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Has Massachusetts health care reform worked for the working poor? Results from an analysis of opportunity

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Abstract

Purpose—Health care reform was introduced in Massachusetts (MA) in 2006 and serves as a model for what was subsequently introduced nationally as the Patient Protection and Affordable Care Act. The Boston Area Community Health survey collected data before (2002–2005) and after (2006–2010) introduction of the MA health insurance mandate, providing a unique opportunity to assess its effects in a large, epidemiologic cohort.

Methods—We report on the apparent effects of the mandate on the same participants over time, focusing specifically on the vulnerable working poor (WP). We evaluated differences in subpopulations of interest at pre- and post-reform periods to explore whether MA health care reform resulted in an overall gain in insurance coverage.

Results—MA health care reform was associated with net gains in health insurance coverage overall and among the subgroups studied. Our findings suggest that despite being targeted by health care reform legislation, the WP in MA continue to report lower rates of insurance coverage compared with both the nonworking poor and the not poor.

Conclusions—MA health care reform legislation, including the expansion of Medicaid, resulted in substantial overall gains in coverage. Disparities in insurance coverage persist among some subgroups following health care reform implementation in MA. These results have important implications for health services researchers and policy makers, particularly in light of the ongoing implementation of the Patient Protection and Affordable Care Act.

Keywords

Health care; Health care reform; Health insurance; Health care disparities; Massachusetts; Patient Protection and Affordable Care Act

Introduction

In 2006, Massachusetts enacted a law extending health insurance coverage to nearly all state residents through expansion of public insurance programs and subsidized private insurance for residents earning 300% or less of the federal poverty level [1]. The impact of this legislation has been closely watched as an indicator of the potential success of the 2010

federally enacted Patient Protection and Affordable Care Act (ACA) [2]. Previous examinations of the effects of the MA law have confirmed that the policy resulted in substantially higher health insurance coverage and improved access to care [3–9]. However, costs associated with maintaining insurance coverage and use of health services continue to be an issue for low-income MA adults, resulting in unstable coverage and persistently lower rates of preventive services use [3,10].

The MA reform law both expanded the MassHealth program (the MA Medicaid program) and created the Commonwealth Care system, which provides no or low-cost insurance for those who meet specific income thresholds [11]. Through these initiatives, the law sought to allow eligible poor adults to purchase affordable, low-cost insurance despite barriers to coverage [10,12]. Despite substantial uptake of these programs, a significant number of low-income MA adults remain uninsured as of mid-2011 [13,14]. Those remaining uninsured are largely employed but lack access to employer-sponsored insurance (ESI). Among this group, as many as 80% are considered “working poor” (WP) (those in the work force whose income falls below federal poverty levels) and, therefore, qualify for subsidized insurance. However, at least a third of the uninsured WP report being unable to find affordable insurance coverage [10].

In 2010, 10.5 million individuals were classified by the U.S. Department of Labor as WP; 7.2% of the work force currently meets this definition, the highest proportion in recent years [15]. The WP often hold the lowest paying and least stable jobs in the U.S. economy; as a result, many are either not offered health insurance by their employer, are unable to maintain insurance coverage due to labor mobility, or work less than full time and thus do not qualify for ESI. In fact, recent U.S. Census data show that the majority of uninsured have worked in the past year and that the highest proportion of uninsured are those with annual household income of less than \$25,000. WP adults may be self-employed or work for small firms not required to provide ESI [16]. For many WP adults who are eligible for ESI, escalating premium costs make ESI unaffordable. In MA, those eligible for ESI but who decline due to premium costs are excluded from the Commonwealth Care program. For those not eligible for ESI, income levels or immigration status may preclude eligibility for subsidized or no-cost insurance through Medicaid or Commonwealth Care programs.

We had a unique opportunity to examine the effects of the 2006 MA reform legislation among participants in an urban, population-based cohort study of Boston, MA residents. We focused our investigation on the WP, who, despite being targeted as potential beneficiaries of MA health care reform, continue to lack insurance coverage and access to care following reform implementation [10,12]. Stratifying by two periods to reflect the pre/during-reform implementation period and the post-implementation period, we sought to determine whether the mandate resulted in increased insurance coverage both overall and among WP. Despite previous valuable studies examining the impact of the legislation in cross-sectional designs, we believe ours is the first to examine the same participants prospectively, moving through time and the MA policy change.

