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Implementation of Massachusetts Health Insurance Reform with Vulnerable Populations in a Safety-net Setting

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Abstract

This qualitative study examines the experience of racial and ethnic minorities receiving behavioral health care in a safety net setting during the early process of health insurance reform in Massachusetts. Three rounds of interviews were conducted between August 2007 and May 2009, collecting information from patients (n=65) on the experience of health reform and delivery of mental health care. Four categories of enrollees transitioning into health reform emerged over the course of the study that grouped into a typology of experiences with reform: early enrollees, middle enrollees, late enrollees, and multiple switchers. With support, a majority of the sample transitioned smoothly to the new health insurance mechanisms. However, some experienced administrative confusion and disruption in mental health care during the transition. Administrative policies providing special accommodations for individuals with mental health disorders and other vulnerable populations may be important to consider during the transition to health insurance reform.

Keywords

Behavioral health; health reform; racial/ethnic minority; safety net; disparities; policy implementation

Individuals living in poverty, immigrants with limited English proficiency (LEP), racial and ethnic minorities, and uninsured people with multiple chronic health and behavioral health

disorders are disproportionately represented in safety net health care settings.¹ Implementation of new policies to improve the delivery of services in these settings may require extra initiatives for vulnerable populations during the initial transition. Health insurance reform in Massachusetts provides an important opportunity to examine how vulnerable populations experience this major change in policy and anticipate obstacles for similar populations as national health reform takes shape. The purpose of this study was to document the experience of this health policy change among a subset of racial/ethnic minority patients receiving behavioral health care in a safety net hospital system, applying qualitative research methods in health services research^{2,3} to better understand what this shift looks like from the perspective of these individuals.

Shifting the financing of health care coverage for the poor and near-poor from what was primarily an institutional responsibility held by community safety-net hospitals and clinics to a health insurance framework in which individuals are responsible for maintaining their coverage presents those implementing it with both challenges and opportunities. In particular, vulnerable populations may be at risk of gaps in care during times of health policy transition, due in part to poor understanding or dissemination of new administrative requirements (e.g., cost-sharing, eligibility rules).^{4,5} Automatic enrollment in public programs, which eliminates administrative responsibility on the part of the enrollee, has been found to have the greatest positive impact on take-up of eligible benefits,⁶ and administrative barriers are a primary reason that children churn on and off SCHIP coverage.^{7,8} Individuals from vulnerable populations may also fall prey to rumor and misinterpretation of public policies by others in their communities who are not fully informed (e.g., concerning deportation). A case in point occurred when the 1996 federal welfare reform law (Personal Responsibility and Work Opportunity Reconciliation Act) was enacted, and new immigrants were barred from receiving Medicaid coverage for the first five years in the country.⁹ Not only did enrollment rates of new immigrants drop, but rates also dropped for those who had been in the country for many years and were, in fact, still eligible for the program.¹⁰

Studies of statewide behavioral health policy change have documented the operational challenges of increased administrative requirements for the delivery of care in safety-net settings that often accompany policy changes.^{11–14} Racial and ethnic minorities in general, and immigrants in particular, have been found to have high rates of uninsurance compared with the U.S.-born non-Latino White population,^{15,16} due to a combination of linguistic barriers, citizenship status, and employment status (e.g., whether employers offer insurance for part-time workers).^{15,17} For people with mental health disorders, too, significant outreach efforts may be necessary from institutions and care providers in order to avoid disruptions in care.¹⁸ Approximately 20% of individuals with mental health disorders are uninsured and not covered by public insurance such as Medicaid.¹⁹

The introduction of health insurance reform and subsidized insurance packages in Massachusetts has led to a cutback in funds available for safety-net institutions where these vulnerable populations receive care, with some estimating that state subsidies to hospitals for treating uninsured have decreased by 50%.²⁰ Such shifts in funding place the onus of responsibility for maintaining continuity of care on individuals who must now purchase and

utilize health insurance, many of whom may never have had insurance before and may be unfamiliar with the requirements and processes necessary to obtain and maintain coverage (while this onus previously fell on safety-net institutions). A better understanding of how individual patients from vulnerable populations respond to these changes may help anticipate potential problems in this transition and ensure continuous care in this group during the policy shift. These patients are embedded in an interdependent framework that includes the care team, the organization and the policy/regulatory environment.^{21,22} Adjustments in financial incentives during periods of health system change affect all of these levels, and may have complex influences based upon interactions among them.²³ How an individual responds to shifting policies and incentives may vary according to personal characteristics, attitudes, and behaviors, as well as interactions with others embedded in these systems; qualitative research that focuses on individuals' behaviors and perceptions within a care system encourages a broader assessment of how the health services system operates on the ground.² Hence, this study focuses on the perspectives of previously uninsured individual patients embedded in a behavioral health care system at a safety-net hospital.

Health insurance reform in Massachusetts.

April 2006 marked the beginning of the Massachusetts health care reform. The law (Chapter 58) was signed with the goal of providing universal health care to all Massachusetts residents,²⁴ and requires all adults living in Massachusetts to obtain health insurance or else face a tax penalty. Overall, the reform has led to an increase in insured adults throughout the state. The 2009 rate of uninsurance in Massachusetts was 2.7%, virtually unchanged from the 2.67% estimate in 2008, and much lower than estimated rates prior to reform, which ranged from 6.4% to 10.4% depending upon the survey.²⁵

Chapter 58 led to many changes in how health care was financed for low-income individuals.²⁶ Many individuals living in poverty moved into the state's new subsidized insurance program, Commonwealth Care, which provides almost fully subsidized coverage for those below 150% of the federal poverty line (FPL), and a sliding-scale premium and cost-sharing through copayments for those from 150 to 300% of the FPL. Some transitioned into coverage through Massachusetts's Medicaid Program, MassHealth, which expanded its enrollment cap as part of the reform. Still others responded to the mandate by taking up private insurance benefits (e.g., Blue Cross/Blue Shield, Tufts Health Plan) through employer-based insurance coverage. Finally, some moved from the Free Care pool (or Uncompensated Care pool), a state-run program that previously provided funds to care for the uninsured that was eliminated during reform, to the Health Safety Net program, a fund that is provided for those who are not eligible for subsidized insurance coverage (often immigrants who do not have documentation of U.S. citizenship). Passage of the MassHealth Section 1115 Research and Demonstration Waiver in 2008 ensured continued federal support through FY 2011 of Chapter 58's coverage expansions, ensuring coverage for over one million low income children, families, and individuals through MassHealth and Commonwealth Care.²⁷

