

Closing the Coverage Gaps:

Reducing Health
Insurance Disparities
in Massachusetts

EXECUTIVE SUMMARY

APRIL 2023



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ACKNOWLEDGEMENTS

The authors would like to thank
Matthew Buettgens and Doug Wissoker from the Urban Institute
for their guidance on the analysis.

BACKGROUND AND PURPOSE

Lack of health insurance is costly to individuals, providers, and the community. People without insurance have less access to health care, and those with chronic or acute conditions are at greater risk of poor health than their insured counterparts. Being uninsured also causes financial stress.

Massachusetts has been exemplary in developing policies to cover its residents, going back over several decades. The percentage of uninsured in the state fell sharply after 2006 when Massachusetts enacted its health care reform law, and this percentage continued to decline steadily after the enactment of the Affordable Care Act in 2010. By 2019, the Massachusetts uninsurance rate was 3.0 percent, the lowest rate in the nation, representing about 204,000 uninsured residents.^{1,2} Expansion of public coverage programs in Massachusetts has not drawn significant numbers of people away from private coverage; in 2019, nearly two-thirds of the Commonwealth's population had coverage through an employer or from a private plan purchased independently or through the Massachusetts Health Connector.³

While the overall uninsured rate at a given point in time is low in Massachusetts, more than twice as many people—503,000, or 7.3 percent of the population—were without insurance at some point in the 12 months preceding a state survey in 2019.⁴ There also are population groups that still struggle with significantly higher uninsured rates. People who are Black or Hispanic are two to three times as likely to be uninsured as White, non-Hispanic people in Massachusetts, as are people with lower incomes relative to those with higher incomes. These groups are therefore more likely to experience the access barriers associated with being uninsured.⁵ Ideally, everyone in Massachusetts would have health insurance.

The purpose of this report is to begin charting a course toward 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 coverage gaps. The report describes the people in Massachusetts without health insurance and the barriers to coverage they face. It then proposes a menu of policy options that address the specific circumstances in Massachusetts. The hope is that this report will spark a serious discussion of approaches to closing the remaining coverage gaps in Massachusetts and removing structural barriers that result in racial and ethnic disparities in health insurance coverage.

CHARACTERISTICS OF UNINSURED MASSACHUSETTS RESIDENTS

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. Analysis of data from national surveys⁶ shows that uninsured rates in Massachusetts vary by demographic, geographic, and socioeconomic characteristics.

YOU ARE MORE LIKELY TO BE UNINSURED IN MASSACHUSETTS IF YOU:

Demographics	<ul style="list-style-type: none">• Are a young adult aged 19–34• Are Hispanic or Black• Were born outside the United States• Have limited English proficiency	<ul style="list-style-type: none">• Are a nonelderly male• Are not a citizen• Are unmarried, with no dependent children
Geography	<ul style="list-style-type: none">• Live in Suffolk County	<ul style="list-style-type: none">• Live in a high-poverty community anywhere in the state (e.g., high seasonal employment areas)
Socioeconomics	<ul style="list-style-type: none">• Have not attended college• Have an income below 300 percent of the federal poverty level (FPL) (\$64,000 for a family of three in 2019)• Live in a rented home• Face difficulty paying housing and food costs	<ul style="list-style-type: none">• Do not have year-round full-time employment• Work for a small firm or in an industry with low wages and limited benefits• Pay more than 30 percent of your household income toward housing

Uninsured adults are less likely than insured adults to have a disability and to have been diagnosed with chronic health conditions, but they also are less likely to report being in excellent or very good health. 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 overall and for nonemergency care.⁷ Though some 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.

Racial and ethnic disparities in health coverage echo the inequities that have long been observed in health care access and health outcomes. There are significantly higher levels of uninsurance among Hispanic residents and non-Hispanic Black residents relative to non-Hispanic White residents. Hispanic residents are 23 percent of the uninsured population but make up only 12 percent of all Massachusetts residents. The Black population of Massachusetts is 7 percent of the total state population but 11 percent of the uninsured population. 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, the Asian population is 7 percent of the total state population and also represents 7 percent of the uninsured population in Massachusetts.⁸

Residents who are not citizens are among those at greatest risk of being uninsured. Nearly 4 in 10 uninsured residents (38 percent) were born outside the United States, and about 3 in 10 (29 percent) are not U.S. citizens.⁹

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](#).

