DISPARITIES IN HEALTH INSURANCE AND ACCESS TO CARE FOR RESIDENTS ACROSS U.S. CITIES

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EXECUTIVE SUMMARY

U.S. metropolitan areas are characterized by pronounced disparities in rates of health insurance coverage and access to care. While it has been well documented that people with lower incomes run a greater risk of being uninsured than those with higher incomes, this study also finds a strong relationship between a city's rate of employer-sponsored health coverage and its overall rates of health coverage and access to care.

We examined health insurance coverage and access to health care among moderate- and low-income, nonelderly residents of the nation's largest metropolitan areas. Our key findings are:

- There is great variation in uninsured rates across U.S. cities, ranging from a high of 37 percent in El Paso, Texas, to a low of 7 percent in both Akron, Ohio, and Harrisburg, Pennsylvania (see Exhibit ES-1).

- There is great variation in rates of employer-based health coverage across cities, from 84 percent in Milwaukee, Wisconsin, to just 49 percent in El Paso, Texas (see Exhibit ES-2).

- Those with lower incomes are especially at risk. Among residents with incomes below 250 percent of the poverty level, uninsured rates vary from 11 percent in Honolulu to 50 percent in El Paso.

- The uninsured are much less likely to have a regular source of health care or to have seen a physician in the last year; they are also much more likely to delay seeking care.

- Residents of cities with high uninsured rates generally have a harder time getting the health care they need than those living in cities with relatively low uninsured rates. The negative impact of high uninsured rates affects individuals with moderate incomes well above the poverty level.

Exhibit ES-1
MSAs with High vs. Low Uninsured Rates, All Income Levels, Ages 0–64, 1997

	Percent Uninsured	Percent of Low- and Moderate-Income Uninsured
Average of All MSAs	**19**	**30**
MSAs with Low Rates of Uninsurance		
Akron, OH	7	18
Harrisburg, PA	7	NR
Honolulu, HI	8	11
Milwaukee, WI	8	20
Ann Arbor, MI	9	NR
Allentown, PA	10	NR
Omaha, NE–IA	10	18
Minneapolis, MN–WI	10	22
Pittsburgh, PA	11	19
Youngstown, OH	11	18
Norfolk, VA–NC	11	22
Cincinnati, OH–KY–IN	12	22
Denver, CO	12	26
Charlotte, NC–SC	12	24
Seattle, WA	12	28
Buffalo–Niagara, NY	12	21
Hartford, CT	13	25
Oakland, CA	13	33
Detroit, MI	13	24
Louisville, KY–IN	13	20
Providence, RI–MA	13	22
Indianapolis, IN	13	28
Albany, NY	13	16
Portland, OR–WA	13	29
Cleveland, OH	14	24
Nassau–Suffolk, NY	14	25
Kansas City, MO–KS	14	29
MSAs with High Rates of Uninsurance		
El Paso, TX	37	50
Jersey City, NJ	36	39
Los Angeles, CA	31	46
Houston, TX	30	48
West Palm Beach, FL	29	47
New York, NY	27	37
Miami, FL	27	36
Tucson, AZ	26	39
Fort Lauderdale, FL	26	48
Phoenix–Mesa, AZ	26	44
Tampa, FL	25	38
Dallas, TX	25	44

NR = Estimate not reported because too unstable.

Source: March 1998 Current Population Survey.

Exhibit ES-2
MSAs with High vs. Low Rates of Job-Based Coverage, All Income Levels, Ages 0–64, 1997

	Percent with Job-Based Coverage	Percent of Low- and Moderate-Income with Job-Based Coverage
Average of all MSAs	**67**	**45**
MSAs with Low Rates of Job-Based Coverage		
El Paso, TX	49	30
New York, NY	50	25
Los Angeles, CA	50	26
Bakersfield, CA	51	37
Jersey City, NJ	51	41
Miami, FL	51	32
Tucson, AZ	55	34
Fresno, CA	56	35
Riverside–San Bernardino, CA	57	41
Tampa, FL	57	34
West Palm Beach, FL	58	35
Houston, TX	59	33
Albuquerque, NM	61	39
MSAs with High Rates of Job-Based Coverage		
Milwaukee, WI	84	56
Harrisburg, PA	83	70
Cincinnati, OH–KY–IN	82	63
Akron, OH	81	53
Ann Arbor, MI	80	50
Albany, NY	78	58
Greenville, SC	78	47
Minneapolis, MN–WI	78	46
Charlotte, NC–SC	77	57
Indianapolis, IN	77	46
Middlesex, NJ	77	48
Omaha, NE–IA	77	55
Baltimore, MD	76	45
Bergen–Passaic, NJ	76	49
Kansas City, MO–KS	76	47
Nassau–Suffolk, NY	76	51
Seattle, WA	76	50
Denver, CO	75	40
Louisville, KY–IN	75	60
Oakland, CA	75	41
Portland, OR–WA	75	45
Birmingham, AL	74	51
Cleveland, OH	74	51
Columbus, OH	74	54
Hartford, CT	74	48
Honolulu, HI	74	57
Monmouth, NJ	74	47
Salt Lake City, UT	74	54

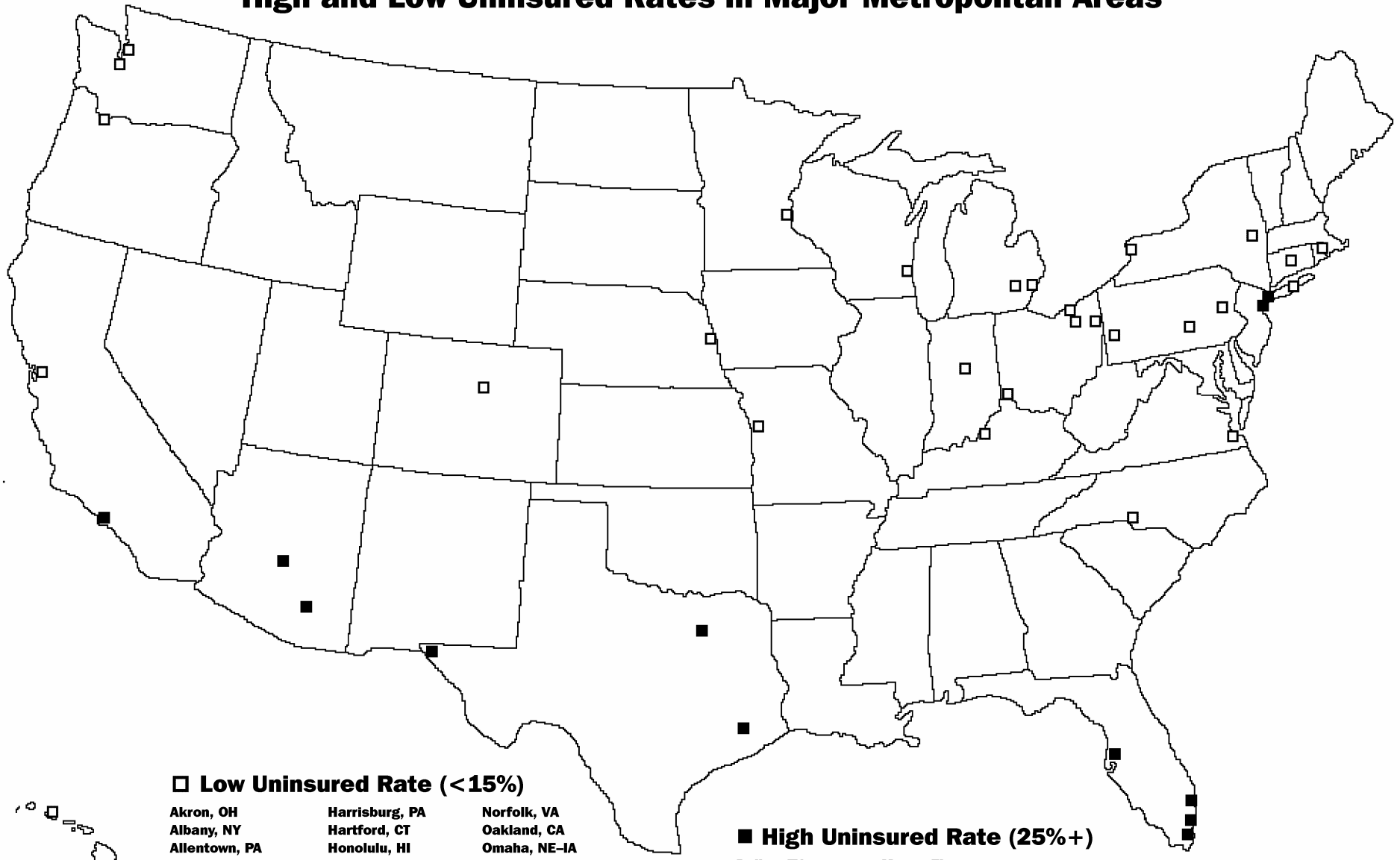
Source: March 1998 Current Population Survey.

VARIATION IN HEALTH INSURANCE COVERAGE

The study found wide variation in health insurance coverage in cities across the United States. The average uninsured rate for the 85 MSAs studied is 19 percent, with 12 of the communities having significantly higher rates (25% to 37%) and 27 having significantly lower rates (7% to 14%). The 12 MSAs with higher-than-average uninsured rates are located in Arizona, California, Florida, New Jersey, New York, and Texas, all of which have large concentration of immigrants, including both naturalized citizens and noncitizens. In these cities, Latinos comprise a large proportion of the moderate- and low-income immigrant residents. The 27 MSAs with lower-than-average uninsured rates are more geographically diverse, although they are generally clustered in the northern half of the United States (see Exhibit ES-3).

Not surprisingly, many of the cities with the highest uninsured rates also have the lowest rates of employer-based health coverage. The MSAs with the lowest rates of job-based insurance are all located in Arizona, California, Florida, New Jersey, New Mexico, New York, and Texas. Low-coverage MSAs have lower proportions of residents living in families with at least one full-time, full-year employed adult and higher proportions of breadwinners working in firms with fewer than 10 employees. These employment situations are less likely to offer workers job-based health benefits. Low-coverage communities also have higher unemployment and poverty rates and larger proportions of the population living in single-parent-headed households. Families with more working adults have more potential for access to job-based insurance.