Eligibility rules for Commonwealth Care require that each applicant be assessed for citizenship status, as well as proof that they are not employed or that their employer does not offer adequate insurance coverage. Patients must also submit information to reauthorize their insurance coverage at least annually, and must reapply if there is a change in status (e.g., switching to a new job, getting married). These requirements are more extensive than the administrative processes that patients previously covered by Free Care (FC) followed. In addition, whereas prior management used to occur at the public health hospital itself and could be processed quickly, these eligibility processes are now centralized at the State Medicaid office. Massachusetts supported extensive training and provided high levels of assistance during the transition process.²⁸ Further, the Executive Office of Health and Human Services in Massachusetts also developed an on-line common application for all public services, including Commonwealth Care, that has streamlined the eligibility requirements. As of March 2010 more than half of all health assistance applications (58%) were submitted *via* this mechanism.²⁹

The purpose of this study was to examine how racial/ethnic minorities receiving behavioral health care in a single safety-net setting navigated the policy change during the early process of health insurance reform in Massachusetts. The goals were to identify the factors that facilitated implementation of the health insurance policy from the perspective of individuals who may be vulnerable to disruption in coverage, as well as those that might impede continuous insurance coverage following reform. We chose to study a population that represents a vulnerable population according to several criteria—racial/ethnic minority (many with LEP) and recent utilizers of behavioral health care services. Although those with mental health disorder are frequently eligible for public insurance programs, studies find that Medicare and Medicaid cover less than half of these individuals;¹⁹ hence, they represent an important group that may require extra accommodation during the policy transition. Three rounds of interviews were conducted between August 2007 and May 2009 with individuals belonging to racial and ethnic minority groups who had received mental health services subsidized through the Free Care Pool (FC) prior to health insurance reform. Through qualitative analysis of the experience of these individuals over three points in time, a typology of enrollee categories emerged from the data. These categories provide important blueprints for policymakers and planners to consider during the national insurance reform process.

Methods

We conducted a thematic analysis³⁰ of the open-ended data collected as part of a longitudinal study examining the experience of individuals undergoing health reform in a safety-net setting. A purposive sample was selected from patient encounter lists in two mental health outpatient clinics that served high numbers of racial and ethnic minority patients. We selected potential respondents according to three criteria. First, to ensure that we could capture the experience of the transition during the study period, we identified patients who had received services paid for by the Free Care Pool (FC) at some time between July 1, 2006 and September 30, 2007, well before the insurance mandate went into effect. Secondly, from this group, we identified patients who recorded at most one shift to a different insurance during this time period, in order to identify respondents who could

describe their initial experiences with the reform process and track subsequent changes in real time during the study period. We identified respondents from racial and ethnic minority groups according to administrative data records of race and language from two clinics, one that specialized in treating Latinos with mental health concerns (61% of our sample) and the other a general outpatient psychiatry clinic (39% of our sample). Both clinics were based in a safety-net hospital system that previously provided a large proportion of their care to individuals without insurance; in 2006, 28% of patients in the Latino-specific clinic and 26% in the general outpatient clinic received care through the FC pool. Lastly, to be included in the sample, respondents had to be traceable to a current address, to live in Massachusetts, and to have a working phone number.

Using these criteria, the research team sent 163 patients introductory letters, of which five were returned due to incorrect addresses. Out of the 158 who received the letters, 42 were not reachable by phone due to wrong number/number out of service or moving out of state, yielding a potential eligible survey sample of 116 patients. Sixty-six of these eligible respondents were interviewed at baseline for a response rate of 56.9%. We only attempted to follow-up individuals who were interviewed at baseline. Sixty-three respondents of these original 66 were re-interviewed at the second interview (follow-up one: FU1), and 53 of the original 66 respondents were interviewed at the third interview (follow-up two: FU2). In describing our study sample, we included all cases re-interviewed at least once at either FU1 or FU2 (n=65). For the qualitative analysis, we included all respondents except those whose only change was from FC to Health Safety Net. We conducted the qualitative analysis on this subsample (n=45) because our focus was on understanding typologies in the process of implementation of the health reform. The shift from FC to Health Safety Net was a change primarily in name only and did not affect coverage for this group during this timeframe. Half of the non-responders for follow-up two fell into this category.

The first telephone interview was conducted between August and December 2007, during reform but before the deadline for the tax penalty for those without insurance. The second phone interview was conducted at least six months later, between February and August 2008. The third telephone interview was conducted between November 2008 and May 2009. All interviews were audiotaped, and IRB approval was obtained through the Cambridge Health Alliance Office for Sponsored Research.

The semi-structured baseline interview instrument included open and close-ended questions in the following domains: health insurance coverage; information, knowledge and decision-making about health reform; process of switching to and from different insurance mechanisms; attitudes towards health insurance; access and delivery of health and mental health care; and demographic characteristics. In addition, there were two questions on functioning that asked whether the respondent had had to cut down on work or normal activities in the last 30 days, and whether the respondent was completely not able to work or carry out normal activities. The follow-up questionnaires included expanded questions on the support respondents received in the process of the health reform, as well as more extensive questions on the impact that the process may have had on their mental health care.

Interviewers were instructed to probe to clarify any confusing answers to the close-ended questions, particularly regarding the respondent's current insurance status, and to encourage detailed answers to the open-ended questions. Interviewers were carefully trained to take notes during the interviewing process, and record *verbatim* the responses to open-ended questions. In the event that the interviewer was not able to record the answers in real time during the interview, a note was made and the interviewer went back to the tape to record the information. Open-ended responses for the interviews conducted in Spanish were translated by the bilingual interviewers before analysis. Completed interviews were edited by an independent interviewer and questions about unclear or missing information were addressed. Continuous quality checks occurred over the course of the project during bi-weekly interviewer meetings, where protocols and questions were reviewed. In addition, 10% of the interviews were randomly selected and formally checked by an independent research assistant for quality control. The research assistant listened to the original tape, checked the interviewers' responses and evaluated each interview according to seven criteria; the interview quality was assessed to be good-to-excellent across all the interviews checked.

Analysis.

