apply for MassHealth or Health Connector coverage until they had a medical need, such as becoming pregnant or needing to provide proof of their children's immunizations for school. In addition, some people do not want to receive government benefits due to perceived stigma, even if it means remaining uninsured.

The individual mandate penalty that Massachusetts imposes on taxpayers who do not have health insurance coverage was designed to address these situations, where people who expect greater needs for health care are more likely than younger and healthier people to seek coverage. Previous surveys and interviews with uninsured adults found that most were aware of the penalty and some were motivated by it to look for coverage, but the possibility of penalties was not a major factor influencing the majority who went without coverage.⁵⁶ Tax filing data show that a large majority of uninsured tax filers are exempt from the penalty.⁵⁷ In 2015, about half of full-year uninsured filers were exempt because of low incomes, over one-quarter were exempt because they lacked access to affordable coverage, and just over 1 in 6 paid the penalty. Among the part-year uninsured, 43 percent did not pay the penalty because they were uninsured for three consecutive months or less, 25 percent were exempt based on their incomes, and 20 percent paid the penalty.

These barriers have varying impacts on the state’s overall uninsurance rate and in the disparities in coverage by race and ethnicity. State policymakers can maximize progress toward universal coverage and health equity by developing strategies to address each of the identified challenges.

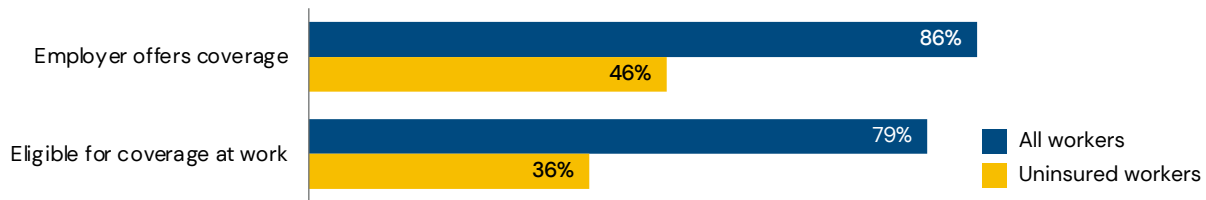
REAL AND PERCEIVED GAPS IN ELIGIBILITY FOR AND ACCESS TO AFFORDABLE COVERAGE

Lack of affordable coverage is the primary barrier to obtaining health insurance. Eight in 10 uninsured respondents in the 2019 MHIS cited the cost of coverage as a reason for not having insurance, and earlier surveys yielded similar findings.⁵⁸ Affordability issues reflect limited access to ESI, eligibility gaps for public coverage and subsidized nongroup coverage, and inability to afford insurance premiums and out-of-pocket health care costs even with subsidies. Some uninsured residents anticipate that expected health care costs and penalties for not having coverage are likely to be less than the costs of purchasing coverage, and previous studies have found some people disenroll because they do not feel their health care use justifies the premium cost.⁵⁹ Uninsured adults may not always understand their risk of exposure to high health care costs or realize that the actual cost of coverage is lower than they expect.

Limited access to ESI and difficulty affording ESI premiums

Uninsured workers’ employment instability and concentration in smaller firms (firm size of one to 99 employees) and lower-wage industries and occupations result in limited access to ESI, which is among the most commonly reported reasons for not having coverage.⁶⁰ Though all or nearly all large firms in Massachusetts offer coverage, only three-quarters of smaller firms do, and part-time workers are generally ineligible.⁶¹ Our analysis of 2017–2019 CPS data shows that just 36 percent of uninsured nonelderly adults who worked for an employer were eligible for ESI through their job, compared to 79 percent of all adults who worked for employers (Figure 8). These low rates of eligibility are consistent with earlier studies, which also found that cost is the main barrier to ESI take-up for those who are eligible.⁶² Strategies to reduce uninsurance could attempt to increase the number of workers with access to affordable ESI or maximize enrollment in alternative coverage options through MassHealth and the Health Connector.

FIGURE 8. ACCESS TO EMPLOYER-SPONSORED HEALTH INSURANCE AMONG MASSACHUSETTS WORKERS AGES 19 TO 64, OVERALL AND AMONG UNINSURED WORKERS, 2017–2019



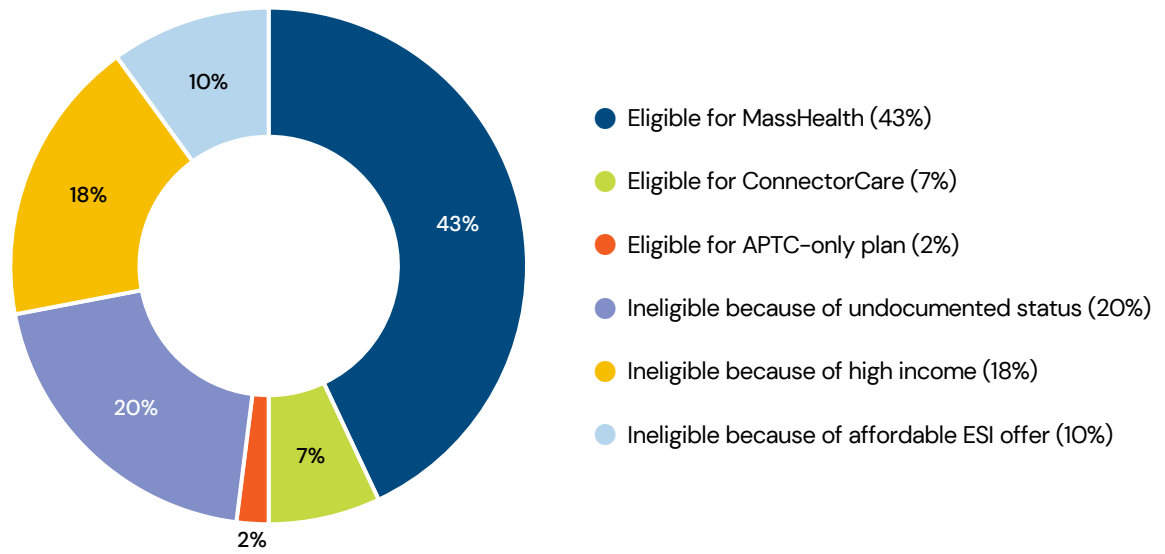
Source: Urban Institute analysis of pooled 2017–2019 Current Population Survey Annual Social and Economic Supplement data reweighted to the characteristics of residents in Massachusetts in the American Community Survey.

Eligibility gaps for MassHealth, ConnectorCare, and advance premium tax credits

We used the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM) to estimate projected eligibility for MassHealth,⁶³ ConnectorCare, and advance premium tax credit (APTC)-only plans sold through the Health Connector for nonelderly uninsured residents in 2023.^{64,65} Under current law, in which the enhanced Marketplace subsidies authorized by the American Rescue Plan Act (ARPA) of 2021 have been extended by the Inflation Reduction Act through the end of 2025, an estimated 233,000 nonelderly residents would be uninsured in an average month in 2023. Of those uninsured nonelderly residents, more than half would likely be eligible for MassHealth or subsidized Connector coverage (Figure 9):

- 43 percent would likely be eligible for MassHealth⁶⁶
- 7 percent would likely be eligible for a ConnectorCare plan
- 2 percent would likely be eligible for an APTC-only plan

FIGURE 9. PROJECTED ELIGIBILITY FOR PUBLIC AND SUBSIDIZED COVERAGE AMONG UNINSURED NONELDERLY MASSACHUSETTS RESIDENTS IN 2023



Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM), simulated for year 2023.

Notes: ESI is employer-sponsored insurance. APTC is advance premium tax credit. Nonelderly residents are under age 65.

The remaining uninsured nonelderly residents would likely be ineligible for MassHealth or subsidized Health Connector coverage for the following reasons:

- 20 percent would likely be ineligible for MassHealth and Health Connector coverage because they are undocumented
- 18 percent would have family incomes that are too high to qualify for APTCs⁶⁷
- 10 percent would not qualify for ConnectorCare or APTC-only plans because they have an offer of ESI deemed to be affordable

Policies to further expand eligibility for MassHealth and Health Connector-based subsidies and policies to increase enrollment among those who are already income-eligible for MassHealth or subsidized Health Connector coverage will have different impacts by race, ethnicity, and family income. For instance, increasing enrollment among MassHealth-eligible residents would benefit many of the most marginalized residents across all racial and ethnic groups. Expanding eligibility for undocumented residents would likely have the greatest effect in reducing racial and ethnic disparities in access to coverage.