Exhibit ES-3
High and Low Uninsured Rates in Major Metropolitan Areas



□ Low Uninsured Rate (<15%)

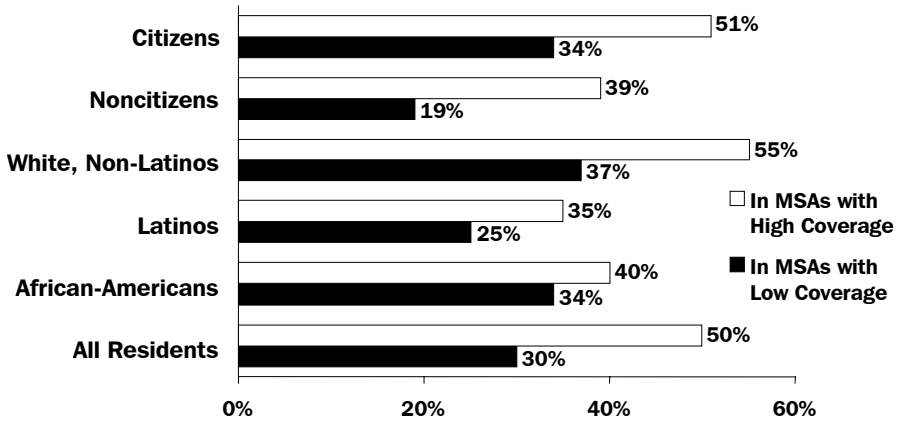
- Akron, OH
- Albany, NY
- Allentown, PA
- Ann Arbor, MI
- Buffalo–Niagara, NY
- Charlotte, NC–SC
- Cincinnati, OH–KY–IN
- Cleveland, OH
- Denver, CO
- Detroit, MI
- Harrisburg, PA
- Hartford, CT
- Honolulu, HI
- Indianapolis, IN
- Kansas City, MO–KS
- Louisville, KY–IN
- Milwaukee, WI
- Minneapolis, MN–WI
- Nassau–Suffolk, NY
- Norfolk, VA
- Oakland, CA
- Omaha, NE–IA
- Pittsburgh, PA
- Portland, OR–WA
- Providence, RI–MA
- Seattle, WA
- Tacoma, WA
- Youngstown, OH

■ High Uninsured Rate (25%+)

- Dallas, TX
- El Paso, TX
- Fort Lauderdale, FL
- Houston, TX
- Jersey City, NJ
- Los Angeles, CA
- Miami, FL
- New York, NY
- Phoenix–Mesa, AZ
- Tampa, FL
- Tucson, AZ
- West Palm Beach, FL

No matter where they live, people with moderate and low incomes are much less likely than more affluent people to have job-based coverage. The disparity is generally greater, however, among the less advantaged living in low-coverage areas—particularly Latinos and noncitizens (see Exhibit ES-4).

Exhibit ES-4
Moderate- and Low-Income People* Are Less Likely to Receive Job-Based Insurance in MSAs That Have Low Rates of Such Coverage, Ages 0–64, 1997



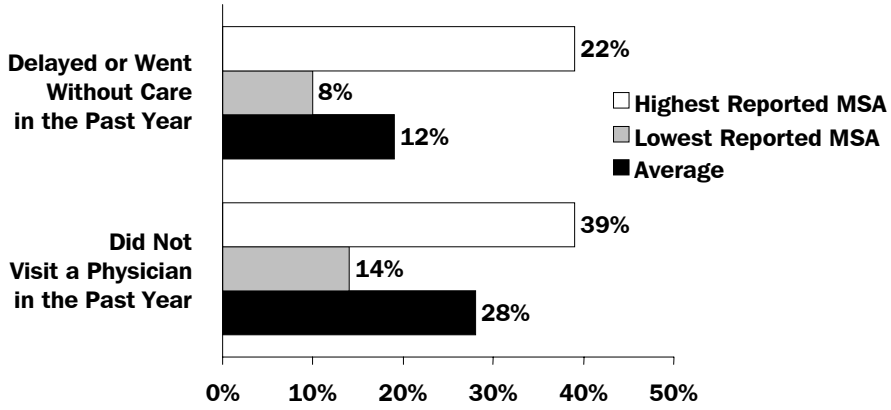
* Below 250 percent of the federal poverty level.
Source: March 1998 Current Population Survey.

Medicaid provides coverage for many moderate- and low-income families with children who do not have access to affordable job-based insurance. To a large degree, MSAs with high rates of Medicaid coverage share the same characteristics as those with low rates of job-based insurance. The average Medicaid rate for the 85 MSAs is 8 percent. In high Medicaid-coverage areas, fully one-third (33%) of the residents rely on Medicaid.

VARIATIONS IN ACCESS TO HEALTH CARE SERVICES

People without health insurance generally have less access to medical care than those with coverage, especially moderate- and low-income individuals who cannot afford out-of-pocket expenses for care. This study found wide variation in access to care among this population across 29 MSAs on three important measures: lack of a usual source of care, delaying care or going without needed care in the past year, and not having a physician visit in the past year (see Exhibit ES-5).

Exhibit ES-5
Access Problems Vary Widely Across Communities for Moderate- and Low-Income Residents,* Ages 0–64, 1995–1996



* Range from highest reported MSA to lowest reported MSA for residents with incomes below 250 percent of the federal poverty level.

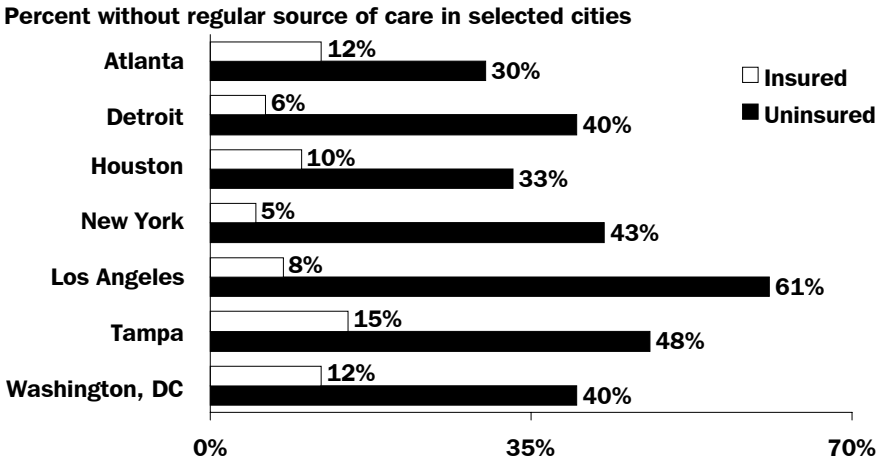
Source: 1995–1996 National Health Interview Survey.

Uninsured at High Risk for Lack of Access to Care

Within each MSA, low- and moderate-income residents without health insurance have less access to needed medical care than those of similar income with insurance. Regardless of whether the city has a higher- or lower-than-average uninsured rate, residents without coverage are less likely to have a regular source of care, more likely to have delayed or forgone needed care, and less likely to have seen a physician during the year.

The contrast between the experiences of the uninsured and insured are typically stark. For example, 40 percent of uninsured residents in Detroit and 61 percent in Los Angeles report having no regular source of care, compared with only 6 percent and 8 percent, respectively, of their insured counterparts (see Exhibit ES-6). Among nearly all the cities with an adequate sample size for access-to-care measures, the uninsured were twice as likely not to have visited a physician (see Exhibit 13 in the main report for city comparisons).

Exhibit ES-6
Moderate- and Low-Income* Uninsured Are Two to Three Times More Likely Than Moderate- and Low-Income Insured to Lack Access to Care, Ages 0–64, 1995–1996

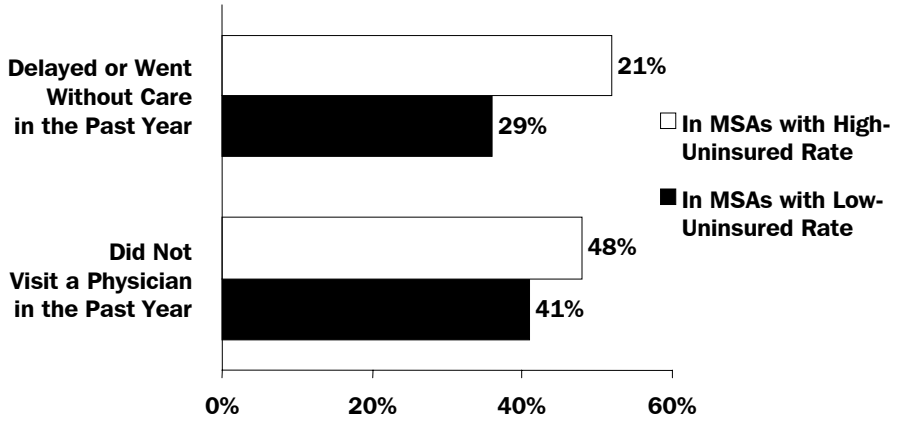


* Below 250 percent of the federal poverty level.
Source: 1995–1996 National Health Interview Survey.

Uninsured Fare Worse in Cities with Generally High Uninsured Rates

Although the uninsured overall have poor access to health care services, the uninsured in urban areas with high uninsured rates have an even higher risk of poor access than their counterparts in communities with low uninsured rates. The uninsured in high uninsured areas are more likely not to have a usual source of care, more likely to have delayed or forgone needed care in the past year, and more likely not to have visited a physician in the past year (see Exhibits ES-6 and ES-7). One possible reason for their having poorer access to services is that public hospitals and community health centers—the safety net—are overwhelmed by uninsured residents in cities that have disproportionately large uninsured populations.

Exhibit ES-7
Moderate- and Low-Income* Uninsured in Communities with High-Uninsured Rates Are at Increased Risk of Access Problems



* Below 250 percent of the federal poverty level.
Source: 1995–1996 National Health Interview Survey.

POLICY IMPLICATIONS

The socioeconomic characteristics of a community affect its job-based insurance rate and its uninsured rate. An area's uninsured rate, however, is also affected by public policy. Given similar demographics and economic conditions, a particular community is likely to have a lower uninsured rate if the state in which it is situated has relatively more generous eligibility requirements for Medicaid and other public health insurance programs.

Cities and counties have limited ability to address their residents' lack of access to employment-based health insurance. Long-term efforts may increase the proportion of residents working and the proportion of employed full-time, but cities and counties may lack the resources or authority to require small employers to offer health benefits or to mandate that employers make their employees' share of health insurance premiums affordable for moderate- and low-income workers. States, on the other hand, have expanded opportunities to cover uninsured children and their families. States can now cover working parents of children eligible for Medicaid using the family coverage options provided by section 1931 of the Social Security Act. The federal Children's Health Insurance Program (CHIP) provides additional opportunities and funding to extend coverage to children in working families with incomes up to 250 percent of the poverty level or higher.

Some states have used state tax resources or leveraged them with federal funds through Medicaid section 1931 options, CHIP eligibility, and/or Medicaid section 1115 waivers. States

can use section 1931 to cover working families, including adults, above traditional Medicaid income eligibility levels. States can also use section 1115 waivers to modify Medicaid's federal eligibility requirements and use their funds to cover more groups, such as adults without children, than would qualify under traditional Medicaid provisions. These policies and programs can reduce uninsured rates in the states and in their urban areas.

In the absence of universal coverage, moderate- and low-income urban residents will continue to experience barriers to needed health care. Cities and counties will bear the responsibility of providing for at least their minimum needs. Although many community-based hospitals and clinics meet some of their expenses through charitable contributions, local governments and community foundations can provide substantial support to these local safety net systems. States and the federal government can help these communities by providing more adequate financial support to the health care safety net, reducing the barriers found in areas with higher-than-average uninsured rates.

INTRODUCTION

Urban areas in the United States vary widely in the proportions of their populations that are uninsured.[1] Moderate- and low-income persons are much less likely to be insured than more affluent people.[2] For example, among nonelderly persons with family incomes below 250 percent of the federal poverty level (i.e., less than $32,000 for a family of three), 30 percent were uninsured in 1997, compared to 10 percent of those with incomes above that level.[3] Little is known, however, about the extent to which health insurance coverage and access to health care services vary across urban areas in the United States among these moderate- and low-income residents.

