LOW-INCOME WORKING FAMILIES AT RISK: UNINSURED AND UNDERSERVED

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Ongoing market trends are increasing the risks that working families will be uninsured or suffer lapses in health insurance coverage, with consequent threats to access to health care. Despite strong economic growth, employer-provided health insurance coverage has continued to erode throughout the past decade. Although a record number of women and men are working, slow wage growth for lower-wage workers, a shift in work toward industries less likely to provide and pay for health benefits for families, and a shift toward temporary and part-time jobs have combined to undermine employment as a base for health insurance coverage for working families.^{1,2} As a result, the nation has seen a steady increase in the number and proportion of working-age Americans without insurance throughout the 1990s: from March 1989 to March 1997, the number of uninsured increased from 33 to 42 million, a jump from 15.2% to 17.6% of the under-65 population.³ Recent projections suggest that the number of uninsured will reach 47 million in 8 years, with one American in five uninsured.⁴

The rise in the number of uninsured comes at a time when access to health care is likely to be ever more difficult to obtain for those who cannot pay. In a search to contain health costs, public and private purchasers of health insurance have turned to managed-care plans with an endorsement of intense efforts to negotiate deep discounts and reduce payments for care for the insured. Enrollment of insured beneficiaries in managed-care plans has proceeded so rapidly that 8 in 10 workers employed by medium and large employers were enrolled in some form of managed care by 1997, compared with 56% in 1992 and 29% in 1988.⁵ Similarly, states have moved rapidly to convert Medicaid to managed care:

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48% of Medicaid beneficiaries were enrolled in managed-care plans by 1997, quadruple the percentage in 1991 (9.5%).⁶

As managed-care plans gain increasing leverage over physicians and hospitals, the resulting downward pressure on payments for the insured may well be squeezing out cross-subsidies that historically have helped pay for care for the uninsured. With direct public support of free or subsidized care also shrinking, public clinics, hospitals and health departments may well find themselves with diminished ability to provide free or reduced-price care. Thus, although the nation remains rich in medical care resources, current trends spell a future of more severe access barriers for the uninsured.

Among all families, low-income working families are likely to be most vulnerable to loss of coverage and access to care. Indeed, most of the growth in the uninsured has been concentrated among low-wage and moderate-wage workers: in the United States, three of four uninsured adults are working full (58%) or part time (18%), and about two-thirds of the uninsured have incomes within twice the federal poverty level. With incomes that are just high enough to bar them from Medicaid or other public insurance programs, low-wage families with incomes of \$25,000 or less and without employer-paid health benefits are left on their own to face annual health insurance premiums that average \$2,500 for a single person and \$6,000 for family coverage.⁷ Working families may well find themselves playing by society's rules of working hard for a living, yet be caught without the keys to the doors of a changing health care system.

To counteract the erosion of private health insurance, a few states have extended Medicaid or new public, subsidized coverage to otherwise uninsured working families. As a result, availability of affordable health insurance coverage has become increasingly variable and dependent on where families live. With public policies varying by state, monitoring the net impact of market and policies on access to care requires analysis of families' experiences within and across different states. National surveys would otherwise mask the extent to which state efforts are making a difference in coverage and access.

With the goal of increasing national understanding of what is happening as states embrace different strategies, the Commonwealth Fund and the Henry J. Kaiser Family Foundation have supported surveys of low-income adults in five states that are actively restructuring their health systems for low-income families, including three states with recent expansions of coverage. As part of a larger project known as the Low Income Access and Coverage Project, which also includes case studies and focus groups,^{8,9*} the *Kaiser/Commonwealth Five State Low*

*Case studies on each state are also available from the Commonwealth Fund.

Income Survey looks to families for insights into coverage and access experiences amid complex system changes.*

The following analysis of survey findings focuses on the extent to which low-income families are at risk for being uninsured and the consequences of lack of insurance on access and quality of care. The discussion addresses four central questions: What are the risks that low-income families are uninsured or experiencing extensive periods without health insurance? What is the impact on access of being uninsured or having a time without coverage? When uninsured families receive care, how do their care experiences differ from families with continuous insurance coverage? Finally, to what extent do coverage and access experiences vary significantly by state?