Study data and methods

Study design and data collection

The Boston Area Community Health (BACH) Survey is a longitudinal cohort study of residents of Boston, MA, USA, aged 30–79 years at baseline (BL) (March 2002 to June 2005) which sought to explore the causes and correlates of urinary symptoms and type 2 diabetes. Detailed methods have been described elsewhere [17,18]. In brief, a stratified two-stage cluster random sampling design was used to recruit an approximately equal number of participants by gender, race/ethnicity (black, Hispanic, white), and age group (30–39, 40–49, 50–59, 60–79 years). Study data were collected on the same participants in two waves: a first interview conducted before mandate implementation (2002–2005, “BL”) and a second during 2006–2010 (“follow-up”), thus creating the conditions for policy evaluation via an unplanned “natural experiment” [19]. In total, 5502 adults participated in BL BACH I (1767 black, 1876 Hispanic, 1859 white; 2301 men, 3201 women). Completed follow-up interviews were obtained for 4144 individuals (1610 men; 2534 women). Loss to follow-up among nonrespondents was mostly due to inability to contact and was more common for Hispanics, those aged 70–79 years at BL, and males. The mean (standard deviation) time between interviews was 4.8 (0.6) years. In both surveys, data were collected during a 2-hour interview in English or Spanish, after written informed consent. Sampling weights were used to produce estimates representative of the black, Hispanic, and white Boston, MA population aged between 30 and 79 years (based on Boston census population in 2000). Features of BACH that make it uniquely suitable for this investigation include the large, random diverse community sample of men and women, followed longitudinally, approximately 20% of whom qualified as WP; use of established survey instruments; and the ability to look at gains in insurance access over the course of health care reform implementation. Various findings in BACH have been compared with the findings of other large-scale regional and national surveys (Behavioral Risk Factor Surveillance System [BRFSS], National Health and Nutrition Examination Survey, and National Health Interview Survey) and results suggest that BACH is highly representative of the city of Boston. In addition, key estimates from BACH are comparable with national trends [18].

Definition of working poor

BACH participants were considered to be “working poor” if they were currently “working for pay” (whether part-time or full-time), and if their annual total household income at the time of the interview was estimated as less than 200% of the U.S. federal poverty threshold for household size; this definition is in line with current use of the Census Bureau’s 2011 Research Supplemental Poverty Measure and is commonly applied as a WP definition [20–22]. “Nonworking poor” (NWP) was defined using the same annual household income range and included adults reporting any current work status other than working for pay. All participants with total annual household income of 200% or more of the U.S. federal poverty threshold for their household size were classified as not poor (NP), regardless of work status. Household income was estimated from predefined categories of total annual household income and the reported number of people supported by that income. WP status was defined for BL and follow-up analyses of insurance coverage using the responses from each respective study period; as a result, some individuals move from one group at BL to

another in the entire follow-up period (FU). The 2003 and 2008 poverty thresholds were applied in the respective definitions, as these years fell at the midpoint of each data collection period.

Health insurance coverage

“Uninsured” was defined as no health insurance coverage at the time of the interview through any private sources (from employer, spouse’s employer, military health, or a self-paid insurance plan), public sources (Medicare, Medicaid/MassHealth, Commonwealth Care), or through workers’ compensation health insurance. Health insurance status was categorized likewise as (any) private, public only (hereinafter, “public”), or none at the time of the interview. We examined changes over time by creating four mutually exclusive groups: (1) Gained insurance (uninsured at BL but insured at FU); (2) Lost insurance (insured at BL but uninsured at FU); (3) Always insured, or (4) Remained uninsured.

Analytic sample and statistical analysis

Because new eligibility for Medicare would confound this analysis, persons aged 65 years or older at FU were removed ($n = 948$), as were 144 persons who were no longer residents of MA at FU. BACH FU data collection (2006–2010) was divided into two periods for comparison to BL (2002–2005): (1) pre- and during-implementation (FU1): July 1, 2006 (start of data collection) to December 31, 2008; and (2) post-implementation (FU2): January 1, 2009 to October 7, 2010 (end of data collection). Health care reform in MA was enacted in 2006 and made effective from January 1, 2007, and rolled out in phases, beginning with the state’s poorest residents in October 2006 via automatic enrollment of uncompensated care pool enrollees into Commonwealth Care. Adults who are not U.S. citizens or in certain noncitizen visa status categories are ineligible for coverage. The law is enforced through tax penalties that were scaled up such that the maximum penalty was effective at the end of 2008 and thus the program may be considered fully implemented at that time (Fig. 1). The periods used in this analysis were also chosen for comparison with other literature [6]. All data analyses were performed using SAS-callable SUDAAN v.10 (Research Triangle Institute, Research Triangle Park, NC). Due to the mainly descriptive goals of this study, statistical testing was not emphasized.

