The Massachusetts Journey to Expand Health Insurance Coverage

John Z. Ayanian, MD, MPP^{1,2,3}

¹Division of General Internal Medicine and Primary Care, Brigham and Women's Hospital and Harvard Medical School, Boston, MA, USA;

²Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; ³Department of Health Policy and Management, Harvard School of Public Health, Boston, MA, USA.

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In July 2006, Massachusetts launched an ambitious state plan to achieve near-universal insurance coverage. This plan took shape amid inaction by the federal government and most states that were failing to address the adverse financial and health consequences faced by uninsured Americans. With strong support from leaders in health care and faith-based organizations in Massachusetts, the Democratic legislature and Republican governor agreed on a hybrid reform plan with three major components.¹ First, additional federal funding has been used to provide Medicaid or fully subsidized private coverage for those with incomes below 150% of the federal poverty level. Second, a new insurance exchange, the Health Connector (www.mahealthconnector.org), has been created as an independent state agency to enroll residents with incomes between 150% and 300% of the federal poverty level in partially subsidized private insurance plans.² Third, for residents with higher incomes, the Health Connector has worked with insurers to facilitate enrollment in unsubsidized private plans.

The Massachusetts reform plan features an “individual mandate” previously proposed at the national level in 1989 by the conservative Heritage Foundation.³ This mandate requires people to enroll in health insurance if an affordable plan is available or face a financial penalty when filing state income taxes if they do not enroll. Massachusetts also levies modest financial assessments on employers with more than 10 employees that do not offer health insurance.

These new programs and policies in Massachusetts have been largely successful in expanding insurance coverage, particularly relative to the national trend in coverage. From 2006 through 2010 as the United States experienced a major economic recession, the number of non-elderly Americans lacking health insurance rose from 44.7 million (17.1%) to 49.1 million (18.4%). Massachusetts countered this national trend with a substantial decline in non-elderly residents who were uninsured from 602,000 (10.9%) to 356,000 (6.3%).⁴

Compared with the state's prior “free care pool” that limited low-income uninsured residents to obtain free care at a specific hospital and its closely affiliated ambulatory practices and pharmacy, newly insured Massachusetts residents are no longer tied to a single hospital and can seek care from a much wider selection of primary care physicians, specialists, hospi-

tals and pharmacies. Importantly, Massachusetts health care reform has retained the support of state residents by a three-to-one margin in a statewide survey conducted during May 2011.⁵

The Massachusetts approach to expanding insurance coverage might have remained a curiosity for the rest of the nation if not for the federal Affordable Care Act enacted by Congress and signed by President Obama in March, 2010. This controversial new law contains many central features of the hybrid approach to expand health insurance coverage that were first adopted in Massachusetts in 2006.^{6,7} Therefore, research to understand the strengths and limitations of Massachusetts health care reform can provide important insights as the Affordable Care Act is implemented by the federal and state governments and as the nation awaits a decision from the U.S. Supreme Court on the constitutionality of the federal mandate requiring individuals to obtain health insurance.⁸

In this issue of JGIM, Nardin et al. contribute to this understanding by assessing the reasons reported by patients why they remained uninsured 3 years after insurance coverage was expanded in Massachusetts.⁹ Over an 8-month period in late 2009 and early 2010, they surveyed over 400 non-elderly adults presenting to the emergency department of the state's only public hospital, including 189 uninsured patients. Strengths of their study included a commendable 78% response rate, a racially and ethnically diverse cohort that was surveyed in four different languages, detailed sociodemographic data obtained from survey respondents, and real-time verification of their insurance status at the time of study recruitment.

Nardin and her colleagues found that uninsured patients and those with subsidized private insurance (i.e. Commonwealth Care) were similarly likely to be employed (both 66%) for 40 or more hours per week (52% vs. 47%) and by firms with more than 10 employees (both 52%). They were also similarly likely to report fair or poor health (26% vs 29%) and at least one chronic medical condition (35% vs. 34%). Surprisingly, uninsured respondents were somewhat more likely to have self-reported incomes low enough to qualify for insurance coverage with no premium (68% vs. 61%) and equally likely to have somewhat higher incomes that would qualify them for subsidized coverage (both 23%).

