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# The Cost of Instability: The Effects of Family, Work, and Welfare Change on Low-Income Women's Health Insurance Status

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*The number of uninsured Americans has risen substantially over the last decade. Despite the availability of Medicaid, low-income women are at particularly elevated risk of having no or inadequate health insurance. How does continuity of work, family, and welfare affect low-income women's health insurance status? A multinomial logistic regression analysis of 1,662 low-income women from the Welfare, Children, and Families: A Three-City Study provides evidence of the consequences of life changes on access to health insurance from 1999–2005. The results show that compared to those with stable welfare, work, and family attachments, new full-time employment actually increases low-income women's risk of being uninsured as does being underemployed, on welfare, or single for extended periods of time. These findings illustrate how health-care reform must adequately address the complexity of low-income women's lives—including the ways labor market, state, and family factors interact to create barriers to health insurance—in order to improve access to care under the current U.S. health insurance model.*

**KEY WORDS:** family; health insurance; income; social inequality; welfare; work.

## INTRODUCTION

In 2009, nearly 50 million Americans under the age of 65 (18.9% of the U.S. nonelderly population) had no health insurance coverage (Holahan, 2011), not including the millions of adults who were underinsured (Schoen et al., 2008). The 2009 recession merely compounded an already existing crisis in access to health insurance. But the risk of being uninsured is not equally distributed across the United States. Approximately two-thirds of the uninsured live in low-income families (Hoffman et al., 2008:4). In the late 1990s, following welfare reform, there were about 8.5 million uninsured low-income women, comprising 19% of the uninsured population (Wyn et al., 2001:14). Despite their high labor force participation rates, low-income women were three times more likely to be uninsured than near-poor women (Wyn et al., 2001:14) and two to three times more likely to face insurance instability

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(Anderson and Eamon, 2004:397). Even as public health insurance programs have been expanding to catch those left behind by welfare reform, the rate of low-income women's health insurance coverage has been falling (Glied et al., 2008; Kaiser Family Foundation, 2008a). With the cost of healthcare rising, more and more women are reporting difficulties accessing care due to cost (Patchias and Waxman, 2007).

Accurately understanding low-income women's access to health insurance requires understanding healthcare as a central component of welfare regimes. According to welfare state scholars, social inequalities in postindustrial societies are shaped by the relationship between the labor market, state, and family (DiPrete et al., 1997; Esping-Andersen, 1990, 1999; O'Connor et al., 1999). Although universal healthcare is a central component of many industrialized welfare states, health insurance is merely a residual feature of the U.S. welfare regime (Hacker, 2002; Quadagno, 2005). The structure of the U.S. health insurance system relies primarily on employer-provided insurance schemes, which assume stable attachment to the labor market or a spouse, and categorical public health insurance programs designed to meet the needs of select categories of women (Iglehart, 2007; Kaiser Family Foundation, 2007). These programs have been developed with a stable, traditional breadwinner/homemaker family model in mind. Because marriage/family, employment, and social policy characteristics shape low-income women's needs for and access to both private/employment-based and public insurance, if we are to accurately understand low-income women's access to health insurance, we must examine their lives in the context of this state-market-family relationship.

## LOW-INCOME WOMEN'S ACCESS TO HEALTH INSURANCE

A fragmented health insurance system that relies on the combination of employer-based benefits and residual public programs creates substantial barriers to obtaining adequate health insurance for low-income women (Glied et al., 2008). Medicaid has primarily been designed to meet the needs of pregnant women, children, and the disabled (Iglehart, 2007; Kaiser Family Foundation, 2007). Although seven in ten adults on Medicaid in the late 1990s were low-income women, less than one-quarter of all low-income women actually qualified for Medicaid due to the program's strict income-eligibility guidelines (Wyn et al., 2001:2, 14). In fact, one study finds that a mother of a family of three working full time at minimum wage would not qualify for Medicaid in 29 states in 2007 based on her income (Hoffman et al., 2008:19). Medicaid's strict categorical and income requirements are particularly consequential for the thousands of low-income women who have been forced into low-wage jobs following welfare reform (Cheng, 2007; Seccombe et al., 2006). Ironically, although the wages of low-income women are often insufficient to meet the needs of their families, in many cases they are significant enough to disqualify them from programs like Medicaid.