THE STATES AND SURVEY

Conducted in late 1995 and early 1996, the *Kaiser/Commonwealth Five State Low Income Survey* interviewed more than 10,000 low-income adults in five states: Minnesota, Oregon, Tennessee, Texas, and Florida. The states used a range of strategies for covering their low-income, working-age families. Both Oregon and Tennessee have expanded beyond traditional Medicaid to offer full coverage to uninsured individuals or families with incomes up to federal poverty levels. At the time of the survey, Tennessee also provided partial subsidies for uninsured families with incomes up to 400% of poverty and allowed families at higher incomes to buy coverage at full premiums.† Minnesota also expanded coverage well beyond traditional Medicaid by establishing a new, subsidized program known as MinnesotaCare for families otherwise ineligible for Medicaid. The program offers insurance to uninsured families with children; the families can have incomes up to 275% of poverty, and subsidized premiums are set on a scale that varies with family income. MinnesotaCare is also open at subsidized premium levels to childless adults with incomes up to 125% of poverty. In contrast to the three expansion states, in Florida and Texas low-income adults are eligible for Medicaid only if they meet eligibility categories and rules for Aid to Families with Dependent Children or other welfare programs. As of 1996, Florida's Aid to Families with Dependent Children income standard was 28%

*The survey was conducted by Louis Harris and Associates, Inc., on behalf of the Commonwealth Fund and the Henry J. Kaiser Family Foundation. All analyses referred to herein were conducted by the authors.

†In January 1995, 1 year after opening the program to persons in all income levels, Tennessee closed enrollment to new entrants except those who would otherwise be uninsurable or eligible under Medicaid/welfare rules. Tennessee also tightened premium collections for those enrolled with partial subsidies. Both actions reduced the total number enrolled in the program and restricted the extent to which the program would insure newly uninsured working families. In late 1996 and 1997, Tennessee began to reopen coverage for a restricted group of families.

of federal poverty levels and Texas's standard was 25% of federal poverty levels, half the entry standards in Minnesota, Oregon, or Tennessee Medicaid even before the expansions. With a goal of direct provision of care rather than insurance, Florida and Texas have both invested public funds in county and local public health systems to serve the uninsured.

Minnesota, Oregon, and Tennessee surveys took place in fall 1995, over 1 year after these states had expanded publicly subsidized coverage for low-income adults and children. Florida and Texas surveys took place in early 1996. In all study states but Texas, restructuring of Medicaid into managed-care plans was well under way at the time of the surveys.

The survey consisted of 20-minute telephone interviews with 2,000 low-income adults per state, for a total 10,013 adults. To be eligible to participate, those interviewed had to be between the ages of 18 and 64 and have family incomes at or below 250% of poverty at the time of the survey (approximately \$25,000 for a family of two). Each adult answered a series of questions on access and use of health care services, as well as insurance and basic demographic data, including health status. To ensure that the sample in each state reflected that state's low-income adult population, data were weighted by sex, age, race, education, number of adults in the household, and urbanization based on population estimates for each state obtained from a 2-year average of 1994 and 1995 Current Population Survey data.

INSURANCE GROUPS

The survey included questions about experience with lapses in insurance in the previous 2 years, as well as current insurance status. In the analysis presented here, we used this information to classify adults into one of three health insurance groups: continuously insured (insured now with no gap in 2 years), recently uninsured (insured now, but lapse in the past 2 years), and currently uninsured. Throughout the analysis, we contrast the experience of the two groups of uninsured adults with those with no recent time without insurance.

ACCESS MEASURES

The survey included six questions that directly asked adults about any problems getting care in the past year. The questions asked whether, in the past year, the respondent had a time they did not get needed care, had a time when they were refused care, or whether they had encountered problems with getting prescription drugs, specialty care, diagnostic tests, or mental health and therapy services. Along with responses for each of the six questions, our analysis used a composite variable that indicates at least one of the six access problems. The questionnaire also included questions about usual source of care, regular doctor, and use of physician services.

By targeting low-income families, the survey sought to examine experiences of those most vulnerable to access barriers and gaps in coverage absent subsidized care or coverage. By design, the screening produced a sample of low-income adults: half of respondents had annual family incomes of \$15,000 or less; 9 of 10 had incomes below \$35,000. Yet, due to the reliance on telephone interviews, the findings below may well understate the risk to low-income families by missing the experience of those without phones. Families without phones are likely to be at even higher risk due to the combined impact of severe poverty and lack of insurance coverage.

FINDINGS

LOW-INCOME ADULTS ARE AT HIGH RISK OF BEING UNINSURED

Across the five states, low-income adults are at high risk of being uninsured or having a recent time without insurance. In total, two of five adults (41%) either were uninsured at the time of the survey or had a time without insurance in the past 2 years. The likelihood of being uninsured or recently uninsured ranged from a low of 34% of low-income adults currently uninsured or with a gap in coverage over the last 2 years in Minnesota, to 35% in Tennessee, 43% in Oregon, 47% in Florida, and 48% in Texas (Fig. 1).