This report examines differences among urban areas in the United States in their rates of job-based health insurance and how those differences affect their residents' overall health insurance coverage and access to health care services. We examine differences in job-based insurance rates among the 85 metropolitan statistical areas (MSAs) with nonelderly populations of more than 500,000 as estimated by the 1998 March Current Population Survey (CPS), a national survey that asked about health insurance coverage during 1997. This report focuses on the nonelderly population in these MSAs whose incomes are less than 250 percent of the federal poverty level—the population that has few options for obtaining private coverage except through employment and is disproportionately uninsured.

MSAs are an appropriate geographic unit of analysis for the urban population in the United States. First, the 85 largest MSAs include 60 percent of the nation's nonelderly population (see Exhibit 1), but their health insurance profile is not very different from the rest of the U.S. population. Among the population living in these 85 MSAs, 19 percent are uninsured, versus 18 percent of those in the rest of the population. Compared with the rest of the nation, the population in the 85 MSAs has a slightly higher rate of employment-based health insurance, a slightly lower rate of privately purchased health insurance, and a slightly lower rate of Medicaid coverage.

---

[1] R. Levan, E. R. Brown, L. Lara, and R. Wyn, *Nearly One-Fifth of Urban Americans Lack Health Insurance,* Los Angeles: UCLA Center for Health Policy Research, December 1998.

[2] L. A. Aday, C. E. Begley, D. R. Lairson, and C. H. Slater, *Evaluating the Medical Care System: Effectiveness, Efficiency, and Equity*. Ann Arbor, MI: Health Administration Press, 1993; R. M. Anderson, T. H. Rice, and G. Kominski (eds.), *Changing the U.S. Health Care System: Key Issues in Health Services, Policy, and Management,* San Francisco: Jossey-Bass, Inc., 1996.

[3] We define as moderate- and low-income those persons with family incomes below 250 percent of the federal poverty level. Poverty levels are standardized measures based on total family income and family size. In 1997, the federal poverty level was $8,350 for one person, $10,805 for two persons, and $12,802 for three-person families (U.S. Department of Commerce, Bureau of the Census: www.census.gov/hhes/poverty/threshld/thresh97.html). Thus, 250 percent of the federal poverty level translates to a family income less than $20,875 for a nonelderly individual, $27,013 for a two-person household, and approximately $41,010 for a household of four.

Exhibit 1
Health Insurance Coverage of the Nonelderly Population Residing in the 85 Largest MSAs and the Rest of the United States, Ages 0–64, 1997

	85 Largest MSAs	Rest of United States
Uninsured	19%	18%
Job-Based Coverage	67%	65%
Privately Purchased	4%	5%
Medicaid	8%	10%
Other	2%	3%
Total Population	141,000,000	95,000,000
Distribution of Population	60%	40%

Source: March 1998 Current Population Survey.

Second, health insurance markets and health care services tend to be localized and differ between large urban areas, even within a state. As the data presented in this report underscore, the differences in health insurance coverage at the MSA level are reflected in patterns of uninsurance and access to care observed at the individual level. For most of the analyses, we divide these 85 MSAs into those with job-based insurance rates significantly above the average among the MSAs, those with rates significantly below the average, and those that do not differ significantly from the average.

We also examine how access to health care varies across MSAs, with a particular focus on the effects of insurance status on access to health care services. We examine how access varies in MSAs with low uninsured rates versus those with high uninsured rates. The 1995 and 1996 National Health Interview Surveys (NHIS) were used for this portion of the report. Due to sample size limitations, the analysis for the access portion of the study was limited to 29 MSAs, a subset of the 85 MSAs. These 29 MSAs have a somewhat higher uninsured rate than the 85 MSAs overall. Among the population living in the 29 MSAs, 21 percent were uninsured in 1998, compared with 17 percent in the rest of the nation. Their higher uninsured rate generates a disproportionate share of the nation's uninsured: the 29 MSAs include 41 percent of all the uninsured in the United States, but only 36 percent of the nation's nonelderly population (data not shown).

THE UNINSURED

Among the 85 MSAs, 27 had uninsured rates significantly below the average for the 85. We refer to these as low-uninsured MSAs. Their uninsured rates ranged from 7 percent in both Harrisburg and Akron to 14 percent in Cleveland; Kansas City, MO–KS; and Nassau–Suffolk, NY (see Exhibit 2).

Exhibit 2
MSAs with High vs. Low Uninsured Rates, All Income Levels, Ages 0–64, 1997

	Percent Uninsured	Percent of Low- and Moderate-Income Uninsured
Average of All MSAs	**19**	**30**
MSAs with Low Rates of Uninsurance		
Akron, OH	7	18
Harrisburg, PA	7	NR
Honolulu, HI	8	11
Milwaukee, WI	8	20
Ann Arbor, MI	9	NR
Allentown, PA	10	NR
Omaha, NE–IA	10	18
Minneapolis, MN–WI	10	22
Pittsburgh, PA	11	19
Youngstown, OH	11	18
Norfolk, VA–NC	11	22
Cincinnati, OH–KY–IN	12	22
Denver, CO	12	26
Charlotte, NC–SC	12	24
Seattle, WA	12	28
Buffalo–Niagara, NY	12	21
Hartford, CT	13	25
Oakland, CA	13	33
Detroit, MI	13	24
Louisville, KY–IN	13	20
Providence, RI–MA	13	22
Indianapolis, IN	13	28
Albany, NY	13	16
Portland, OR–WA	13	29
Cleveland, OH	14	24
Nassau–Suffolk, NY	14	25
Kansas City, MO–KS	14	29
MSAs with High Rates of Uninsurance		
El Paso, TX	37	50
Jersey City, NJ	36	39
Los Angeles, CA	31	46
Houston, TX	30	48
West Palm Beach, FL	29	47
New York, NY	27	37
Miami, FL	27	36
Tucson, AZ	26	39
Fort Lauderdale, FL	26	48
Phoenix–Mesa, AZ	26	44
Tampa, FL	25	38
Dallas, TX	25	44

NR = Estimate not reported because too unstable.

Source: March 1998 Current Population Survey.

In contrast, 12 MSAs had significantly high uninsured rates, ranging from 25 percent of nonelderly residents in Dallas and Tampa to 37 percent in El Paso. We refer to these as high-uninsured MSAs (see Exhibit 2). These high-uninsured MSAs also include another urban area in Texas (30% in Houston), three in Florida (ranging from 26% in Fort Lauderdale to 27% in Miami to 29% in West Palm Beach), two in Arizona (26% in both Phoenix and Tucson), New York City (27%) and Jersey City (36%) in the Middle Atlantic states, and Los Angeles (31%).

The 12 high-uninsured MSAs include a disproportionate share of the nation's uninsured. Together, these MSAs account for 22 percent of all uninsured persons, but only 14 percent of the nation's nonelderly population (data not shown).

MSAs with high uninsured rates also have higher rates of poverty (18% vs. 9% with low-uninsured MSAs), lower rates of unionization (12% vs. 19%), and greater income inequality (see Exhibit 3).[4] Per capita incomes are only slightly lower in MSAs with high uninsured rates ($26,326 vs. $27,212). Not surprisingly, job-based coverage rates are low in high-uninsured MSAs (56% vs. 76% in MSAs with low uninsured rates).

Exhibit 3
Selected Indicators by Average for MSAs with High vs. Low Uninsured Rates, All Income Levels, Ages 0–64, 1997

	MSAs with High Rates of Uninsurance	MSAs with Low Rates of Uninsurance
Noncitizens	16%	3%
Naturalized Citizens	8%	3%
Family Income Below Poverty	18%	9%
Unionization	12%	19%
Distribution of Income (Gini Index)	0.44	0.39

Source: Noncitizens, naturalized citizens, and family income below poverty computed from the March 1998 Current Population Survey; Gini index computed from an average of estimates from the 1997 and 1998 March Current Population Surveys; and unionization from U.S. Bureau of Census, 1997.

A striking difference between high- and low-uninsured MSAs is the generosity of their state's Medicaid eligibility policies. High-uninsured MSAs are found in states with less generous Medicaid programs—with an average Medicaid generosity index of only 0.96, compared with 1.21 for low-uninsured MSAs.[5] This difference of 0.25 is two and a half times the difference between high- and low-Medicaid–coverage MSAs (0.10), suggesting the important role Medicaid plays for low-income persons who do not have access to employment-based health insurance.

[4] MSAs with high uninsured rates have an average Gini index of 0.44, versus 0.39 for MSAs with low uninsured rates. Please see "Income Inequality" in Appendix III for further explanation of the Gini index.

[5] The Medicaid generosity index is an average for each state of the income eligibility levels across pregnant women, infants, and children. See Appendix III for further details.

The MSAs with high uninsured rates are nearly all urban areas and states with large concentrations of immigrants, including both noncitizens (16% of nonelderly residents in high-uninsured MSAs vs. 3% in low-uninsured MSAs) and naturalized citizens (8% vs. 3%). This differential by citizenship status is partially reflected in the ethnic distributions of these MSAs. High-uninsured MSAs, on average, have much larger proportions of Latinos among their nonelderly populations than low-uninsured MSAs (32% vs. 4%). Latinos include a large proportion of immigrants, and a large proportion of poor and near-poor persons—28 percent had family incomes below poverty in 1997 and another 31 percent were near-poor (compared with rates of 9% and 14% for non-Latino whites). High-uninsured MSAs also have larger proportions of African-American residents than low-uninsured MSAs (15% vs. 10%), a group that also, on average, has low incomes (27% lived below poverty and 24% were near-poor in 1997).[6]

In general, lack of health insurance coverage is more prevalent among lower-income persons than the more affluent. Of the nation's nonelderly population with family incomes of less than 250 percent of the federal poverty level who live in the 85 largest MSAs, one-third (33%) do not have any form of health insurance coverage—well above the rate of 19 percent for all nonelderly residents in these same MSAs.

JOB-BASED HEALTH INSURANCE COVERAGE

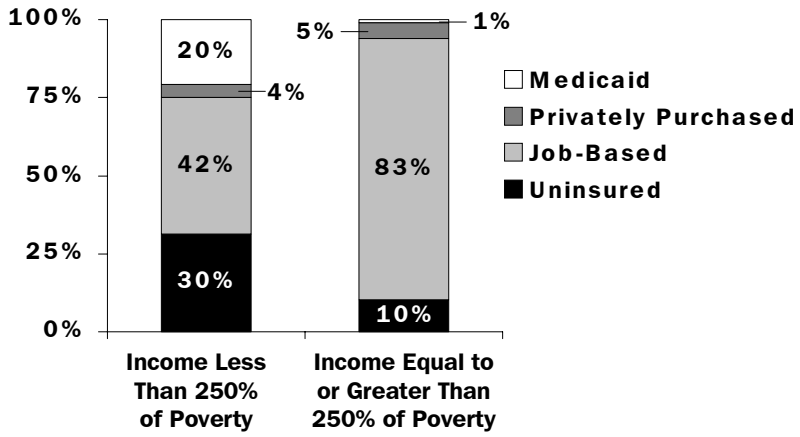
Most people in the United States obtain health insurance through their own employment or the employment of a family member. In 1997, 67 percent of all nonelderly persons in the United States were covered by employment-based health insurance. The group rates employers obtain from health plans, the contributions most employers provide for their employees' coverage, and the tax advantage offered by the government all make job-based insurance far more affordable for most workers than privately purchased health insurance. Because of its relative affordability, job-based insurance accounts for 94 percent of all private health insurance coverage in the United States, and nonelderly persons who do not have job-based coverage are much more likely to be uninsured. Employment-based health insurance coverage is thus the most important determinant of whether a nonelderly person has coverage for health care costs.