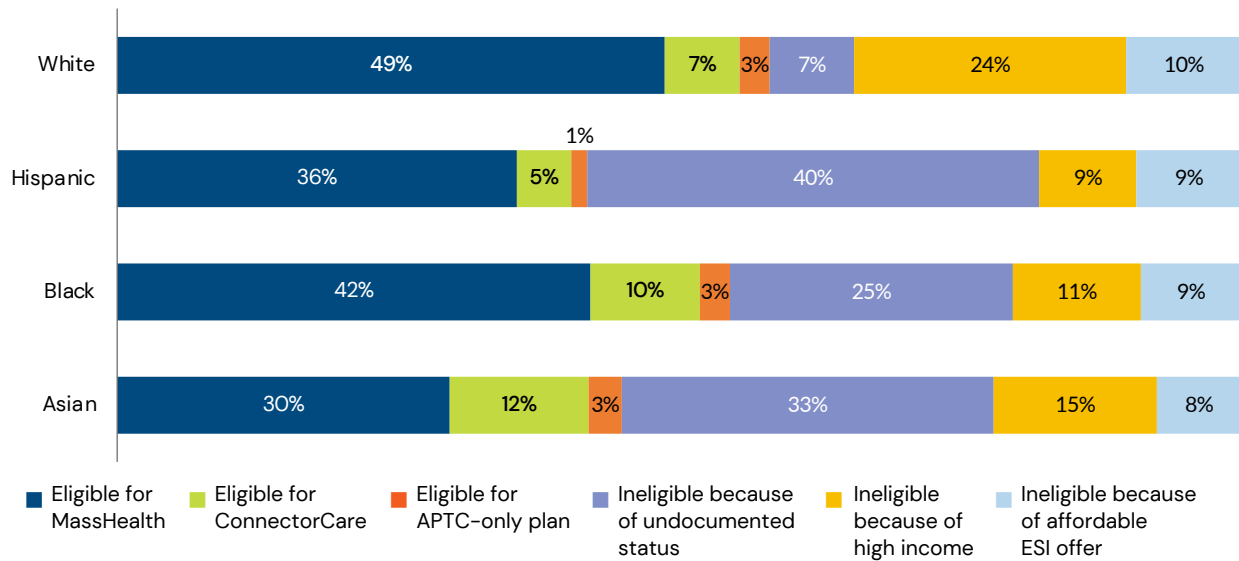
- **Eligibility by race and ethnicity.** Substantial shares of uninsured people in each racial and ethnic group are eligible for MassHealth (Figure 10). Uninsured non-Hispanic White residents are more likely than other racial and ethnic groups to be MassHealth-eligible or to be ineligible for APTCs because of a high income. Ineligibility for MassHealth or Health Connector coverage because of undocumented status is most common for uninsured Hispanic residents, followed by those who are non-Hispanic Asian or Black. Roughly 1 in 10 uninsured residents in each racial and ethnic group are ineligible for subsidized Health Connector coverage because of an affordable ESI offer.
- **Eligibility by family income.** Most nonelderly uninsured residents with family incomes below 138 percent FPL are eligible for MassHealth, though a notable minority is ineligible for MassHealth or Health Connector coverage because of undocumented status (Figure 11).⁶⁸

Among those with incomes between 138 and 300 percent FPL, eligibility is about evenly split between being eligible for ConnectorCare, ineligibility for MassHealth and Health Connector coverage due to undocumented status, and being ineligible for subsidized Health Connector coverage because of an affordable ESI offer. ESI is deemed affordable if the premium for individual coverage is less than 9.12 percent of household income. While this is the regulatory definition of affordability, this may or may not be considered affordable by a given individual or family depending on their other life circumstances (e.g., housing costs).

About 4 in 10 uninsured residents with incomes between 300 and 400 percent FPL are eligible for APTC-only plans, and the remainder are ineligible for MassHealth and Health Connector coverage because of undocumented status or ineligible for subsidies because of an affordable ESI offer. Most uninsured residents with incomes above 400 percent FPL are ineligible for APTCs based on their income because the premium cost of a benchmark plan would be less than their required contribution of 8.5 percent of their family income.

The [appendix tables](#) highlight other differences in eligibility by age, nativity and citizenship status, and region.⁶⁹

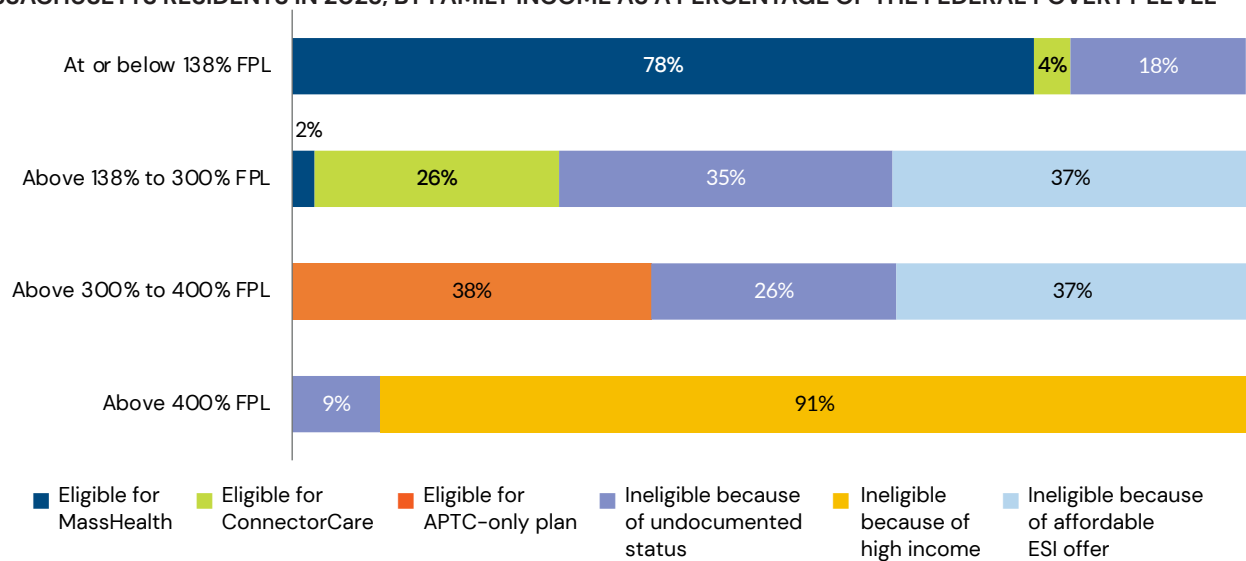
FIGURE 10. PROJECTED ELIGIBILITY FOR PUBLIC AND SUBSIDIZED COVERAGE AMONG UNINSURED NONELDERLY MASSACHUSETTS RESIDENTS IN 2023, BY RACE/ETHNICITY



Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM), simulated for year 2023.

Notes: ESI is employer-sponsored insurance. APTC is advance premium tax credit. The categories for White, Black, and Asian refer to individuals who do not identify as Hispanic. Estimates are not shown for people who are Native Hawaiian or Pacific Islander, American Indian/Alaska Native, some other race, or more than one race. Estimates for these groups were suppressed because they had small sample sizes in one or more eligibility categories. See Appendix Table 13a for further details. Nonelderly residents are under age 65.

FIGURE 11. PROJECTED ELIGIBILITY FOR PUBLIC AND SUBSIDIZED COVERAGE AMONG UNINSURED NONELDERLY MASSACHUSETTS RESIDENTS IN 2023, BY FAMILY INCOME AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL



Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM), simulated for year 2023.

Notes: ESI is employer-sponsored insurance. APTC is advance premium tax credit. FPL is federal poverty level. The definition of family for family income is based on tax units. Nonelderly residents are under age 65.

Premium affordability challenges, even with eligibility for subsidized Health Connector coverage

Even among those who are eligible for subsidized coverage through the Health Connector, uninsured residents often cannot afford premiums after covering other essential expenses such as rent, car payments, and grocery bills. One study found that as premium subsidies in the Health Connector decline at each income level, take-up of coverage falls sharply, suggesting additional subsidies would increase enrollment.⁷⁰ In addition, uninsured residents are not always aware of affordable public and subsidized options that are available to them, especially if they do not have prior experience with MassHealth and the Health Connector, suggesting the need for broad-based public awareness campaigns outside of MassHealth and the Health Connector.