Low-income workers are more likely to be uninsured since they are less likely to be offered job-based coverage and are less able to afford the cost of private health insurance premiums (Kaiser Family Foundation, 2008b,c). The employment patterns of low-income women in particular put them at significantly greater risk of falling into the cracks left by a patchwork of public and private health insurance schemes (Wyn et al., 2001). In the late 1990s, 58% of low-income women were employed and 72% lived in working families (Wyn et al., 2001:48). Two-thirds of employed low-income women worked in service, administrative support, or sales occupations (Wyn et al., 2001:53). Despite their high employment rate, low-income women were two times less likely to have job-based health insurance than near-poor women across every occupation category (Wyn et al., 2001:25, 54). Whether employed full or part time, year round or seasonally, about one-third of low-income working women are uninsured (Wyn et al., 2001:51; Kaiser Family Foundation, 2008c). Job changes and/or job loss are one of the biggest reasons for a lack of insurance among the uninsured (Hoffman et al., 2008), and low-income women's job instability puts them at significantly greater risk of insurance instability than higher-income women (Anderson and Eamon, 2004:400).

Family structure influences health insurance coverage by providing access to resources and the ability to access benefits as a dependent (Institute of Medicine, 2002). Overall, women are more than twice as likely as men to obtain access to employer-based insurance through a spouse (Wyn et al., 2001:23), but their coverage is contingent on the stability of their relationships, the continuity of men's employment, and the willingness of employers to continue offering family benefits, making dependent coverage a much less stable form of insurance for women (Patchias and Waxman, 2007). Although many low-income women want to marry, they are often unwilling to assume the risk of dependency to economically unstable men, which contributes to the relationship instability of low-income couples (Edin and Kefalas, 2005; Rogers-Dillon and Haney, 2005). One consequence is that low-income women are less likely to be married and stay married than near-poor women and thus significantly less likely to have insurance through a spouse (Anderson and Eamon, 2004:399). In spite of their labor force participation, in the late 1990s only 27% of low-income single moms were able to secure benefits through their employment, resulting in Medicaid being a significant source of insurance for 39% of low-income single moms (Wyn et al., 2001:23).

Not having insurance or having inadequate coverage creates barriers to regular healthcare (Kaiser Family Foundation, 2008b; Raiz, 2006). Because low-income families are more likely to have no financial reserves to cover the cost of an unexpected medical need, they are significantly more likely to delay or forgo needed care (Hoffman et al., 2008). Even temporary gaps in coverage put one at greater risk of poor health by preventing both access to preventative care and early detection of illness (Marquis and Kapur, 2003). Lack of access to adequate health insurance and resultant poor health affects worker productivity and results in employment disruption (Institute of Medicine,

2003). Ultimately, the un- and underinsured are at greater risk of medical debt, bankruptcy, and even poverty (Collins et al., 2008; Hoffman et al., 2001, 2008; Institute of Medicine, 20034; Kaiser Family Foundation, 2008b). These risks pose substantial barriers to low-income women's economic progress.

Immediately following welfare reform and up to five years later (when some women would begin hitting the five-year time limit on benefits) there was a plethora of research examining the consequences of welfare-to-work programs on the lives of low-income women. Some of this work did include examining the effects of welfare reform on women's health insurance access, but soon after this work was accomplished, the attention of health insurance scholars turned to examining the effects of skyrocketing health-care costs on the middle class (i.e., Pandey and Cantor, 2004). What has happened to low-income women 10 years after welfare reform? What changes have these women endured? What are the consequences of these changes on low-income women's access to health insurance?