For the moderate- and low-income nonelderly population in particular, employment is an essential means of obtaining health insurance coverage. Without group rates, an employer's contribution, and exclusion from taxable income, private health insurance is likely to be out of reach for low- and even moderate-income workers and their families. Yet those with low incomes are much less likely than the more affluent nonelderly population to have this form of coverage: 42 percent of those with incomes below 250 percent of the poverty level have

[6] The ethnic group-specific poverty rates are from E. R. Brown, V. Ojeda, R. Wyn, and R. Levan, *Racial and Ethnic Disparities in Access to Health Insurance and Health Care,* Los Angeles and Menlo Park, CA: UCLA Center for Health Policy Research and Henry J. Kaiser Family Foundation, 2000.

employment-based coverage, compared with 83 percent of those with incomes above that level (see Exhibit 4).

Exhibit 4
Health Insurance Coverage by Family Income Relative to the Federal Poverty Level, All Income Levels, Ages 0–64, 1997



Source: March 1998 Current Population Survey.

Variation in Job-Based Health Insurance Coverage Across Urban Areas

In 1997, 28 of the nation's largest MSAs had job-based health insurance rates significantly above the average (67%) for the 85 MSAs examined in this study. We refer to these as high-coverage MSAs. In these high-coverage MSAs, job-based insurance among nonelderly residents of all income levels ranged from 74 percent in several MSAs to 84 percent in Milwaukee. Another 13 MSAs had significantly lower job-based coverage rates, with job-based insurance coverage ranging from 49 percent of the nonelderly in El Paso to 61 percent in Albuquerque. We refer to these as low-coverage MSAs. The remaining 44 MSAs had rates of job-based insurance that did not differ statistically from the average among all 85 MSAs. (See Exhibit 5 for the list of high- and low-coverage MSAs.)

Exhibit 5
MSAs with High vs. Low Rates of Job-Based Coverage, All Income Levels, Ages 0–64, 1997

	Percent with Job-Based Coverage	Percent of Low- and Moderate-Income with Job-Based Coverage
Average of all MSAs	**67**	**45**
MSAs with Low Rates of Job-Based Coverage		
El Paso, TX	49	30
New York, NY	50	25
Los Angeles, CA	50	26
Bakersfield, CA	51	37
Jersey City, NJ	51	41
Miami, FL	51	32
Tucson, AZ	55	34
Fresno, CA	56	35
Riverside–San Bernardino, CA	57	41
Tampa, FL	57	34
West Palm Beach, FL	58	35
Houston, TX	59	33
Albuquerque, NM	61	39
MSAs with High Rates of Job-Based Coverage		
Milwaukee, WI	84	56
Harrisburg, PA	83	70
Cincinnati, OH–KY–IN	82	63
Akron, OH	81	53
Ann Arbor, MI	80	50
Albany, NY	78	58
Greenville, SC	78	47
Minneapolis, MN–WI	78	46
Charlotte, NC–SC	77	57
Indianapolis, IN	77	46
Middlesex, NJ	77	48
Omaha, NE–IA	77	55
Baltimore, MD	76	45
Bergen–Passaic, NJ	76	49
Kansas City, MO–KS	76	47
Nassau–Suffolk, NY	76	51
Seattle, WA	76	50
Denver, CO	75	40
Louisville, KY–IN	75	60
Oakland, CA	75	41
Portland, OR–WA	75	45
Birmingham, AL	74	51
Cleveland, OH	74	51
Columbus, OH	74	54
Hartford, CT	74	48
Honolulu, HI	74	57
Monmouth, NJ	74	47
Salt Lake City, UT	74	54

Source: March 1998 Current Population Survey.

Among the moderate- and low-income population, job-based coverage also varies across the MSAs. In 1997, 51 percent of those living in the high-coverage MSAs obtained health insurance through their own or a family member's employment. This rate is well above the rate of 34 percent for moderate- and low-income residents of low-coverage MSAs.

What Distinguishes High- from Low-Coverage MSAs?

Economic Conditions. MSAs with high rates of job-based insurance are characterized by stronger economic conditions, which lead to better employment opportunities and higher incomes for residents. Unemployment rates in the high-coverage MSAs are about half those of MSAs with lower than average rates of job-based coverage (3.8% in high-coverage MSAs versus 7.4% in low-coverage MSAs in 1997; see Exhibit 6). Among MSAs with lower than average rates of job-based coverage, we also find that high unemployment rates combine with other factors such as geographic isolation of inner-city residents from available jobs to discourage people from seeking work, resulting in lower rates of labor force participation (87% vs. 93%). High-coverage MSAs are also distinguished by higher proportions of residents who live in families with at least one adult who is a full-time, full-year employee (74% vs. 63%), the type of employment most likely to give workers access to employer-sponsored health benefits.

Exhibit 6
Selected Indicators by Average for MSAs with High vs. Low Rates of Job-Based Coverage, All Income Levels, Ages 0–64, 1997

	MSAs with High Rates of Job-Based Coverage	MSAs with Low Rates of Job-Based Coverage
Unemployment Rate	3.8%	7.4%
Labor Force Participation	93%	87%
At Least One Full-Time/Full-Year Worker in Family	74%	63%
Family Breadwinner Working in Agriculture Sector	1%	5%
Family Breadwinner Working in Retail Sector	14%	17%
Family Breadwinner Working in Durable Manufacturing	11%	9%
Family Breadwinner Working in Financial Services	8%	6%
Employment in Firms with Fewer than 10 Employees	14%	20%
Employment in Firms with 500 or More Employees	50%	44%
Union Membership	16%	12%
Employer Offering Health Benefits	89%	78%
Per Capita Income	$28,286	$24,272
Poverty Rate (% Population Below 100% FPL)	9%	21%
Proportion with Family Income at Least 400% FPL	47%	27%
Income Inequality (Gini Index)	0.39	0.44

Source: All data reported are from the March 1998 Current Population Survey, with the exception of the unemployment rate, which is from the 1999 Area Resource File (1997 data reported), per capita income, which is from the 1999 U.S. Department of Commerce Survey of Current Business (1997 data reported), and income inequality, which is a two-year average of the March 1997 and March 1998 Current Population Surveys.

The relative size of particular sectors of the labor market also differentiates high- and low-coverage MSAs. Low-coverage MSAs are more likely to have family breadwinners employed in agriculture (5% vs. 1%) and retail businesses (17% vs. 14%), while high-coverage MSAs have larger proportions of family breadwinners employed in durable manufacturing (11% vs. 9%) and financial services (8% vs. 6%).

One of the most striking characteristics of low-coverage MSAs is the large proportion of family breadwinners employed in firms with fewer than 10 employees (20% in low-coverage MSAs vs. 14% in high-coverage MSAs) and the relatively smaller proportion employed in firms with 500 or more workers (44% vs. 50%).

The extent to which workers are represented by unions also affects an MSA's rate of job-based insurance because unions tend to negotiate comprehensive benefits packages, including health insurance, for all employees in a workplace. In low-coverage MSAs, a smaller proportion of workers are union members or covered by a union contract (12% vs. 16% in high-coverage MSAs). Clearly, an employee (as well as his/her family members) can obtain job-based coverage only if the employer offers it. It is not surprising, then, that in high-coverage MSAs a substantially larger proportion of adult employees work for employers who offer health benefits to at least some workers (89% vs. 78%).

Income Level. Average income among the nonelderly population, the extent of inequality in the distribution of income, and the proportion of the population living below the federal poverty level are all very related to an MSA's job-based insurance coverage. It is noteworthy that the per capita income is greater in high-coverage MSAs versus low-coverage MSAs ($28,286 vs. $24,272). It is also striking that high-coverage MSAs have much lower poverty rates (9% vs. 21%) and much larger proportions of their populations whose family incomes are at least four times the poverty level (47% vs. 27%). High-coverage MSAs also have a more equal distribution of income.[7] With income inequality increasing in the United States, its association with low rates of health insurance coverage suggests troubling implications for the future of job-based health insurance.[8]

Ethnicity and Citizen Status. Given the enormous inequalities in U.S. society and the high rates of poverty among Latinos, it is not surprising that MSAs with low rates of job-based coverage have a larger proportion of Latinos (35% vs. 4%) and a smaller proportion of non-Latino

[7] High-coverage MSAs have a Gini index value of 0.39, versus 0.44 in low-coverage MSAs. Please refer to "Income Inequality" in Appendix III for further explanation of the Gini index.

[8] D. H. Weinberg, *A Brief Look at Postwar U.S. Income Inequality,* pp. 60–191. Washington, DC: U.S. Bureau of the Census, June 1996.

whites (46% vs. 78%), as well as larger proportions of naturalized citizens (7% vs. 3%) and noncitizens (15% vs. 4%). Noncitizens are two to three times more likely than citizens to work for an employer that does not offer health benefits to any worker.[9]

Family Unit. Family composition—whether a person lives in a family unit headed by one or two adults—is also associated with poverty rates. Families with more working adults have more potential earners and, thus, more opportunities for family members to have access to employment-based health insurance. Consequently, larger proportions of the populations in high-coverage MSAs live in married-couple households, both with children (47% vs. 42%) and without children (17% vs. 14%), and fewer live in single-adult households (24% vs. 26%) and single-parent-headed households (12% vs. 17%).

No HMO Effect. If one accepts the argument that health maintenance organizations (HMOs) are better able than indemnity insurers to keep health insurance premiums lower, and thus more affordable, then one would expect high-coverage MSAs to have a larger proportion of residents enrolled in HMOs. Interestingly, however, HMOs enroll a smaller proportion of residents in high-coverage MSAs than in low-coverage areas (33% vs. 38%). This pattern suggests that high HMO market penetration does not increase coverage.

How Does Job-Based Coverage Differ for Moderate- and Low-Income Residents of High- Versus Low-Coverage MSAs?

All moderate- and low-income residents of low-coverage MSAs have a higher risk of not receiving job-based insurance compared with their counterparts who live in high-coverage MSAs. The disparity between high- and low-coverage MSAs affects virtually every subgroup of those with incomes below 250 percent of poverty (see Exhibit 7). Moderate- and low-income Latinos, who have among the lowest rates of job-based insurance, have even lower rates in low-coverage MSAs than in high-coverage MSAs (25% vs. 35%). This disparity is also observed for other ethnic groups. Among moderate- and low-income African-Americans, 34 percent have job-based insurance in low-coverage MSAs, compared with 40 percent in high-coverage MSAs. Among moderate- and low-income noncitizens, 39 percent have such insurance in high-coverage MSAs compared with 19 percent in low-coverage MSAs. And among moderate- and low-income Asian-Americans and Pacific Islanders, 56 percent and 29 percent, respectively, have employment-based insurance in high- and low-coverage MSAs.

[9] E. R. Brown and T. Rice, "Employees' Access to Job-Based Insurance," in H. H. Schauffler, E. R. Brown, et al., *The State of Health Insurance in California, 1998,* Berkeley and Los Angeles: Health Insurance Policy Program, January 1999.

