Reasons Why Patients Remain Uninsured after Massachusetts' Health Care Reform: A Survey of Patients at a Safety-Net Hospital

Rachel Nardin, MD^{1,3}, Assaad Sayah, MD^{2,3}, Hermione Lokko, BSc³,
Steffie Woolhandler, MD, MPH⁴, and Danny McCormick, MD, MPH^{1,3}

¹Department of Medicine, Cambridge Health Alliance, Cambridge, MA, USA; ²Department of Emergency Medicine, Cambridge Health Alliance, Cambridge, MA, USA; ³ Harvard Medical School, Boston, MA, USA; ⁴ City University of New York School of Public Health, New York, NY, USA.

BACKGROUND: Following the 2006 Massachusetts health care reform, an estimated 316,492 residents remain uninsured. However, there have been no published studies that examine why Massachusetts residents remain uninsured four years into health reform.

OBJECTIVE: To describe the characteristics of uninsured patients seeking acute medical care in Massachusetts after implementation of health care reform and reasons for lacking insurance.

DESIGN AND PARTICIPANTS: We performed an in-person survey of a convenience sample of patients visiting the emergency department of the state's second largest safety net hospital between July 25, 2009 and March 20, 2010. We interviewed 431 patients age 18–64, 189 of whom were uninsured.

MAIN MEASURES: Demographic and clinical characteristics, employment and insurance history, reasons for lacking insurance and views of the state's new "individual mandate".

KEY RESULTS: The uninsured were largely employed (65.9%), but only a quarter (25.1%) of the employed uninsured had access to employer-sponsored insurance. The majority qualified for subsidized insurance (85.7% earned $\leq 300\%$ of the federal poverty level), yet many reported being unable to find affordable insurance (32.7%). Over a third (35.2%) were uninsured because they had lost insurance due predominantly to job loss or policy cancellation. For nearly half of the uninsured (48.6%), the individual mandate had motivated them to try to find insurance, but they were unable to find insurance they could afford.

CONCLUSIONS: After full implementation of the Massachusetts health reform, those remaining without insurance are largely the working poor who do not have access to, or cannot afford, either employer sponsored insurance or state subsidized insurance.

KEY WORDS: uninsured; health reform; health policy; safety-net institutions; health insurance.

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INTRODUCTION

In 2006 Massachusetts enacted a multifaceted health care reform law with the explicit goals of reducing the number of Massachusetts residents without health insurance, improving healthcare affordability, decreasing racial and ethnic disparities, and reducing the state's reliance on safety-net hospitals.^{1,2} The Massachusetts plan became the model for the 2010 national reform law, the Patient Protection and Affordable Care Act (ACA).

Since enactment of the Massachusetts reform, there have been a number of estimates of the effect of the law, which was fully implemented by 2008, on the uninsurance rate in Massachusetts. The state most often reports data from the Massachusetts Division of Health Care Finance and Policy's Health Insurance Survey (HIS) suggesting that the percentage of uninsured non-elderly adults was 3.7% in 2008 and 3.5% in 2009.³ However, a significant amount of data suggests that the rate of uninsurance for non-elderly adults is higher. The statewide Massachusetts Health Reform Survey found uninsurance rates of 4.0% in 2008 and 4.8% in 2009.⁴ The Massachusetts Department of Revenue (DOR) reported that 5% of income tax filers were uninsured for the 2008 tax year.⁵ The Behavioral Risk Factor Surveillance System and the U.S. Census Bureau found uninsurance rates for non-elderly adults of 5.0% and 7.3% respectively in 2008 and 6.2% in 2009.^{6–9} Based on current population estimates from the Census Bureau, and the uninsurance rate estimate from the only peer-reviewed publication on this topic, approximately 316,492 non-elderly adults remain uninsured after full implementation of the reform.^{4,10}

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Previous studies have assessed the demographics of uninsured residents, suggesting that the uninsured in Massachusetts post-reform are more likely to be young, male, single, minority and either non-citizens or non-English speaking.^{4,11,12} However, there have been no published studies that examine why Massachusetts residents remain uninsured four years into health reform, and particularly why the most policy-relevant group of uninsured, i.e. those requiring medical treatment, remain uncovered. Such data could improve understanding of how patients can still “fall through the cracks” and could bolster future efforts to further expand coverage in Massachusetts and nationally. We surveyed patients treated in the emergency department (ED) of a large safety-net hospital to understand the characteristics of the uninsured and determine their self-reported reasons for remaining uninsured post-reform.

