



## Policy matters

## Women and Health Reform: How National Health Care Can Enhance Coverage, Affordability, and Access for Women (Examples From Massachusetts)

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Article history: Received 21 March 2013; Received in revised form 15 November 2013; Accepted 19 November 2013

### A B S T R A C T

**Background:** Massachusetts women have the highest rates of health insurance coverage in the nation and women's access to care has improved across all demographic groups. However, important challenges persist. As national health reform implementation moves forward under the Affordable Care Act (ACA), states will likely encounter many of the same women's health challenges experienced in Massachusetts over the past 7 years.

**Methods:** A review of the literature and data analyses comparing health care services access, utilization, and cost, and health outcomes from Massachusetts pre- and post-2006 health care reform identified two key challenges in women's continuity of coverage and affordability.

**Conclusion:** These areas are crucial for state and national policymakers to consider in improving women's health as they work to implement health care reform at the state and federal levels.

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National health reform is a priority for women as patients, caregivers, and providers. Women have more complex reproductive health care needs, higher rates of chronic disease, and longer average lifespans than men that require more frequent and regular use of medical care. Because of their greater health care needs, women spend more on medical care than men despite having lower average incomes, leading to greater challenges affording and accessing care throughout their lifetime (Lambrew, 2001; Sered, 2008; The Henry J. Kaiser Family Foundation, 2012). Women are also more vulnerable to gaps in health insurance coverage and access to care because they are more likely to transition through the workforce, hold part-time

jobs, and be insured as a dependent through a spouse's health plan (The Henry J. Kaiser Family Foundation, 2012). Women are more likely to develop multiple chronic illnesses, resulting in high associated costs and difficulties coordinating care as they age (Wood et al., 2009). This paper examines women's experience with health reform in Massachusetts, an important analysis to undertake given that national health care reform is largely modeled on the state's health care reform law.

### The Landscape Before State Reform

Before the passage of Massachusetts' health care reform law, known as "Chapter 58," Massachusetts women had higher health insurance rates compared with women nationally (DeNavas-Walt, Proctor, & Lee, 2006). Massachusetts women also enjoyed a comprehensive list of mandated covered services, including maternity care, contraception, Pap smears, mammography, mental health services, and strong consumer protections that

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prohibited discriminatory practices such as gender rating, which bases premium rates on sex and gender (Bachman, Highland, Nordahl, Schiff, & Huang, 2008).

### *The Landscape After State Reform*

Chapter 58 built on these protections by expanding the Massachusetts' Medicaid program, instituting an individual mandate, offering coverage subsidies to low-income residents, and creating a regulated health insurance exchange to facilitate access to affordable health insurance (Massachusetts Health Connector, n.d.). As a result of state health care reform, Massachusetts women have the highest rate of health insurance coverage in the nation and access to care among women has improved across all demographic groups. However, despite higher insurance coverage rates, 60,000 women remain uninsured in Massachusetts. Furthermore, insurance coverage does not convey the same level of protection from affordability challenges and coverage disruptions for women compared with men (Long, Stockley, Birchfield, & Shulman, 2010).

As implementation of the Affordable Care Act (ACA) moves forward, states will likely encounter some of the same women's health challenges experienced under Massachusetts health reform. This paper presents important women's health findings and recommendations that state and national policymakers should consider as they work to implement the ACA.

### **Methods**

We reviewed the literature and data analyses comparing health care services access, utilization, and cost, and health outcomes from Massachusetts pre- and post-2006 health care reform. We rely on gender-stratified data analysis from the Blue Cross Blue Shield of Massachusetts Foundation's 2006 and 2009 Massachusetts Health Reform Survey, data analysis from IBIS Reproductive Health, and data analyses by the Massachusetts Health Connector Authority (the state's health insurance exchange), the Massachusetts Division of Health Care Finance and Policy, and the Massachusetts Department of Revenue. Because of privacy and confidentiality issues, we were unable to access raw data from the Massachusetts Health Insurance Survey, an important state-level source for evaluating outcomes associated with Massachusetts health reform.

We also rely on national-level data from the American Community Survey, Current Population Survey, and data from the Congressional Budget Office analyzed and published by the Henry J. Kaiser Family Foundation and The Commonwealth Fund, in addition to peer-reviewed publications, in comparing Massachusetts with the United States. This study builds on our 2010 report, *Massachusetts Health Reform: Impact on Women's Health* (Hyams & Cohen, 2010).

### **Results**

A review of the data findings identified two key issues impacting women's health in Massachusetts post reform. These include challenges associated with continuity of coverage and affordability.