Results

Working poor and insurance status

Overall, 18.5% and 17.2% of the 3052 study participants met the definition of WP at BL and FU, respectively (Table 1). Examination of insurance status at BL and in the FU reveals a substantial decline in the overall number of participants who reported no health insurance coverage (13.3% vs. 6.4%) (Table 2). Over the FU, 10.7% of participants gained health insurance, whereas only 3.7% lost insurance and 2.6% remained uninsured from BL (Table 3). The proportion of uninsured was higher in FU1 (9.2%) compared with FU2 (3.1%).

Table 2 also displays health insurance status stratified by the three groups representing poverty status as well as by period. Fewer than half (43.6%) of WP were privately insured at BL compared with 14.4% of NWP and 88.9% of NP, whereas 29.9% of WP were publicly

insured at BL compared with 69.8% of NWP and only 2.7% of NP. Those classified as WP had the highest proportion reporting no insurance at BL (26.5%), followed by NWP (15.7%) and NP (8.4%). Subsequently, in the FU, the corresponding proportions for reporting no insurance were 13.3% for WP, 4.7% for NWP and 5.0% for NP. Thus, the proportion reporting no insurance was reduced by half among the WP and reduced by more than half among the NWP. Looking at the pre/during and post-implementation follow-up periods, we observed that for WP and NP, the proportion uninsured was lower in the post-reform FU2 period compared with the pre/during reform FU1 period (WP: 15.5% in FU1 vs. 10.0% in FU2; NP: 9.0% in FU1 vs. 0.9% in FU2), suggesting coverage gains over the course of reform rollout, whereas among NWP, the proportion of uninsured at FU1 and FU2 did not differ much (4.4% vs. 5.0%, respectively). Despite overall improvements and significant gains in coverage among the WP at FU, these data also show that the gap in insurance coverage between WP and the other groups persisted, with higher rates of uninsured among WP as compared with NWP and NP at FU.

Changes in insurance status

Changes in insurance status from the BL to the FU period provide additional details about the effect of reform on all three groups studied (Table 3). Among NP at FU, 87.1% reported insurance coverage at both BL and FU, whereas only 1.6% reported being uninsured at both periods. By contrast, only 68.9% of WP at FU reported insurance coverage at both periods, 17.8% gained insurance coverage at FU, 6.4% lost insurance coverage at FU and 6.9% did not have insurance coverage at either BL or FU. Twice as many of the WP interviewed at FU2 (post-reform) reported being newly insured (25.2%) as compared with WP interviewed pre/during-implementation (12.8%), again suggesting that gains were a direct effect of reform legislation. Among NWP at FU, 82.4% reported coverage at both periods, whereas 13.0% gained insurance and approximately 2% reported loss of coverage in FU or lack of coverage at both periods, respectively. Gains in coverage among the NWP at FU were similar for those interviewed pre/during-implementation and those interviewed post-reform, whereas the NP at FU had a higher proportion of gains during the pre/during-implementation period.

We looked at specific gains in insurance in the FU overall and for all three groups (data not shown). Overall, gains were split almost evenly between public (54.3%) and private (45.7%) insurance. Insurance gains among WP and NWP at FU were overwhelmingly via public insurance, whereas most of the net gain among NP was via private coverage. Among all individuals reporting a gain via public insurance in FU, 76.6% reported obtaining coverage via the Medicaid/MassHealth program, whereas 10.2% reported coverage gains via Commonwealth Care programs and 13.2% reported gaining Medicare (due to new disability). Among those who reported gaining insurance coverage through Medicaid/MassHealth in the FU, 37.8% were WP at FU and 43.3% were NWP at FU, whereas those gaining Commonwealth Care were 52.9% WP compared with fewer than 3.9% of NWP.

Discussion

Using an urban epidemiologic cohort containing a high proportion of impoverished adults, we examined the impact of implementation of the MA health care mandate in the same cohort over time, with respect to health insurance coverage. We observed that despite losses in insurance coverage among some individuals, this cohort experienced a substantial decline in the proportion of those reporting no health insurance coverage: the prevalence of no insurance was more than halved comparing 2002–2005 to 2006–2010. Furthermore, when stratified by stage of mandate implementation, we observed a steeper decline in the proportion with no insurance, with the lowest prevalence observed after full policy implementation, suggesting policy effectiveness.