COVERAGE UNDER THE MASSACHUSETTS REFORM

The Massachusetts reform law aimed to achieve near universal coverage through several mechanisms. It increased coverage for the poor by expanding Medicaid and also by subsidizing private insurance for Massachusetts residents with incomes $\leq 300\%$ of the federal poverty level (FPL), but excluded workers who turn down employer sponsored insurance (ESI), undocumented immigrants and legal immigrants who have been in the U.S. for less than 5 years. It did this by creating Commonwealth Care, a group of publicly subsidized, private insurance plans for residents with low income who are not eligible for Medicaid. Residents with incomes below 150% FPL are eligible for fully subsidized insurance that requires no premium payments, whereas residents with incomes between 150% and 300% of FPL pay a sliding scale premium. The 2006 law created a new state agency, which runs an insurance exchange called the Connector, which brokers subsidized insurance, as well as non-subsidized private plans, to individuals with incomes $>300\%$ FPL and to small businesses. The Connector is also tasked with ensuring that the plans offered through the exchange are affordable and provide adequate coverage of medical services.

The reform law also requires employers with more than 10 employees to offer ESI and make a “fair and reasonable” contribution to the premiums or pay a \$295 fine per year per employee. The law defines a “fair and reasonable” contribution as having at least 25% of full-time employees enrolled in an employer-sponsored plan and covering at least 33% of the premium cost of the individual health insurance plan offered.

Lastly, the law mandates that all state residents carry health insurance or pay a substantial financial penalty enforced through the tax code.

Before passage of the reform law, many low-income uninsured patients received free or nearly free care at designated safety-net hospitals and community health centers; the state-administered uncompensated care pool reimbursed providers for this care. After passage of the reform law, a limited version of this program called the health safety net (HSN) continues to reimburse providers for the costs of medical care for some of

the low-income individuals who remain uninsured. According to the state, HSN is not health insurance and does not meet the individual mandate requirement.¹³

METHODS

Study Design and Setting

We performed an in-person survey of a convenience sample of uninsured patients visiting the ED of the state's second largest safety net hospital, located in Cambridge, Massachusetts. The ED receives approximately 33,000 visits annually. Trained research assistants conducted the study during daytime shifts (usually between 9 am and 5 pm), between July 25, 2009 and March 20, 2010. The Cambridge Health Alliance Institutional Review Board approved the study protocol.

The survey included patients who were uninsured; for comparison, we also included patients with one of several categories of insurance. The two categories of uninsured patients surveyed were those who were eligible to have their care reimbursed through the state's Health Safety-Net (HSN) fund (income $<400\%$ FPL and ineligible for Commonwealth Care or Medicaid) and those who were entirely self-pay. The insured patients had one of three types of coverage: private (commercial) insurance and the two types of insurance made available to low-income residents under Massachusetts health reform, Medicaid and Commonwealth Care. Insurance status was determined by patient report and verified by electronic querying of a continuously updated on-line insurance status database maintained by a consortium of all Massachusetts health insurers, including public payers.¹⁴ This database allows real-time determination of insurance status, which is likely to be highly accurate since this information is provided by the insurers themselves. When patients' report of insurance status differed from that listed in the electronic database, we used the database results in determining insurance status.

Subjects

We included all patients aged 18–64 years, the age range directly affected by the Massachusetts health reform law. We excluded subjects who had altered mental status or inability to speak according to the assessment of the treating physician. We also excluded patients with the highest severity of illness at presentation, defined as those with an Emergency Severity Index Score of 1. This is a widely used and validated ED triage algorithm that stratifies patients into five groups from 1 (most urgent) to 5 (least urgent) at the time of initial emergency department triage.¹⁵ We also excluded patients whose primary language was other than one of the four languages in which the survey was conducted (English, Spanish, Portuguese or Haitian Creole).

Study Recruitment and Survey Procedure

Research assistants stationed in the ED reviewed the demographic and insurance information of all patients presenting

for care during a shift. For patients meeting study entry criteria, the research assistant approached the patient to invite participation, obtain informed consent and verbally administer the survey. For patients whose primary language was Spanish, Portuguese or Haitian Creole, an interpreter was used for study consent and survey administration.