We conducted our thematic analyses using a matrix approach,³⁰ and consisting of two components. First, we conducted within-subject analyses whereby every respondent who switched into a new insurance program was reviewed, basic demographic characteristics and insurance patterns were summarized, and the open-ended data were extracted. We organized all open-ended data by respondent across the three interview time points according to four *a priori* domains: administrative issues; support with insurance shifts; medical and mental health needs; and attitudes/values regarding insurance. Descriptive responses to these relevant open-ended questions were summarized in a table, and individuals who expressed positive experiences as well as distress due to the changes in their health insurance coverage were noted.

We then grouped the respondents into four enrollee categories that began to emerge based on their insurance transitions during the within-subject analysis: 1) one insurance switch before baseline without a subsequent switch at either follow-up interview (FU1 or FU2); 2) one insurance switch reported at the first follow-up (FU1), without a subsequent shift at the second follow-up (FU2); 3) one insurance switch reported at the second follow-up only (FU2); and 4) multiple insurance switches throughout the interview period. Data were then analyzed across these four categories and compared with each other to develop a typology of stages of enrollment. Categories were analyzed and re-grouped as necessary until a coherent typology appeared. These analyses were conducted first by the lead author, and then reviewed with the research team in multiple meetings to check interpretation and confirm the face validity of the experiences that were emerging and the grouping of the categories.

To inform this analysis, we also conducted independent confirmatory coding to identify those respondents who experienced particular problems receiving mental health care during the health reform implementation process. Studies have found that people with mental health disorders, and other vulnerable populations, adjust their health care behavior in response to cost-sharing, often in ways that have negative effects on receipt of appropriate care;³¹ other

evidence suggests that individuals with mental health disorders who experience an increase in medication copayments may discontinue other medications for physical health disorders to offset the cost increase.³² We wanted to highlight qualitatively the potential tradeoffs that respondents in our study were making regarding their health care choices during reform. Hence, in the absence of a clinical gold standard to identify need, we carefully coded each respondent to assess their experience of mental health service delivery during this period of reform.

Two independent coders reviewed all open and closed-ended questions and coded each case according to two criteria: 1) respondent expressed difficulty with the process of the insurance reform (e.g., increase in paperwork, poor understanding of insurance coverage, communication problems regarding change, disruptions in insurance coverage during this time) and 2) respondent reported that he or she experienced disruption or concern regarding mental health care (e.g., cut back on the mental health care without saying s/he wanted to do so, experienced difficulty paying for mental health care). Simply cutting back on health care because they did not want to go any more did not satisfy the criteria for cutting back on needed mental health care. Respondents where both coders indicated a positive code for both conditions were reviewed for consistency and coded as an *identified case*, which we defined using qualitative terminology as a respondent who represents a particular phenomenon of interest,^{33,34} namely one who experienced problems with both administrative processes and mental health care delivery during reform. In cases where the coders disagreed, the lead author reviewed each discordant case according to the definitions above, reconciled differences between the two, and then discussed the outcome with at least one other research assistant for confirmation.

Results

Descriptive findings.

The sample was mostly female, low-income, and immigrant (see Table 1). Over half the sample (60.0%, n=39) was Spanish-speaking or mostly Spanish-speaking, and three quarters were Latino (75.4%, n=49). Although about half reported at least some college education (47.3%, n=18), 83.1% (n=54) reported an income of less than \$10,000 in the previous six-month period. The group was unstable in terms of work status, with 41.5% (n=27) changing their work situation in some way in the period before the final interview. Almost 30% of the sample (n=18) was an *identified case* according to the criteria described above, meaning they reported both administrative difficulties with reform and had to cut back on needed mental health services during this time.

The cases fell into one of three categories. A little less than a third of the cases remained on Free Care/Health Safety Net during the entire study period (FC only, n=20). Forty percent switched one time during the course of the study, but remained stable on that insurance once they switched (n=26), although these switches occurred during different time frames: a) cases that switched off of FC to a new insurance before baseline (early enrollees, n=8); b) cases that switched at the first follow-up (middle enrollees, n=9); and c) cases that switched at the second follow-up (late enrollees, n=9). The final category reported at least two

switches across insurance categories during the study period, including reporting insurance gaps during the time frame (multiple switchers, n=19, 29%).

Coding for identified cases was conducted after both the second and third interview. This process resulted in a total of 18 cases over the entire time frame that experienced problems with mental health care delivery during insurance reform (see Table 1): eight at the first follow-up only, five at the second follow-up only, and five at both follow-up interviews. By far the greatest proportion of cases that experienced disruption in mental health care and difficulties with insurance reform fell in the multiple switcher category (n=12).

Typology of enrollment.

From our subsample of respondents who switched into insurance coverage during the study period, we developed a typology of characteristics for their experiences with this transition. In particular, we focused on *a priori* thematic categories that we thought could illuminate an individual's risk of disruption in their health insurance coverage and subsequent disruptions in mental health care during health insurance reform—administrative difficulties with the reform, support during the transition, health and mental health needs, and attitudes towards insurance (see Box 1). The typology consisted of five categories: early enrollees, middle enrollees, late enrollees, and two categories of multiple switchers, which were split into Group 1 and Group 2 for the purposes of the analysis.

Early enrollees.—The early enrollees of the health reform (n=8) reported already having switched into a different insurance before baseline, and remained stable with that insurance throughout the study period. Six were immigrant Latino, and five were Spanish-speaking. Four attended some college and the rest attended some high school. Only two in this group fell into the bottom income category, reporting less than \$5,000 income in the previous six months.

Across the board, these cases reported smooth transitions into Commonwealth Care category (CC) (n=5), private insurance (n=2), and MassHealth (n=1), sometimes reporting that they were switched automatically. Four out of the five CC cases transitioned into the fully subsidized CC program, reporting that clinic administrators called CC and helped facilitate the switches. Individuals in this category also reported getting help from hospital administrators, doctors, spouses, and a priest, while only a single case reported talking with a mental health provider about the insurance reform.

Most of the cases in this category reported no administrative difficulties with the transition. A few mentioned increased cost, late payment charges and paperwork with the new insurance policies, but this did not influence their positive attitude towards the insurance reform. One case mentioned that she wished the insurance office was not so far away so she did not have to communicate with them by phone. Overall, people in this category were extremely pleased with the administrative components of the new insurance plans.