Our overall estimate of participants having any insurance at FU (93.6%) is similar to the 94.2% proportion of the nonelderly reported to be insured in 2010 in the Massachusetts Health Reform Survey [23], as well as the 93.9% coverage reported for 2009 from the MA BRFSS [7]. Similarly, local BRFSS estimates for the Boston-Quincy Metropolitan Division showed that 93.7% and 94.6% of respondents reported having health care coverage in 2009 and 2010, respectively [24]. Our study provides additional longitudinal evidence of policy impact by considering the cohort, moving through time and the law's implementation. We observed that among those who gained insurance following reform, over 50% of this gain was via public channels such as Medicaid and Commonwealth Care programs, confirming earlier findings [6].

Overall, the percent uninsured declined to 13.3%, 4.7%, and 5.0% for WP, NWP, and NP, respectively. We observed that a higher percentage of WP at FU (17.8%) gained insurance, compared with NP (13.0%), with the largest relative gains observed in the period following policy implementation. Most of the WP gains in insurance coverage came in the form of increased coverage by public insurance (predominantly Medicaid/MassHealth) and may be attributable to Medicaid expansion as a result of health care reform. Less than half of WP reported private insurance coverage following reform, compared with more than 80% of NP. Despite substantial gains, post-implementation disparities remained, with the greatest levels of no insurance among WP at FU. Although it appears that expansion of public insurance programs have benefitted WP, other aspects of the law tying private insurance coverage to employment (such as the employer mandate to provide health benefits to full-time employees) do not appear to have provided substantial benefits to WP. This may be related to occupational differences among subgroups: in BACH, more than half of WP reported working in service or construction and repair occupations at the time of FU, compared with only 17% of NP. Jobs in these industries are often part-time or seasonal in nature, and therefore, the employer mandate may not apply [25].

Our findings may have implications for the 2014 rollout of federal healthcare reform, modeled on the MA experiment. Among the WP who reported gaining insurance coverage in the FU, use of the Medicaid/MassHealth program was high. Some of these individuals may have previously been eligible for these programs but enrolled following reform as a result of both the individual mandate and what has been referred to as the “welcome mat effect” of Medicaid expansion [26]. To date, 26 states [27] have opted out of Medicaid

expansion, which will leave many individuals still ineligible for Medicaid while also foregoing the benefit of a welcome mat effect among those who are eligible but unenrolled. Locally, changes to some programs in MA under the ACA (such as expansion of Medicaid/MassHealth, additional state subsidies) may actually lead to increased coverage for some WP adults who are not currently eligible for these subsidies or programs under the MA health reform law [28].

There are limitations for understanding the true impact of reform in this study population. Our study may include individuals who are ineligible for subsidized insurance because of the requirements for U.S. citizenship or certain visa status categories. Such individuals receive limited MassHealth coverage for emergency health care services only but are not eligible for any of the programs established by health care reform legislation [29]. Our study does not collect information on immigration status, so the extent of this problem cannot be known. In addition, the MA mandate makes exceptions for extreme financial hardship [30]. Financial information collected in our survey is not detailed enough to determine hardship and subsequent eligibility for waiver of penalty. Our study included only adults aged older than 30 years, living in the city of Boston at the time of the BL interview. Although the response rate for our study was high (80.5%), the socioeconomic characteristics of nonresponders differed from those who responded, which may have affected insurance status in the FU. In the BACH study, loss to follow-up was more common among Hispanics, those aged 70–79 years, and males. Both MA and the ACA implemented an insurance connector (in MA, the Health Connector) to link uninsured individuals to coverage. Respondents to the BACH study were not asked through which means coverage was obtained and as a result, we are unable to report on how this important aspect of health reform affected the attainment of coverage in our study population. The strengths of our study include our study population, which was uniquely suitable for this research question and had a broad age range as well as both genders, race/ethnicity, and socioeconomic diversity. Unlike other previously published studies, we were able to follow a cohort over time and during reform implementation in MA. In addition, our sampling strategy allows our results to be generalizable to the Boston, MA population aged between 30 and younger than 65 years. The severe economic downturn coincided with implementation, making it difficult to extricate effects of the policy versus the effects of the recession. In addition, 6 months of the post-reform period in our study coincided with the officially recognized U.S. recession. By defining WP at each period, we were able to ameliorate some of the effects of the recession by eliminating current unemployment as an underlying cause of lack of insurance. This also allowed us to examine the net effect of health care reform among a population that may move in and out of eligibility for free or subsidized care [31]. As such, the gains observed seem even more impressive in this context, despite persistent gaps in coverage between the disadvantaged and others [12].