The stakeholders we interviewed described how cost barriers manifest across the income distribution. Though ConnectorCare plans for eligible residents with incomes below 300 percent FPL have zero or low-cost premiums, no deductibles or co-insurance, and low co-payments,⁷¹ some residents miss the open enrollment period or a special enrollment period after a qualifying life event, and others cannot afford even heavily subsidized premiums. The pre-ARPA premium subsidy cliffs at 300 percent FPL (above which subsidy amounts declined substantially) and 400 percent FPL (above which subsidies were unavailable) were also cited as important barriers.⁷² Interviewees noticed that the enhanced APTCs under ARPA helped some long-term uninsured residents to afford coverage. However, these larger subsidies are projected to produce only a small increase in coverage overall, primarily among those with incomes above 300 percent FPL, since people below that income level were already eligible for substantial subsidies under ConnectorCare.⁷³

Cost sharing and access challenges

Cost sharing requirements (i.e., deductibles, co-insurance, and co-payments that people must pay at the point of care) for plans sold through the Health Connector can also discourage people from buying coverage. Some people with APTC-only and unsubsidized plans forgo care because they cannot afford the deductibles. Though ARPA increased federal premium subsidies across the income scale, people enrolled in health insurance plans through the Health Connector continue to face a significant affordability cliff at 300 percent FPL, the income level above which federal and state cost sharing subsidies are not available. Residents with incomes below that level who are eligible for ConnectorCare plans face no deductibles or co-insurance and low co-payments; residents with incomes above that level who are eligible for APTC-only or unsubsidized plans face much higher cost-sharing requirements.⁷⁴ Some ConnectorCare enrollees also have difficulty affording co-payments.⁷⁵ Uninsured residents may choose to go to the emergency room and make a payment plan for resulting medical bills rather than incurring monthly premium costs and paying for co-payments at the point of service.

Other delays in access to care can diminish the perceived value of insurance. People may be less likely to renew their coverage when they have trouble getting timely appointments for primary and specialty care and difficulty getting insurance to cover needed services. Some interviewees noted that MassHealth members are more likely than other insured residents to have difficulty finding providers who accept their insurance and to face longer wait times for appointments.

LANGUAGE BARRIERS AND OTHER ENROLLMENT BARRIERS AFFECTING IMMIGRANT FAMILIES

People who are not U.S. citizens, many of whom are unfamiliar with the U.S. health care system, must navigate more complex eligibility rules compared to citizens. These rules differ across coverage programs and can create barriers to successful enrollment for those who are eligible. The sole legal restriction for purchasing Health Connector plans is that the immigrant must be lawfully present in the United States. In contrast, eligibility for MassHealth for people who are not U.S. citizens but who are lawfully present may depend on having a qualified immigration status, the number of years they have had that status, and factors such as age, pregnancy, income, and disability.⁷⁶ Further, some people who are not lawfully present may be eligible for MassHealth.^{77,78} But even eligible immigrants face other unique coverage barriers, including limited language access, low literacy levels, and fear of immigration authorities, particularly if they live with other immigrants who are not eligible.

Language access

Our analysis of the ACS data revealed significant linguistic diversity among uninsured residents that varies widely across racial and ethnic groups. Among uninsured Hispanic adults who spoke another language at home, nearly all spoke Spanish.⁷⁹ Other common languages spoken by uninsured non-Hispanic adults included Portuguese, Haitian Creole, Chinese, French, Vietnamese, Russian, Niger-Congo languages, Arabic, Mon-Khmer/Cambodian, Greek, Korean, and Cape Verdean Creole.⁸⁰

Interview participants emphasized that limited language access is among the most important barriers to coverage, and these barriers have been an ongoing challenge.⁸¹ Online and paper applications, redetermination forms, and eligibility notices are available in English and Spanish.⁸² Notices are sent with an insert containing multilanguage taglines informing recipients that the information is important and should be translated right away and providing them with a customer service number they can call to receive translation assistance.⁸³ However, some immigrants do not open or respond to the letters because they are unable to understand them or prefer to get in-person help over calling customer service for interpretation services. The inability to understand important notices increases the risk of losing coverage during renewal periods and fosters greater reliance on enrollment assisters.

Concerns about public charge determinations and other immigration consequences

In 2018, the Trump administration proposed a rule expanding criteria for public charge determinations, which immigration officials may use to deny applications for permanent residency or admission to the United States. Among the changes was to include Medicaid participation as a negative factor considered in the public charge test.⁸⁴ The rule, which took effect in February 2020 and was reversed in March 2021,⁸⁵ was expected to cause up to 129,000 residents to disenroll from MassHealth, and studies have documented these chilling effects nationally and in other states.⁸⁶ Most interviewees thought immigrants were increasingly aware that the expanded rule was no longer in effect but noted it will take time to rebuild trust. Several suggested immigration lawyers tend to err on the side of caution by discouraging clients from applying for state coverage even when doing so would not have immigration consequences. Beyond the public charge rule, immigrant households, particularly those with undocumented members, are concerned that interacting with state-run health insurance systems will jeopardize applications for a change in immigration status or have other immigration consequences.⁸⁷

Enrollment challenges for mixed-status households and immigrants who are not lawfully present

Living in a mixed-status household, in which there are both lawfully present and undocumented people, can add to the complexity of the application and renewal process in other ways. For instance, because the undocumented household member lacks a Social Security number, these households cannot go through the regular electronic data matching processes with the state tax filing database to verify income and would instead be sent a request for additional information and verification materials.⁸⁸ Several interviewees cited confusion among immigrants, enrollment assisters, and customer service staff about MassHealth eligibility for people with PRUCOL (Persons Residing Under Color of Law) status; they viewed recent state efforts to update application forms and staff training processes as encouraging.

COMPLEXITY OF COVERAGE OPTIONS LEADS TO DIFFICULTY NAVIGATING TRANSITIONS IN ELIGIBILITY

The separate systems of health insurance coverage and health care for the nonelderly population—including ESI, MassHealth, the Health Connector, and the Health Safety Net—do not always interact well with each other, making transitions from one system to another difficult. Nearly half of uninsured 2019 MHIS respondents cited losing eligibility for MassHealth and one-third reported losing or changing jobs as reasons for being uninsured.⁸⁹ The stakeholder interviews highlighted some of the challenges that led to lapses in coverage during these transitions.

- **Transitions from ESI to MassHealth or the Health Connector:** Workers who lose their jobs and ESI may be unfamiliar with MassHealth and the Health Connector and may not learn about coverage options through the Health Connector until after the 60-day special enrollment period. This is in part because employers typically only inform laid-off workers about options for COBRA coverage, which is often too expensive for former employees who must incur the full cost of the employer health plan premiums. Coverage transitions resulting from job loss or loss of a parent's or spouse's insurance may

coincide with other financial challenges such as family disruption, loss of income, and difficulty paying rent, mortgage, or other bills.

- **Transitions from MassHealth and the Health Safety Net to the Health Connector:** When MassHealth enrollees become ineligible because of a change in income or other circumstances, the state determines their eligibility for subsidized and unsubsidized health coverage. The Health Connector will notify the individual if they qualify for Health Connector coverage and explain further actions needed to enroll. However, these transitions may result in coverage losses if the person does not receive the notice or respond to it, does not provide required documentation, is unfamiliar with how private health insurance works, or does not know how to apply without help. Some ConnectorCare-eligible people receiving provisional benefits through the Health Safety Net also fail to enroll in a ConnectorCare plan after 90 days for reasons similar to those described above, and later find out they no longer have Health Safety Net coverage when they seek care.

Other transitions in coverage and care may happen when former students are no longer covered by insurance from their schools, formerly incarcerated people reenter the community,⁹⁰ or families stop receiving Department of Transitional Assistance (DTA) benefits.⁹¹ These transitions may occur when people are facing other challenges, including finding a job or a place to live.

ADMINISTRATIVE PROCESSES CAUSE GAPS IN COVERAGE FOR PEOPLE ELIGIBLE FOR MASSHEALTH OR HEALTH CONNECTOR COVERAGE

Complex application and renewal requirements make it difficult for some residents to get and maintain coverage.⁹² Administrative processes designed to verify eligibility and ensure program integrity often require multiple transactions that can result in disenrollment and contribute to insurance churning. Common challenges include difficulty understanding the enrollment process, not receiving mailed notices because of address changes, and missing deadlines for returning forms or submitting verification documents. It is noteworthy that certain administrative processes that cause gaps in coverage, such as not receiving mailed notices, disproportionately affect those who have unstable housing. These processes are more difficult for people who do not speak English or Spanish or have low literacy, who have physical and behavioral health conditions, or who have experienced job loss, food insecurity, homelessness, and other forms of instability or crisis situations.