Across the board, the early enrollees expressed high levels of satisfaction with the care they were receiving. The vast majority (n=6) were receiving regular mental health care all or some of the time, and those who cut back on mental health during the reform process did not

express distress about it. Most individuals in this category reported chronic mental health and physical health conditions, but reported not being in crisis. The only consistent complaint in this group concerned lack of coverage for dental care, but they were otherwise satisfied with their health and mental health care.

Attitudes about the reform in Massachusetts were positive in this group across all three interviews. The cases in this group valued insurance, with many emphasizing the importance of insurance, and they felt that being insured cost more but was worth the tradeoffs. A few had heard about the mandate, but this did not seem to factor into their decision-making about insurance. Overall, this group seemed to shift smoothly off FC onto insurance coverage, as they were receiving regular, continuous health and mental health care, and clinic personnel told them they had to change and helped manage the shift.

Middle enrollees.—Middle enrollees (n=9) were cases who were still on Free Care at baseline, but reported switching into an insurance category at the first follow-up and remaining on that one insurance. Eight were immigrants, with seven Spanish-speaking Latinos. The highest proportion of cases fell into the poorest income category, with seven earning less than \$5,000 in the previous six months. Five had less than a college education.

This group reported initial confusion about the insurance reform at the baseline interview. Some had not heard about the reform, whereas others reported hearing about it but not getting good information. A few expressed concern about the different plans and costs of Commonwealth Care (CC), not understanding CC or already trying to get CC and not getting it. By the second interview, this group had transitioned to insurance (four to CC, four to public insurance, and one to private). For most of these cases, the switch was supported by administrators in the clinic, and a number of individuals reported being automatically shifted (e.g., receiving a letter or a card saying they had a new insurance, not needing to fill out any paperwork). About half the cases in this category reported speaking about it with their mental health providers, or described help from PCPs and social workers in reading and filling out the forms.

Eight of the nine cases in this category were receiving mental health care throughout the period, and most expressed being extremely satisfied with the care received during the reform. Only a single case expressed any distress about the reform; she reported cutting back on seeing her psychologist due to the expense and concern about copayment charges. However, despite having to cut back on visits to her mental health provider, this case also expressed pride in not cutting back on medications, saying that she made an effort and looked for sales. By the final interview, she reported that the quality of health care under CC was good. She stated at one point, “Now I can demand since I pay,” suggesting she acquired personal agency over her care from purchasing her insurance, rather than relying on Free Care.

Like the early enrollees, this group also supported the reform and valued insurance. In contrast to the early enrollees, however, most in this group knew about the mandate and expressed worry about it. Additionally, in this category, respondents started to discuss the pros and cons of the insurance shift, some describing how much better it is to be able to get

medications anywhere rather than just at the safety-net clinic, and others mentioning the advantages of having better access to specialists. Such comments provided some evidence of the personal cost/benefit analyses that these new enrollees in insurance policies were practicing.

Late enrollees.—The cases in this late enrollees category (n=9) were individuals who waited until the Free Care plan ran out without making a change. Eight were immigrant, Spanish-speaking Latinos, representing the highest proportion of LEPs across all categories. Most of this group (n=7) fell into the middle income category (\$5,000 to \$9,999 in the last six months) and five reported either some college or having graduated from college. Hence, many in this group fell outside the income requirements for the fully subsidized CC plan.

Everyone in the late enrollees category expressed high levels of confusion about the insurance change, and concerns about eligibility and payment even at the first interview. Most expressed a strong preference for the FC program. In contrast to the first two categories, none of the respondents here reported being automatically switched. Four of the cases eventually switched into private insurance, either through employment or through their spouses' insurance plan. Three joined CC by the final interview, and in all three cases the switch was primarily facilitated by either a mental health or primary care provider, with their providers calling them and helping them with the applications. Once they switched, most in this category reported satisfaction with the experience, although one case had to cut back on mental health visits, required a lot of help from her mental health provider filling out forms, and was in distress about this. Two cases in this group had just lost FC at the time of the second follow-up and had not yet figured out how to find insurance to take its place.

Although this group reported a great deal of confusion about the reform, and had the highest proportion of Spanish or mostly Spanish-speaking people, they also appeared to be less constrained by mental health and general health issues compared to the other categories. Only half was currently in mental health care, and few discussed co-occurring physical health concerns. The few who reported having to cut back in mental health care did not express distress about it, suggesting low illness severity.

In contrast to the earlier groups, a number of the late enrollees were openly opposed to or did not know what they thought about the insurance reform, though there was transition over time in their attitudes. Many in this group had heard of the mandate and the penalty, but did not express being worried about that. In fact, almost half thought they were complying with the mandate in the first and second interviews because they were on FC. Some expressed that they did not go to the doctor often, and were not willing to pay for insurance if they were not going to see a doctor. However, all but one of the respondents in this group supported reform by the end of the study period.

Multiple switchers.—The final category included respondents who had multiple different insurance coverage types over the course of the study period. There were 19 cases that fell into this final category, by far the largest category of those who switched out of Free Care. Only five in this group reported speaking only or mostly Spanish, although 11 were Latino and 14 were immigrants. This group had the highest proportion of individuals who were

either college graduates or reported some college (n=11), and the highest proportion of individuals who reported making \$10,000 or more in the previous six months (n=6). This group also had the highest proportion of women (n=16).

This category was split into two groups for the purposes of our typology (see Box 1). Group 1 (n=8) experienced multiple shifts across the study time frame, but with no gaps in coverage and smooth transitions across the insurance categories. Group 2 (n=11) experienced multiple gaps in insurance coverage over the time period, were forced to cut back on mental health care and expressed high levels of distress due to these transitions.

Those in Group 1 reported being employed, having spouses who helped with insurance coverage, or were students and able to join their school plans. About half reported currently being in some mental health care, and only a single case reported co-occurring physical health problems. Most complained about the cost of their insurance and not always being able to pay their bills. For the most part, this group was doing well, despite the fact that they shifted across several different insurance coverage types during the time period.