Exhibit 7
Job-Based Insurance by Residence in MSAs with High vs. Low Rates of Job-Based Coverage, Persons with Family Incomes Below 250% of Federal Poverty Level, Ages 0–64, 1997

	Percent with Job-Based Coverage Rates	
	MSAs with High Rates of Job-Based Coverage	MSAs with Low Rates of Job-Based Coverage
All Residents Below 250% FPL	50	30
Non-Latino Whites Below 250% FPL	55	37
Latinos Below 250% FPL	35	25
African-Americans Below 250% FPL	40	34
Asian-Americans & Pacific Islanders Below 250% FPL	56	29
Noncitizens Below 250% FPL	39	19
U.S. Citizens Below 250% FPL	51	34

Source: March 1998 Current Population Survey.

The disparity is also great among those moderate- and low-income groups who are less likely to face cultural or discrimination barriers. Among moderate- and low-income non-Latino whites, 55 percent have job-based insurance in high-coverage MSAs versus 37 percent in low-coverage MSAs. Similarly, among moderate- and low-income U.S. citizens, 51 percent have job-based insurance in high-coverage MSAs, compared with 34 percent in low-coverage MSAs.

Education Level. Education is strongly related to employment opportunities, earnings, and access to employment-based health insurance, but residents of low-coverage MSAs fare worse regardless of the educational attainment of their family's primary wage earner. Among moderate- and low-income residents whose family breadwinner has less than a high school education, 29 percent of those in high-coverage MSAs have job-based insurance compared with just 18 percent in low-coverage areas (data not shown). The disparity is even greater, however, for those whose primary breadwinner is a college graduate: 65 percent versus 52 percent.

Work Status. Dramatic differences in rates of job-based insurance also prevail among residents regardless of family work status. Even among moderate- and low-income residents who are full-time, full-year employees or their family members, 71 percent of those in high-coverage MSAs have employment-based insurance compared with just 47 percent of those in low-coverage MSAs (data not shown). Similarly, a very large disparity between high-coverage versus low-coverage MSAs is found among moderate- and low-income residents whose primary breadwinner works in durable goods manufacturing (73% vs. 50%), financial services (79% vs. 54%), professional services (65% vs. 45%), and retail firms (46% vs. 25%).

Although large disparities might be expected among families whose breadwinners work in small firms, differences between high- and low-coverage MSAs are nearly as great among those

with wage earners in large firms. Among moderate- and low-income residents whose primary breadwinner is employed in a firm with fewer than 25 workers, 33 percent in high-coverage MSAs have job-based insurance, while 17 percent in low-coverage areas do. Among those whose primary wage earner works in a firm with 500 or more employees, 67 percent in high-coverage MSAs have job-based insurance versus 53 percent in low-coverage MSAs.

More Affluent Affected. More affluent residents also experience this disparity. Among families with incomes of 250 percent of the poverty level or higher, 77 percent in low-coverage MSAs have job-based insurance versus 87 percent in high-coverage MSAs. Most of the more affluent share this disadvantage if they live in low-coverage MSAs compared with high-coverage MSAs, including non-Latino whites (80% vs. 88%); those whose primary breadwinner has less than a high school education (53% vs. 76%); those whose primary wage earner is a college graduate (85% vs. 90%); those in families headed by a full-time, full-year employee (83% vs. 90%), and those whose primary breadwinner works full-time for less than the full year (64% vs. 80%).

MEDICAID COVERAGE

Medicaid is a safety net for those who meet the program's stringent eligibility provisions. Although it is widely believed to be a health insurance program for the poor, Medicaid eligibility is restricted to people who are both poor—as defined by the state in which they live—and meet categorical requirements (such as being a pregnant woman or in a family with a dependent child, being a disabled nonelderly adult, or being age 65 or older). Due to the high cost of purchasing private health insurance without an employer's group rates and financial contribution, lower-income persons who do not have job-based insurance are very likely to be uninsured if they do not qualify for Medicaid.

In 15 MSAs, Medicaid rates fall significantly below the average for the entire nonelderly populations of the 85 MSAs in the study. We refer to these as low-Medicaid-coverage MSAs (see Exhibit 8). Medicaid coverage for the nonelderly populations in seven of the MSAs significantly exceeds the average for all 85 MSAs in this study; we classify these as high-Medicaid-coverage MSAs.

Exhibit 8
MSAs with High vs. Low Rates of Medicaid Coverage, All Income Levels, Ages 0–64, 1997

	Percent with Medicaid	Percent of Low- and Moderate-Income with Medicaid
Average of All MSAs	**8**	**18**
MSAs with Low Rates of Medicaid Coverage		
Fort Lauderdale, FL	3	10
Milwaukee, WI	4	16
Louisville, KY–IN	4	12
Dallas, TX	4	10
Nassau–Suffolk, NY	4	14
Norfolk, VA–NC	4	NR
Indianapolis, IN	4	14
Orlando, FL	4	8
Kansas City, MO–KS	4	12
Oklahoma City, OK	4	10
Oakland, CA	4	15
Middlesex, NJ	4	14
Las Vegas, NV–AZ	5	10
Salt Lake City, UT	5	12
Charlotte, NC–SC	5	10
MSAs with High Rates of Medicaid Coverage		
Knoxville, TN	21	42
Bakersfield, CA	21	31
New York, NY	19	35
Fresno, CA	17	31
Riverside–San Bernardino, CA	15	29
Sacramento, CA	15	31
Providence, RI–MA	12	33

NR = Estimate not reported because too unstable.
Source: March 1998 Current Population Survey.

In the high-Medicaid-coverage MSAs, an average of one of three (33%) moderate- and low-income residents rely on Medicaid—three times the average of one of 10 (10%) moderate- and low-income residents for low-Medicaid-coverage MSAs.

On average, MSAs with high rates of Medicaid coverage, like those with low rates of job-based insurance, have poorer economic conditions. Compared to MSAs with low Medicaid coverage rates, MSAs with high Medicaid coverage rates have higher unemployment rates (7.9% vs. 3.9%); a larger proportion of nonelderly residents who live in a nonworking family (14% vs. 7%); lower per capita incomes ($26,326 vs. $27,212); and a larger share of residents who have family incomes below the poverty level (21% vs. 9%; see Exhibit 9). High-Medicaid-coverage

MSAs also have slightly more unequal distributions of income.[10] These areas also have larger populations with relatively low educational attainment: 22 percent of residents live in families whose primary wage earner has less than a high school education, compared with 10 percent of residents of low-Medicaid-coverage MSAs.

Exhibit 9
Selected Indicators by Average for MSAs with High vs. Low Rates of Medicaid Coverage, All Income Levels, Ages 0–64, 1997

	MSAs with High Rates of Medicaid Coverage	MSAs with Low Rates of Medicaid Coverage
Unemployment Rate	7.9%	3.9%
Residents Living in Nonworking Family	14%	7%
Per Capita Income	$26,326	$27,212
Family Income Below Poverty	21%	9%
Inequality of Income (Gini Coefficient)	0.43	0.40

Source: Residents in nonworking family and family income below poverty computed from the March 1998 Current Population Survey; Gini coefficient computed from an average of estimates from the 1997 and 1998 March Current Population Surveys; unemployment rate from the 1999 Area Resource File (1997 data reported); and per capita income from the 1999 U.S. Department of Commerce Survey of Current Business (1997 data reported).

High-Medicaid-coverage MSAs also share several demographic features with low-job-based-coverage MSAs. Namely, they have larger proportions of residents who are Latino (22% vs. 8%) and are noncitizens (10% vs. 6%). These MSAs also have larger proportions of residents living in single-parent-headed families (17% vs. 12%) and under age 18 (32% vs. 28%).

Thus, high-Medicaid-coverage MSAs are characterized by weak economic indicators—greater poverty, higher unemployment rates, lower rates of labor force participation, and low average educational attainment. These factors contribute to low rates of job-based insurance, forcing low-income residents to depend more on Medicaid as their only coverage option.

Fortunately for these MSAs' low-income residents, the states in which they live have responded with more generous Medicaid income eligibility policies, with an average Medicaid generosity index equal to 1.14 versus 1.04 for low-Medicaid-coverage MSAs.[11] The combination of economic and social factors plus responsive Medicaid eligibility policies contribute to higher Medicaid enrollments. Although high-Medicaid-coverage MSAs' poor employment and other economic indicators might be expected to result in higher uninsured rates, the more generous Medicaid enrollments, in fact, result in lower proportions of their moderate- and low-income

[10] High-Medicaid coverage MSAs have an average Gini index value of 0.43, compared to 0.40 for low-Medicaid coverage MSAs. Please see "Income Inequality" in Appendix III for further explanation of the Gini index.

[11] The Medicaid generosity index is an average for each state of the income eligibility levels across pregnant women, infants, and children. See Appendix III for further details.

residents being uninsured—27 percent in high-Medicaid-coverage MSAs versus 31 percent in low-Medicaid-coverage MSAs.

ACCESS TO HEALTH CARE AND THE EFFECTS OF INSURANCE COVERAGE

Health insurance coverage promotes financial access to health care services and protects families and individuals against the potentially prohibitive costs of medical care. Individuals who lack health insurance generally have less access to care than those with coverage—especially moderate- and low-income individuals who cannot afford out-of-pocket expenses for health care.[12] If care is sought, it is often for advanced conditions and at emergency rooms. Thus, despite having less access to care, moderate- and low-income uninsured individuals and families may impose substantial financial costs on public and private hospitals, community clinics, and other providers.

In this section of the report, we examine three measures of reduced access to care: the lack of a usual place to receive care; delayed or entirely forgone care in the past year; and no physician visit in the past year. We examine how these measures of access vary across the MSAs and also within MSAs, comparing persons who are insured with those who are uninsured. We further examine how access varies among the uninsured depending upon whether they live in an MSA with high or low uninsured rates. Due to sample size limitations, the analysis for this access portion of the study is limited to 29 MSAs, a subset of the 85 MSAs studied in the coverage section.[13]

VARIATION ACROSS MSAs IN MEASURES OF REDUCED ACCESS TO CARE

Having an identifiable physician or place where care is received influences a person's decision to seek care and his or her ability to obtain care in a timely fashion.[14] Considerable variation exists across MSAs with regard to the portion of the moderate- and low-income population that lacks a usual source of health care. Across the 29 MSAs examined, 19 percent of the moderate- and low-income population lacks a usual source of care. This proportion varies across these MSAs, ranging from 39 percent in Fort Worth to 10 percent in both Nassau–Suffolk and Baltimore (see Exhibit 10). In seven MSAs, over one-quarter of the moderate- and low-income population is without a usual source of care.

[12] Aday et al., 1993; and Anderson et al., 1996.

[13] The access portion of the study, focusing on the 29 MSAs, draws on data from the National Health Interview Survey; the coverage analyses, focusing on 85 MSAs, uses data from the Current Population Survey.

[14] Aday et al., 1993.

Exhibit 10
Percent of Moderate- and Low-Income Population with No Usual Source of Care, by MSA, Ages 0–64, 1995–1996

	Percent with No Usual Source of Care
Fort Worth, TX	39
San Francisco, CA	32
Miami, FL	30
Los Angeles, CA	28
Austin–San Marcos, TX	27
Tampa, FL	26
Orange County, CA	26
Riverside–San Bernardino, CA	23
Dallas, TX	22
Kansas City, MO–KS	21
Phoenix–Mesa, AZ	21
San Antonio, TX	20
Washington, DC–MD–VA–WV	20
San Diego, CA	19
Houston, TX	19
Atlanta, GA	17
New York, NY	16
Chicago, IL	14
Newark, NJ	14
Pittsburgh, PA	14
Oakland, CA	13
Detroit, MI	13
St. Louis, MO–IL	13
Bergen–Passaic, NJ	12
Philadelphia, PA	12
Minneapolis, MN–WI	11
San Jose, CA	11
Baltimore, MD	10
Nassau–Suffolk, NY	10

Source: 1995–1996 National Health Interview Survey.