Survey Development

We developed a survey instrument to obtain data on patient age, race/ethnicity, income, primary language spoken at home, country of origin, employment status, education level, self-rated health, number of chronic medical conditions and the emergency severity index. We also asked about health insurance history, reasons for lacking insurance and the effects of the individual mandate. Trained medical interpreters translated the survey instrument into Spanish, Portuguese and Haitian Creole. We did not ask patients about their legal immigration status, to address the human subjects concern that such questions might frighten sick patients or discourage them from seeking emergency care in the future. We field-tested the survey instrument and study recruitment procedures on 30 ED patients and made iterative refinements to the 66-item survey.

Statistical Analysis

We used Chi square tests for comparisons between groups; a p -value of ≤ 0.05 was considered to be statistically significant. Because we found few demographic differences between the uninsured in our sample who were self-pay and who had HSN, most analyses are presented for the group of uninsured as a whole. All analyses were performed using SAS software version 9.2 (SAS Institute, Cary, North Carolina).

RESULTS

We interviewed 431 out of 549 patients invited to participate in the study (response rate 78.4%). There were no statistically significant differences between study subjects and those declining to participate with regard to age or Emergency Severity Index. 189 uninsured patients participated in the study, 84 of whom were self-pay and 105 of whom had HSN.

Table 1 shows the characteristics of the study population. Most uninsured patients (91.0%) had low incomes, earning $\leq 300\%$ of the FPL. The uninsured study population was racially and ethnically diverse (26.8% white, 22.0% black/non-Hispanic and 43.5% Hispanic), but nearly three quarters (74.1%) preferred to conduct the survey in English. About one quarter (26.1%) reported their health as fair or poor and over a third (35%) reported having at least one chronic medical condition. Nearly 40% of the uninsured sample had at least some college education. There were no differences between HSN and self-pay uninsured patients except that HSN patients were more likely to be Hispanic (56.7% vs. 28.2%) and foreign-born (73.5% vs. 41.8%), and self-pay patients were more likely to be white (35.9% vs. 18.9%) and English speaking (90.5% vs. 61.0%). The demographics of the

uninsured population were similar to those of patients with Commonwealth Care or Medicaid, although the uninsured were more likely to be foreign born. This was in contrast to the privately insured, who were more likely to be white, high income, English-speaking, employed and have higher self-rated health status and educational attainment.

Nearly two thirds (65.9%) of uninsured patients were currently employed with the majority of these (67.0%) employed for longer than one year (Table 2). Of those who were employed, about half (48.2%) worked part-time and only 24.1% were self-employed. Half (51.6%) of those working for an employer worked for one with more than 10 employees, the firm size above which the Massachusetts reform law mandates that employers offer health insurance or pay a fine. Approximately half (51.1%) of those working for an employer reported that they had not been offered employer-sponsored insurance. Patients who worked at firms with 10 or fewer employees were much less likely to have been offered ESI (20.0% vs. 77.8% for employees of larger firms, $p=0.0005$), as were patients who worked at a job for less than one year (39.0% vs. 63.6% for longer term employees, $p=0.0079$). The uninsured were as likely to be employed (65.9%) as those with private insurance (72.3%) or Commonwealth Care (66.1%), and much more likely to be employed than those with Medicaid (27.3%). The uninsured were less likely than the privately insured, but just as likely as those with Commonwealth Care or Medicaid, to work for an employer who offered ESI.

Figure 1 shows the relationship between employment status, income level and access to ESI for our uninsured sample. One-third (34.1%) of the sample was unemployed and thus did not have access to ESI; 86.4% of these had incomes $\leq 300\%$ of the FPL, a level that would qualify eligible residents for subsidized insurance. Another 15% of the sample was self employed and thus lacked access to ESI; 90% of these had incomes $\leq 300\%$ of the FPL. An additional 24% worked for an employer that did not offer insurance and 93% of these had incomes $\leq 300\%$ of the FPL. Lastly, 25% of the sample worked for an employer that offered insurance. Nearly three-quarters of these patients earned $\leq 300\%$ of the FPL; these individuals would qualify for state-subsidized insurance only if their employer's plan did not cover at least 20% of the annual family premium or 33% of the annual individual premium.

Nearly a quarter of the uninsured (23.7%) had never had insurance and an additional 57.2% had been uninsured for at least a year. Compared with patients who were uninsured for less than a year, long-term (≥ 1 year) uninsured patients were more likely to be non-white and non-English speaking, but were similar in age and health status, and were just as likely to be employed.