Low-income adults with any time uninsured in the past 2 years were likely to have been uninsured for long periods. Of uninsured adults, 7 in 10 had been uninsured for 1 year or more of the past 2 years. Moreover, only 1 in 10 of those with a time uninsured had been uninsured for 3 months or less of the preceding 2 years (Fig. 2).

Working provides little protection for low-income adults against the risks of being uninsured. Whether working full time, part time, or self-employed, one-third or more of low-income adults reported that they were either currently

FIG. 1 Low-income uninsured rates by state. Risk of being uninsured among low-income adults: 4 in 10 have been uninsured in the past 2 years. From *Kaiser/Commonwealth Five State Low Income Survey, 1995–96*.

Uninsured: Months without insurance

FIG. 2 Time without insurance in past 2 years: most are uninsured for long periods of time. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

uninsured or recently uninsured. Indeed, part-time and self-employed workers were as likely to report a time uninsured as were those who were currently unemployed: 43% of part-time and 56% of self-employed workers had a time uninsured, compared with 45% of the unemployed (Table I).

Working also provided little protection against long periods without coverage. Low-income adults in all work categories were at high risk for lengthy spells without insurance. Full-time or part-time workers with any gap in coverage during the 2 years (including those currently uninsured) were likely to have been uninsured for most of the 2-year period (Fig. 3).

As the income decreases, the risk for a time without insurance increases. Half of adults with incomes at or below federal poverty levels (\$10,000 for a two-person family at the time of the survey) had a time uninsured compared with 28% of those with incomes between 200% and 250% of poverty. As illustrated by Table I, the percentage with a gap or currently uninsured declined as income relative to poverty increased.

Although younger adults were at higher risk of having a time without coverage, risks remained high across all age groups. Despite increasing needs for health care to address the onset of chronic conditions and aging, one-third of low-income adults aged 50 to 64 reported a time uninsured. Risks remained high regardless of health status. In fact, those in excellent health were slightly more likely to have been continuously insured for the most recent 2 years than were those in fair or poor health.

Poverty rather than health status was the best predictor of the likelihood of long periods without health insurance, as well as the likelihood of being uninsured. Half of those uninsured for 19 months or more of the preceding 2-year period were poor, compared with one-third of those with no recent lapse in coverage. On the other hand, health status had little apparent influence on length of time without coverage. Contrary to common misconceptions that most of the

TABLE 1 Risk of Being Uninsured or Having a Recent Gap in Coverage*

	Total, N	Insured for 2 Years, % Population	Insured Now But Gap in Last 2 Years, % Population	Currently Uninsured, % Population
Total population	10,013	59	17	24
Gender				
Male	2,678	56	17	27
Female	3,164	61	18	22
Age				
<30	1,687	51	22	28
30-39	1,690	59	18	23
40-49	1,220	62	15	22
50-64	1,228	68	12	20
Poverty status				
Up to 100%	2,036	51	19	30
100-150%	1,480	55	18	26
150-200%	1,857	69	16	15
200-250%	1,301	72	14	14
Health status				
Fair/poor	2,703	54	17	28
Excellent	7,299	61	18	21
Serious illness in year†	1,705	61	20	19
No serious illness in year	8,289	58	16	25
Employment status				
Full time	4,814	62	18	20
Part time	1,219	56	18	25
Self-employed	646	44	16	40
Retired	384	74	9	16
Unemployed	2,947	54	17	28

*Kaiser/Commonwealth Five State Low Income Survey, 1995-96.

†Question asked: Have you had a serious illness, chronic condition, injury, or disability that has required a lot of medical care in the last 12 months?

FIG. 3 Time uninsured: working low-income adults are at high risk of lengthy time uninsured. Kaiser/Commonwealth Five State Low Income Survey, 1995-96.

uninsured are healthy, low-income adults suffering long periods without health insurance were as likely to be in fair or poor health as were those with only short lapses in coverage. Those with continuous coverage were somewhat more likely to be in excellent health and less likely to be in fair or poor health than those who had been uninsured for 19 or more of the previous 24 months (Table II).

LACK OF INSURANCE UNDERMINES ACCESS TO CARE

Being uninsured or having a recent gap in coverage sharply increased the difficulty of obtaining needed care (Table III). Adults with a lapse in coverage in the previous 2 years, as well as those currently uninsured, were two to three times more likely to report access problems than were those with continuous coverage based on responses to an array of questions on access to care and use of services. Uninsured adults with health problems were at even higher risk: two-thirds of the uninsured in poor health encountered access barriers in the previous year.