The respondents in Group 2, however, experienced gaps that disrupted their receipt of mental health services. Eight respondents in this subcategory were on the sliding scale CC plan at some point during the study period, requiring these respondents to pay premiums and copayments. Many of the stories involved problems with administrative components of moving into the plan as well as difficulties due to cost: a) not realizing that one had to wait for the card before coverage started; b) not understanding the reauthorization process, in which the individual must re-apply yearly for CC; c) being denied CC suddenly because respondent got married, and the office thought he had an income; d) experiencing a change in income and being told she needed to apply for CC again; e) missing a few premium bills and being bumped off the insurance; and f) being put on a plan where the premium was too high from the outset. Whereas many of the respondents in the other groups of our typology reported receiving administrative supports, the individuals in this group either did not receive or could not utilize these supports.

The interaction of these administrative problems with the continuity of their mental health care was both negative and distressing. Everyone who had gaps in their coverage described having to cut back on their mental health coverage, and almost everyone reported high levels of distress about it. Respondents articulated the link between the administrative headaches of the health reform and their difficulty in maintaining and managing their mental health symptoms. A *verbatim* transcription from one respondent provides insight into this dynamic:

They say that all the time ... residents must have a health insurance that's all everybody hears ... that I know. That's it. So what? What's the first step? How to start? I never got orientation about this. All came from the mail and I have to read the information, keep asking, calling it, miscommunication, one says one thing ... another says another ... until you get so stressed out and you didn't get help from stressed out because you can't afford the co-payment every week

Every case in distress in this category reported that the insurance switching and gaps had led to cutbacks in their mental health care. These respondents also described high levels of

comorbidity with physical health concerns that limited the amount of money they could afford to pay for mental health copayments. About half of this group discussed in some detail having to ration their medications by cutting back on the least important ones, or not taking medications for depression at all. One respondent described this experience in the following way:

I haven't been able to go to my appointments because the cost of the appointments is very expensive. So that's why I've cancelled them until I can get some kind of insurance. And I can't buy my medicine at a lower price, because there are three of them and they're expensive. ... Right now it's been about four days that I have been without my medicine. ... The one I take during the day is the most important so that I don't fall into depression again, or to feel bad. So that's the most urgent one to buy.

The co-payments and the out-of-pocket costs for those who had experienced a gap in their insurance coverage had a dramatic effect on the ability of this group to maintain treatment and stay in care.

A striking factor for this most constrained group was the lack of support described in maneuvering the insurance landscape in comparison to the earlier categories. Many described hearing about the CC only through a letter in the mail, and only a few mentioned talking with a mental health provider about it. A marked difference here was also the lack of description of clinic administrators or health providers helping to make phone calls, filling out forms, and facilitating the insurance process. Although a few complained about lack of information in Spanish, interestingly there were a greater number of English-speakers than Spanish-speakers in this category.

Despite the differences between Groups 1 and 2 in the multiple switchers category depending upon whether the switches were smooth or whether there were gaps in coverage, everyone in this group expressed negative attitudes about insurance coverage overall. Many felt that they were forced to get coverage, that it was not a choice, and opposed the reform. Many also expressed knowledge and concern about the effect of the mandate. A theme in the multiple switchers group, in contrast to the other categories, was that parts of the insurance coverage were not "fair." For example, issues about immigrants and their coverage were raised, with some saying that it was not fair that immigrants were not covered, and others that it was not fair that undocumented immigrants could get cheaper insurance coverage through the Health Safety Net than people on CC. Some expressed the view that insurance was not good value for the money, since they did not go to the doctor very much and were only getting it because they were required by law. Although a handful of people did support reform throughout, the majority expressed much lower value and more complaints with the reform process than in any other group.

Discussion

This qualitative analysis and typology of the stages of enrollment in the health insurance reform at a safety-net hospital system in Massachusetts finds that for most of the patients in our purposive sample, the process of transition out of a Free Care mechanism into a health

insurance mechanism was smooth. Massachusetts subsidized the transition to health insurance reform significantly with extensive outreach and education.³⁵ These efforts included a health Care Reform Outreach and Education Unit through the Office of Medicaid to coordinate state activities, joint training sessions for community outreach and enrollment workers through MassHealth and the Health Connector, \$11.5 million in grants for community groups to provide outreach and education, and an extensive statewide communications plan.²⁸ However, in some cases, despite this supportive climate, some patients in this qualitative study struggled with the reform. It is important to note that this group represents only one sixth of the entire study sample, and that in most cases the supports and administrative processes sufficed to support the participants in this study during the transition. However, for this vulnerable subset, our study illustrates the indicators at an individual level that are important to assess, and suggests potential interactions with clinic characteristics, organizational structure and the policy/regulatory environment that should be closely monitored during the health policy transition.

Individual attitudes, while difficult to disentangle from the levels of support received within the clinic, were an important component of the transition. Those patients who were generally supportive of the notion of insurance coverage switched earlier in the process of the reform, whereas respondents who made a late but successful switch also shifted their attitudes more positively towards the insurance reform over time. Thus, it seems important to address individual attitudes and values as part of educating uninsured individuals for timely enrollment in the new health insurance initiatives.³⁶ Social marketing strategies targeting those who are skeptical of the value of insurance may be a useful adjunct to general education about the health insurance reform.³⁷

How the individual responded to the reform was embedded in the *experiences in the clinic* in which he or she received care. For example, respondents reported that facilitation of the enrollment process by clinic administrators in the early stages of reform and institutional support was critical for those who transitioned into public programs or the fully subsidized CC program. Further, all the respondents in higher-income categories who successfully moved into the CC program that required premium payments and cost-sharing reported assistance from their mental health and health care providers in supporting their transition. Despite the fact that around 50% of the individuals in three out of the four categories had at least some college, education on its own did not buffer general confusion about the transition. This need for support during the transition suggests that mental health providers who serve individuals with chronic mental health conditions such as depression and anxiety may need to know the details of health insurance reform. Providing support may include filling out forms and explaining the rules of health insurance coverage during the clinical encounter.

The *safety-net organization* where the study took place had previously provided ready access to health and mental health care without cost sharing *via* a Free Care program and experienced significant transition over the course of this study in its financing mechanisms. Despite efforts to protect care for their patients during the transition, patients in this setting necessarily experienced a shift in their delivery of care. It is possible that despite the organization's best efforts, the fact that the institution previously provided such a high

proportion of Free Care could have interacted with individual level attitudes such that these respondents were more negative about the policy change than they would have been in other settings where care for the uninsured was previously more limited. This possibility seems unlikely given that many respondents reported being pleased with the increased level of choice at an organizational level provided by the insurance reform, allowing more visits to specialists as well as flexibility in where to obtain their prescription medications.