BARRIERS TO COVERAGE AMONG UNINSURED RESIDENTS

Most uninsured residents want coverage, but they are often excluded from the employer-based health insurance market and face obstacles to getting coverage through MassHealth (the name for Massachusetts' Medicaid program and Children's Health Insurance Program [CHIP]) and/or the Health Connector, which are governed by federal and state policies and processes. Our synthesis of research and data, simulation modeling, and stakeholder interviews identified four general categories of coverage barriers:

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

Eight in 10 uninsured respondents to the 2019 Massachusetts Health Insurance Survey (MHIS) cited the cost of coverage as a reason for not having insurance.¹⁰ The most common source of insurance coverage is an employer, either one's own or that of a family member. Employer-sponsored insurance (ESI) makes coverage more affordable by requiring the employee to pay just a percentage of the premium, with the employer paying the balance as an employee benefit. Without access to ESI, coverage can become unaffordable. 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.¹¹

METHODOLOGY AND APPROACH

The methodology for this project included a mixed methods approach. It is described in more detail in the full report, [Closing the Coverage Gaps: Reducing Health Insurance Disparities in Massachusetts](#), and in a separate [Methodology Report](#).

An uninsured person who does not have access to insurance subsidized by an employer might qualify for publicly subsidized coverage through MassHealth or the Health Connector, if their income is below a certain level and they meet other eligibility standards. This is true of a large number of uninsured people. About half of uninsured nonelderly residents are likely eligible for MassHealth (43 percent), ConnectorCare (7 percent), or a subsidized qualified health plan (2 percent).¹² There are many reasons that people do not avail themselves of these coverage options, despite their eligibility:

- People without insurance are not always aware of affordable public and subsidized options that are available to them.
- Premiums for Health Connector coverage, even with subsidies, may still not be affordable after covering other essential expenses.
- Some people with subsidized premiums or unsubsidized coverage may forgo care because they cannot afford the deductibles; some ConnectorCare enrollees have difficulty affording co-payments. An uninsured person might decide to rely on the emergency room and agree to a payment plan for the resulting bill, rather than incurring monthly premium costs and co-payments at the point of service.
- Access problems, such as excessive delays for appointments and difficulty getting insurance to cover needed services, diminishes the value of insurance for some and might dissuade people from renewing their coverage.

The other half of uninsured nonelderly residents are likely to be ineligible for MassHealth or subsidized Health Connector coverage, for one of several reasons:¹³

- 20 percent are undocumented immigrants; significantly higher percentages of Hispanic (40 percent), Asian (33 percent), and Black (25 percent) uninsured people are ineligible because of immigration status compared to non-Hispanic White individuals (7 percent).
- 18 percent have family incomes too high to qualify for advance premium tax credits.¹⁴
- 10 percent do not qualify for subsidies because they have an offer of ESI considered to be affordable.

2. LANGUAGE BARRIERS AND OTHER ENROLLMENT BARRIERS AFFECTING IMMIGRANT FAMILIES

People who are not U.S. citizens must navigate more complex eligibility rules compared to citizens, which can prevent enrollment even for those eligible for coverage. While the only legal requirement for purchasing Health Connector plans is that an immigrant be lawfully present in the United States, eligibility for MassHealth may depend on having a qualified immigration status, the number of years an individual has had that status, and factors such as age, pregnancy, income, and disability.¹⁵ Immigrants face other coverage barriers as well:

- Language is an important barrier. Notices for MassHealth and the Health Connector are available in English and Spanish, but many enrollees speak other languages; 28 percent of uninsured adults have limited English proficiency. Notices include a multilanguage insert advising recipients to have it translated right away, but some people do not open or respond to the letters because they are unable to understand them or prefer to get in-person help.
- Many immigrants are reluctant to apply for benefits because of a concern that they will be determined a “public charge”¹⁶ or face other consequences that affect their or a family member’s immigration status.
- Mixed-status households—which include both lawfully present and undocumented people—face added complexity to application and renewal processes.