#### *Challenge 1: Continuity of Coverage*

Before Massachusetts reform, the uninsurance rate for Massachusetts women was lower than the rate for women nationally (Current Population Survey, 2004). Massachusetts women

also had higher rates of insurance coverage compared with their male counterparts, mainly owing to Medicaid eligibility. In 2004, 2 years before passage of Chapter 58, 43% of women were uninsured compared with 57% of men (Massachusetts Division of Health Care Finance and Policy, 2006).

As a result of Chapter 58, men saw a 9.9-percentage point increase in coverage to 93.1% in the three years post reform, compared with women, who saw a 5.7-percentage point increase to 97.1% during this time period (Long et al., 2010). Although coverage rates for women remain higher than for men, approximately 60,000 women were uninsured in 2009, and the majority of these women seem to have incomes that would make them eligible for Medicaid or subsidized exchange plans (Long et al., 2010). An analysis requested by the authors for gender-specific outcomes of women and subgroups of women<sup>1</sup> indicated that the remaining uninsured women were disproportionately young (ages 18–25), Hispanic, single, less likely to have a college degree, and more likely to be unemployed, working part time, and low-income compared with insured women (Long et al., 2010).

Specific groups of women in Massachusetts continue to experience coverage volatility despite improvements in overall insurance coverage rates achieved post reform. A significant number of low-income residents transition between Medicaid and subsidized insurance plans owing to changes in eligibility status, a process often referred to as "churn." According to monthly estimates, an average of 9,800 residents transitioned from Commonwealth Care (CommCare), which provides coverage and premium subsidies for individuals below 300% of the Federal Poverty Level (FPL), and the Health Safety Net, Massachusetts' "free care" program, to MassHealth, Massachusetts' Medicaid program, between January 2008 and April 2009. Additionally, an average of 9,400 residents transitioned from MassHealth and Health Safety Net to CommCare during the same time period. Approximately 1,500 to 1,700 (16%–17%) of these enrollees experienced a gap in coverage during their transition (Seifert, Kirk, & Oakes, 2010).

There is evidence that suggests women are most at risk of transitioning between insurance programs and experiencing gaps in coverage given that women comprise the majority of non-elderly Medicaid enrollees in Massachusetts and a higher percentage of women are enrolled in subsidized insurance plans (Sered, 2008; Email communication with Nancy Turnbull, Consumer Representative, Board of Directors, Commonwealth Health Insurance Connector Authority, May 8, 2010). Data from 2011 show that a greater percentage of adult women aged 18 to 64 lacked coverage at some time over the past year compared with men (9.3% vs. 7.9%, respectively) despite higher health insurance coverage rates (Goin & Long, 2012). This suggests that a high insurance rate may not protect women when it comes to maintaining continuity of coverage over time. More research on gender differences in longitudinal coverage patterns and resultant gaps in access to care are necessary to fully assess these differences.

Although Massachusetts has made substantial progress in expanding coverage to most women, women continue to be vulnerable to churn and gaps in coverage owing to 1) employment patterns, 2) dependent status, and 3) income fluctuations.

<sup>1</sup> Analysis of the Massachusetts Health Reform Survey (MHRS) was completed by researchers at the request of the authors and has not been replicated or analyzed by sex differences; therefore, comparable analysis over time, or for men, are not currently available from this data set or from the Massachusetts Health Insurance Survey (MHIS).

### *Employment patterns*

Women are more likely to have variable employment patterns, including part-time work or gaps in employment, compared with men, placing them at higher risk of losing or being denied unsubsidized health insurance coverage. In Massachusetts, employer-sponsored insurance is the major provider of health insurance, covering three fourths of the non-elderly population ([Commonwealth of Massachusetts, 2011](#)). However, women hold part-time jobs more frequently than men (35.8% vs. 17.5% in Massachusetts, respectively), making them less likely to qualify for employer-sponsored insurance benefits and further exacerbating women's vulnerability to coverage gaps ([Patchias & Waxman, 2007](#); Authors' tabulations of the American Community Survey, 2007–2011). Nationwide, part-time workers experience higher rates of uninsurance compared with full-time workers (26% vs. 18%), who often receive health coverage through their employers ([Patchias & Waxman, 2007](#)).

### *Dependent status*

Women are more likely to be covered as a dependent on a partner's insurance plan ([Patchias & Waxman, 2007](#)). In Massachusetts, more than half of men (59%) have their own job-based insurance compared with 44% of women ([Caiazza, 2002](#)). Coverage for dependents is inherently less stable, because continuity depends on the partner's continued employment, the employer's decision to continue offering dependent coverage, and the dependent's ongoing relationship with the covered partner. At the same time, dependent status makes women vulnerable to coverage gaps, because life events such as pregnancy, marriage, death, and divorce can cause women's coverage to change or to be dropped altogether ([Sered, 2008](#); [Sered & Proulx, 2011](#)).