Examining patients' self-reported reasons for remaining uninsured, we found that a third (32.7%) reported being uninsured because they could not find affordable insurance. Another third (35.2%) reported having lost their insurance. Of these, nearly half had lost insurance due to job loss (46.3%), but an additional third had had their insurance cancelled without notice or because of lapsed paperwork (33.3%). Additional reasons for loss of insurance included loss of spouse's insurance (7.4%), transition between jobs (5.6%), aging out of parents' insurance (5.6%) and need to cancel insurance due to cost (1.9%). Additional reasons why patients remained uninsured included their belief that they did not require insurance because of HSN coverage (12.4%), their fear of giving personal information (8.0%), the fact that they were denied insurance for which

Table 1. Demographic and Health Characteristics of Study Patients

Characteristics	Insurance Status				p-value	
	Uninsured	Insured				
		(n=189) %	Commonwealth Care (n=66) %	Medicaid (n=91) %		Private (n=86) %
Age (years)					0.25	
18–30	42.9	29.5	38.6	41.0		
31–50	43.5	45.9	37.5	41.0		
51–64	13.6	24.6	23.9	18.1		
Race/Ethnicity					<0.0001	
White/Non-Hispanic	26.8	49.2	38.4	61.3		
Black/Non-Hispanic	22.0	18.0	33.7	13.8		
Hispanic	43.5	26.2	17.4	12.5		
Other	7.7	6.6	10.5	12.5		
Income (as % FPL)*					<0.0001	
0–150%	68.2	60.6	76.1	23.0		
151–300%	22.8	22.7	16.3	13.8		
>300%	9.0	16.7	7.6	63.2		
Country of Origin					<0.0001	
US Born	40.7	74.5	84.0	81.9		
Foreign Born	59.3	25.5	16.0	18.1		
Language					<0.0001	
English	74.1	92.4	96.7	100.0		
Portuguese	19.6	1.5	1.1	0.0		
Spanish	4.2	1.5	1.1	0.0		
Haitian-Creole	2.1	4.6	1.1	0.0		
Education Level					<0.0001	
<High School	16.5	11.3	24.1	2.4		
High School	43.8	33.9	28.7	18.1		
Some College or Graduate School	39.8	54.8	47.1	79.5		
Self-rated Health					<0.005	
Excellent/Very Good	39.1	36.9	33.7	61.2		
Good	34.8	33.9	32.6	24.7		
Fair or Poor	26.1	29.2	33.7	14.1		
Self-reported Chronic Medical Conditions†					0.49	
None	65.1	65.6	56.0	62.4		
One or more	35.0	34.4	44.0	37.7		
Emergency Severity Index‡					0.14	
1	0	0	0	0		
2	7.7	6.1	1.1	4.8		
3	34.8	53.0	46.7	47.6		
4	43.7	31.8	38.0	36.9		
5	13.8	9.1	14.1	10.7		

* FPL=Federal Poverty Level

† Includes the following conditions: heart disease, cancer, arthritis, hypertension, diabetes, asthma and obesity

‡ The Emergency Severity Index is a validated measure of severity of illness at the time of presentation to an emergency department and is used to stratify patients into 5 groups (Level 1=most severe; Level 5=least severe) for triage priority

they had applied (6.2%) and their belief that they did not need insurance (5.6%).

Lastly, we examined the effect of the individual mandate on the uninsured in Massachusetts (Table 3). Over two-thirds of the uninsured (65.7%) were aware of the legal requirement that they carry health insurance; this was similar to patients with Medicaid (75.9%), but significantly lower than those with Commonwealth Care (90.5%) or private insurance (90.5%). For nearly half of the uninsured (48.6%), the mandate had motivated them to try to find insurance, but they had been unable to find insurance they could afford (88.4% of these paid no tax penalty). For an additional 38.5%, the mandate had had no effect on their decision to carry health insurance. Nearly half of uninsured patients (47.8%) believed the health care reform law had been bad for Massachusetts' residents; this was significantly higher than for patients with any type of insurance.

DISCUSSION

This survey of uninsured patients seen in a major safety net hospital ED describes some reasons why residents remain uninsured in Massachusetts four years after passage of health reform. Lack of health insurance was rarely voluntary. Despite a third of patients reporting at least one chronic medical condition, 80.9% had been uninsured for more than a year. The uninsured were mostly working poor, but only 25% had access to ESI. The vast majority of patients reported being uninsured because of a loss of insurance (predominantly from job loss or policy cancellation) or because insurance was unaffordable. Only 5.6% of our sample said they were uninsured because they didn't think they needed insurance, suggesting few "free riders."