Complex application and verification requirements

Uninsured people often feel overwhelmed by and have difficulty completing the long and complex application for MassHealth and Health Connector coverage. It can be challenging to understand who to include in the household and how to report income. Verification requirements, such as those for establishing residency and providing proof of income, are not intuitive, and verifying income is more difficult for self-employed workers and those with multiple jobs. People without stable housing are less likely to have identification needed for identity proofing and other required documents. Interviewees also mentioned fluctuating income and seasonal employment as potential reasons why people with low annual incomes may be eligible for MassHealth but do not enroll. These residents may think they do not qualify for MassHealth during months with higher incomes or worry they will soon be ineligible.⁹³

Multistep process for enrolling in a Health Connector plan

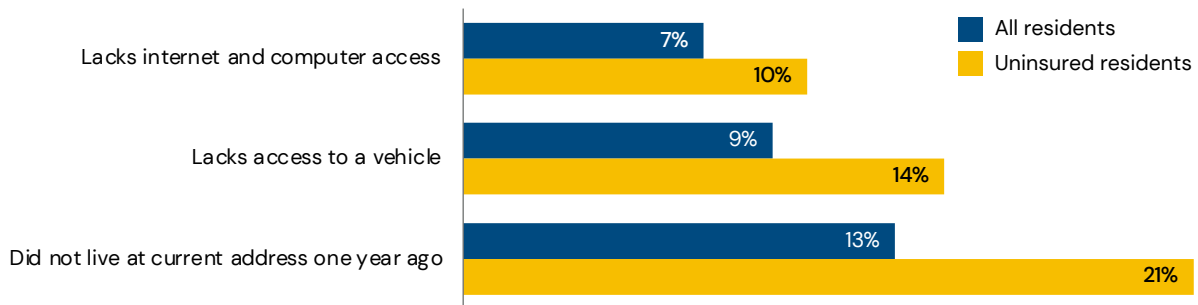
Some residents struggle with the multistep process for enrolling in a Health Connector plan, in which people must apply, provide verification documents if information cannot be verified electronically, choose a health plan, and effectuate their coverage by paying their premiums.⁹⁴ Missing premium payment deadlines is one of the main barriers to activating and staying enrolled in Health Connector coverage. Interviewees also emphasized the consequences of not providing proof of income requested by the Health Connector, which can lead to the cancellation of premium subsidies. When enrollees are informed they owe the unsubsidized premium, they are likely to drop coverage until the next open enrollment period.

Emphasis on computer, internet, and email access for enrollment activities

The lack of computer, internet, and email access for some uninsured residents can be another enrollment barrier, since paper applications are processed more slowly and lack of internet access creates other inefficiencies (e.g., inability to make online

payments or upload verification documents). Our analysis of 2017–2019 ACS data found that 1 in 10 uninsured residents did not have household internet and computer access (Figure 12).

FIGURE 12. INTERNET ACCESS, TRANSPORTATION ACCESS, AND HOUSING MOBILITY AMONG MASSACHUSETTS RESIDENTS, OVERALL AND AMONG UNINSURED RESIDENTS, 2017–2019



Source: Urban Institute analysis of pooled 2017–2019 American Community Survey data from IPUMS USA.

However, internet access alone is not enough. Interview participants noted that many uninsured people with internet access use text messaging instead of email, and other families share a single email address, which cannot be used to create separate applications for multiple households. People must have an email address to apply online without help from enrollment assisters. When assisters complete an application on behalf of a client, the client must contact MassHealth or the Health Connector to have a link sent by email that grants the client access to their account.⁹⁵ Those who lack an email address cannot gain access, and assisters cannot grant them access to update and upload their own information in the future.⁹⁶

Use of mail to notify members of forms that must be completed

Failure to respond to mailed notices was cited as one of the most important reasons for disenrollment and has been a longstanding challenge in MassHealth.⁹⁷ Some MassHealth members, and immigrants in particular, move frequently and often do not receive renewal notices and requests for information if they do not update their addresses. Our analysis of 2017–2019 ACS data found that 1 in 5 uninsured residents did not live at their current address one year ago (Figure 12). People experiencing homelessness are especially at risk of losing coverage because they do not receive mailed notices, though a continuous coverage provision under the state’s recently approved MassHealth demonstration waiver could help mitigate this issue (see Box 5). Some interviewees suggested multilingual text messaging could improve communication with residents who have cell phones.⁹⁸

Complex renewal processes

In addition to problems receiving mailed notices, some MassHealth members are unfamiliar with the redetermination and renewal process, which is complex and can be difficult even for people who are familiar with it. Members may not realize they need to update and return renewal forms and send additional verification documents, and the excessive volume and complexity of mailed information can lead them to overlook important notices and requests.⁹⁹ Members also risk disenrollment if they do not report job or income changes or they do not respond to requests for information about job or income changes during the year. For instance, people may not answer requests for information about access to ESI at work because they think they will no longer qualify for MassHealth, even though they may be eligible for MassHealth premium assistance.

Like MassHealth, the Health Connector uses available data sources as well as application information on file to make a preliminary eligibility determination and then requests that enrollees provide updated information if needed before a final eligibility determination is made prior to the open enrollment period.¹⁰⁰ People who remain eligible for Health Connector coverage are automatically reenrolled in the same plan if it remains available and they do not select a different plan. Recent changes to MassHealth and Health Connector enrollment processes have the potential to reduce insurance churning and wrongful termination of coverage (Box 5).

BOX 5. RECENT PROGRAMMATIC CHANGES MAY EASE ENROLLMENT CHALLENGES AND MITIGATE COVERAGE LOSSES

Though residents continue to face challenges with MassHealth and Health Connector enrollment processes, interview participants noted several programmatic improvements in recent years, some of which were put in place in response to the COVID-19 pandemic, including:

- An increase in the “reasonable compatibility” threshold from 10 percent to 20 percent for electronic data matches to verify income¹⁰¹
- The use of blue envelopes to distinguish MassHealth renewal notices from other mail related to MassHealth
- The ability to upload documents online
- Shorter wait times for customer service and faster processing of applications
- Flexibilities during the pandemic regarding use of electronic signatures
- The addition of a checkbox on the online health insurance application form to facilitate automatic enrollment into zero-premium ConnectorCare plans for those who do not select a plan, which is also expected to improve transitions between MassHealth and ConnectorCare
- The extension of the state’s Section 1115 MassHealth demonstration waiver contains other provisions likely to improve coverage continuity. These provisions include retroactive MassHealth eligibility for pregnant people and children under 19; 24 months of continuous eligibility for people experiencing homelessness; and 12-month continuous eligibility following release from incarceration or Department of Youth Services custody.¹⁰²

Our analysis of ACS data suggests there may also be opportunities to build on the state’s express lane eligibility (ELE) policies.¹⁰³ Thirteen percent of uninsured residents live in households receiving Supplemental Nutrition Assistance Program (SNAP) benefits.¹⁰⁴ Additional efforts to increase insurance coverage among households participating in SNAP could help reduce racial and ethnic disparities, since 21 percent of uninsured Hispanic residents and 21 percent of uninsured non-Hispanic Black residents were in households receiving SNAP versus 8 percent of those who are non-Hispanic White and 13 percent who are non-Hispanic Asian.

Limited awareness of and access to in-person enrollment assistance

In-person enrollment assistance often plays an important role in connecting people with coverage.¹⁰⁵ But some uninsured residents are not aware of places offering help, and others find that enrollment assistance is not always available at convenient times or locations. One in 7 uninsured residents does not have access to a vehicle (Figure 12), including larger shares who are Hispanic, Black, or Asian.¹⁰⁶ Several interview participants stated that some clients had difficulty taking time off work to get application assistance or finding time to complete applications. Others emphasized the lack of MassHealth and Health Connector customer service after normal business hours and the need for enrollment assistance during evening hours. Though some navigators work evenings and weekends to assist clients, others cited a lack of capacity (with all appointments booked for the next month) as a barrier to accessing application assistance.

VI. POTENTIAL POLICIES AND PROGRAMS TO ADDRESS DISPARITIES AND GAPS IN COVERAGE

Sections IV and V describe the characteristics of people in Massachusetts who do not have health insurance, and the current barriers they face to becoming insured. This information offers guides for policymakers and other stakeholders to devise solutions that are customized to address specific populations facing specific barriers. Because the people who remain uninsured are not homogeneous, there is not a single solution that will close the coverage gap.

