Massachusetts has long been a leader in expanding access to affordable health insurance. Reforms pioneered here have provided a blueprint for national efforts, including the landmark Affordable Care Act. But despite our leadership, uninsurance remains a reality in the Commonwealth, especially for our most vulnerable residents. What can the next governor do to continue our tradition of leadership and move closer to truly universal coverage?

In this piece, we analyze the state’s current uninsurance challenge and outline a policy path for the incoming administration.

The Current State of Uninsurance in Three Statistics

Stat #1: 160,000 Uninsured

As of 2021, about 160,000 Massachusetts residents lacked health insurance, representing 2.4% of the state’s population. This statistic illustrates both the state’s historic success on coverage and its continuing challenge.

First the success: a 2.4% uninsured rate is the lowest of any state in the nation and is well below the national uninsured rate of 9.1%. This success is not an accident. Years before the debate over Obamacare, the 2006 health reform law was passed under then-Governor Mitt Romney, dramatically expanding access to affordable coverage. Romneycare brought the uninsured rate below 4.5%, and Obamacare extended these gains, bringing the uninsured rate to 3.0% or lower since 2015.

But it also shows the challenge: Despite a system that theoretically offers affordable insurance to all citizens, 160,000 people still lack coverage. People without health insurance have a tougher time finding a primary care doctor, seeing a specialist, paying for medications, and affording medical bills. They are more likely to delay or go without necessary care because of the cost. Growing evidence finds that uninsurance results in greater medical debt, harms mental health, and increases mortality.

Why does so much uninsurance persist? Our next statistics break down the reasons for lack of coverage.

Stat #2: 58% of the Uninsured

The uninsured in Massachusetts in 2021 can be divided into three groups:

• 18% are non-citizens who are therefore ineligible for subsidized ACA coverage.
• 24% are (largely high-income) people who qualify for affordable job-based or individual insurance without subsidies.

Stat #3: Uninsured by Income

Of those uninsured, 48% are low-income people who are eligible for subsidized ACA coverage but who fail to enroll. The remainder are high-income people who self-select out of public programs.

How much does the uninsurance cost us? An estimated $4 billion in medically related costs are borne by the state in avoidable care, including premature mortality.

The next governor can help Massachusetts continue its leadership in making universal health care a reality for all our residents.

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• 58% are people who qualify for free or subsidized coverage from Medicaid (MassHealth) or the Massachusetts Health Connector.

It is notable that by far the largest group of uninsured – the 58% – already qualify for subsidized insurance in which they have not been enrolled. Indeed, most in this group likely qualify for not just discounted, but completely free coverage via MassHealth or a Connector plan.5

This fact runs counter to the standard assumption that uninsurance is about lack of affordable health insurance options. Unaffordability is a real barrier for many people, notably non-citizens, but most uninsured do not fall into this category. Rather, most of the remaining uninsurance challenge is about failure to connect people to affordable options for which they already qualify.

What explains this gap? Opaque enrollment processes, burdensome paperwork, and overstretched state agencies all make signing up for coverage a difficult task. For many residents, the situation is complicated by the fact that job, income, and demographic changes lead to frequent changes, or “churn”, in program eligibility – from employer-sponsored insurance to MassHealth to subsidized Connector coverage, and back again. Every time someone changes eligibility, they must actively re-enroll in new coverage – a process that imposes burden and can result in falling through the cracks. This problem of churn between coverage sources will be especially pressing for the incoming administration, as MassHealth redeterminations restart with the end of the COVID-19 Public Health Emergency (PHE).5

Taken together, these conditions lead to our third statistic.

**Stat #3: 6.4% Part-Year Uninsured Rate**

While only 2.4% of people are uninsured at a single point in time, 6.4% of Massachusetts families – almost three times as many – have a member spend part of the year uninsured. This figure that was even worse (12.5%) for low-income families.7 Many of these uninsured spells are short, reflecting the churn between eligibility sources noted above. But even short gaps involve a real risk. An unexpected injury or sickness may result in an ER visit and a huge medical bill. Or worse, care for an acute problem may be skipped or delayed, resulting in long-term health decline.

**Policy Steps toward Universal Coverage**

How can the next governor ensure that Massachusetts extends its leadership on health insurance coverage and moves towards real universal coverage? We outline several steps, starting from the easiest that would incrementally boost coverage, and escalating to the most fundamental. Our focus is on strategies that would automatically enroll people in insurance options they already qualify for, but we also note the need for additional assistance or incentives for higher-income people and non-citizens.