On the other hand, the fact that the organization supported a clinic targeting Latinos may have actually influenced patient attitudes positively. This option is perhaps more likely, given that the multiple switcher category that experienced the highest degree of distress had fewer Spanish-speaking respondents than any of the other categories. Although some of the Spanish-speakers delayed taking up the insurance in the first place, the fact that fewer fell into the multiple switcher category may have been due to organizational support for ethnic specific clinics, and strong administrative functions and clinician supports in Spanish that enabled continuity of care despite the increased administrative burden of the insurance mechanism. A limitation of this study is that we were not able to collect these data at the clinic level to confirm this hypothesis.

Despite primarily positive experiences during the transition, at the level of the *policy environment*, our results do provide some cautionary tales to consider during the national health reform process. One sixth of our respondents (n=11) experienced a lot of difficulty maintaining continuous insurance coverage and reported significant distress and difficulty maintaining what appeared to be necessary mental health care. These individuals did not report benefiting from the institutional supports in the same way that buffered the other respondents. Many reported multiple co-occurring physical health conditions in addition to their chronic mental health concerns, and were almost universally on the CC program that required premiums and copayments for visits. Numerous studies have demonstrated that for those with great clinical need, cost-containment strategies can lead to self-rationing of care.³⁸ The burden of copayments for those who have multiple health and mental health concerns is a barrier to antidepressant medication use,³⁹ and cost-sharing for prescription medications in general has potentially serious consequences for those in lower-income groups.⁴⁰ Although Massachusetts has a yearly cap on the copayment amounts, individuals' monthly budgets may not be able to sustain the cost of necessary copayments in a single month, still leading to self-rationing of care. Further, the administrative processes for determining when copayment ceilings are reached depend upon the patient keeping track of the information and filing the request, which may be burdensome for patients with comorbid conditions.

In our study, the respondents who had the most difficulty meeting copayments and expressed the greatest confusion with the administrative insurance processes also cut back on their medications and mental health care in the midst of insurance gaps. An important contribution of this study is the in-depth look at what churning on and off insurance actually looks like to the individuals who experience it. Individuals who are struggling with high copayment levels or having trouble with authorization processes may continue to simply ration care rather than track their copayments, especially without support in managing these administrative processes. A recent report outlining barriers that Latinos have experienced during the transition to health reform in Massachusetts suggests that decision-making about

cost primarily focused on premium costs, without sufficient attention to the impact of higher copayments in the lower premium plans.⁴¹ Several respondents in that study selected low premiums and then were unable to meet the copayment requirements given their multiple chronic conditions. Consideration of trade-offs and coaching about the costs and benefits of the different plans may be critical to successful transition to an insurance mechanism for low-income individuals with multiple health and mental health concerns.

An important limitation of this study is that it did not include an objective measure of mental health functioning. Hence, expressions of distress were based purely on self-report, and we cannot determine whether these respondents were objectively in need of mental health care, or simply had a difficult time adjusting to the shifts required by the insurance reform. In addition, it is difficult to pull apart how much of the stress about the administrative components of reform influenced the mental health concerns of the respondent, or how much the respondent's mental health concerns exacerbated the administrative complexity of reform. Certainly, there was some relationship between experiencing gaps in insurance coverage during the transition period and respondents cutting back on what they considered necessary mental health care.

Given the advent of health insurance reform on the national stage, this study suggests that attention to the interactions of individual level needs of vulnerable populations with multiple levels of the health care environment during the implementation process is necessary. Such approaches can provide important information to health care administrators on the ground who are preparing to implement these reforms. For example, states that are planning to shift resources away from coverage of free care in safety-net settings to fund subsidies for low-income people to purchase insurance may need to consider the level of resources provided for administrative functions in safety-net clinics to monitor the implementation process, particularly for those whose characteristics are similar to the multiple switcher category in our typology. Our results document the administrative problems that the multiple switchers encountered, including problems with reauthorizations, missing payments for premium bills and signing up for the wrong plan to start. Potential strategies to avoid these gaps in coverage might include extra support by a case manager during the transition to health insurance or financing strategies that could spread copayment costs over a greater period of time.

Further, although we recognize that our analytic categories in Box 1 were identified *post hoc*, clinics could use these factors to develop a checklist to assess patients ahead of the rollout in the areas we considered in this study (e.g., negative attitudes toward reform, multiple health and mental health concerns, lack of communication with health care personnel about the insurance reform). In this way, personnel might identify individuals at greatest risk for disruption in insurance coverage early in the process, and target resources for support towards these individuals. Future studies of the health reform should examine in more detail the interactions among individuals, care teams, organizations and the regulatory environment; in-depth data collection and ethnographic observations in the clinic and the safety-net organization will enable researchers to describe these relationships and the differing impact of policy changes across these levels. In particular, future studies that consider the effects of different outreach and education strategies are needed.

During the ongoing national health reform, special attention to the needs of vulnerable populations may help encourage a smooth transition away from health care provided for free in safety-net and emergency settings to that delivered through a health insurance mechanism.⁴² Our study suggests that consideration of administrative supports in safety-net institutions may be important to avoid gaps in needed care during health reform.⁴³ Increasing access to health care in the aggregate, a goal of health insurance reform, is a different objective than the goal of reducing disparities within a population, and may sometimes be in conflict.⁴⁴ It is important to proceed with care, protecting the health care safety net in the process of making these policy transitions,^{28,43,45,46} and taking steps to ensure that health insurance reform is implemented in ways that also pay attention to overarching goals to reduce health disparities for vulnerable populations.^{47,48}