In this section, we present a set of policy and program ideas to address longstanding inequities in coverage and increase coverage specifically among those who have been economically, racially, ethnically, and/or linguistically marginalized from the health insurance coverage system in Massachusetts. Each idea addresses particular characteristics of the uninsured population and would seek to dismantle a particular barrier (or barriers) to coverage that were identified. The policy and programmatic ideas that follow are organized into four groups, corresponding to the barriers identified in Section V:

1. Gaps in affordable coverage
2. Barriers faced by immigrant groups
3. Loss of insurance following eligibility transitions
4. Administrative barriers related to application and renewal processes

In most cases, the policies and programs are drawn from examples that other states have implemented or proposed. In some cases, similar ideas have been proposed but not yet implemented in Massachusetts. Table 1 summarizes each of the policy and program ideas, and a more detailed description follows.

TABLE 1. POLICIES AND PROGRAMS FOR COVERING THE REMAINING UNINSURED IN MASSACHUSETTS

BARRIERS TO COVERAGE	PROPOSED POLICY OR PROGRAMMATIC OPTIONS
<p>1. Affordability barriers: Current federal and state policies that define whether coverage is “affordable” for purposes of program eligibility may not, in reality, be affordable. The prospect of unaffordable out-of-pocket expenses in some insurance plans may deter people from obtaining coverage.</p>	1a. Raise income eligibility level for ConnectorCare above 300 percent FPL
	1b. Expand zero-premium ConnectorCare coverage to 200 percent FPL
	1c. Reduce out-of-pocket spending limits, or eliminate co-pays for certain health services and treatments for chronic conditions
	1d. Implement a program to help those whose incomes would make them eligible for ConnectorCare and advance premium tax credits to afford ESI by expanding the MassHealth Premium Assistance Program to higher income levels
<p>2. Specific challenges facing immigrant groups: These barriers include language, complex eligibility rules, immigration concerns, and lack of documentation.</p>	2a. Expand MassHealth and ConnectorCare coverage to individuals and families regardless of immigration status
	2b. Enhance implementation of agency-specific Language Access Plans
<p>3. Eligibility transitions: A common reason for not having insurance is due to not successfully transitioning to other coverage after losing eligibility for MassHealth or losing ESI coverage because of a job loss or change.</p>	3a. Provide information about coverage options and outreach efforts to uninsured individuals who indicate interest on state tax forms or who are leaving employment
	3b. Automatically enroll people losing MassHealth eligibility into a Health Connector program, with an opt-out option
<p>4. Administrative processes: Short-term coverage gaps often result from not submitting documents to MassHealth and the Health Connector in the required timeframe.</p>	4a. Expand MassHealth’s use of automated eligibility practices
	4b. Streamline administrative requirements for individuals applying for MassHealth and Health Connector programs
	4c. Use of multilingual text messaging to complement outreach, eligibility, and enrollment efforts
	4d. Adopt a policy of 12-month continuous eligibility for adults in MassHealth
	4e. Enhance the enrollment assister workforce and its capabilities

1. POLICIES ADDRESSING GAPS IN AFFORDABLE COVERAGE

As Section V describes, actual or perceived affordability of coverage is the most common barrier to people obtaining health insurance. In Massachusetts, residents with incomes at or below 300 percent FPL—\$83,250 for a family of four in 2022—are eligible for both state and federal subsidies when they purchase coverage through the Health Connector. Those with incomes greater than 300 percent FPL, however, are eligible only for federal subsidies calculated on a sliding scale to keep premium expenses below a maximum percentage of income (currently 8.5 percent). Certain people do not qualify for any subsidy, because of other factors, such as the availability of employer-sponsored insurance or immigration status.

1a. Raise the income eligibility level for ConnectorCare above 300 percent FPL. Nearly one-third (31 percent) of Massachusetts residents without insurance have family incomes that exceed the current eligibility limits for ConnectorCare, which supplements federal premium subsidies with additional state support. Currently, ConnectorCare eligibility extends to incomes up to 300 percent FPL. Extending eligibility further up the income scale would make coverage more affordable for individuals and families for whom this extra subsidy is now just out of reach.

The Massachusetts Legislature passed an increase for ConnectorCare eligibility to up to 500 percent FPL as part of the Fiscal Year (FY) 2023 budget. Governor Baker vetoed the item, giving a number of reasons and stating that “maximizing the uptake of those currently eligible [for subsidized health plans through the Health Connector] should be a priority.”¹⁰⁷ In fact, as the discussion earlier in this report demonstrates, both of these strategies—focusing on those eligible but not enrolled, and also making more people eligible—are integral to closing remaining coverage gaps.

In New Jersey, the New Jersey Health Plan Savings program supplements federal subsidies with state support up to 600 percent FPL.¹⁰⁸ These efforts aim to lower individual and overall premium costs within the marketplace, and to help with affordability.

1b. Expand zero-premium ConnectorCare coverage to 200 percent FPL. Most people who are uninsured have low incomes. Many might appear to be eligible for MassHealth based on their annual incomes, but their incomes may fluctuate, leading to frequent changes in eligibility. Currently, ConnectorCare coverage is available with a zero-premium option up to 150 percent FPL. Removing small premiums up to 200 percent FPL might increase enrollment and retention by eliminating monetary and administrative coverage barriers (such as the need for a bank account) and make transitions between MassHealth and ConnectorCare smoother. It would also reduce the administrative costs of collecting small premiums and of enrollment churn.

1c. Reduce out-of-pocket spending. Stakeholders we interviewed noted that deductibles and other cost sharing may discourage people from purchasing coverage because of the burden of other life expenses. People reason that high cost sharing would deter them from using the insurance and so they opt to go without it. One strategy to reduce out-of-pocket costs for low- and moderate-income people is to provide additional state subsidies to supplement the federal cost sharing reductions available to people with incomes up to 250 percent FPL purchasing coverage through the Health Connector. Another would be an approach embodied in the More Affordable Care (MAC) Act, which has been introduced in the Massachusetts Legislature. One provision of the MAC Act would eliminate cost sharing for “targeted high-value services, treatments, and prescription drugs used to treat certain chronic conditions,” including diabetes, asthma, chronic obstructive pulmonary disease, hypertension, coronary artery disease, congestive heart failure, opioid use disorder, bipolar disorder, and schizophrenia.¹⁰⁹ These conditions account for a large portion of health care utilization, and they disproportionately affect low-income communities and people of color.¹¹⁰

1d. Expand the Premium Assistance Program beyond MassHealth to include people eligible for ConnectorCare and APTCs. Premium Assistance is a MassHealth program that pays the employee share of the premium for offered ESI, if the employee meets MassHealth eligibility standards. This proposal would extend that concept to people with incomes too high for MassHealth who would qualify for ConnectorCare or APTCs but have an offer of “affordable” ESI that makes them ineligible. About 1 in 3 uninsured workers (36%) are eligible for ESI through their jobs but do not take it up.

At least two states—Colorado and Washington—have created programs to broaden coverage by extending subsidies to individuals and families who are ineligible for federal tax credit subsidies, either because of immigration status or because they are affected by the “family glitch.” This so-called glitch results from an interpretation of the ACA that excluded some dependents of people with access to ESI from eligibility for federal tax credits because the ESI was deemed affordable for the employee, even though the cost of family coverage was beyond the family’s means. While Massachusetts has eliminated the “family glitch” in response to federal

Get Covered NJ, **New Jersey’s** marketplace, offers the New Jersey Health Plan Savings program, which supplements federal subsidies with state support up to 600 percent FPL. This makes premium costs more affordable up to higher levels of income.

Source: “Lower Your Monthly Premiums with the NJ Health Plan Savings.” Get Covered NJ. <https://nj.gov/getcoverednj/financialhelp/premiums/>. Accessed Oct. 11, 2022.

New York’s Essential Plan was established in 2015 as a Basic Health Program authorized by the ACA. The Essential Plan offers coverage to individuals and families up to 200 percent FPL. In 2021, New York eliminated all premiums for the Essential Plan.

Source: Compare New York State Health Insurance. <https://www.nyhealthinsurer.com/new-york-essential-plan/>. Accessed Nov. 4, 2022.

In **New Mexico**, a new law eliminated out-of-pocket and prescription drug costs for covered behavioral health services. The law applies to private plans and to state employee health plans.

Source: “SB317—No Behavioral Health Cost Sharing.” NM Office of Superintendent of Insurance. <https://newmexico.networkofcare.org/content/client/1446/31-SB317-NoBehavioralHealthCostSharingfinal.pdf>. Accessed Oct. 11, 2022.