Although cross-sectional analyses of health insurance coverage provide important information about the distribution of health insurance access at any given time, they may not adequately represent the fluctuating life circumstances of low-income workers, the contingent nature of insurance eligibility, or the long-term effects of prior conditions. Such models may work well for describing families that have access to stable sources of employment and economic resources, but are less appropriate for describing the lives of low-income women who are more likely to face frequent job changes and/or job loss, resulting in a disruption of health insurance coverage (Dodson and Bravo, 2005; Dubay and Kenney, 2004; Feder et al., 2001; Tallon and Rowland, 2007; Wyn et al., 2001). If we examine insurance status only at one point in time, we severely underestimate the risks associated with being unstably insured (Schoen and DesRoches, 2000; Short and Graefe, 2003). Therefore, analyzing a panel of low-income women living in low-income neighborhoods provides the ideal opportunity to examine the effects of *individual-level* changes on low-income women's insurance instability and poverty status over time.

## DATA AND ANALYSIS

To assess how changes in women's work, family, and welfare situations affect women's health insurance status at later time points, I conduct a secondary analysis of three waves of data from the Welfare, Children, and Families Project: A Three-City Study using a series of multinomial logistic regression models. Data were collected in 1999 (Wave 1), 2001 (Wave 2), and 2005 (Wave 3) and drawn from a representative sample of low-income families living in low-income neighborhoods in Boston, Chicago, and San Antonio (Angel et al., 2009). The timing of the second data collection is particularly important given that it marked the five-year anniversary of PRWORA, and meant some women would begin to reach the five-year limit on welfare

benefits. The results of my analysis are based on data collected from primary female caregivers who participated in all three surveys. I exclude from the models individuals who had military or unidentified forms of health insurance and those who had both public and private/employer insurance simultaneously, for a total sample of 1,662 women.

The data are "stacked," meaning each respondent may be represented twice in the data set, resulting in 3,324 possible observations. Stacking the data allows me to test the effects of changes between Waves 1 and 2 on insurance status while simultaneously testing the effects of changes between Waves 2 and 3 on insurance status. To control for this, the analysis is clustered by respondent. For ease of reference and clarity, T1 is used to represent data collected at Wave 1 or Wave 2, while T2 is used to represent data collected at Wave 2 or Wave 3. Controls for which time point the data are drawn and the length of time in between data-collection time points are also included. All control variables are measured at T2. The welfare, work, and family change variables measure changes from either Wave 1 to Wave 2, or Wave 2 to Wave 3.

Normalized household panel weights are used in all models to prevent bias in point estimates (Cherlin et al., 2002). To prevent loss of cases to list-wise deletion, Stata's imputation by chained equations (ICE) program was used to impute missing values on four key demographic variables—income, citizenship, education, and marital status—using available data from all other independent and dependent variables included in the models (StataCorp, 2007). Thirty-four percent (572) of the sample required imputation on one variable, 13% (223) required imputation on two variables, 3% (54) required imputation on three variables, and 1% (17) required imputation on all four of the variables for which imputation of missing values was conducted. Despite imputation on these variables, a total of 59 observations are dropped in the final analysis due to list-wise deletion. The final statistical analysis is based on $N = 3{,}265$ observations.

With the exception of the ratio-level variables (*kids, age, income*, and *months*), all other independent variables are treated as dummy variables. Where variables have more than one response category, each category is treated as a separate dummy variable comparing the specified group to a reference category. In the results tables, reference categories are identified in parentheses.

In the following analysis the dependent variable is *women's health insurance status at T2*, where women with private/employer health insurance serve as the reference category. *Employment change* measures transitions into and out of full-time (FT) employment at T2. The variable categories include those who obtained FT employment, those who lost FT employment, and those who stayed less than FT employed, with those who stayed employed FT serving as the reference category. *Welfare change* measures changes in women's welfare status at T2. The variable categories include those who went off welfare (TANF), those who went on welfare, and those who stayed on welfare,

with those who stayed off welfare at T2 serving as the reference category. *Marital change* measures changes in women's marriage status at T2. Because marital status affects access to employment-based and public insurance, only transitions into and out of marriage are considered. The variable categories include those who became married, those who left a marriage, and those who stayed unmarried, where those who stayed married at T2 serving as the reference category.

*Health* is a measure of respondents' self-rated general health at T2. Responses were recoded to reflect three simplified categories: excellent or very good, good, and fair or poor health. Those with excellent or very good health serve as the reference category. In addition, respondents were asked if any health problems they experienced affected their ability to work. *Health problem* is a dichotomous variable used to identify those said "yes," health problems prevented them from working (coded as 1) at T2. Respondents were also asked if over the previous 12 months they ever needed but could not afford necessary healthcare. *Health need* is a dichotomous variable that identifies those who answered "yes," they needed but could not afford care (coded as 1) at T2.