Another indicator of access to health care is the ability of the population to obtain needed care in a timely fashion. This indicator measures respondents' perceptions of their ability to get care when needed. Therefore, it measures not only perceived need for care, but also the respondents' expectations of the health care system. The proportion of the moderate- and low-income population that reports delaying care or going without needed care ranges from a high of 22 percent in Fort Worth to a low of 8 percent in both Baltimore and Oakland (with an average across MSAs of 12%; see Exhibit 11).

Exhibit 11
Percent Moderate- and Low-Income Population Who Delayed Care or Went Without Needed Care, by MSA, Ages 0–64, 1995–1996

	Percent Who Delayed Care or Went Without Needed Care
Fort Worth, TX	22
Tampa, FL	17
St. Louis, MO–IL	17
San Diego, CA	16
San Francisco, CA	15
Newark, NJ	15
Phoenix–Mesa, AZ	15
Detroit, MI	14
Miami, FL	14
Kansas City, MO–KS	13
Riverside–San Bernardino, CA	13
Dallas, TX	12
Orange County, CA	12
New York, NY	12
Atlanta, GA	12
Pittsburgh, PA	11
Austin–San Marcos, TX	11
Minneapolis, MN–WI	11
Houston, TX	11
Philadelphia, PA–NJ	10
Washington, DC–MD–VA–WV	10
San Antonio, TX	9
Los Angeles, CA	9
Chicago, IL	9
Nassau–Suffolk, NY	9
Baltimore, MD	8
Oakland, CA	8
Bergen–Passaic, NJ	NR
San Jose, CA	NR

NR = Estimate not reported because too unstable.
Source: 1995–1996 National Health Interview Survey.

Finally, a physician visit in the past year is a broad measure of access to the health care system for both acute and chronic conditions as well as preventive checkups. Considerable variability exists across MSAs in the proportion of the moderate- and low-income population not visiting a physician in the past year, with a nearly three-fold difference between the lowest and highest MSAs. In Philadelphia, 14 percent of the nonelderly population did not have a physician visit in the previous year, compared with 39 percent in both Fort Worth and San Francisco (see Exhibit 12).

Exhibit 12
Percent of Moderate- and Low-Income Population* Without a Physician Visit in the Past Year, by MSA, Ages 0–64, 1995–1996

	Percent with No Physician Visit in the Past Year
San Francisco, CA	39
Fort Worth, TX	39
San Jose, CA	36
Los Angeles, CA	34
Miami, FL	34
Orange County, CA	34
Chicago, IL	33
Tampa, FL	32
Houston, TX	32
San Antonio, TX	32
Newark, NJ	32
Bergen–Passaic, NJ	32
Riverside–San Bernardino, CA	31
San Diego, CA	31
Dallas, TX	30
Austin–San Marcos, TX	30
St. Louis, MO–IL	29
Phoenix–Mesa, AZ	28
Kansas City, MO–KS	28
Oakland, CA	27
Nassau–Suffolk, NY	26
Washington, DC–MD–VA–WV	23
Minneapolis, MN–WI	22
New York, NY	21
Pittsburgh, PA	21
Detroit, MI	20
Atlanta, GA	19
Baltimore, MD	16
Philadelphia, PA–NJ	14

Source: 1995–1996 National Health Interview Survey.
* Income below 250 percent of the poverty level.

The average across MSAs of the proportion of moderate- and low-income residents without an annual physician visit is 28 percent. In the vast majority of MSAs (21 of 29), one-quarter or more of the moderate- and low-income population did not visit a physician in the past year.

HOW ACCESS TO CARE VARIES IN MSAs WITH HIGH VERSUS LOW UNINSURED RATES

MSAs with higher-than-average uninsured rates are characterized by poorer access to care for their residents. Nearly one-quarter (23%) of the moderate- and low-income population in MSAs with high uninsured rates does not have a usual source of care. By contrast, across the MSAs with lower than average uninsured rates, 14 percent are without a usual source.

MSAs with high uninsured rates also have larger proportions of moderate- and low-income, nonelderly residents who have not visited a physician within the past year: 30 percent of those living in MSAs with high uninsured rates, compared with 24 percent of those in MSAs with low uninsured rates.

Finally, MSAs with high rates of uninsured nonelderly residents also have larger proportions of moderate- and low-income nonelderly residents who reported having delayed or forgone care in the past year: 13 percent in MSAs with high uninsured rates versus 11 percent in MSAs with low uninsured rates.

HOW ACCESS TO CARE VARIES BETWEEN UNINSURED AND INSURED MODERATE- AND LOW-INCOME RESIDENTS

Within each MSA—regardless of whether it is an MSA with a higher-than-average or lower-than-average uninsured rate—the uninsured are consistently less likely than those with insurance to have a usual source of care, more likely to have delayed or forgone care, and less likely to have seen a physician within the past year (see Exhibit 13).

In each of the MSAs that had a sufficient sample size for this section of the study, the moderate- and low-income uninsured members of the population are less likely than those with coverage to have a regular connection to the health care system. For example, of the moderate- and low-income uninsured population in Detroit and Riverside–San Bernardino, 40 percent and 54 percent, respectively, report having no usual source of care, compared with only 6 percent and 7 percent, respectively, of their insured counterparts in these MSAs.

Additionally, in the 18 MSAs that had adequate sample size to measure delayed or forgone care, moderate- and low-income uninsured residents are more likely to have delayed or forgone care. For example, while nearly one-fifth (18%) of moderate- and low-income uninsured persons in Houston reports having delayed or forgone care, only 6 percent of the insured persons in this income group indicate having done so. Other urban areas across the United States mirror this pattern. In New York City, for example, one-quarter (25%) of the moderate- and low-income uninsured population reports having delayed or forgone needed care, compared with only 7 percent of the insured nonelderly New York population with comparable income. In Los Angeles, 17 percent of the moderate- and low-income uninsured population reports having delayed or forgone care, versus 4 percent who have health insurance.

In nearly all MSAs (26 of 28 with adequate sample size), the moderate- and low-income uninsured population is only about half as likely as their insured counterparts to have visited a physician in the past 12-month period. In Tampa, 47 percent of the uninsured moderate- and

low-income population had no physician visit compared with 24 percent of those with insurance. In Chicago, 50 percent of the uninsured, versus 26 percent of the insured, had not visited a physician in the past year; in Oakland, the numbers were 44 percent versus 23 percent.

Exhibit 13
Moderate- and Low-Income Uninsured and Insured Differences in Access Within an MSA, Ages 0–64, 1995–1996

	No Usual Source of Care		Delayed Care or Went Without Needed Care		No Physician Visit in Past Year	
Percent with Access Problems, by Insurance Status	**Insured**	**Uninsured**	**Insured**	**Uninsured**	**Insured**	**Uninsured**
Atlanta, GA	12	30	7	24	11	39
Austin–San Marcos, TX	17	44	NR	21	22	43
Baltimore, MD	NR	30	6	16	10	32
Bergen–Passaic, NJ	NR	NR	NR	NR	28	37
Chicago, IL	6	33	5	16	26	50
Dallas, TX	12	46	12	13	26	40
Detroit, MI	6	40	9	37	16	35
Fort Worth, TX	27	49	17	26	33	43
Houston, TX	10	33	6	18	21	49
Kansas City, MO–KS	14	46	8	27	21	50
Los Angeles, CA	8	61	4	17	23	53
Miami, FL	NR	67	NR	28	21	53
Minneapolis, MN–WI	6	37	7	28	17	46
Nassau–Suffolk, NY	NR	NR	NR	27	18	44
New York, NY	5	43	7	25	14	39
Newark, NJ	NR	31	NR	33	27	43
Oakland, CA	8	34	NR	NR	23	44
Orange County, CA	NR	63	13	NR	23	55
Philadelphia, PA–NJ	5	39	9	16	8	37
Phoenix–Mesa, AZ	11	45	12	23	21	47
Pittsburgh, PA	10	33	8	32	20	NR
Riverside–San Bernardino, CA	7	54	8	21	20	53
San Antonio, TX	10	35	NR	21	22	47
San Diego, CA	12	35	10	30	22	50
San Francisco, CA	NR	71	NR	25	31	52
San Jose, CA	NR	28	NR	NR	30	59
St. Louis, MO–IL	9	27	14	29	24	47
Tampa, FL	15	48	11	30	24	47
Washington, DC–MD–VA–WV	12	40	NR	24	16	43

NR = Estimate not reported because too unstable.
Source: 1995–1996 National Health Interview Survey.

HOW THE UNINSURED FARE IN MSAs WITH HIGH VERSUS LOW UNINSURED RATES

Although the uninsured overall have poor access, there is a difference between the experience of the uninsured in MSAs with high uninsured rates versus those with low rates. The moderate- and

low-income uninsured who live in MSAs with lower-than-average uninsured rates typically have better access to care than the uninsured who live in MSAs with higher-than-average uninsured rates.

Slightly more than half (52%) of the uninsured in high-uninsured MSAs have no usual source of care, compared with 36 percent of those in low-uninsured MSAs (see Exhibit 14). In contrast, for the insured, the insurance status of the MSA they live in had no effect: 8 percent of both those in high- and low-uninsured MSAs had no usual source of care.

Exhibit 14
Access to Care for the Uninsured in High-Uninsured and Low-Uninsured MSAs, All Income Levels, Ages 0–64, 1995–1996

	Percent with No Usual Source of Care	Percent with No Physician Visit in Past Year	Percent with Delayed/Forgone Care
Uninsured			
High-Uninsured MSAs*	52	48	21
Low-Uninsured MSAs**	36	41	29
Insured			
High-Uninsured MSAs*	8	20	6
Low-Uninsured MSAs**	8	19	7

* High-Uninsured MSAs include Dallas, Houston, Los Angeles, Miami, New York, Phoenix, Tampa.
** Low-Uninsured MSAs include Detroit, Kansas City, Minneapolis, Nassau-Suffolk, Oakland, Pittsburgh.
Source: 1995–1996 National Health Interview Survey.

The percent of persons having had at least one physician visit also differs for the uninsured according to the uninsured rate of the MSA in which they live: 48 percent of those in high-uninsured MSAs versus 41 percent in low-uninsured MSAs had no physician visit in the past year. As was seen for usual source of care, the insured did not differ based on MSA type; 20 percent of the insured in high-uninsured MSAs and 19 percent of those in low-uninsured MSAs did not have a recent physician visit.

This pattern was different for delayed or forgone care. Of the uninsured surveyed who lived in high-uninsured MSAs, 21 percent reported delayed or forgone care as did 29 percent of those in low-uninsured MSAs. Among insured persons, a similar proportion reported delayed or forgone care (6% and 7%), regardless of the uninsured status of the MSA in which they live.

CONCLUSIONS AND POLICY IMPLICATIONS

Documenting Disparities in Coverage and Access to Care

The risk of being uninsured is high for those who have moderate or low incomes, but, as this study found, it is even higher for persons living in areas with disproportionate numbers of

uninsured residents. Three of every 10 moderate- and low-income nonelderly persons in the United States are uninsured—three times the rate for more affluent persons. Moderate- and low-income residents of the nation's 85 largest urban areas are also more likely to be uninsured if their metropolitan area has a significantly low rate of employment-based insurance than if their area has a significantly high job-based coverage rate (see Appendix I). Akron and Albany, for example, have significantly low uninsured rates due to their significantly high job-based coverage rates, while both Houston and Los Angeles have significantly high uninsured rates due to their significantly low job-based insurance rates.