Colorado’s Health Insurance Affordability Enterprise (HIAE) will use a health insurance affordability fee assessed on certain insurers and a special assessment on hospitals to fund subsidies to purchase coverage for low-income people (up to 300 percent FPL) who are not eligible for federal premium tax credits.

Source: Emma Oppenheim. October 2021. “Health Insurance Affordability Enterprise.” Connector for Health Colorado. <https://ckf.cchn.org/wp-content/uploads/Health-Insurance-Affordability-Enterprise-Overview.pdf>. Accessed Oct. 11, 2022.

regulatory changes enacted in 2022, there continue to be individuals in Massachusetts with access to ESI that makes them ineligible for ConnectorCare or APTCs, despite the individual or family experiencing that the premium contribution for ESI is not affordable in their budget. This concept, akin to a premium assistance program, could also be applied to a situation of ineligibility because of an offer of “affordable” ESI.

2. POLICIES ADDRESSING CHALLENGES FACING IMMIGRANT GROUPS

People born outside the United States, people who are not U.S. citizens, and people with limited English proficiency are much more likely to be uninsured than English-speaking citizens. Nearly 4 in 10 uninsured residents were born outside the United States. This group faces unique challenges in obtaining coverage, in addition to confronting the same barriers—affordability, complexity, etc.—as the general population. Increased enrollment assister capacity would help immigrants address language issues and information gaps regarding health insurance, eligibility, and policies such as public charge. In addition, these policies could help to reduce the number of immigrants who are uninsured.

2a. Expand MassHealth and ConnectorCare coverage to individuals and families regardless of immigration

status. Many people who were born outside the United States are not American citizens and for that reason face eligibility restrictions for public programs, either permanently or for a period of time, depending on their precise status. These restrictions are federally imposed; Massachusetts could use its own funds to expand eligibility to MassHealth and ConnectorCare. California recently did exactly that, using only state funds to extend full Medicaid coverage to people aged 50 and older whose eligibility had been restricted because of their immigration status.¹¹¹ Partial models for this approach also exist in Colorado’s Health Insurance Affordability Enterprise and Washington’s Cascade Care Savings programs, mentioned under policy option 1d above.

2b. Enhance implementation of agency-specific Language Access Plans (LAP).

MassHealth and the Health Connector have published LAPs to improve their delivery of culturally competent and linguistically appropriate services and materials.¹¹² A LAP is a document that spells out how to provide services to individuals who are non-English speaking or have limited English proficiency. The LAPs aim to identify consumer language needs, assess language resources available, and develop a plan for monitoring Limited English Proficiency (LEP) needs among their respective membership. LAPs could be updated and used as a vehicle to more assertively target assistance to people for whom language is the primary barrier to coverage.

3. POLICIES ADDRESSING ELIGIBILITY TRANSITIONS

According to the 2019 MHIS, nearly half of uninsured respondents said they became uninsured after losing eligibility for MassHealth, and one-third became uninsured when they lost or changed jobs.¹¹³ Most people in Massachusetts, upon losing one source of coverage, should have access to another one. ConnectorCare, for example, offers an opportunity for uninterrupted coverage when increased income makes one no longer eligible for MassHealth. Depending on income, MassHealth, ConnectorCare, or a subsidized Qualified Health Plan may be available for someone who loses their ESI. Smoothing transitions between types of coverage has the potential to reduce the number of people without insurance.

3a. Provide information about coverage options and outreach efforts to uninsured individuals who indicate interest on state tax forms or who are leaving employment.

Most adults without insurance in Massachusetts have incomes below 300 percent FPL. Massachusetts updated its Schedule HC income tax form in 2021 to include a checkbox for tax filers to authorize the Department of Revenue to share some of the filer’s information with the Health Connector, which assesses potential eligibility and provides tailored information to the filer about available coverage options. The program—known as “Simple Sign-up”—has been in place for just one year and nearly 16,000 checked the box to have their information shared with the Health Connector.¹¹⁴ Similar programs have recently begun in Maryland and Colorado, and Pennsylvania and Virginia will soon

Maryland’s Easy Enrollment program launched in the 2020 tax year. In its first year, 53,000 people who shared their information were found eligible for Medicaid or subsidized marketplace plans; 15 percent of Medicaid-eligible and 11 percent of marketplace-eligible enrolled. Nearly one-quarter (23%) of marketplace enrollees were Black, greater than the 17 percent who enrolled during the open enrollment period; 40 percent of marketplace enrollees were younger (ages 18–34), greater than the 28 percent who enrolled during open enrollment.

Source: Rebecca Schwab et al. August 3, 2021. “State ‘Easy Enrollment’ Programs Gain Momentum, Lay Groundwork for Additional Efforts to Expand Coverage.” Commonwealth Fund blog. <https://www.commonwealthfund.org/blog/2021/state-easy-enrollment-programs-gain-momentum-lay-groundwork-additional-efforts-expand>.

follow.¹¹⁵ The Health Connector is monitoring enrollments from this process and looking at possible enhancements for the second year. Staff have engaged in efforts to broadly publicize and promote the program, for example through enrollment assisters and tax preparation assistance organizations.

In addition, Massachusetts might work with employer groups to close the information gap for people who are leaving their employment and, therefore, their employer-sponsored coverage. MassHealth and Health Connector plans are important alternatives to COBRA for many people making this transition, and many do not learn about them until they have been without coverage for a period and when, in the case of Health Connector plans, they may have to wait until the next open enrollment period to enroll. A targeted outreach and information program for people leaving their jobs could help close this gap.

3b. Automatically enroll people losing MassHealth eligibility into a Health Connector program, with an opt-out option. When a person enrolled in MassHealth gains income, they may lose their eligibility for MassHealth but simultaneously become eligible for ConnectorCare, which is a separate program that requires a multi-step process to enroll. Despite receiving notification about their eligibility for this transition, individuals may not know what actions to take without the help of an enrollment assister. Some ConnectorCare-eligible people who receive time-limited (90-day) benefits through the Health Safety Net may also fail to enroll in a ConnectorCare plan in time. A remedy for this transitional friction is to automatically enroll people into coverage they qualify for, with the opportunity for the individual to opt out of that coverage. The Health Connector would enroll individuals into zero-premium plans when available, or otherwise into the lowest cost silver plan available. A potential unintended consequence, however, is that enrolling in a plan with an APTC could result in unexpected tax liability if an individual's income fluctuates over the course of the year. Massachusetts could address this by attaching a hold-harmless provision to the new autoenrollment policy, which would require a change in tax law and administrative steps to implement it. The expansion of eligibility for zero-premium plans to a higher income threshold (see above) would also reduce the likelihood of owing additional taxes.

In **California**, a 2019 state law authorized the state exchange (Covered California) to automatically enroll consumers in a Qualified Health Plan when they lose Medicaid coverage and gain eligibility for APTCs. (California does not have an equivalent program to ConnectorCare.) The law took effect in June 2022, but implementation is delayed until the end of the COVID-19 federal public health emergency. Consumers must affirmatively accept the coverage (by making their first monthly premium payment if there is one required), or they may decline by taking no action or actively cancelling.

Source: Rebecca Schwab et al. March 31, 2022. "California's Marketplace Tries New Tactics to Reduce the Number of Uninsured and Underinsured." Commonwealth Fund blog. <https://www.commonwealthfund.org/blog/2022/californias-marketplace-tries-new-tactics-reduce-number-uninsured-and-underinsured>.

4. POLICIES ADDRESSING ADMINISTRATIVE PROCESSES

We estimate that 43 percent of nonelderly residents without insurance are eligible for MassHealth and another 9 percent are eligible for Health Connector subsidized plans. Many of these people may not successfully enroll or may experience temporary (sometimes months-long) coverage gaps because of difficulties submitting requested documents for eligibility determination or renewal to MassHealth or the Health Connector in the required timeframe. Eligibility may be denied or terminated for such administrative lapses, an experience known as churning. There are several ways to lower this type of coverage barrier; many of them are employed in other states.

4a. Expand MassHealth's use of automated eligibility practices. "Express Lane Eligibility" (ELE) allows Medicaid and CHIP programs to make eligibility determinations using information from other income-tested federal programs for which eligibility standards are similar. MassHealth currently uses only information from the Supplemental Nutrition Assistance Program (SNAP) for ELE, and only uses it for renewals. Other states use ELE for initial applications in addition to renewals, and several more¹¹⁶ partner with agencies administering other programs, such as Temporary Assistance for Needy Families (TANF), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the National School Lunch Program (NSLP), and others.