Uninsured Are Two to Three Times as Likely to Go Without Needed Care. Whether currently uninsured or recently uninsured, lack of insurance at least doubled the likelihood of an access problem for low-income uninsured adults compared with those with continuous coverage. When asked whether there had been a time "when you didn't get needed care" in the past year, one in five currently uninsured adults said "yes," three times the rate reported by continuously insured adults. Access problems were compounded by health problems. One-third of currently uninsured adults in fair or poor health or with a recent serious illness

TABLE II Poverty and Health Characteristics of Adults with Shorter-term and Longer-term Gaps in Health Insurance Coverage*

	Total	No Lapse in Past 2 Years	Up to 3 Months' Lapse	4 to 11 Months' Lapse	12 to 18 Months' Lapse	19 to 24 Months' Lapse
Total, N	9,907	5,840	414	782	846	2,031
Poverty status, % of total above						
Up to 100%	41	36	40	46	45	51
100%–150%	27	26	30	26	31	30
150%–200%	19	22	19	16	16	12
200%–250%	13	16	10	12	9	8
Health status, % of total above						
Excellent	27	28	31	26	28	22
Good	46	47	43	45	49	44
Fair	21	19	22	24	18	27
Poor	6	6	4	5	6	6

*Kaiser/Commonwealth Five State Low Income Survey, 1995–96.

TABLE III Access Problems, Uninsured Low-Income Adults versus Continuously Insured*

Access to care	Total	Insured for 2 Years	Insured Now But Gap in Past 2 Years	Currently Uninsured
All low-income adults	10,013	5,844	1,702	2,438
Problems in the past 12 months, % of total above				
Had a time when did not get needed care	12	7	17	22
Refused health care	3	2	5	5
Problems getting the following:				
Medication	6	4	8	9
Mental health or physical therapy	3	3	4	4
Specialty care	5	4	5	6
Diagnostic tests	3	2	4	5
One or more of six access problems†	20	14	27	31
Low-income adults in fair or poor health or with a serious illness in the past year, N	3,232	1,856	589	797
Problems in the past 12 months, % of total above				
Had a time when did not get needed care	21	12	27	34
Refused health care	6	4	9	10
Problems getting the following:				
Medication	11	8	14	17
Mental health or physical therapy	6	4	8	7
Specialty care	9	7	9	12
Diagnostic tests	6	4	6	10
One or more of six access problems†	32	22	42	46

*Kaiser/Commonwealth Five State Low Income Survey, 1995-96.

†The summary measure shows the percentage with at least one of the six access problems: not getting needed care, refused care, and problems getting medication, diagnostic tests, specialty care, or mental health and physical therapy care.

had a time without needed care compared with 12% of those continuously insured. Those currently uninsured and in poorer health were also twice as likely to report problems getting needed medication and diagnostic tests and to have been refused care in the previous year.

Adults who were recently uninsured were also at high risk of encountering access barriers, with 17% having a time they did not get needed care in the past year, more than double the rate of those continuously insured (7%). Among those in poorer health, adults with a gap in coverage were, again, twice as likely to have had time without needed care: 27% reported such a time.

The composite measure of six access problems highlights the extent to which insurance matters for access. Whether currently or recently uninsured, uninsured adults were twice as likely to have had at least one of the six problems compared with adults who had been covered continuously. One-third of the currently uninsured had encountered at least one of six problems, as had 27% of those with a recent gap in coverage, compared with 14% of persons with continuous coverage.

Comparison of access across insurance groups and health status underscores the strong relationship of health, access, and insurance for low-income adults. The worse the health status, the greater is the likelihood of access problems, controlling for insurance coverage. Lack of insurance compounds the problems. Within each health status group, being currently or recently uninsured doubles or more the risk of access problems. As illustrated by Fig. 4, for low-income adults, being uninsured and in poor health meant access problems for the majority of adults surveyed: two-thirds of the currently uninsured in poor health reported a problem getting care, as did half of those recently uninsured.

Uninsured Lack Regular Care. Past studies have found that having a regular provider or source of primary care is instrumental in providing preventive care and timely services and, over time, in preventing unnecessary hospitalization and more serious acute-care episodes.^{10,11} Having both a regular doctor and preventive care thus mark the likelihood that continuity of care and access exist.