3. 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.

When MassHealth members become ineligible because of a change in income or other circumstances, the Health Connector may notify them that they qualify for other coverage, but activating that coverage requires further action. Nearly half (47 percent) of uninsured 2019 MHIS respondents had lost eligibility for MassHealth, suggesting that people often fail to successfully transition from MassHealth to other coverage types.

Loss of ESI is another common transition that sometimes leads people to become uninsured. One-third (33 percent) of uninsured 2019 MHIS respondents cited losing their job or changing jobs as their reason for being uninsured. Workers who lose their jobs and ESI may be unfamiliar with MassHealth and the Health Connector, where they might be eligible for coverage or help paying for premiums, and unable to afford COBRA coverage from their former employer.

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, or families stop receiving public assistance benefits. These transitions occur when people may be facing other challenges, including finding a job or a place to live.

4. ADMINISTRATIVE PROCESSES THAT CAUSE GAPS IN COVERAGE FOR PEOPLE ELIGIBLE FOR MASSHEALTH AND HEALTH CONNECTOR COVERAGE

Administrative processes designed to verify eligibility and ensure integrity in public programs require multiple transactions that can result in disenrollment and contribute to insurance churning (transitioning on and off insurance programs). Complicated processes span the gamut of application and eligibility verification, enrollment, and eligibility renewal. 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. Certain administrative process failures, such as not receiving mailed notices, disproportionately affect people with unstable housing. People without computers and/or internet and email access face additional challenges. In-person enrollment assistance often plays an important role in navigating complex processes and connecting people with coverage. 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.

POTENTIAL POLICIES AND PROGRAMS TO ADDRESS DISPARITIES AND GAPS IN COVERAGE

Using as a guide the characteristics of uninsured Massachusetts residents and the barriers to coverage they face, we present a set of policy and program ideas for closing coverage gaps and reducing racial and ethnic disparities in coverage. Each idea addresses particular characteristics of the uninsured population and would seek to dismantle a particular barrier (or barriers) to coverage. 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.

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

Actual or perceived affordability of coverage is the most common barrier to people obtaining health insurance. Three of these policy options (1a and 1d, as well as 2a) would improve affordability by extending eligibility for public programs or for subsidized coverage to people who do not currently qualify. Two of the options (1b and 1c) would seek to increase the take-up of programs by people who already are eligible for them by reducing their premiums or cost sharing obligations.

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. These groups face unique challenges in obtaining coverage, in addition to confronting the same barriers as the general population. The most significant policy option addressing this barrier (2a) is to extend eligibility for MassHealth and ConnectorCare to people regardless of their immigration status, including using state funds to cover people who are disqualified under federal rules. A second policy (2b) would strengthen

agency-specific use of Language Access Plans to assertively target assistance to people for whom language is the primary barrier to coverage.

3. POLICIES ADDRESSING ELIGIBILITY TRANSITIONS

Most people in Massachusetts, upon losing one source of coverage, should have access to another one. These policy options focus on smoothing the transitions between types of coverage, by improving information and outreach about available coverage (3a) or by automatically enrolling eligible people into a Health Connector program when they lose MassHealth eligibility rather than requiring a new application (3b).

4. POLICIES ADDRESSING ADMINISTRATIVE PROCESSES

One-half of uninsured adults are eligible for but not enrolled in public or publicly subsidized programs. These options focus on the barriers this group faces. Two of the policies (4a and 4c) use technology to simplify processes. One (4d) would lessen the frequency of enrollment churn by making MassHealth eligibility continuous for 12 months. And two of these options would help applicants and enrollees in public programs better navigate administrative processes by streamlining requirements (4b) and increasing the numbers and capabilities of state employees and contractors who assist people in enrolling in coverage (4e).

The [full report](#) describes each of these options in more detail.