A 2016 report on states' use of ELE for Medicaid and CHIP enrollment concluded that "ELE appears to meet the intended objective of easing the eligibility and enrollment process." It found that 13 of the 14 states using ELE reported reduced administrative burden for state agencies and for families. Many states reported that ELE increased enrollment and retention

in Medicaid and CHIP, that it is useful for outreach, and that the simplified process ELE engenders increased the likelihood that families would act to complete applications and renewals.¹¹⁷

4b. Streamline administrative requirements for individuals applying for MassHealth and Health Connector programs. Applicants to public coverage programs are often hindered by administrative barriers such as not understanding a complex enrollment process, not receiving important mailed notices, and missing deadlines for submitting forms or verification documents. Reducing some of these burdens would make enrollment easier for applicants who otherwise meet the programs' eligibility requirements.

With such streamlining in mind, the Health Connector is currently working with a consultant to help “identify areas where residents newly applying for nongroup health coverage through the Health Connector and Health Connector nongroup members may encounter administrative burdens and general member abrasion,” and then “identify actions to address the administrative burdens surfaced.” A similar approach by MassHealth could facilitate easier enrollment in that program; improvements to Health Connector processes might also affect MassHealth via the Integrated Eligibility System.

4c. Use of multilingual text messaging to complement outreach, eligibility, and enrollment efforts. In a time when many people regularly communicate electronically, notices about eligibility and other important communication come to MassHealth and Health Connector members by mail, which may not be received or opened because of moving or losing a home or because of language barriers. Other states have found texting to be effective for communicating timely information and reminders to Medicaid members. MassHealth is planning to implement a text messaging strategy to send members reminders to respond to requests for information.¹¹⁸ MassHealth currently has text messaging capacity in English and Spanish; adding additional languages could improve communication with residents who experience language barriers.

4d. Adopt a policy of 12-month continuous eligibility for adults in MassHealth. Massachusetts is among the five states with the highest churn rates in their Medicaid programs, according to a recent national study. More than 12 percent of adults under age 65 who disenrolled in 2018 were reenrolled within 12 months, which is the study's definition of churn; the national churn rate was 9 percent. Non-Hispanic Black and Hispanic adults had higher churn rates than non-Hispanic White adults across the 26 states with reliable race and ethnicity data.¹¹⁹

The presence of certain policies is associated with state-level differences in churn rates. States, such as Massachusetts, that conduct mid-year data checks for changes in circumstance have higher rates of churn. States with low churn rates, such as Arizona and Hawaii, employ policies such as 12-month continuous eligibility for children.¹²⁰ This simply means that, once eligibility is established, it stays in place for 12 months, regardless of changes in circumstances that may occur in the interim. Changes are then considered at the time of eligibility redetermination, which must occur every 12 months. This policy makes retention of eligibility easier by reducing the chance of disenrollment because of a failure to comply with an administrative request. New York now provides 12-month continuous

In 2020, **Montana** began sending texts to individuals from whom the Medicaid program received returned, undelivered mail. Early results indicate that about 25 percent of members receiving the text contacted the state to update their mailing address, a 40 percent improvement over members who did not receive a text. The response has been positive. Montana is exploring whether to expand texting to include reminders about upcoming renewals and requests for information.

Source: Medicaid and CHIP Learning Collaboratives. August 3, 2021. “Ensuring Continuity of Coverage and Preventing Inappropriate Terminations for Eligible Medicaid and CHIP Beneficiaries: Part 2.” <https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/ensrng-contnty-cvrg-prvntng-inprprte-trmntns-part-2.pdf>. Accessed Oct. 12, 2022.

New York is the only state that currently provides 12-month continuous eligibility for adults, via a federal Medicaid demonstration waiver (federal Medicaid law prohibits continuous eligibility for adults). An interim evaluation of the demonstration found a moderate increase in Medicaid enrollment duration associated with the policy.

Source: Harry H. Liu et al. 2021. “New York State 1115 Demonstration Independent Evaluation: Interim Report.” RAND Corporation. https://www.rand.org/pubs/research_reports/RRA951-1.html. Accessed Oct. 12, 2022.

California has a long-established network of community-based outreach, enrollment, utilization, and retention (OEUR) counselors. Enrollers live in the communities they serve, which often are low-income populations, communities of color, and families with mixed immigration status. They provide information about programs, give step-by-step assistance in completing applications and redetermination reviews, and help people navigate the health care system.

Source: Veronica Flores et al. 2017. “Understanding and Preserving California's Network of Community-Based Outreach, Enrollment, Utilization and Retention (OEUR) Services.” Community Health Councils. <https://chc-inc.org/understanding-preserving-cas-network-of-community-based-outreach-enrollment-utilization-and-retention-services/>. Accessed Oct. 12, 2022.

eligibility for adults, and Illinois, New Jersey, and Oregon are taking actions to implement similar policies for adults (Oregon's would offer 24-month continuous eligibility).¹²¹ Oregon also recently received a federal Medicaid waiver to provide continuous eligibility to children from birth until age 6, and 24-month continuous eligibility for children ages 6 and older.¹²² Washington is pursuing a similar policy for children under 6.

4e. Enhance the enrollment assister workforce and its capabilities. As Section V notes, enrollment assisters can play a vital role in securing coverage for eligible people, particularly those facing language or cultural barriers. But enrollment assistance is not always available at convenient times or locations. Approaches to expanding enrollment assister capacity might include (1) recruiting an expanded workforce in immigrant and other underserved communities; (2) providing education to enrollment assisters to clarify eligibility rules, increase consumer awareness of available coverage options, and address consumer concerns related to attaining coverage (such as public charge policies); and (3) expand assisters' technological capabilities, for example by providing tablets for remote enrollments, documentation, and redetermination actions.

VII. CONCLUSION

This report presents a data-rich profile of Massachusetts residents without health insurance, who disproportionately include immigrants and others who are economically, racially, ethnically, and/or linguistically marginalized. It explores the barriers to coverage they face, including real and perceived gaps in eligibility for and access to coverage, the complexity of navigating program transitions, administrative processes that cause gaps in coverage, and language and other barriers unique to immigrants. The policy options the report discusses—which have been contemplated, studied, or proposed, and in many cases, implemented elsewhere—would address these barriers and correct longstanding inequities in access to health insurance coverage in Massachusetts. The proposed policies range from administrative solutions that would help the many people who already are eligible to get or stay enrolled in coverage, to more ambitious, transformative initiatives that would include groups of people who have historically been explicitly excluded from coverage. Each would help certain groups of people and has its own benefits, costs, and challenges to adoption. They can and should be considered in different combinations as part of a matrix of solutions critical to moving the state forward in addressing its inequities in health insurance coverage.

The information presented here may be thought of as guideposts for future policy deliberations. Those discussions should view the goal of closing the state's remaining gaps in coverage as achievable, and as part of the larger goal of making health care more equitable, affordable, and accessible for everyone who lives in Massachusetts. The Commonwealth has long been a leader in promoting access to health insurance coverage; addressing the coverage gaps described in this report is an opportunity for Massachusetts to continue to lead by erasing health inequities that remain in the existing coverage system.