For low-income adults, the survey found that insurance is critical for having a regular source of care. More than half of currently uninsured adults reported no regular doctor, compared with 27% of those with continuous coverage. One in six uninsured adults said she or he relied on a hospital emergency room or “nowhere” as a source of care when sick. Of the uninsured, one-fourth reported no visit to a physician in the previous year.

Even more troubling, low-income adults with health problems were no more likely to report a regular provider. More than half (57%) of currently uninsured adults with health problems and one-third of those with a gap in insurance had no regular doctor. One-fourth of the uninsured with health problems continued to rely on an emergency room or nowhere as a usual place for care (Table IV).

FIG. 4 Percent with an access problem in past year*. Access problems, health status, and insurance are inter-related. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

*Percentage with at least one of six problems: not getting needed care, being refused care, or having problems getting medication, diagnostic tests, specialty care, or mental health and physical therapy care.

TABLE IV Preventive Care and Contacts with Physicians*

	Total	Insured for 2 Years	Insured Now But Gap in Past 2 Years	Currently Uninsured
All low-income adults, N	10,113	5,874	1,702	2,438
No regular provider, %	39	32	37	58
No visit to doctor in past year, %	25	21	19	40
Use emergency room or "nowhere" as usual source of care	12	7	8	17
No preventive care received in past year, %†				
Women with no Papanicolaou test	42	38	39	57
Women with no breast exam	51	47	50	65
Women 50 or older with no mammogram	53	47	60	73
Men 50 or older with no prostate exam	65	60	62	81
Low-income adults in fair or poor health or with a serious illness in the past year, N	3,242	1,856	589	797
No regular provider, %	36	27	32	57
No visit to doctor in past year, %	14	10	9	25
Use emergency room or "nowhere" as usual source of care	12	6	12	26
No preventive care received in past year, %†				
Women with no Papanicolaou test	45	40	41	59
Women with no breast exam	51	45	46	67
Women 50 or older with no mammogram	52	45	57	72
Men 50 or older with no prostate exam	62	59	56	74

*Kaiser/Commonwealth Five State Low Income Survey, 1995-96.

†The base for preventive care questions varies by age of the respondent.

Moreover, despite their health concerns, one-fourth of the uninsured with health problems had not visited a physician in the past year.

Adults who were currently insured but had been uninsured recently were also at risk. However, having insurance now appeared to facilitate more-regular contacts with physicians. On many of the physician contact measures, the recently uninsured appeared more similar to those with continuous coverage than to those currently without insurance.

Preventive Care: Rare for Uninsured Low-income Adults. The survey found generally low rates of preventive care services across all groups of low-income women and men. However, preventive care was notably rare for the uninsured. Two-thirds or more of low-income, currently uninsured women said they had not had a breast examination or mammogram in the past year, and more than half said they had not had a Papanicolaou test. Similarly, currently uninsured men were unlikely to receive preventive care: three-fourths of uninsured men aged 50 or older had not had a prostate examination, compared with 59% of those men with continuous insurance (Table IV). Recently uninsured individuals were

also more likely than women and men with continuous coverage to say that they had not received preventive care services in the prior year.

The likelihood of preventive care for uninsured adults did not improve among those in worse health. Although those with health problems might be expected to have more-frequent contacts with the health care system and, as a result, catch up on preventive care, lack of insurance continued to erode the likelihood of care. Nearly half or more of both uninsured groups reported no preventive care in the past year on the various measures of care.

LOWER-QUALITY CARE SIGNALLED BY WORSE PATIENT CARE EXPERIENCES FOR UNINSURED ADULTS

The quality of care that uninsured and low-income patients receive has long been of concern. Past studies have found that lack of insurance can lead to differential treatment and more negative health outcomes, as well as care foregone. In other words, being uninsured is often a predictor of lower-quality care.¹²⁻¹⁴ Even with insurance, low-income patients may be at risk for poor-quality care if their insurance identifies them as being in a separate, lower class of patients. This survey of low-income adults confirmed findings from other studies: insurance matters for quality of care. The uninsured were notably more likely to rate care they received negatively than were adults with continuous coverage.

Negative Ratings of Care Overall. On a 4-point scale ranging from excellent to good, fair, and poor, currently uninsured adults were nearly twice as likely to rate services and doctors' care negatively overall as were the continuously insured: nearly one-third of those giving care received a negative rating. Care experiences were even worse for uninsured adults with health problems: nearly half (47%) of uninsured adults with health problems rated overall care negatively (Table V).

Physician Care Experiences Are More Negative for the Uninsured. Across an array of questions probing experiences with physicians, the uninsured were consistently more likely than those with no breaks in coverage to rate physician care as either fair or poor. Ratings by those with health problems of the extent to which their doctor cared about them or spent enough time with them were particularly disturbing: one-third of currently uninsured adults with health problems rated caring and time negatively.