We found that half of the uninsured worked for employers other than themselves, but only half of these worked for an employer who offered insurance. Of the uninsured that worked

Table 2. Employment Status and Characteristics of Study Patients

Characteristics	Insurance Status				
	Uninsured	Insured			p value
	%	Commonwealth Care %	Medicaid %	Private %	
Employment Status (n)	(179)				<0.0001
Employed	65.9	66.1	27.3	72.3	
Unemployed	34.1	33.9	72.7	27.7	
Among Employed (n)	(118)	(41)	(24)	(60)	0.14
Number of Jobs					
1	88.0	87.8	95.8	78.3	
2 or more	12.0	12.2	4.2	21.7	0.30
Duration of current employment					
1 year or less	33.0	27.5	37.5	19.0	
2-5 years	45.0	42.5	45.8	44.8	
More than 5 years	22.0	30.0	16.7	36.2	<0.0001
Hours per week worked					
<40	48.2	52.9	78.3	13.3	
40	27.7	20.6	17.4	40.0	
>40	24.1	26.5	4.4	46.7	0.02
Type of Employment					
Self-Employed	24.1	20.5	20.8	5.0	
Employed by someone else	75.9	79.5	79.2	95.0	0.0002
Size of Employer					
≤10 employees	48.4	47.8	27.3	9.3	
>10 employees	51.6	52.2	72.7	90.7	<0.0001
Employer Offers Insurance					
Yes	51.1	58.6	62.5	93.0	
No	48.9	41.4	37.5	7.0

Figure 1. Employment status, access to employer sponsored insurance and income (percent $\leq 300\%$ of the federal poverty level (FPL)) of study patients. The percent $\leq 300\%$ of FPL is given only for those patients providing income information.

for an employer, half worked for a small firm (≤ 10 employees), exempt from the requirement to offer insurance. These findings imply that the exemption for small firms may be making ESI unavailable to those least able to find alternative sources of coverage. In addition, the current penalty for larger firms not offering ESI—\$295 per full time employee—may be too low to encourage employer participation and thus ESI availability.

The finding that some of the working uninsured had access to ESI but declined it suggests that for many, the available ESI is out of reach financially. This is not surprising, since the state requires that an employer cover only 20% of an annual family premium or 33% of an annual individual premium. Recent data suggest that annual increases in medical insurance costs are being increasingly shifted from employers to their employees with ESI.¹⁶ This could lead to even lower uptake rates for ESI in the future.

Irrespective of employment status, more than 85% of this uninsured sample had incomes that were low enough that they should have qualified for state subsidized insurance (either Medicaid or Commonwealth Care). Why, then, were these patients uninsured? Nearly a third of our cohort (29.9%) reported being uninsured because they could not afford insurance, suggesting that for some working poor, even heavily subsidized insurance premiums may be unaffordable. Although the Connector is charged with ensuring that adequate and affordable insurance options are available, the rising cost of healthcare has made this difficult. Nearly three-quarters of HSN patients were foreign-born, suggesting that a high proportion of these patients may be ineligible for state subsidized insurance on the basis of their legal immigration status.

Surprisingly, over a third of the sample reported “loss of insurance” as the reason for being uninsured at the time of the

Table 3. Awareness and Effects of Massachusetts' "Individual Mandate" Among Study Patients

Characteristics	Insurance Status				p value
	Uninsured	Insured			
		Common-wealth Care	Medicaid	Private	
Aware of the “individual mandate” (n)	(175)	(63)	(87)	(84)	<0.0001
Yes	65.7	90.5	75.9	90.5	
No	34.3	9.5	24.1	9.5	
Effect of “individual mandate” on respondent’s coverage (n)	(109)	(55)	(65)	(76)	<0.0001
“Made me get coverage”	9.2	34.6	15.4	11.8	
“Made me try to get coverage but there wasn’t any coverage I could afford”	48.6	5.5	6.2	2.6	
“It did not influence my decision about getting coverage”	38.5	52.7	78.5	85.5	0.02
Other	3.7	7.3	0.0	0.0	
Effect of Massachusetts health care reform law on Massachusetts Residents (n)	(92)	(50)	(58)	(69)	
Good	31.5	48.0	43.1	53.6	
Bad	47.8	30.0	25.9	26.1	
Neither good nor bad	20.7	22.0	31.0	20.3	

survey. For subsidized insurance plans, yearly re-enrollment is required to maintain coverage and the state mails re-enrollment forms to enrollees yearly. However, if completed forms are not received by the state within 10 days, the policy is terminated. For low-income residents, who often experience substantial housing instability in the expensive Boston area, these stringent re-enrollment policies could contribute to unnecessary loss of insurance for eligible residents. In addition, even a small increase in income may disqualify residents for income-based subsidized insurance.