### *Income fluctuations*

It is often more difficult for women to provide the regular income documentation required to maintain subsidized health coverage because women are more likely to have variable employment status and inconsistent income compared with men ([Sered & Proulx, 2011](#)). In Massachusetts, the majority of Medicaid and CommCare cases were closed because of failure to furnish required information, including income documentation, rather than financial eligibility ([Seifert et al., 2010](#)). Data show that, even with reforms in place, the percentage of Massachusetts adults who became uninsured but then gained coverage within three months remained nearly unchanged pre and post reform ([Graves & Swartz, 2012](#)).

Income variability also contributes to gaps in coverage ([Seifert et al., 2010](#)). Under Medicaid rules, eligibility can end in any month that the recipient's income exceeds the allowable limit ([Sommers & Rosenbaum, 2011](#)). Yet in Massachusetts, individuals who lose Medicaid eligibility when they exceed the income limit cannot receive coverage under subsidized care until the beginning of the following month ([Seifert et al., 2010](#)). This coverage gap exists in addition to any administrative delay during enrollment processing.

### *Coverage volatility under the ACA: How the United States compares with Massachusetts*

Churning interferes with health care quality in the form of gaps in treatment, redundant testing, impaired follow-up, inefficient recordkeeping, and disruptive medication changes ([Sered & Proulx, 2011](#)). Lack of continuous coverage also reduces the likelihood of having a regular source of care and can impact

disease management, which is a particular problem for women, who have demonstrated higher rates of chronic disease than men ([Lavarreda, Gatchell, Ponce, Brown, & Chia, 2008](#)). We predict that the issue of inconsistent coverage, churn, and gaps in coverage disproportionately impacting women in Massachusetts could be more pronounced among U.S. women for two reasons.

First, the dependent status of women nationally is likely to contribute to higher levels of churn across the United States compared with Massachusetts. Massachusetts women are more likely to be insured in their own name on group insurance compared with women nationally (57% vs. 34%, respectively). Additionally, U.S. women are more likely to be insured as dependents compared with Massachusetts women (23% vs. 14%, respectively) ([Caiazza, 2002](#); [Sered, 2008](#); [The Henry J. Kaiser Family Foundation, 2012](#)). As noted, dependent status is linked to more volatile insurance coverage, suggesting that U.S. women may experience higher rates of churn than Massachusetts women.

Second, churn rates may also be higher for U.S. women compared with Massachusetts women owing to higher poverty rates, another important factor contributing to churn ([Sommers & Rosenbaum, 2011](#)). Currently, 20% of women and 18% of men live in poverty nationwide compared with 16% of women and 14% of men in Massachusetts ([Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey, n.d.](#)). Efforts to expand coverage nationally for those living in poverty are substantial as 28 million Americans under 200% FPL are expected to experience a shift in eligibility between Medicaid and subsidized plans in 2014 under the ACA ([Sommers & Rosenbaum, 2011](#)). Therefore, the economic impact of coverage volatility will likely be significant: In 2010, the total annual administrative expenses associated with churn in Massachusetts alone is conservatively estimated at \$46 million ([Seifert et al., 2010](#)). Continued inefficiency in enrollment and coverage changes will likely impose further administrative costs on the government and disrupt access to care ([Seifert et al., 2010](#)).

### *Challenge 2: Affordability*

Women have seen some improvements in health care affordability post-reform ([Long, Stockley, & Shulman, 2011](#)). For instance, the percentage of Massachusetts women reporting unmet medical needs owing to cost dropped from 17.2% in 2006 to 13.6% in 2009 ([Long et al., 2010](#)). However, even with improved coverage rates post reform, women are equally likely to struggle with many of the same affordability issues they experienced before reform. Specifically, between 2006 and 2009, there was no significant change in the percentage of women spending 5% or more of family income on out-of-pocket medical expenses, the percentage of women who reported paying off medical debt over time, and the percentage of those who had problems paying medical bills three years post reform ([Long et al., 2010](#)).

Data suggest that insurance coverage itself may have less of an effect on increasing affordability for women versus men post reform ([Long et al., 2011](#)). For example, younger women were significantly more likely to have unmet need owing to cost and have problems paying medical bills compared with younger men despite having higher insurance rates. Additionally, older

women were more likely to have problems paying medical bills compared with older men (Long et al., 2011).