The recently uninsured also had more-negative care experiences than did those with continuous coverage. Across all questions about care and physicians, ratings by those insured now but with a recent gap in coverage were more negative than ratings by those with continuous coverage. The pattern persisted for those with health problems as well: low-income adults with health problems

TABLE V Satisfaction With Care*

	Total	Insured for 2 Years	Insured Now But Gap in Past 2 Years	Currently Uninsured
All low-income adults, % rating care as fair or poor				
Overall rating of health care services	21	15	25	31
Overall rating of doctor	12	10	15	18
How doctor cares about you	21	17	25	27
Time the doctor spends with you	23	20	26	29
Time to obtain appointments	27	22	32	36
Time you wait in doctor's office	37	33	42	46
Low-income adults in fair or poor health or with a serious illness				
Overall rating of health care services	29	22	31	47
Overall rating of doctor	19	14	20	28
How doctor cares about you	25	21	27	35
Time the doctor spends with you	28	15	29	36
Time to obtain appointments	32	27	35	44
Time you wait in doctor's office	42	35	45	53

*Kaiser/Commonwealth Five State Low Income Survey, 1995-96.

and recent lapses of insurance were 50% more likely to rate services and doctor care overall negatively as were those with no breaks in coverage.

Waiting Time and Time with Physicians Is of Concern. Low-income uninsured adults also expressed strong concerns about waiting time. Whether waiting for an appointment or in a doctor's office, those currently without insurance or with a recent time uninsured were more likely to rate waits negatively than those with continuous coverage. Waiting times for appointments and in the doctor's office were of particular concern for the uninsured with health problems: half of the currently uninsured reported problems with office waits, and 44% reported problems with the time it took to get appointments. The recently uninsured also rated waits negatively: 35% rated waits for appointments and 45% rated waits in doctors' offices as fair or poor. In general, time with physicians is of concern; based on these reports, the uninsured wait longer for care and believe their doctors spend insufficient time with them.

STATE VARIATIONS: COVERAGE VARIES DRAMATICALLY BY STATE

As reported in an earlier article based on the survey,¹⁵ state policies regarding the availability of Medicaid and other publicly subsidized coverage resulted in dramatic differences in coverage patterns reported by respondents across the five survey states. As illustrated in Figs. 1 and 5, the likelihood of being currently uninsured was much lower in the three states that have expanded coverage (Minnesota, Oregon, and Tennessee) than in the two states maintaining traditional

FIG. 5 Time uninsured, by state. Length of time without insurance: number of months uninsured in past 2 years. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

Medicaid coverage for adults (Florida and Texas). In contrast, private coverage varied little across the states, reaching barely half of adults with incomes 250% of poverty or less.

Medicaid made the critical difference between states' rates of uninsured. Whereas Medicaid covered only 11% of adults with incomes below 250% of poverty in Texas and 14% of those living in Florida, Medicaid expansions had reached one-third of low-income adults in Tennessee and one-fifth or more of those in Oregon and Minnesota. Without Medicaid, it is likely that half of the low-income adult population would have been uninsured (Fig. 6).

Not only was the proportion uninsured higher in Florida and Texas, the uninsured in these states, including the recently uninsured, were also more likely to remain without coverage for lengthy periods. In both states, the uninsured were typically without coverage for most of the preceding 2 years: approximately three of five of the uninsured (60% Florida and 69% Texas) were uninsured for

FIG. 6 Percent of low-income adults covered by Medicaid or uninsured. Low-income persons have a high risk of being uninsured. If not for Medicaid, nearly half could be uninsured. *Kaiser/Commonwealth Five State Low Income Survey, 1995–96.*

19 months or more of the preceding 24 months. In contrast, relatively fewer uninsured adults endured lengthy gaps in coverage in the three expansion states: 43% of the uninsured in Minnesota, 40% in Oregon, and 30% in Tennessee were uninsured for 19 months of the preceding 2 years. These patterns across states of lack of insurance and time without coverage held irrespective of work status. The three states that had expanded public programs to working families with incomes up to or beyond poverty exhibited a clear pattern of improved coverage as a result of these efforts. Not only were fewer workers uninsured in Minnesota, Oregon, and Tennessee, those uninsured were uninsured for shorter periods.