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Notes

1. Davidson PL, Andersen RM, Wyn R, et al. A framework for evaluating safety-net and other community-level factors on access for low-income populations. *Inquiry*. 2004 Spring;41(1):21–38.
2. Hoff TJ. Toward a culture of qualitative thinking in health services research. *Med Care Res Rev*. 2011 2;68(1):49–55. Epub 2010 Oct 1. [PubMed: 20889575]
3. Cunningham PJ, Felland LE, Ginsburg PB, et al. Qualitative methods: a crucial tool for understanding changes in health systems and health care delivery. *Med Care Res Rev*. 2011 2;68(1):34–40. Epub 2010 Nov 11. [PubMed: 21075752]
4. Ackerson LK, Viswanath K. The social context of interpersonal communication and health. *J Health Commun*. 2009;14 Suppl 1:5–17. [PubMed: 19449264]
5. Dutta MJ, King AJ. Communication choices of the uninsured: implications for health marketing. *Health Mark Q*. 2008;25(1–2):97–118. [PubMed: 18935881]
6. Remler DK, Glied SA. What other programs can teach us: increasing participation in health insurance programs. *Am J Public Health*. 2003 1;93(1):67–74. [PubMed: 12511389]
7. Sommers BD. Why millions of children eligible for Medicaid and SCHIP are uninsured: poor retention versus poor take-up. *Health Affairs (Millwood)*. 2007 Sep-Oct;26(5):w560–7. Epub 2007 Jul 26.
8. Wolfe B, Scrivner S. The devil may be in the details: how the characteristics of SCHIP programs affect take up. *J Policy Anal Manage*. 2005 Summer;24(3):499–522. [PubMed: 15973794]
9. Ku L, Matani S. Left out: immigrants' access to health care and insurance. *Health Affairs (Millwood)*. 2001 Jan-Feb;20(1):247–56.
10. Kandula NR, Kersey M, Lurie N. Assuring the health of immigrants: what the leading health indicators tell us. *Annu Rev Public Health*. 2004;25:357–76. [PubMed: 15015925]
11. Arfken CL, Zeman LL, Koch A. Perceived impact by administrators of psychiatric emergency services after changes in a state's mental health system. *Community Ment Health J*. 2006 6;42(3):281–90. [PubMed: 16683184]
12. Horton S. The double burden on safety net providers: placing health disparities in the context of the privatization of health care in the U.S. *Soc Sci Med*. 2006 11; 63(10):2702–14. Epub 2006 Sep 5. [PubMed: 16908090]
13. Willging C, Wagner W, Waitzkin H. Medicaid managed care for mental health services in a rural state. *J Health Care Poor Underserved*. 2005 8;16(3):497–514. [PubMed: 16118839]

14. Willging CE, Waitzkin H, Lamphere L. Transforming administrative and clinical practice in a public behavioral health system: an ethnographic assessment of the context of change. *J Health Care Poor Underserved*. 2009 8;20(3):866–83. [PubMed: 19648713]
15. Alegria M, Cao Z, McGuire TG, et al. Health insurance coverage for vulnerable populations: contrasting Asian Americans and Latinos in the United States. *Inquiry*. 2006 Fall;43(3):231–54. [PubMed: 17176967]
16. Derose KP, Escarce JJ, Lurie N. Immigrants and health care: sources of vulnerability. *Health Affairs (Millwood)*. 2007 Sep-Oct;26(5):1258–68.
17. Ku L, Waidmann T. How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, 2003.
18. Ware NC, Tugenberg T, Dickey B, et al. An ethnographic study of the meaning of continuity of care in mental health services. *Psychiatr Serv*. 1999 3;50(3):395–400. [PubMed: 10096646]
19. McAlpine DD, Mechanic D. Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk. *Health Serv Res*. 2000 4;35(1 Pt 2):277–92. [PubMed: 10778815]
20. Vesely R Massachusetts safety net frays: insurance mandate costly for providers. *Modern Healthcare*. 2008;38(12):12.
21. Ferlie WB, Shortell SM. Improving quality of health care in the United Kingdom and the United States: a framework for change. *Milbank Q*. 2001;79(2):281–315. [PubMed: 11439467]
22. National Academy of Engineering and Institute of Medicine. A framework for a systems approach to health care delivery In: Reid PP, Compton WD, Grossman JH, et al., eds. *Building a better delivery system: a new engineering/health care partnership*. Washington, DC: National Academies Press, 2005.
23. Shortell SM. Increasing value: a research agenda for addressing the managerial and organizational challenges facing health care delivery in the United States. *Med Care Res Rev*. 2004 9; 61(3 Suppl):12S–30S. [PubMed: 15375281]
24. Long SK. On the road to universal coverage: impacts of reform in Massachusetts at one year. *Health Affairs (Millwood)*. 2008 Jul-Aug;27(4):w270–84. Epub 2008 Jun 3.
25. Long SK, Stockley K. Sustaining health reform in a recession: an update on Massachusetts as of fall 2009. *Health Affairs (Millwood)*. 2010 6;29(6):1234–41.
26. Doonan MT, Tull KR. Health care reform in Massachusetts: implementation of coverage expansions and a health insurance mandate. *Milbank Q*. 2010 3;88(1):54–80. [PubMed: 20377758]
27. Anthony S, Seifert RW, Sullivan JC. *The MassHealth waiver: 2009–2011 ... and beyond*. Worcester, MA: University of Massachusetts Medical School, 2009.
28. Raymond AG. *Lessons from the implementation of Massachusetts Health Reform*. Boston, MA: Foundation Massachusetts, 2011.
29. Commonwealth of Massachusetts. *EOHHS virtual gateway: health insurance and health assistance programs*. Boston, MA: Commonwealth of Massachusetts, 2011.
30. Ryan GW, Bernard HR. Techniques to identify themes. *Field Methods*. 2003;15(1): 85–109.
31. Care AJM. Impact of copays on vulnerable population. *Am J Managed Care*. 2006 11;12(13 Suppl):S359–63.
32. Goldman DP, Joyce GF, Escarce JJ, et al. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA*. 2004 5;291(19):2344–50. [PubMed: 15150206]
33. Baxter P, Jack S. Qualitative case study methodology. *The Qualitative Report*. 2008 12;13(4):544–59.
34. Creswell JW. *Qualitative inquiry and research design*. Thousand Oaks, CA: Sage Publications, 2007.
35. McDonough JE, Rosman B, Butt M, et al. Massachusetts health reform implementation: major progress and future challenges. *Health Affairs (Millwood)*. 2008 Jul-Aug;27(4):w285–97. Epub 2008 Jun 3.
36. Jacobs LR, Shapiro RY. Questioning the conventional wisdom on public opinion toward health reform. *Political Science and Politics*. 1994 6;27(2):208–14.