With these comparable socioeconomic and clinical characteristics, what distinguished adults who remained uninsured from those who had subsidized coverage? Most importantly, Nardin et al. found that uninsured patients were much more likely than those with subsidized private insurance to be foreign-born (59% vs. 26%). The researchers did not ask respondents whether they were citizens or legal U.S. residents, but a sizable fraction of foreign-born adults in their cohort were probably recent or

undocumented immigrants and thus ineligible for Medicaid or subsidized private coverage. These factors will also preclude eligibility for Medicaid and subsidized private coverage nationally as the federal Affordable Care Act is implemented in 2014. Therefore, this study indicates that safety-net providers such as public hospitals and community health centers will remain essential as health-care providers of first and last resort for recent or undocumented immigrants who cannot afford to pay the full costs of their health care.

More than 40% of the 189 uninsured respondents in this study, however, were U.S. citizens or long-term legal residents and thus could have been eligible for free or subsidized coverage through the Health Connector. Two-thirds of the uninsured adults studied were either unemployed or working for small employers that were not required to offer health insurance. Although about half of these uninsured adults said they had tried to get insurance and could not afford it, many of them were likely eligible for Medicaid or fully subsidized private coverage based on their very low incomes. This inference underscores a major limitation of this observational study based solely on participants' perceptions of their ability to afford coverage.

Just as patients' with complex symptoms may not understand their diagnosis and potential treatments until they are carefully evaluated and advised by a physician, uninsured adults in this Massachusetts study may not have been fully aware of their eligibility for subsidized insurance coverage when they presented to the emergency department. In Massachusetts now and in other states as the Affordable Care Act expands coverage options in 2014, researchers and health care providers can go beyond asking uninsured patients why they lack coverage and evaluate steps to help them obtain and retain Medicaid or subsidized private coverage if they are eligible.

In fact, hospitals and community health centers in Massachusetts are already authorized to help uninsured patients enroll in these types of coverage through rapid eligibility assessments, but the effectiveness of these efforts is not well understood. By studying the process of "assisted enrollment" in health insurance for low-income residents and connecting them with primary care, research can advance beyond describing the deficiencies of health care reform to guide more effective enrollment and implementation of expanded insurance coverage. Furthermore, by studying the use of health services and outcomes of people who are newly insured and those who remain uninsured, such research can inform voters and federal and state policymakers about the value of expanding insurance coverage for those with low incomes who otherwise would remain uninsured. Prior research of this nature has helped to build public and political support for efforts to expand coverage in Massachusetts and the nation.

Before 2002, most research on the effects of lacking health insurance was based on observational studies¹⁰ that were often cross-sectional in nature.¹¹ These studies consistently demonstrated that uninsured Americans have worse health outcomes than those with insurance,^{12,13} with serious economic consequences for the nation.¹⁴ The conclusiveness of this evidence, however, has been challenged by some observers because unmeasured factors such as health beliefs or behaviors could account for the observed associations of insurance coverage with improved health outcomes.¹⁵

Over the past decade, much stronger evidence from quasi-experimental longitudinal studies has shown that health

insurance makes an important difference in improving people's health, particularly for those with low incomes or major chronic conditions such as cardiovascular disease or diabetes.^{16–18} Early findings from the ongoing evaluation of a randomized expansion of Medicaid coverage in Oregon are consistent with this growing body of more conclusive evidence on the consequences of lacking or gaining health insurance.^{19,20} The Oregon study also demonstrates the financial insecurity and related psychological toll faced by people with low incomes when they are unable to afford care or burdened by medical expenses.

As the nation prepares for results of the Presidential and Congressional elections of 2012 that may either affirm or undermine the federal Affordable Care Act, state efforts to achieve a more equitable and effective health care system will continue. Rigorous research to assess the limitations and strengths of these federal and state reforms will be needed to ensure that expansions of insurance coverage are implemented effectively and sustained with public support.

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Corresponding Author: John Z. Ayanian, MD, MPP; Department of Health Care Policy, Harvard Medical School, 180 Longwood Avenue, Boston, MA 02115, USA (e-mail: Ayanian@hcp.med.harvard.edu).

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