**Connecting People to Insurance They Qualify For**

• **Outreach:** Many uninsured do not know their coverage options or how to sign up. This suggests a role for outreach – particularly at key points like job loss and transitions out of MassHealth, events that the state can observe in administrative Medicaid and unemployment insurance tax databases. Research suggests that outreach and reminders modestly boost take-up at very low direct cost.8

• **Automatic Enrollment in Free Coverage:** One step more intensive than outreach is to
**auto-enroll** individuals who have applied and qualified for a $0 insurance policy in the Connector, but who have not completed enrollment by selecting a plan. This policy is standard practice in Medicaid and was used in the Massachusetts Connector prior to 2010. Evidence suggests it worked quite well, boosting take-up by 50% among the relevant population. A similar policy may be used for some people who lose MassHealth at the end of the PHE.

- **Automatic Retention in Free Coverage:** Another way to reduce churn into uninsurance is to make it easier to retain or transition to $0 premium coverage. In Medicaid, states may allow enrollees to retain coverage for 12 months regardless of any changes in income, an approach already implemented in New York and Montana. Reducing disenrollment from the Connector due to premium non-payment is a priority: it affects about 20% of Connector enrollees per year. Prior to 2014, the Connector “auto-retained” many such individuals by switching them to a $0 premium plan if available, a strategy that substantially reduced disenrollment. This policy could be reimplemented today.

**Broadening Automatic Insurance toward True Universal Coverage**

A key insight of recent research on insurance coverage is that eliminating uninsurance requires enrollment to be automatic. Several steps are required to extend automatic insurance more widely:

- **Tracking Uninsurance in Real-Time:** First, the state needs to track the insurance status of its residents. Without this information, the state is unable to identify the uninsured, measure progress, and make sure insurance coverage is not duplicated. A database would be comprised of information linked from MassHealth, the Connector, Medicare, and commercial insurers, and would be updated at least monthly to facilitate real-time decision-making.

- **Automatic Premium Collection:** The automatic insurance policies described above apply only to lower-income groups who qualify for $0 coverage (typically people with incomes below 150% of the poverty line). To extend auto-enrollment to higher-income groups requires a way to collect premiums automatically. A natural way to do so is annually via tax filing. This will be controversial, and will require careful rules and forgiveness to address any income or coverage errors. But tax-based premium collection is a standard feature of universal coverage programs around the world, including market-based programs like those in Switzerland and the Netherlands.

- **Automatic Backstop Insurance:** The state could subsequently establish a default form of coverage, likely MassHealth or a low-cost plan on the Connector. Anyone who is or becomes uninsured would be automatically enrolled in a plan, with any post-subsidy premium billed automatically as a tax, as described above.

**New Solutions for Immigrants**

True universal coverage doesn’t exclude anyone from affordable coverage: non-citizens who are currently ineligible for federal help need a solution, too. Massachusetts currently covers non-citizens in the less-comprehensive, state-funded programs MassHealth Limited and the Health Safety Net. These would need to be reformed to function as a real health insurance product for immigrants and others who fall through cracks in eligibility.
PERCENT OF UNINSURED IN MASSACHUSETTS BY INSURANCE ELIGIBILITY, 2021

- Medicaid/Other public eligible: 29%
- Tax credit eligible: 29%
- Ineligible for financial assistance due to offer of employer coverage: 15%
- Ineligible for financial assistance due to affordable marketplace plan available: 9%
- Ineligible for financial assistance due to citizenship: 18%
- Ineligible for financial assistance due to affordable marketplace plan available: 9%

Total eligible for financial assistance: 58%

Source: Kaiser Family Foundation

Conclusion
Massachusetts has a strong foundation of insurance coverage and a history of innovative coverage reforms. Even still, there are significant barriers to reducing uninsurance – the reforms proposed here make enrollment as automatic as possible while staying mindful of the significant affordability challenges that still exist for many. The next governor should make true universal coverage a health policy priority.

Endnotes
3. For summaries of recent evidence, see KFF 2020; Baicker, Gawande, Sommers (NEJM, 2017); Miller et al (AER 2021), Goldin Lurie McCubbin (QJE 2021).
4. See KFF 2022 estimates.
5. See KFF 2021.
6. Cite ASPE white paper.
8. Domurat, Menashe, and Yin (AER, 2021); Myerson et al (Health Affairs, 2022).
10. See Georgetown CCF.