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, or linguistically marginalized. The menu of policy and programmatic options in the report—which have been contemplated, studied, or proposed, and in many cases, implemented elsewhere—address barriers to coverage that residents face. Each would help certain groups of people and has its own benefits, costs, and challenges to adoption. They will not all be adopted, but they can and should be considered in different combinations.

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 coverage gaps as achievable and as part of the larger goal of making health care more equitable, affordable, and accessible for everyone who lives in Massachusetts.

ENDNOTES

- 1 Keisler-Starkey, Katherine, and Lisa N. Bunch. 2020. "Health Insurance Coverage in the United States in 2019." Washington, DC: U.S. Census Bureau. <https://www.census.gov/library/publications/2020/demo/p60-271.html>; "S2702. Selected Characteristics of the Uninsured in the United States." 2019 ACS 1-Year Estimate Tables. <https://data.census.gov/cedsci/table>. Accessed August 31, 2022.
- 2 With the COVID-19 pandemic and the temporary freeze on MassHealth disenrollment during the COVID-19 federal public health emergency, the uninsurance rate declined again, falling from 3.0 percent to 2.5 percent between 2019 and 2021. However, the uninsurance rate may rebound at least partially toward pre-pandemic levels as the temporary policies intended to mitigate the pandemic's impact on health insurance coverage expire.
- 3 SHADAC analysis of American Community Survey (ACS) Public Use Microdata Sample (PUMS) file. 2019. State Health Compare, SHADAC, University of Minnesota. statehealthcompare.shadac.org. Accessed February 10, 2023.
- 4 Center for Health Information and Analysis. 2020. "Findings from the 2019 Massachusetts Health Insurance Survey." <https://www.chiamass.gov/assets/docs/r/survey/mhis-2019/2019-MHIS-Report.pdf>.
- 5 Ibid.
- 6 The American Community Survey (ACS), Current Population Survey (CPS), and Behavioral Risk Factor Surveillance System (BRFSS).
- 7 Center for Health Information and Analysis. "Findings from the 2019 Massachusetts Health Insurance Survey"; Long, Sharon K., Dana Goin, and Victoria Lynch. 2013. "Reaching the Remaining Uninsured in Massachusetts: Challenges and Opportunities." Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. <https://www.bluecrossmafoundation.org/publication/reaching-remaining-uninsured-massachusetts-challenges-and-opportunities>; Long, Sharon K., and Ariel Fogel. 2014. "Health Insurance Coverage and Health Care Access, Use, and Affordability in Massachusetts: An Update as of 2012." Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2020-10/MHRS_2012%20Full%20Report.pdf; Long, Sharon K., Karen Stockley, and Heather Dahlen. 2012. "Health Reform in Massachusetts as of Fall 2010: Getting Ready for the Affordable Care Act & Addressing Affordability." Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. <https://www.urban.org/sites/default/files/publication/25041/412491-Health-Reform-in-Massachusetts-as-of-Fall--Getting-Ready-for-the-Affordable-Care-Act-amp-Addressing-Affordability.PDF>.
- 8 Urban Institute analysis of pooled 2017–2019 American Community Survey data from IPUMS USA; Ruggles, Steven, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. 2022. Minneapolis, MN: IPUMS. <https://www.ipums.org/projects/ipums-usa/d010.v12.0>.
- 9 Ibid.
- 10 Center for Health Information and Analysis. "Findings from the 2019 Massachusetts Health Insurance Survey."
- 11 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.
- 12 Urban Institute Health Insurance Policy Simulation Model (HIPSM), simulated for year 2023.
- 13 Ibid.
- 14 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.
- 15 Pulos, Vicky. 2022. "Understanding Non-citizens' Eligibility for Health Coverage." Boston, MA: Massachusetts Law Reform Institute. <https://www.masslegalservices.org/content/understanding-immigrants-eligibility-masshealth-other-subsidized-coverage-2020-0>.
- 16 The federal government's public charge test may be used to deny an immigrant's application for permanent residency or a person seeking admission to the United States. The Trump administration expanded the public charge test in 2020 to include Medicaid participation as a negative factor. The rule was reversed in March 2021, but a chilling effect on participation remains.



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