ENDNOTES

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- 64 Estimates represent health insurance eligibility in an average month of 2023 under the assumption that states have fully processed Medicaid eligibility redeterminations following the expiration of the continuous coverage requirements. In December 2022, however, Congress passed, and the president signed the Consolidated Appropriations Act (CAA), which decouples the Medicaid continuous coverage requirement from the end of the public health emergency and ends the continuous coverage requirement after March 31, 2023.
- 65 An advance premium tax credit (APTC) is a federal tax credit that lowers the cost of the health insurance premium. It is available to individuals meeting certain income and other eligibility criteria when purchasing insurance through a Marketplace, or the Health Connector in Massachusetts.
- 66 Our estimate of the share of uninsured nonelderly residents who would likely be eligible for MassHealth in 2023 is slightly larger than the share of residents with self-reported annual family income below 138 percent FPL in the 2017–2019 ACS. This apparent discrepancy can be explained by two differences between the HIPSM and ACS estimates. First, the HIPSM estimates are projections for a future year. Second, changes have been made to the underlying HIPSM data to better align with administrative targets for specific groups in the state, such as MassHealth enrollment for certain detailed eligibility types.
- 67 Even though the American Rescue Plan Act and the Inflation Reduction Act removed the income eligibility threshold for APTCs, this group would not receive APTCs because the premium cost of the benchmark plan would not exceed 8.5 percent of their family income.
- 68 A small percentage of uninsured nonelderly residents with incomes below 138 percent FPL are people eligible for ConnectorCare who would likely be eligible for MassHealth if not for the five-year waiting period for most permanent residents.
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- 73 Buettgens, Banthin, and Green. “Expanded Coverage and Savings.”
- 74 Massachusetts Health Connector. “Massachusetts Cost Sharing Subsidies.”
- 75 Ibid.
- 76 Pulos. “Understanding Non-citizens’ Eligibility.”
- 77 People who are not lawfully present may be considered “nonqualified PRUCOL” (Persons Residing Under Color of Law) for MassHealth eligibility purposes. This group includes “any noncitizen living in the United States with the knowledge and consent of the DHS [Department of Homeland Security], and whose departure the DHS does not contemplate enforcing.” Examples include people granted an indefinite stay of deportation, granted or with a pending application for Deferred Action for Childhood Arrivals (DACA), or with a pending application for asylum. See 130 CMR 504.003(C)(11); Pulos. “Understanding Non-citizens’ Eligibility.”
- 78 Other people who are not lawfully present may be eligible for MassHealth Limited, the Health Safety Net, or the Children’s Medical Security Plan. Undocumented residents are only eligible for full MassHealth if they are pregnant and have low incomes or if they are grandfathered in because they were enrolled in 1997.
- 79 See Appendix Table 8a.
- 80 These are also among the most common languages spoken by MassHealth and Health Connector enrollees. Office of Medicaid. 2021. “Language Access Plan.” <https://www.mass.gov/doc/masshealth-language-access-plan-2021-23-0/download>. Accessed September 2, 2022; Massachusetts Health Connector. 2016. “Language Access Plan.” <https://betterhealthconnector.com/wp-content/uploads/Language-Access-Plan.pdf>. Accessed September 2, 2022.
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- 87 Chin et al. “The Remaining Uninsured.”
- 88 Even though they are ineligible for comprehensive public or subsidized coverage, undocumented people also face barriers to getting more limited health care benefits. Interview participants noted that undocumented people who apply for health safety net programs receive multiple confusing letters about ineligibility for Health Connector coverage and eligibility for MassHealth Limited or the Health Safety Net, which cause some people to think they cannot receive any help with their health care costs.

- 89 Center for Health Information and Analysis. “Findings from the 2019 Massachusetts Health Insurance Survey.”
- 90 The 2022-2027 MassHealth demonstration waiver will increase continuity of coverage for formerly incarcerated people. It will maintain continuous MassHealth eligibility for one year following release from incarceration and Department of Youth Services custody.
- 91 DTA benefits include cash assistance through the Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) programs. Participants in these programs are eligible for MassHealth without filing a separate application. Those who are terminated from the programs can remain enrolled in MassHealth for four to 12 months, depending on their specific circumstances, which gives them the opportunity to submit an application directly to MassHealth and have eligibility determined for continued health coverage.
- 92 Chin et al. “The Remaining Uninsured”; Capoccia, Victor, Colette Croze, Martin Cohen, and John P. O’Brien. 2013. “Sustaining Enrollment in Health Insurance for Vulnerable Populations: Lessons from Massachusetts.” *Psychiatric Services* 64(4): 360–65; Nardin et al. 2012. “Reasons Why Patients Remain Uninsured”; Paradise, Julia, Sara Rosenbaum, Peter Shin, Jessica Sharac, Carmen Alvarez, Julia Zur, and Leighton Ku. 2013. “Providing Outreach and Enrollment Assistance: Lessons Learned from Community Health Centers in Massachusetts.” Menlo Park, CA: Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/providing-outreach-and-enrollment-assistance-lessons-learned-from-community-health-centers-in-massachusetts/>.
- 93 Because MassHealth eligibility is based on current monthly income, residents may not think they qualify during months with higher incomes or overtime pay. However, in cases when an individual has seasonal income or other reasonably predictable future income, the annual gross taxable income is typically divided by 12 to obtain a monthly taxable gross income for eligibility purposes. Further, a safe harbor rule allows people to qualify for MassHealth if their current monthly income would result in financial ineligibility for MassHealth but their projected annual income based on Health Connector income counting rules is below 100 percent FPL. See 130 CMR 506.003(A)(4) and 130 CMR 506.007(D); Brooks, Tricia, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan. 2020. “Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey.” San Francisco, CA: Kaiser Family Foundation. <https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf>.
- 94 Pulos, Victoria. 2019. “ConnectorCare Advocacy Guide.” Boston, MA: Massachusetts Law Reform Institute. <https://www.mlri.org/publications/connectorcare-advocacy-guide/>.
- 95 Enrollment assisters can also contact an assister customer service line with the client to have an invitation link sent when applying.
- 96 Interview participants also noted that some people have trouble establishing a new individual account following a change in their family circumstances, such as divorce or separation, especially when the original accountholder is no longer present in their lives.
- 97 Capoccia et al. “Sustaining Enrollment in Health Insurance”; Nardin et al. “Reasons Why Patients Remain Uninsured.”
- 98 MassHealth currently has text messaging capacity in English and Spanish.
- 99 MassHealth first attempts to redetermine eligibility using information from available federal and state data sources. If these electronic data matches can establish continued eligibility, coverage is renewed automatically. If a member’s eligibility cannot be verified or it appears they are no longer eligible, MassHealth sends them a prepopulated renewal form with a request for information that must be provided within a specified period of time to avoid termination of coverage. 130 CMR 502.007; Serafi and Boozang. “The End of the Federal Continuous Coverage Requirement”; Gershon, Rachel, Robert Seifert, Rebecca Elliott, and Lisa Braude. 2022. “The MassHealth Proposed Demonstration Extension 2022-2027: Building on Success, Focusing on Equity.” Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. <https://www.bluecrossmafoundation.org/publication/masshealth-proposed-demonstration-extension-2022-2027-building-success-focusing-equity>.
- 100 Pulos. “ConnectorCare Advocacy Guide.”
- 101 If self-attested income is lower than income from federal and state data sources and the difference between attested income and income from these sources is less than 20 percent, the attested income is used to determine eligibility.
- 102 Gershon et al. “The MassHealth Proposed Demonstration Extension.”
- 103 In Massachusetts, children and parents enrolled in both MassHealth and SNAP can have their MassHealth renewals processed more quickly based on income information provided to SNAP under the ELE policy. Edwards, Jennifer, and Diana Rodin. 2013. “Case Study of Massachusetts’ Express Lane Eligibility Processes.” Washington, DC: Mathematica Policy Research and Health Management Associates. <https://www.mathematica.org/publications/case-study-of-massachusetts-express-lane-eligibility-processes>.
- 104 See Appendix Table 4a.
- 105 Chin et al. “The Remaining Uninsured”; Paradise et al. “Providing Outreach and Enrollment Assistance”; Mulvaney-Day, Norah, Margarita Alegría, Anna Nillni, and Sabrina Gonzalez. 2012. “Implementation of Massachusetts Health Insurance Reform with Vulnerable Populations in a Safety-net Setting.” *Journal of Health Care for the Poor and Underserved* 23(2): 884–902.
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- 107 Governor’s Veto Message, FY2023 Budget, Attachment R. <https://malegislature.gov/Bills/192/H5132>. Accessed December 6, 2022.

- 108 “Lower Your Monthly Premiums with the NJ Health Plan Savings.” Get Covered NJ, <https://nj.gov/getcoverednj/financialhelp/premiums/>. Accessed October 11, 2022.
- 109 An Act to Ensure More Affordable Care, <https://malegislature.gov/Bills/192/H1247>. Accessed Oct. 11, 2022.
- 110 Health Care for All. Undated Fact Sheet. “An Act to Ensure More Affordable Care (The MAC Act).” <https://hcfama.org/wp-content/uploads/2021/05/More-Affordable-Care-Act-Fact-Sheet-4.26.21.pdf>.
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- 113 Center for Health Information and Analysis. “Findings from the 2019 Massachusetts Health Insurance Survey.”
- 114 Information from the Health Connector.
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- 118 Serafi and Boozang, “The End of the Federal Continuous Coverage Requirement.”
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- 121 “More States Move to Expand Continuous Eligibility for Children and Adults in Medicaid.” May 2022. Center for Children and Families, Georgetown University Health Policy Institute. <https://ccf.georgetown.edu/2022/05/24/more-states-move-to-expand-continuous-eligibility-for-children-and-adults-in-medicaid/>. Accessed October 12, 2022.
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