Several other control variables are also included in the model. *Time point* controls for historical moment by indicating which survey (Wave 2 or 3) independent variables are drawn from. *Months* measures the total number of months between data-collection time points. *City* of residence (Boston, Chicago, or San Antonio) is included in the models as a series of dummy variables where Boston serves as the reference category. *U.S. citizens* (both foreign born and U.S. born) are coded as 1 and noncitizens are coded as 0. Self-reported *race/ethnicity* is included in the models as a series of dummy variables, where whites serve as the reference category. *Age* is a ratio-level variable measured in years and *kids* measures the number of children in the respondent's household for whom they are legally responsible at the time of the survey. Highest level of *education* is included in the model as a series of dummy variables where those with no degree serve as the reference category. The other categories include those with a high school diploma or GED (including a vocational tech diploma) and those with a college degree (defined as an associate's or higher). Finally, *income* measures the respondent's total monthly household income per $1,000.

## DESCRIPTIVE STATISTICS

Table I provides important descriptive statistics. Eight percent of the families were white, 42% black, and 48% Hispanic. The number of white respondents is not proportional to the number of black and Hispanic respondents due to a lack of high-poverty white neighborhoods. Nevertheless, the study is generalizable to low-income families living in low-income neighborhoods in Boston, Chicago, and San Antonio (ICPSR, 2008). Overall, about

**Table I.** Descriptive Statistics for Demographic Variables by Wave ($N$ = 1,662)

| | Wave 1 (1999) | Wave 2 (2001) | Wave 3 (2005) |
|---|---|---|---|
| City | | | |
| Boston | 35.1% (584) | | |
| Chicago | 33.2% (551) | | |
| San Antonio | 31.7% (527) | | |
| Race | | | |
| Black | 42.4% (705) | | |
| Hispanic | 47.7% (793) | | |
| White | 8.0% (133) | | |
| Other | 1.9% (31) | | |
| Not U.S. citizen, imputed | 14.4% (239) | 13.2% (220) | 12.2% (202) |
| Mean age (*SD*) | 32.76 (9.68) | 34.12 (9.64) | 38.54 (9.65) |
| Marital status, imputed | | | |
| Single | 68.2% (1134) | 56.4% (938) | 55.1% (916) |
| Cohabiting | 6.4% (106) | 10.8% (179) | 9.5% (158) |
| Separated | 11.4% (190) | 15.6% (260) | 15.8% (263) |
| Married | 14.0% (232) | 17.1% (285) | 19.6% (325) |
| Mean kids responsible for (*SD*) | 2.66 (1.43) | 2.69 (1.45) | 2.77 (1.52) |
| Education, imputed | | | |
| No degree | 37.8% (629) | 39.9% (664)[a] | 35.4% (589) |
| HS grad/GED | 56.1% (933) | 52.9% (879)[a] | 55.0% (914) |
| College | 6.0% (100) | 7.2% (119) | 9.6% (159) |
| Mean monthly total household income, imputed (*SD*) | 1,089.85 (814.21) | 1,567.39 (1107.70) | 1,846.38 (1353.07) |
| Household income 100–200% FPL | 22.6% (376) | 30.7% (510) | 34.4% (572) |
| Household income below 100% FPL | 73.3% (1218) | 59.6% (990) | 53.2% (884) |
| On welfare (enrolled in TANF) | 36.7% (610) | 25.8% (429) | 14.6% (243) |
| Employment | | | |
| Employed | 40.0% (658) | 55.8% (927) | 54.6% (908) |
| Employed 35+ hrs at main job | 22.8% (379) | 36.0% (599) | 33.7% (560) |
| Respondent HI | | | |
| Medicaid | 53.0% (881) | 49.3% (819) | 48.9% (812) |
| Private or employer HI | 15.5% (257) | 20.2% (336) | 21.0% (349) |
| Uninsured | 30.0% (499) | 28.7% (477) | 27.9% (464) |
| General health | | | |
| Excellent/very good | 38.9% (646) | 38.0% (631) | 32.9% (546) |
| Good | 31.5% (523) | 33.6% (559) | 32.8% (545) |
| Fair/poor | 29.6% (492) | 28.1% (467) | 34.2% (568) |
| Health problems prevent working | 14.5% (241) | 16.2% (270) | 22.5% (374) |
| Needed but could not afford care | 12.9% (215) | 12.9% (215) | 15.7% (261) |