Women at the greatest risk for having unmet medical needs owing to cost and problems paying medical bills include women who report being in fair or poor health, those with incomes between 100% and 299% of the FPL, women with dependent children, and women who were divorced, separated, or widowed (Long et al., 2011). Other groups of women at greater risk of having unpaid medical bills include women ages 26 to 34, women with chronic conditions, and women with physical limitations owing to health problems (Long et al., 2010). Women who were less likely to face these problems include older women ages 50 to 64, women who with full-time employment, women with employer-sponsored insurance, and women with incomes over 500% of the FPL (Long et al., 2010).

#### Unsubsidized health insurance plans

Massachusetts health care reform created unsubsidized Commonwealth Choice (CommChoice) health insurance plans to extend comprehensive, affordable coverage to moderate-income residents. Currently, CommChoice plans are available to individuals with incomes too high to qualify for subsidized plans (>300% FPL) and are not offered insurance through an employer (Massachusetts Health Connector, n.d.). CommChoice plans provide three levels of coverage—Bronze, Silver, and Gold—that have varying premiums, cost sharing, and benefit coverage. Individuals often choose a Bronze plan because they have the lowest upfront costs despite higher cost sharing and more limited benefit coverage (Krughoff, Francis, & Ellis, 2012; Lore, Gabel, McDevitt, & Slover, 2012).

Moderate-income women who select low-premium, high-deductible plans may face unexpected financial burdens owing to their greater health care needs, vulnerability to unpredictable out-of-pocket costs, and overall lower incomes (Sered, 2008; Sered & Proulx, 2011). Figure 1 illustrates the range of out-of-pocket costs among different plan types based upon calculated averages from CommChoice plans in 2008.

In some cases, women who purchase low-premium coverage plans (i.e., Bronze) that initially seem to be more affordable, may ultimately spend more than their counterparts who select higher premium plans (i.e., Gold). For the average woman's health conditions, the Silver-level plan provides the lowest total out-of-

pocket expenditures, despite costing \$1,000 more in annual premiums than the Bronze-level plan (Krughoff et al., 2012; Sered, 2008). Despite this, 55% of CommChoice beneficiaries were enrolled in Bronze plans in June 2013 compared with 30% in Silver plans and just 8% in Gold plans (Commonwealth Health Insurance Connector Authority, 2013).

#### Affordability under the ACA: How the United States compares with Massachusetts

Despite higher overall levels of insurance coverage, affordability remains an issue for women more so than for men in Massachusetts, a trend that is likely to occur in states across the United States under national reform for several reasons. First, data show that, before reform, Massachusetts residents were less likely to report unmet medical needs owing to cost than the United States overall. In 2006, the year Massachusetts health reform was enacted, 4.8% of residents delayed medical care owing to cost compared with 9.1% for all states (Assistant Secretary for Planning and Evaluation, n.d.). Second, the Massachusetts health exchange features products with lower cost sharing than products offered in most other states. If this trend continues under the ACA, women in other states will likely experience difficulty with affordability more intensely than women in Massachusetts (Schoen, Fryer, Collins, & Radley, 2011). Third, premium affordability may also be particularly burdensome for women in other states. Although Massachusetts is often cited as having the most expensive health insurance premiums in the country, premium levels in the state have demonstrated to be among the lowest in the country when adjusted as a percentage of median household income (Schoen et al., 2011). Affordability measures will need to be in place to ensure that women are able to afford the health care they need.

#### Implications for Practice and/or Policy

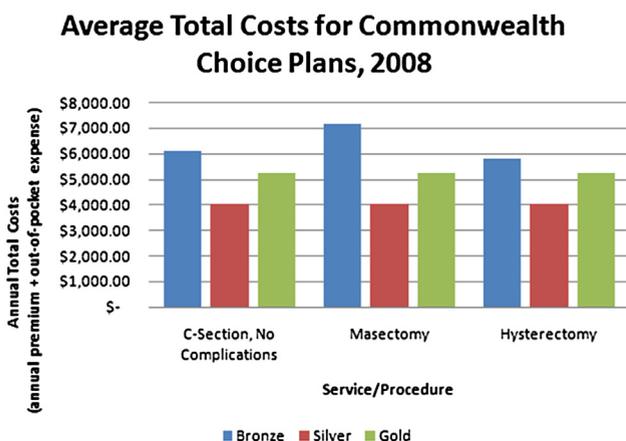
Three key areas where federal and state policymakers implementing the ACA can improve outcomes for women include 1) reducing coverage volatility among women, 2) creating comprehensive affordability standards, and 3) assessing the impacts and outcomes of health reform through collection, stratification and reporting of enrollment data by gender and gender/race groups.