Conclusion

A large ongoing prospective epidemiologic study, the BACH survey, conducted in Boston from 2002 to 2010, provided a serendipitous opportunity to examine the effects of implementation of the MA health care reform law and provide some insight into the potential success of the ACA. Unlike other studies, we were able to examine the same

individuals over time and focus on the impact of health care reform on a growing and chronically uninsured population: the WP. We found that MA health care reform was associated with substantial gains in health insurance coverage overall and appeared to assist WP in gaining coverage, although disparities were not entirely ameliorated, suggesting its reach in our sample was not universal. Gains in insurance coverage among WP were overwhelmingly via public insurance programs, specifically Medicaid/MassHealth, whereas less than half of WP reported private insurance coverage in the FU, despite current employment at the time of the interview. Medicaid/MassHealth expansion due to MA health reform legislation may have played a role in public insurance uptake among the WP. We believe that the findings presented here may be relevant for predicting the potential future success of the ACA among similar populations.

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The Boston Area Community Health (BACH) survey is a longitudinal panel design epidemiological study. The introduction of mandatory health insurance in Massachusetts coincided with the follow-up data collection period.

Fig. 1.

Timeline of BACH data collection and MA health reform: sample size reflects participants with BL and FU information, a MA resident and age less than 65 years at follow-up.

Table 1

Prevalence of sociodemographic characteristics and certain chronic health conditions, overall and by WP status, at BL and FU, BACH Survey

Subgroup	BL			FU				
	Overall	WP [†]	NWP [‡]	NP [§]	Overall	WP [†]	NWP [‡]	NP [§]
Overall	100 (3052)	18.5 (848)	21.6 (901)	59.9 (1304)	100 (3052)	17.2 (784)	21.5 (954)	61.4 (1314)
Age group (y)								
30–39 (32–39 at follow-up)	43.7 (944)	51.5 (337)	38.1 (221)	43.2 (386)	19.1 (422)	25.0 (156)	12.7 (89)	19.6 (177)
40–49	33.8 (1100)	34.5 (318)	35.2 (318)	33.1 (464)	42.8 (1125)	43.4 (327)	41.5 (308)	43.1 (490)
50–59	21.7 (977)	13.7 (188)	25.5 (345)	22.8 (443)	27.5 (1026)	24.0 (229)	29.3 (348)	27.8 (449)
60–64	0.8 (31)	0.2 (4)	1.3 (17)	0.9 (10)	10.7 (479)	7.7 (72)	16.5 (208)	9.5 (198)
<i>P</i> [*]	.0002				.0013			
Gender								
M	47.8 (1208)	40.0 (328)	41.9 (292)	52.3 (588)	47.8 (1208)	45.0 (296)	42.6 (326)	50.3 (585)
F	52.2 (1844)	60.0 (519)	58.1 (609)	47.7 (716)	52.2 (1844)	55.0 (488)	57.4 (627)	49.7 (729)
<i>P</i> [*]	.0007				.0591			
Race/ethnicity								
Black	29.8 (996)	41.1 (260)	41.8 (330)	22.0 (407)	29.8 (996)	37.2 (221)	44.3 (351)	22.7 (424)
Hispanic	14.9 (1087)	32.4 (497)	22.9 (389)	6.5 (202)	14.9 (1087)	35.5 (469)	21.5 (410)	6.7 (208)
White	55.3 (969)	26.4 (91)	35.3 (182)	71.5 (695)	55.3 (969)	27.4 (94)	34.1 (193)	70.6 (682)
<i>P</i> [*]	<.001				<.001			
Language of interview								
English	89.9 (2216)	74.1 (428)	83.2 (589)	97.3 (1199)	90.6 (2241)	71.6 (399)	86.0 (634)	97.6 (1207)
Spanish	10.1 (836)	25.9 (420)	16.8 (312)	2.7 (105)	9.4 (811)	28.4 (385)	14.0 (319)	2.4 (107)
<i>P</i> [*]	<.001				<.001			

Subgroup Ns do not always sum to overall totals due to rounding over multiply imputed data sets.

^{*} *P* .05 indicate a statistically significant difference between subgroups within the period.

[†] BACH participants were considered to be “working poor” if they reported their current work status as “working for pay” (regardless of part-time or full-time status), and if their annual total household income was estimated to be less than 200% of the U.S. federal poverty threshold for household size. Status was defined by responses provided in the respective period.