ACCESS A SHARED CONCERN ACROSS STATES FOR THE UNINSURED

Access variations across states were mainly driven by insurance coverage (Table VI). In fact, within each of the three insurance status groups, reported access problems were remarkably similar across the five states. In all five states, the likelihood of an access problem was at least doubled when comparing the currently uninsured with the continuously insured. Among the continuously insured, low-income adults in Minnesota were the least likely to report one of the six access problems, with responses varying little across the other four states.

Within each state, adults who had been recently uninsured reported access problems at frequencies nearing those currently uninsured. Moreover, patterns reported by those currently uninsured were strikingly similar across states, ranging from 24% with problems in Minnesota to 37% in Tennessee. The uninsured living in Minnesota, Oregon, Tennessee, Florida, and Texas appeared to have more in common with counterparts in other states than with the continuously insured in their own states.

TABLE VI Access Problems Across Different States*

	Total	Minnesota	Oregon	Tennessee	Florida	Texas
Percentage with no regular doctor						
Insured with no lapse in 2 years	32	30	25	34	35	38
Insured now but had time uninsured	37	42	30	31	42	42
Currently uninsured	57	54	52	58	62	59
Percentage with at least one of six access problems†						
Insured with no lapse in 2 years	14	8	17	17	14	14
Insured now but had time uninsured	27	24	25	31	29	27
Currently uninsured	31	24	30	37	34	29

*Kaiser/Commonwealth Five State Low Income Survey, 1995–96.

†The six access problems include not getting needed care in past year, refused care in past year, or having a major or minor problem getting medication, diagnostic tests, specialty care, or mental health and physical therapy care.

Similarly, the likelihood of having no regular provider was similar across the five states after controlling for insurance status. One-half or more of the currently uninsured in each state had no regular provider, compared with one-fourth to one-third of the continuously insured.

In sum, having insurance and keeping it continuously appeared to be the critical factor in explaining access differences across states. Knowing whether the low-income adult had continuous coverage, had been recently uninsured, or was currently uninsured was more predictive of access problems than state of residence. The strategies employed by officials in Minnesota, Oregon, and Tennessee to improve the insurance coverage of their low-income adult populations appear to be paying off in terms of reduced likelihood of access problems.

DISCUSSION AND IMPLICATIONS

The survey findings lead to one central conclusion: without public action to make subsidized insurance available, low-income working families are at high risk of being uninsured and underserved. With incomes too low to pay for needed care directly, having health insurance was critical for facilitating access to care. The survey found that the 4 in 10 low-income adults who experienced a time without health insurance over a 2-year period were often left with no "choice" but to forego needed care. Those currently uninsured or recently uninsured both faced access barriers. The survey findings also confirm a variety of recent studies that the uninsured go without preventive care and tend to rely on emergency rooms or nowhere as their regular source of care.

Moreover, when the uninsured or those with gaps in coverage do receive care, their negative care experiences indicate lower-quality care. Too often, they are left waiting longer for care and feeling that their doctors have not spent enough time with them, and that those providing care do not care about their health problems.

Such care experiences raise the concern that the nature of care received by the uninsured may undermine the effectiveness of care and, as a result, compromise care outcomes. Studies of patient care experiences have found that patient trust in physicians and confidence that physicians care about them directly affect the quality of care.¹⁶ The high proportion of the uninsured who believe that physicians are not spending enough time with them and that physicians do not care about them suggests that care may be less effective than it otherwise could be, eroding the benefits of services and health outcomes over time.

The experiences of those in poor health who are uninsured negate hopes that somehow those with greater health care needs will be cared for or find insurance when they need it. The uninsured, including those without coverage for lengthy periods, are, if anything, sicker than low-income adults with continuous coverage.

When in need of care, those in poor health without insurance are the most likely to encounter access difficulties: two-thirds reported problems in getting care and one-third to one-half rated doctor care experiences negatively.

Lack of insurance is a shared risk factor across all five study states, with access problems strikingly similar for those without coverage irrespective of state of residence. Moreover, low-income working families in different states share the high risk of being uninsured unless publicly subsidized care is available. Whether working full or part time, low-income adults were at risk for gaps in coverage that typically lasted for lengthy periods. Despite different economies and industry structures, in each state barely half of low-income adults had private insurance through work or other sources.

The survey thus supports the general conclusion that, for low-income adults, insurance is necessary to open the doors to care. Yet, having insurance is not necessarily sufficient to remove problems in getting needed care. Compared with the general population, low-income adults in this survey reported lower rates of preventive care, were less likely to have a regular care provider and more likely to rely on emergency rooms, and, in general, reported more difficulties in accessing services. Insurance is necessary, but not sufficient, to remove barriers arising from tight family budgets and health problems.