It is also possible that patients who may have been eligible for subsidized insurance by income criteria may have been ineligible due to immigration status requirements. A limitation of our study is that we did not ask about citizenship or legal status directly (due to concerns about human subject protections) and thus cannot determine which respondents were uninsured because of ineligibility on the basis of legal status. While we found that 59.3% of the total uninsured patients in our sample were born outside the United States, three-quarters of our sample answered the survey in English, suggesting that this is not predominantly a population of recent immigrants.

We found significant demographic differences between the uninsured and the privately insured patients in our sample; namely, the uninsured were more likely to be non-white, low income, non-English speaking and have lower educational attainment. However, with the exception of more foreign-born patients among the uninsured, our uninsured patients resembled those insured by Medicaid and Commonwealth Care, the major forms of insurance gained under the reform. This suggests that at least in part, the reform failed to fully reach the demographic groups it targeted and emphasizes the fragility of a system requiring voluntary uptake, periodic renewal, dependence on employment and cost-sharing.

Two-thirds of uninsured patients in our sample (65.7%) were aware of the reform law's individual mandate. Half of our sample (48.6%) had responded to the mandate by trying to get insurance, but were unable to find insurance they could afford. This may explain why only 31.5% of our uninsured sample thought the reform had been good for Massachusetts, compared to the support of 67% reported for unselected nonelderly adults surveyed state-wide, which

is more similar to the support for the reform we found among our privately insured patients (53.6%).⁴

The major limitation of our study is that the sample is drawn from a single safety-net ED. The uninsured are more likely to seek care in safety-net institutions, so this strategy allowed us to locate the uninsured efficiently, to obtain a high response rate, and to focus our investigation on persons actually requiring medical care. Moreover, our methods allowed us access to members of marginalized groups such as the homeless, the marginally housed, undocumented immigrants and linguistic minorities – groups that may be both unable to obtain health coverage and difficult to sample in phone, mail, and even neighborhood-based surveys. Comparison to neighborhood-based American Community Survey data on the uninsured in Massachusetts suggests that our ED-based sample may over-represent non-white and very poor (<150% FPL) individuals, but in terms of age, education level and employment status, does not differ significantly from the state's uninsured.¹⁷

Another limitation of our study is that it was conducted at a single point in time. This limits our ability to understand the temporal changes in factors contributing to uninsurance, something that is also important when setting policy designed to promote continuous coverage.

Our findings suggest that several modifications of health care reform in Massachusetts could further expand insurance coverage. Employer sponsored coverage could be expanded by increasing incentives for more employers to offer insurance to employees and by increasing the proportion of premiums employers pay for employees, which would increase the proportion of low-income employees who could afford their employer-sponsored insurance. Our study suggests that the state could reexamine the affordability guidelines for state subsidized insurance; reducing premium cost sharing for low-income residents would likely increase the proportion of eligible residents actually able to afford subsidized insurance. Reducing the stringency of the enrollment process could also increase the chances that low-income residents will obtain—and retain—insurance. Our study illustrates some of the ways in which a piecemeal insurance coverage system leads to persistent uninsurance. An alter-

native for Massachusetts would be to adopt a more comprehensive reform guaranteeing coverage to all residents without eligibility restrictions.

Although many thought the Massachusetts health reform would eliminate or substantially reduce the need for a safety net by providing universal insurance that could be used with any provider, our study shows that under the current reform, patients continue to fall through the cracks of the insurance system. Until the barriers to universal coverage that we identify here are addressed, safety-net hospitals will remain necessary in Massachusetts to provide care for those left uninsured who can be turned away from non-safety-net institutions. Safety-net institutions will continue to be an important source of care for undocumented immigrants who are explicitly left out of health care reform.

Whether such modifications are financially or politically feasible in the current political and fiscal climate is debatable. However, because the uninsured experience both worse health outcomes across a broad range of medical conditions as well as higher mortality,^{18,19} preventing residents from falling through the cracks of the reformed health coverage system should be a high priority.

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Corresponding Author: Rachel Nardin, MD; Department of Medicine, Cambridge Health Alliance, 1493 Cambridge St; Macht 420, Cambridge, MA 02139, USA (e-mail: rnardin@challiance.org).

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