[‡] BACH participants were considered to be “nonworking poor” if they reported their current work status as anything other than “working for pay,” and if their annual total household income was estimated to be less than 200% of the U.S. federal poverty threshold for household size. Status was defined by responses provided in the respective period.

[§]BACH participants were considered to be “not poor” if their annual total household income was estimated to be equal to or greater than 200% of the U.S. federal poverty threshold for household size, regardless of work status. Status was defined by responses provided in the respective period.

Table 2
Type of health insurance coverage at BL and FU, overall and by WP status, BACH Survey

Subgroup	BL			FU			FU1 (pre/during-mandate)						FU2 (post-implementation)					
	N = 3052			N = 3052			N = 1750			N = 1302			N = 1302			N = 1302		
	2002-2005			July 1, 2006, to October 7, 2010			July 1, 2006, to December 31, 2008			January 1, 2009, to October 7, 2010			January 1, 2009, to October 7, 2010			January 1, 2009, to October 7, 2010		
	Private			Public			Private			Public			Private			Public		
	%	n	%	%	n	%	%	n	%	%	n	%	%	n	%	%	n	%
Overall	64.4	1518	22.2	986	13.3	548	64.5	1521	29.1	1267	6.4	264	59.5	776	31.3	773	9.2	201
WP [†]	43.6	307	29.9	259	26.5	282	43.1	320	43.6	336	13.3	128	42.6	190	41.9	200	15.5	95
NWP [‡]	14.4	86	69.8	659	15.7	155	15.4	99	79.9	806	4.7	48	18.4	63	77.3	505	4.4	32
NP [§]	88.9	1125	2.7	68	8.4	111	87.6	1102	7.4	125	5.0	87	81.3	523	9.7	67	9.0	73
P*	<.001			<.001			<.001			<.001			<.001			<.001		

Subgroup Ns do not always sum to overall totals due to rounding over multiply imputed data sets.

* P .05 indicate a statistically significant difference between subgroups within the period.

[†] BACH participants were considered to be “working poor” if they reported their current work status as “working for pay” (regardless of part-time or full-time status), and if their annual total household income was estimated to be less than 200% of the U.S. federal poverty threshold for household size. Status was defined by responses provided in the respective period.

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[§] BACH participants were considered to be “not poor” if their annual total household income was estimated to be equal to or greater than 200% of the U.S. federal poverty threshold for household size, regardless of work status. Status was defined by responses provided in the respective period.

Table 3

Change in insurance status from BL to FU, overall and by WP status, BACH Survey

Subgroup	FU		FU1 (pre/during-mandate)								FU2 (post-implementation)													
	N = 3052				N = 1750				N = 1302				N = 1302											
	July 1, 2006, to October 7, 2010				July 1, 2006, to December 31, 2008				January 1, 2009, to October 7, 2010															
	Always insured	Gained insurance	Lost insurance	Remained uninsured	Always insured	Gained insurance	Lost insurance	Remained uninsured	Always insured	Gained insurance	Lost insurance	Remained uninsured	Always insured	Gained insurance	Lost insurance	Remained uninsured								
	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n								
Overall	82.9	2359	10.7	429	3.7	145	2.6	119	79.3	1328	11.6	221	5.4	114	3.7	87	87.2	1031	9.7	208	1.7	31	1.4	32
WP [†]	68.9	474	17.8	182	6.4	57	6.9	71	71.7	308	12.8	83	7.2	41	8.3	54	64.8	167	25.2	99	5.2	16	4.8	17
NWP [‡]	82.4	762	13.0	144	2.4	23	2.2	26	81.4	482	14.2	87	2.3	16	2.0	17	83.7	280	11.2	57	2.6	7	2.5	9
NP [§]	87.1	1123	7.9	104	3.4	66	1.6	22	80.9	538	10.1	52	6.1	57	2.9	16	93.5	585	5.6	52	0.6	8	0.3	6
P*	<.001				.05				<.001				<.001				<.001							

Subgroup Ns do not always sum to overall totals due to rounding over multiply imputed data sets.

* P 0.05 indicate a statistically significant difference between subgroups within the period.

† BACH participants were considered to be “working poor” if they reported their current work status as “working for pay” (regardless of part-time or full-time status), and if their annual total household income was estimated to be less than 200% of the U.S. federal poverty threshold for household size. Status was defined by responses provided in the respective period.

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