37. Randolph W, Viswanath K. Lessons learned from public health mass media campaigns: marketing health in a crowded media world. *Annu Rev Public Health*. 2004;25:419–37. [PubMed: 15015928]
38. Stone D The false promise of consumer choice In: Rich RF, Erb CT, eds. *Consumer choice: social welfare and health policy*. New Brunswick, NJ: Transaction Publishers, 2005.
39. Wang PS, Patrick AR, Dormuth CR, et al. The impact of cost sharing on antidepressant use among older adults in British Columbia. *Psychiatr Serv*. 2008 4;59(4):377–83. [PubMed: 18378836]
40. Tamblyn R, Laprise R, Hanley JA, et al. Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *JAMA*. 2001 1 24–31;285(4):421–9. [PubMed: 11242426]
41. Cortes D “No one asked me”: Latinos’ experiences with Massachusetts health care reform. Boston, MA: Robert Wood Johnson Foundation, 2010.
42. McGuire TG, Sinaiko AD. Regulating a health insurance exchange: implications for individuals with mental illness. *Psychiatr Serv*. 2010 11;61(11):1074–80. [PubMed: 21041344]
43. Hall MA. Rethinking safety net access for the uninsured. *New Engl J Med*. 2011 1 6;364(1):7–9. Epub 2010 Dec 29. [PubMed: 21190449]
44. Disadvantage Mechanic D., inequality, and social policy. *Health Affairs (Millwood)*. 2002 Mar-Apr;21(2):48–59.
45. Hall MA. After insurance reform an adequate safety net can bring us to universal coverage. *Hastings Cent Rep*. 2009 Nov-Dec;39(6):9–10.
46. Redlener I, Grant R. America’s safety net and health care reform—what lies ahead? *New Engl J Med*. 2009 12 3;361(23):2201–4. [PubMed: 19955523]
47. Carrasquillo O, Betancourt J. Massachusetts health disparities: key lessons for the nation. *J Gen Intern Med*. 2010 12;25(12):1266–7. [PubMed: 20957446]
48. Zhu J, Brawarsky P, Lipsitz S, et al. Massachusetts health reform and disparities in coverage, access and health status. *J Gen Intern Med*. 2010 12;25(12):1356–62. Epub 2010 Aug 21. [PubMed: 20730503]

Box 1.
TPOLOGY OF ENROLLMENT IN HEALTH REFORM

	Early Enrollees (N = 8)	Top Enrollees (N = 9)	Late Enrollees (N = 9)	Multiple Switchers Group 1 (N = 8)	Multiple Switchers Group 2 (N = 11)
Administrative difficulties	Few concerns about process of the insurance reform.	Expressions of reticence at baseline about the reform; worried about cost and did not understand components of the reform.	Waited till FC had run out; confusion expressed both at baseline and FU1 about cost, eligibility due to documentation, what is covered. Eight out of nine were immigrant and Spanish speaking all or most of the time.	Complained about cost, and not being able to pay bills; were not confused about administrative details of the reform.	Extraordinary difficulties with administrative factors. Experienced gaps and discontinuation in coverage that affected continuity of care.
Support with the transition	Automatically switched by hospital and clinic administrators. Reported help from spouses, doctors and a priest.	Many switched automatically by clinic administrators but also mention PCP and MH providers helping with the switch as well.	Do not describe being switched automatically; instead describe looking for the information themselves, making the phone calls on their own, in addition to help from providers.	Most reported having jobs, being students or having spouses with jobs.	Little to no support with transition process. Few spoke with mental health providers or got support from clinic administrators in the transition.
Health and mental health needs	Chronic mental health issues but in MH care throughout the study period.	Chronic mental health and physical health issues under control.	Only half in mental health care; few descriptions of chronic health concerns.	About half currently receiving mental health care. Only one with chronic general health conditions.	High levels of distress due to cutting back on mental health care; multiple mental and physical health conditions.
Attitudes towards insurance	Supports reform; values insurance. Heard of the mandate but not worried.	Supports reform; values insurance. Worried about the mandate.	Many think they are already complying with the mandate as they have Free Care. Shift in attitude to insurance over time from oppose/don't know to support by end of period.	Negative attitudes about the reform; felt that it was not a choice. Overall opposed to the reform. Worried about the mandate.	Negative attitudes about the reform; felt that it was not a choice. Overall expressed being opposed to the reform. Worried about the mandate.

Table 1.**SUMMARY OF ENTIRE SAMPLE (N=65) BY INSURANCE COVERAGE**

	TOTAL (n=65)	FC Only (n=20)	Early Enrollees (n=8)	Middle Enrollees (n=9)	Late Enrollees (n=9)	Multiple Switches (n=19)
Identified Case	27.7 (18)	5.0 (1)	25.0 (2)	11.1 (1)	22.2 (2)	63.2 (12)
Female	76.9 (50)	75.0 (15)	75.0 (6)	66.7 (6)	77.8 (7)	84.2 (16)
6-month income up to 5K	40.0 (26)	45.0 (9)	25.0 (2)	77.8 (7)	11.1 (1)	36.8 (7)
5K to \$9999	43.1 (28)	45.0 (9)	62.5 (5)	11.1 (1)	77.8 (7)	31.6 (6)
\$10K or more	15.4 (10)	5.0 (1)	12.5 (1)	11.1 (1)	11.1 (1)	31.6 (6)
Refused	1.5 (1)	5.0 (1)	0	0	0	0
Education <HS	30.3 (20)	20.0 (4)	50.0 (4)	55.6 (5)	33.3 (3)	21.1 (4)
High school grad	20.0 (13)	35.0 (7)	0	11.1 (1)	11.1 (1)	21.1 (4)
Some college	27.3 (18)	15.0 (3)	50.0 (4)	22.2 (2)	33.3 (3)	31.6 (6)
College grad +	20.0 (13)	30.0 (6)	0	0	22.2 (2)	26.3 (5)
Don't know	1.5 (1)	0	0	11.1 (1)	0	0
Immigrant	86.2 (56)	100.0 (20)	75.0 (6)	88.9 (8)	88.9 (8)	73.7 (14)
Latino	75.4 (49)	85.0 (17)	75.0 (6)	77.8 (7)	88.9 (8)	57.9 (11)
Spanish or mostly Spanish speaking	60.0 (39)	70.0 (14)	62.5 (5)	77.8 (7)	88.9 (8)	26.3 (5)
Work situation changed	41.5 (27)	35.0 (7)	50.0 (4)	22.2 (2)	44.4 (4)	52.6 (10)