[a]There were some inconsistencies in the way vocational tech training and diplomas were coded at T2. The small number of respondents affected by this were flagged in the data set. The inconsistency does not appear to affect the results of this analysis.

35% of the sample was from Boston, 33% from Chicago, and 32% from San Antonio. At Wave 1, about 86% of respondents indicated they were U.S. citizens. The average age of respondents at Wave 1 was 32.8 years and about 38% had no high school diploma or GED, while only 6% had a college degree. The average number of children women were responsible for was about 2.7 across all three time points.

Table I also reveals that the sample experienced a great deal of aggregate-level change over the six-year study period. For example, the proportion of

women with incomes below the federal poverty line decreased 20% (from 73% at Wave 1, to 53% at Wave 3). A comparable reduction in welfare recipients was also observed; at Wave 1, 36.7% of the women were receiving TANF benefits, but by Wave 3, only 14.6% of the panel was on welfare. Consistent with the goals of welfare reform, the proportion of women gainfully employed increased almost 15% (from 40% at Wave 1, to 54.6% at Wave 3). The proportion of women working full time (35 hours or more) increased about 11% (from 22.8% at Wave 1, to 33.7% at Wave 3). Also consistent with welfare reform, the proportion of women married increased from 14% at Wave 1 to 19.6% at Wave 3. Nevertheless, the number of women experiencing separation from a spouse also increased, from 11.4% at Wave 1 to 15.8% at Wave 3. These trends are consistent with other research examining the effects of welfare reform on low-income women.

Despite the increase in women's labor force participation and marriage, overall trends in health insurance status were far less substantial. For example, the proportion of women who were uninsured decreased only slightly, from 30% at Wave 1 to about 28% at Wave 3, whereas the proportion of women who had private or employer-provided health insurance increased 5.5% (from 15.5% at Wave 1, to 21% at Wave 3). Consistent with the existing literature on welfare reform, the proportion of women receiving Medicaid decreased 4.1% over the study period (from 53% at Wave 1, to 48.9% at Wave 3).

In addition, the proportion of women who self-rated their health as excellent or very good decreased from 38.9% at Wave 1 to 32.9% at Wave 3, while the proportion of women reporting fair or poor health increased from 29.6% to 34.2% over the study period. Similarly, the proportion of women reporting that they needed but could not afford care increased by about 2.8%, while the proportion of women reporting that health problems prevented them from working increased 8% to a total of 22.5% at Wave 3.

Although interesting, these overall trends mask important *individual-level* changes that were occurring (see Table II). When we examine the proportion of women who experienced change in any of the aforementioned statuses, we begin to learn more about the dynamic work, family, and welfare patterns of this population. For example, from Wave 1 to Wave 2, 13.6% of the women moved into full-time work (35 hours or more), while only 2.9% lost access to full-time work. But from Wave 2 to Wave 3, only 7.3% of the women moved into full-time work, while 6.9% lost full-time status, revealing much more variability in employment opportunities over the data-collection period. A similar trend was observed in marriage transitions. From Wave 1 to Wave 2, 6.6% of the women moved into marriage while 3.4% left a marriage. But from Wave 2 to Wave 3, 9.3% of women moved into a marriage, while 6.9% left a marriage. In addition, over both time periods, more women moved out of Medicaid than into Medicaid, while more women moved into private or employment-based health insurance than out of such insurance.