Without health insurance, most individuals and families—especially those living with moderate and low incomes—struggle to pay the full cost of even basic physician services and prescription drugs. Because health insurance provides financial access to health care services, it is not surprising that uninsured persons have less access to health care. These persons are less likely to report having a person or place they usually go to for care, less likely to visit a physician each year, and more likely to delay or forgo care they believe they need.

However, uninsured residents of urban areas with high uninsured rates have an even higher risk of poor access than uninsured residents of areas with low uninsured rates. Uninsured residents of high-uninsured areas are more likely not to have a usual source of care, more likely not to have visited a physician in the past year, and more likely to have delayed or forgone needed care—a difference not found for insured persons in those areas (see Appendix II). The disparity between the uninsured in high- and low-uninsured areas persists across a wide range of demographic characteristics, including education.

This study does not provide evidence that explains the finding that uninsured residents of high-uninsured areas face more access barriers than those in low-uninsured areas. But it is likely that the health care safety net—public and community health centers and hospitals—is overwhelmed by uninsured residents in cities that have disproportionately large uninsured populations. It is also likely that in some urban areas where the need is greatest—that is, those with high uninsured rates—the per capita resources to meet the need are fewer than in areas with lower uninsured rates.

The high uninsured rates in these heavily impacted urban areas are a direct result of their low rates of employment-based health insurance. Moderate- and low-income persons whose employers do not provide health benefits, or who cannot afford to pay their share of cost for health insurance offered by an employer, have few affordable alternatives for obtaining private insurance. Consequently, metropolitan areas with low rates of job-based insurance also tend to have high uninsured rates.

Residents of areas with low rates of job-based coverage pay a high price for living in these communities. These metropolitan areas have much higher unemployment rates; somewhat lower rates of labor force participation; smaller proportions of persons living in families with at least one full-time, full-year worker; smaller proportions of family breadwinners working in durable goods manufacturing and financial services; larger proportions of breadwinners working in agriculture and retail trades; and more individuals working in small firms.

Metropolitan areas with high uninsured rates also share the characteristics of cities with low job-based coverage. Compared with urban areas with low uninsured rates, high-uninsured areas also have larger proportions of noncitizens and naturalized citizens, lower rates of unionization, higher poverty rates, and less equal distributions of income. It is thus a mix of economic and labor market conditions, population characteristics, and social and economic divisions that distinguishes high-uninsured areas from those with low uninsured rates.

In sum, the characteristics of an area's population and its economic and social conditions together affect the area's job-based insurance rate. An area's overall uninsured rate is also determined in part by its population characteristics and economic conditions, as well as by public policy. Given similar population characteristics and economic conditions, a particular MSA is likely to have a lower uninsured rate if the state in which it is situated has more generous eligibility policies for Medicaid and other public health insurance coverage programs.

Medicaid has provided a health insurance safety net for many low-income families with children who do not have access to affordable employment-based insurance. During the second half of the 1990s, however, Medicaid coverage declined dramatically in response to welfare reform policies and procedures that made enrolling in and keeping Medicaid more difficult for those who formerly received public assistance and for noncitizens. Many families cycle on and off Medicaid coverage over time, finding themselves without any health insurance when their Medicaid coverage lapses. To a large degree, metropolitan areas with high rates of Medicaid coverage share the same characteristics as those with low rates of job-based insurance. Consistent with lower rates of labor force participation, these areas have larger shares of their populations living in nonworking families and, thus, larger proportions living below the poverty level.

Policy Implications

Cities and counties have limited ability to address their residents' lack of access to employment-based health insurance. Long-term efforts may increase the proportion of residents working and the proportion employed full-time for the full year, but cities and counties have little power to require small employers to offer health benefits or to mandate that employers make their employees' share of health insurance premiums affordable for moderate- and low-income

workers. States have also been barred from mandating employer contributions for health benefits both by federal law and opposition from powerful political forces.

States, on the other hand, have expanded opportunities to cover uninsured children and their families. States can now cover working parents of children eligible for Medicaid using the family coverage options provided by section 1931 of the Social Security Act.[15] The federal Children's Health Insurance Program (CHIP) gives states additional opportunities and funding to extend coverage to children in working families with incomes up to 250 percent of the poverty level or higher—with federal matching dollars even more generous than those provided by Medicaid.

Some states—including Minnesota, Washington, Massachusetts, Tennessee, Rhode Island, Wisconsin, and New York—have used state tax resources or leveraged them with federal funds with Medicaid section 1931 options, CHIP eligibility, and/or Medicaid section 1115 waivers. States can use section 1931 to cover working families, including adults, above traditional Medicaid income eligibility levels. States can also use section 1115 waivers to modify Medicaid's federal eligibility requirements and use their funds to cover more groups, such as adults without children, than would qualify under traditional Medicaid provisions. These policies and programs can reduce uninsured rates in the states and in their urban areas.[16] Memphis, for example, benefits from Tennessee's expanded Medicaid program (TennCare).[17]

In the absence of universal coverage, moderate- and low-income urban residents will continue to experience barriers to needed health care. Cities and counties will bear the responsibility of providing for at least their minimum needs. Public and community-sponsored clinics and hospitals are important providers of care to the uninsured, as well as to low-income community residents in general. Although many community-based clinics meet some of their expenses through charitable contributions, local governments and community foundations can—and in many cities and counties do—provide substantial support to these local safety net systems. States and the federal government can help these communities by providing more adequate financial support to the health care safety net, reducing the barriers found in areas with higher than average uninsured rates.

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[15] J. Guyer and C. Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents,* Washington: Center on Budget and Policy Priorities, August 1998.

[16] R. Kronick and T. Gilmer, "Lessons from Other States' Efforts to Increase Coverage," in *Expansion of Health Care to the Working Poor,* Berkeley: California Policy Research Center, 1999, pp. 1–20.

[17] R. Levan, E. R. Brown, L. Lara, and R. Wyn, *Nearly One-Fifth of Urban Americans Lack Health Insurance* (policy brief), Los Angeles: UCLA Center for Health Policy Research, December 1998.

This study makes it clear that urban areas are not meeting moderate- and low-income uninsured residents' health care needs. In some cases, these communities may be unable to provide the resources for the large number of uninsured within their jurisdictions. States and the federal government can help these urban centers by offering more adequate support to improve uninsured residents' access to health care and by developing creative approaches to expand coverage for the currently uninsured.

APPENDIX I

Uninsured and Job-Based Coverage Rates for MSAs, All Income Levels, Ages 0–64, 1997

	Uninsured		Job-Based Insurance	
	Percent	H/L	Percent	H/L
Akron, OH	7	L	81	H
Albany, NY	13	L	78	H
Albuquerque, NM	20		61	L
Allentown, PA	10	L	72	
Ann Arbor, MI	9	L	80	H
Atlanta, GA	19		70	
Austin–San Marcos, TX	23		71	
Bakersfield, CA	23		51	L
Baltimore, MD	15		76	H
Bergen–Passaic, NJ	17		76	H
Birmingham, AL	16		74	H
Boston, MA–NH	15		71	
Buffalo–Niagara, NY	12	L	72	
Charlotte, NC–SC	12	L	77	H
Chicago, IL	15		72	
Cincinnati, OH–KY–IN	12	L	82	H
Cleveland, OH	14	L	74	H
Columbus, GA–AL	13		73	
Columbus, OH	17		74	H
Dallas, TX	25	H	65	
Dayton, OH	14		73	
Denver, CO	12	L	75	H
Detroit, MI	13	L	72	
El Paso, TX	37	H	49	L
Fort Lauderdale, FL	26	H	64	
Fort Worth, TX	24		67	
Fresno, CA	18		56	L
Grand Rapids, MI	17		72	
Greensboro, NC	19		66	
Greenville, SC	16		78	H
Harrisburg, PA	7	L	83	H
Hartford, CT	13	L	74	H
Honolulu, HI	8	L	74	H
Houston, TX	30	H	59	L
Indianapolis, IN	13	L	77	H
Jacksonville, FL	19		65	
Jersey City, NJ	36	H	51	L
Kansas City, MO–KS	14	L	76	H
Knoxville, TN	13		61	

NR = Estimate not reported because too unstable.
H, L = Significantly high (or low) rate compared to mean of all MSAs.
Source: March 1998 Current Population Survey.

Uninsured and Job-Based Coverage Rates for MSAs, All Income Levels, Ages 0–64, 1997 (continued)

	Uninsured		Job-Based Insurance	
	Percent	H/L	Percent	H/L
Las Vegas, NV–AZ	21		67	
Los Angeles, CA	31	H	50	L
Louisville, KY–IN	13	L	75	H
Memphis, TN–AR–MS	16		66	
Miami, FL	27	H	51	L
Middlesex, NJ	17		77	H
Milwaukee, WI	8	L	84	H
Minneapolis, MN–WI	10	L	78	H
Monmouth, NJ	16		74	H
Nashville, TN	14		70	
Nassau–Suffolk, NY	14	L	76	H
New Orleans, LA	21		68	
New York, NY	27	H	50	L
Newark, NJ	19		70	
Norfolk, VA–NC	11	L	73	
Oakland, CA	13	L	75	H
Oklahoma City, OK	18		70	
Omaha, NE–IA	10	L	77	H
Orange County, CA	20		66	
Orlando, FL	22		66	
Philadelphia, PA–NJ	15		70	
Phoenix–Mesa, AZ	26	H	62	
Pittsburgh, PA	11	L	71	
Portland, OR–WA	13	L	75	H
Providence, RI–MA	13	L	71	
Raleigh, NC	15		72	
Richmond, VA	14		72	
Riverside–San Bernardino, CA	22		57	L
Rochester, NY	16		68	
Sacramento, CA	16		64	
Salt Lake City, UT	16		74	H
San Antonio, TX	24		61	
San Diego, CA	22		61	
San Francisco, CA	23		64	
San Jose, CA	16		72	
Seattle, WA	12	L	76	H
St. Louis, MO–IL	14		70	
Syracuse, NY	17		73	
Tacoma, WA	NR	L	73	
Tampa, FL	25	H	57	L
Tucson, AZ	26	H	55	L
Tulsa, OK	16		70	
Ventura, CA	17		74	
Washington, DC–MD–VA–WV	15		72	
West Palm Beach, FL	29	H	58	L
Youngstown, OH	11	L	73	

NR = Estimate not reported because too unstable.

H, L = Significantly high (or low) rate compared to mean of all MSAs.

Source: March 1998 Current Population Survey.