The survey findings on access and coverage have two general implications for public policies concerned with the health of working families. First, the nation needs to broaden the definition of the uninsured to include those who have been recently uninsured if we are to monitor the extent to which the population is at risk for access problems. Providing sporadic coverage is not enough to address access. Policy efforts in this regard need to focus on continuity of coverage, as well as covering the uninsured. Second, availability of publicly subsidized insurance coverage is a critical determinant of the extent to which low-income working families are uninsured and underserved. Federal, as well as state, efforts to expand coverage to low-income families will be essential to offset further erosion in coverage.

BROADENING THE DEFINITION OF UNINSURED AND IMPROVING CONTINUITY OF COVERAGE

The voices of the low-income adults in the five survey states speak strongly to the need to broaden the definition of the uninsured, at least for low-income families, to include those who have had a recent time without coverage although they are currently insured. Findings that those with a recent gap in insurance encountered access problems at double the rate of those with continuous coverage and exhibited a pattern of lower care ratings and less preventive care indicate that gaps in coverage, as well as current insurance status, are predictors of access

barriers and lack of primary care. Among low-income adults, all with any time uninsured are at risk for long periods without coverage.

These data indicate that national efforts to estimate the uninsured population are likely to undercount the population at risk. To the extent that surveys ask only about current insurance status or, instead, ask whether the respondent has had any time with coverage, estimates will miss those who are in and out of coverage during the year and, as a result, will underestimate the proportion of the population who are likely to face barriers to care due to being uninsured. For low-income adults, the undercount is likely to be particularly severe due to the high turnover rates in Medicaid and less-stable work relationships.¹⁷ Notably, the annual US Census Current Population Survey, the source of annual estimates of the uninsured, is particularly likely to underestimate the extent to which low-income families are at risk, since it asks only whether a respondent has had any coverage in the past year and not whether families have had periods without insurance.

The finding that periods without coverage undermine access further indicate that policies to provide coverage to low-income families need to focus on continuity of coverage and providing temporary havens in time of need. Strategies that allow families to continue their health insurance coverage as their incomes, work status, or family status change are essential to curb the access difficulties that arise from lapses in coverage. The extent to which working families can maintain Medicaid coverage when they take a job, increase their work hours, or earn a raise will be critical in reducing gaps in coverage as family status changes due to business cycles or fluctuations in job markets or life-cycle transitions.

SUBSIDIZED INSURANCE FOR LOW-WAGE FAMILIES IS ESSENTIAL

Amid the erosion of employment-based coverage for working families, Medicaid has emerged as an essential support. The survey found that, without Medicaid, half of low-income adults would likely have been uninsured, and the length of time without coverage was shorter in states with expanded public programs. These findings regarding expansions that reach up the income ladder to cover low-wage workers underscore the importance of public health insurance for low-income families.

Subsidized premiums will be necessary to make premiums affordable. At minimum wage, it takes more than one worker, working full time, to pull a family out of the poverty income range. Even with two workers working full time, family income would be around \$25,000. At these levels, \$6,000 annual health insurance premiums for families are prohibitive. Unless employers or public programs pay part of the costs, health insurance will be beyond the reach of those with incomes at or near poverty levels.

Yet, dependence on state-initiated expansions is not likely to suffice to meet the national need. While three of the states in this study have expanded coverage, the majority of states have not broadened eligibility for adults beyond that required by federal law for low-income pregnant women. To date, federal policy has focused primarily on expanding coverage for children, leaving their parents to fend for themselves. This survey highlights the vulnerability of adults and the need for national expansions to all members of low-income families.

In coming years, public program expansions may be necessary to maintain coverage, much less decrease the number of uninsured. With welfare reform requiring more families to leave welfare rolls over time, the traditional doorway into Medicaid coverage will be closing for many low-wage workers. Yet, federal law has left Medicaid coverage standards linked to state welfare standards, with no recognition that the wages earned from even minimum wage jobs are likely to put families beyond standards for welfare, yet leave them too poor to buy coverage on their own. Federal reforms in support of state efforts to expand coverage for adults, as well as children, are likely to be necessary to offset what would otherwise be an increase in the numbers of uninsured low-wage workers. Those leaving the welfare rolls are unlikely to have employer-paid coverage available.

Given the dynamic restructuring taking place in insurance markets and the workplace, low-income adults are likely to be at increasing risk of being uninsured without federal initiatives to expand coverage. Taking the next steps in incremental reform appears necessary to meet the needs of the changing workforce and economy.

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