##### Reduce Coverage Volatility Among Women

Full eligibility redeterminations for Medicaid and subsidized exchange plans in Massachusetts are conducted at least once per year; however, eligibility updates can occur at any time during the year. Rather than conducting sporadic eligibility updates, states could institute a 12-month guaranteed eligibility period for Medicaid and subsidized plan recipients to reduce churn among the low-income population. This would help to reduce gaps in coverage and could potentially reduce the administrative burdens on state exchanges.

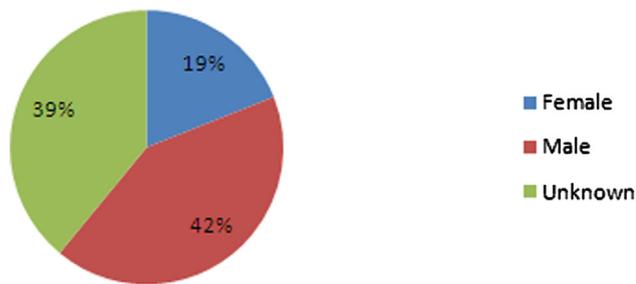
##### Improve Insurance Affordability for Women

The ACA establishes a number of tools, including cost calculators and navigators, to help consumers enroll in appropriate and affordable health plans through state exchanges. States should tailor these tools to address women's unique affordability concerns by including out-of-pocket costs in cost calculators and requiring navigators to take these expenses into account when



**Figure 1.** Average total costs for Commonwealth Choice Plans, 2008. (Source: Sered S. Women and Health Care Reform in Massachusetts. 2008.).

## Uninsured Tax Filers in Massachusetts, 2010



**Figure 2.** Uninsured tax filers in Massachusetts in 2010. (Source: Massachusetts Health Connector and Department of Revenue, Tax Year 2010.)

helping consumers enroll in coverage. Including gender as a variable in cost calculators is essential, given the distinct health care needs of both men and women.

### *Make Health Reform Data Available by Gender and Gender–Race/Ethnicity*

Massachusetts state agencies responsible for monitoring state reform do not routinely report data on critical health care reform indicators by gender or gender–race/ethnicity groups, making it difficult to understand the full impact of reform on vulnerable subpopulations. For example, the Massachusetts Department of Revenue, responsible for monitoring compliance with the state's individual mandate, does not require tax filers to denote gender (Figure 2; Massachusetts Health Connector, Department of Revenue, 2012). The lack of data is a barrier to developing policies that address health disparities and the social determinants that contribute to them.

Failure to assess the impact of national health care reform on various subpopulations of women is a missed opportunity to improve population health and understand the impact of health reform on more than 50% of the population. Various federal agencies already administer national-level surveys that monitor health insurance status, out-of-pocket spending, access to care, and health status, but rarely present data by gender and gender–race/ethnicity groups publically. In addition to making the data publically available in this format, state and national surveys will also need updated questions about new benefits under the law, such as access to mandatory and no-cost preventive services and compliance with the individual mandate, analyzable by sex and gender, so that states and policymakers can effectively monitor the impacts of health reform on women, particularly around gaps in coverage and cost barriers.

### **Conclusion**

The findings presented on women's experience with continuity of coverage and affordability post Massachusetts health reform have implications for national health reform implementation. We expect to see these coverage and affordability challenges replicated at the national level given that Chapter 58 was used as the model for the ACA. The challenges that Massachusetts women face will likely be more severe for women

throughout the rest of the nation given that Massachusetts has traditionally provided greater health protections for its citizens, including the landmark implementation of universal health care coverage, compared with the rest of the country. It will be imperative for policymakers to ensure that women's unique health care challenges are addressed, and in particular that gender differences are considered in all aspects of ACA implementation, not only for the benefit of women, but also to target resources and tailor implementation to meet the lifetime needs of both demographic and socioeconomically distinct subgroups of women and men post national reform.

Finally, understanding the experience of women as health care reform is implemented will be important in guiding future efforts to improve and implement national health care reform. Failure to assess the impact of health care reform on women is a missed opportunity to improve population health. It will be critically important to both collect and to report data by gender, race/ethnicity, gender/race groups, age, and socioeconomic status to understand the impact of the ACA on specific populations of women.

### **Acknowledgments**

The authors acknowledge Carolyn Luk for her assistance in researching, editing and formatting this paper.

**Authors' Certification:** The authors certify that this material has not been published previously and is not under consideration by another journal. We further certify that we have had substantive involvement in the preparation of this manuscript and are fully familiar with its content.

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