APPENDIX II

Access-to-Care Indicators for Populations with Moderate and Low Incomes (1995–96) and Uninsured Rates (1997) for All Income Levels, Ages 0–64

	Percent with No Usual Source of Care	Percent with No Physician Visit in Past Year	Percent Who Delayed or Went Without Needed Care	Percent Uninsured (all incomes)	
				Percent	Rank
Atlanta, GA	17	19	12	19	
Austin–San Marcos, TX	27	30	11	23	
Baltimore, MD	10	16	8	15	
Bergen–Passaic, NJ	12	32	NR	17	
Chicago, IL	14	33	9	15	
Dallas, TX	22	30	12	25	H
Detroit, MI	13	20	14	13	L
Fort Worth, TX	39	39	22	24	
Houston, TX	19	32	11	30	H
Kansas City, MO–KS	21	28	13	14	L
Los Angeles, CA	28	34	9	31	H
Miami, FL	30	34	14	27	H
Minneapolis, MN–WI	11	22	11	10	L
Nassau–Suffolk, NY	10	26	9	14	L
New York, NY	16	21	12	27	H
Newark, NJ	14	32	15	19	
Oakland, CA	13	27	8	13	L
Orange County, CA	26	34	12	20	
Philadelphia, PA–NJ	12	14	10	15	
Phoenix–Mesa, AZ	21	28	15	26	H
Pittsburgh, PA	14	21	11	11	L
Riverside–San Bernardino, CA	23	31	13	22	
San Antonio, TX	20	32	9	24	
San Diego, CA	19	31	16	22	
San Francisco, CA	32	39	15	23	
San Jose, CA	11	36	NR	16	
St. Louis, MO–IL	13	29	17	14	
Tampa, FL	26	32	17	25	H
Washington, DC–MD–VA–WV	20	23	10	15	

NR = Estimate not reported because too unstable.

Source: Access measures from 1995–1996 National Health Interview Survey; Uninsured rates from March 1998 Current Population Survey.

APPENDIX III

DATA AND METHODS

This report uses two main data sources: the March 1998 Current Population Survey (CPS) and an average of the 1995 and 1996 National Health Interview Surveys (NHIS) Health Insurance Supplements. Because the NHIS Health Insurance Supplements contain dummy records (i.e., records that are either incomplete or report no information), the data set was re-weighted to eliminate these records. Because 1995 NHIS contains a full-year sample while 1996 NHIS contains only a half-year sample, we weighted 1995 NHIS two-thirds and 1996 one-third to obtain a full year's worth of data in our analysis. Also, some variables from the 1995 and 1996 NHIS Access Supplement were merged into the Health Insurance Supplement for our analysis.

In CPS, we examined rates of uninsurance, job-based coverage, and Medicaid in 85 metropolitan statistical areas (MSAs) with nonelderly populations (i.e., ages 0–64) of more than 500,000. In NHIS, due to sample size limitations, we examined access indicators in a subset of the 85 MSAs (n = 29) with nonelderly populations of more than 500,000.

We determined the high, average, and low groupings for uninsurance, job-based coverage, and Medicaid by classifying each MSA according to whether it was significantly above or below the mean ($p < 0.05$) of the selected 85 MSAs in the March 1998 CPS. For example, MSAs with uninsurance rates significantly above the average of all MSAs were classified as "high uninsured"; MSAs with uninsurance rates significantly below the average of all MSAs were classified as "low uninsured"; and MSAs with uninsurance rates neither significantly above nor below the average of all MSAs were classified as "average uninsured." This methodology was applied to job-based coverage and Medicaid as well. MSAs in NHIS were assigned to high, average, and low classifications using the groupings obtained in the March 1998 CPS. For MSA-level analysis, each MSA was given equal weight (i.e., simple averages were used).

The population used to create the initial groupings was the nonelderly residents of the 85 largest MSAs in the March 1998 CPS. The entire nonelderly population was used rather than the subset of moderate- and low-income residents to provide more stable estimates and a more informed portrait of each MSA. Apart from the initial grouping of MSAs into high, average, and low categories, all analyses in this report focused specifically on nonelderly MSA residents with incomes less than 250 percent of the federal poverty level (i.e., "moderate- and low-income").

Many contextual-level variables were also used in the analysis. The data sources for such variables are noted throughout the report under the Exhibits in which they are presented.

INDIVIDUAL AND FAMILY-LEVEL VARIABLES USED IN THE ANALYSIS

Health Insurance Status. The March CPS asks respondents about health insurance coverage for each family member during the previous calendar year. Individuals insured by any source at any time during 1997 were counted as insured. Because a person may have multiple sources of coverage reported for 1997, a single hierarchical variable was created to reflect rank ordering of reported health insurance coverage. We counted persons who reported having coverage through their own or a family member's employment at any time during 1997 as covered by job-based health insurance. Those who did not have any private coverage but who had Medicaid coverage at any time during the year were counted as having coverage through that federal-state program. Persons who had other public coverage or privately purchased health insurance (i.e., not obtained through employment) were counted as "other coverage." Those with no reported coverage of any kind during the year were categorized as "uninsured."

Age. We determined each individual's age using respondents' self-reports. For the purposes of this study, nonelderly persons are those individuals ages 0 to 64. Elderly adults (ages 65+) were not examined in this report.

Ethnicity. We categorized respondents into five broad ethnic groups: white, Latino, African-American, Asian, and Other. Ethnic classification is based upon the respondents' self-reports.

Citizenship Status. We classified individuals into two citizenship categories: U.S. citizen (includes U.S-born or naturalized), and non-U.S. citizen.

Family Income Related to Poverty. We classified individuals into two poverty level groups based on the family income measured in relation to the federal poverty level: below 250 percent of the federal poverty level, and equal to or greater than 250 percent of the federal poverty level. In 1997, earning less than 250 percent of the federal poverty level translated into less than $20,875 for one nonelderly individual and less than $41,010 for a household of four (U.S. Census Bureau). At that time, earning less than 100 percent of the federal poverty level translated into less than $8,350 for one nonelderly individual and less than $16,400 for a household of four (U.S. Census Bureau).

Family Work Status. We characterized the family's employment status based on the characteristic of the primary wage earner. A family was classified as a "full-time, full-year employee family" if at least one of the adults reported working for an employer at least 35 hours per week for 50–52 weeks in the specified calendar year; a "full-time, part-year employee family" if an adult worked for an employer full-time for less than 50 weeks; a "part-time employee

family" if no adult worked as a full-time employee but one worked for an employer less than 35 hours a week; "self-employer" if an adult was self-employed; or "nonworking" if no adult worked during the year. Using this hierarchical classification, we identified the person with the most advantageous employment tenure as the primary wage earner or primary breadwinner. We thus ranked employment classifications from full-time, full-year employees at the top to nonworking at the bottom.

Family Education Status. We classified each person based upon the characteristic of the primary wage earner. We used four education categories: no high school, high school graduate, some college, and college graduate.

Insurable Unit Type. We classified each person based upon the characteristic of the primary wage earner. We used four insurable unit categories: single without a child/children, married without a child/children, married with at least one child, and single with at least one child.

Family Industry. We classified each person based upon the characteristic of the primary wage earner. We used 11 industry categories: agriculture, construction, durable goods manufacturing, nondurable goods manufacturing, transportation, wholesale, retail, financial services, business, professional service, and public administration.

Firm Size Where Primary Wage Earner Works. We classified each person based upon the characteristic of the primary wage earner. We used three firm size categories: less than 25 employees (i.e., small firm), 25 to 499 employees, and 500+ employees (i.e., large firm).

Union Membership. We classified each person based upon the characteristic of the primary wage earner. If the primary wage earner reported that he/she belonged to a union, family members were classified as union members. We used two union categories: member and nonmember.

Usual Source of Care. Information about whether or not a respondent has a person to whom or a place he/she regularly would go for medical care was based on the NHIS question, "Is there a particular person or place that (name) usually goes to when sick or needs advice about health?" This includes those with one or more regular sources of care, and a small number who use a hospital emergency room as a regular source of care. Having a regular source of care has been shown to be a robust measure of access to health services. We used two usual source of care categories: usual source of care and no usual source of care.

Delayed/Forgone Care. Estimates of care that was delayed or forgone were based on two questions in the NHIS: "During the past 12 months, was there any time when someone in the

family needed medical care or surgery but did not get it?" and "During the past 12 months, has anyone in the family delayed seeking medical care because of worry about the cost?"

Physician Visit in Past 12 Months. Information about physician visits was obtained using the NHIS question, "During the past 12 months, about how many times did (name) see or talk to a medical doctor or assistant?" We used two physician visit categories: one or more visits in the past 12 months and no visits in the last 12 months.

MSA-LEVEL VARIABLES USED IN THE ANALYSIS

Per Capita Income. Per capita income is the total personal income of the residents of a given area divided by the resident population of the area. Personal income is the income received by persons from all sources. In calculating per capita income for 1996, the U.S. Department of Commerce used Census county population totals as of July 1.

Unemployment Rate. We used the 1997 unemployment rate as reported by the U.S. Bureau of Labor Statistics.

Income Inequality. We used the Gini index as our measure of income inequality. The Gini index ranges from a value of zero, indicating that every household has the same income, to one, indicating that one household has all the income. The closer the Gini coefficient is to zero the more equal the income distribution in an area; the closer the coefficient is to one, the more unequal the income distributions in an area. Gini coefficients were calculated using an average of estimates from the March 1997 and 1998 Current Population Surveys.

Health Insurance Offer Rate. This variable is the percent of workers in a given MSA offered health insurance by their employers.

Medicaid Generosity Index. We developed an index of the generosity of each state's Medicaid (or equivalent program) eligibility. The index is the average of each state's income eligibility levels in 1997 (the health insurance study year) for pregnant women, children, and infants, standardized to the same age distribution for all MSAs. The index ranges from 84.4 percent for Alabama up to 300 percent for Hawaii, which included all pregnant women and children living at up to 300 percent of the federal poverty level.

HMO Penetration. This variable is the total enrollment (both traditional and open-ended) in managed care as reported by managed care organizations divided by the total population of the MSA.

HMO Competition. This variable is computed as one minus the sum of the squared managed care market shares. A value close to one indicates several nearly equal competitors; a value close to zero indicates a monopoly.

STATISTICAL NOTE

Comparisons of the above contextual variables across all MSAs have not been tested for statistical significance because their variances are unknown. All other comparisons reported in this study are statistically significant at $p \leq .05$.

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Differences in Access to Health Care Among the Moderate- and Low-Income Population Across Urban Areas (July 2000). Roberta Wyn, Stephanie Teleki, and E. Richard Brown, UCLA Center for Health Policy Research. In this policy brief, the authors explore differences access to health care services for the moderate- and low-income, nonelderly population residing in 29 urban areas. Copies are available from the UCLA Center for Health Policy Research, 10911 Weyburn Avenue, Suite 300, Los Angeles, CA 90024, Tel: 310-794-0909, Fax: 310-794-2686, http://www.healthpolicy.ucla.edu/.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70—Findings from* The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70 (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This survey report finds that older adults ages 50 to 70 trust Medicare, feel more secure once they are enrolled, and are interested in participating before age 65.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. Based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* this executive summary finds that older adults ages 50 to 70 trust Medicare, feel more secure once they are enrolled, and are interested in participating before age 65.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

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#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 *Current Population Survey* and *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

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1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.

Nearly One-Fifth of Urban Americans Lack Health Insurance (December 1998). Rebecka Levan, E. Richard Brown, Lisa Lara, and Roberta Wyn, UCLA Center for Health Policy Research. In this policy brief, the authors explore regional differences in uninsured, Medicaid, and employment-based coverage rates in 85 urban areas. Copies are available from the UCLA Center for Health Policy Research, 10911 Weyburn Avenue, Suite 300, Los Angeles, CA 90024, Tel: 310-794-0909, Fax: 310-794-2686, http://www.healthpolicy.ucla.edu/.