In other areas, change across the two time intervals was more stable. For example, just over 6% of the sample moved on to welfare from Wave 1 to

**Table II.** Descriptive Statistics for Change Variables by Wave ($N = 1{,}662$)

| | Wave 1–Wave 2 | Wave 2–Wave 3 |
|---|---|---|
| Mean months between time points (*SD*) | 16.34 (2.8) | 53.10 (3.1) |
| Marital status change | | |
| Stayed married | 10.5% (175) | 10.3% (171) |
| Got married | 6.6% (110) | 9.3% (154) |
| Left marriage | 3.4% (57) | 6.9% (114) |
| Stayed unmarried | 79.4% (1320) | 73.6% (1223) |
| FT employment change | | |
| Stayed employed FT | 16.1% (268) | 21.2% (353) |
| Got FT work | 13.6% (226) | 7.3% (122) |
| Lost FT work | 2.9% (49) | 6.9% (114) |
| Stayed < FT employed | 67.3% (1119) | 64.5% (1072) |
| Welfare change | | |
| Stayed off welfare | 56.7% (942) | 67.2% (1117) |
| Moved off welfare | 16.9% (281) | 17.7% (295) |
| Moved into welfare | 6.1% (101) | 6.5% (108) |
| Stayed on welfare | 19.7% (328) | 8.0% (133) |
| Insurance transition | | |
| Stayed uninsured | 15.5% (257) | 14.5% (241) |
| Out of insurance | 13.2% (219) | 13.4% (223) |
| Into insurance | 14.6% (242) | 14.1% (235) |
| Stayed insured | 56.4% (937) | 57.5% (955) |
| Public insurance transition | | |
| Stayed on Medicaid | 38.7% (643) | 36.3% (604) |
| Into Medicaid | 10.6% (176) | 12.5% (208) |
| Out of Medicaid | 14.3% (238) | 12.9% (215) |
| Stayed off Medicaid | 36.4% (605) | 38.2% (635) |
| Private/employer HI transition | | |
| Stayed out of private/employer HI | 75.6% (1256) | 70.6% (1173) |
| Out of priv/employ HI | 4.2% (70) | 8.4% (140) |
| Into priv/employ HI | 9.0% (149) | 9.2% (153) |
| Stayed on priv/emp HI | 11.3% (187) | 11.8% (196) |

Wave 2, and a comparable proportion moved on to welfare from Wave 2 to Wave 3. Similarly, the proportion of women moving off welfare remained at about 17% during both intervals. Consistent patterns of change in insurance coverage were also observed between time points; about 14% of the women gained insurance over both time periods, while 13% of women lost insurance coverage over both intervals. The amount of change these women experienced illustrates the need to consider how patterns of change across time points might affect women's access to health insurance over time.

## FINDINGS

Table III presents the relative risk ratios and 95% confidence intervals for the multinomial logit models. I find that low-income women's welfare, work, and family changes do indeed have important effects on women's health insurance status at T2, that certain changes are more important in predicting low-income women's health insurance status than others, and that the effects of

**Table III.** Multinomial Logit Estimates of Woman's Health Insurance Status, Compared to Those with Private/Employer Insurance, at T2 ($N$ = 3,265 Observations)

| | Uninsured | | | Medicaid | | |
|---|---|---|---|---|---|---|
| T2 Predictors | Relative Risk Ratio | 95% Confidence Interval | | Relative Risk Ratio | 95% Confidence Interval | |
| Time Point | 0.65 | 0.053 | 7.976 | 3.964 | 0.388 | 40.479 |
| Months | 1.024 | 0.958 | 1.095 | 0.982 | 0.923 | 1.044 |
| Race/ethnicity (white) | | | | | | |
| Black | 1.724 | 0.443 | 6.700 | 0.957 | 0.381 | 2.406 |
| Hispanic | 3.110 | 0.739 | 13.090 | 1.001 | 0.374 | 2.676 |
| Other | 2.914 | 0.456 | 18.603 | 2.188 | 0.455 | 10.520 |
| U.S. citizen | 0.547 | 0.294 | 1.020 | 1.267 | 0.706 | 2.275 |
| Kids | 1.102 | 0.944 | 1.286 | 1.296*** | 1.127 | 1.489 |
| Age | 0.977 | 0.952 | 1.003 | 0.952*** | 0.929 | 0.974 |
| Income | 0.649*** | 0.538 | 0.783 | 0.640*** | 0.540 | 0.760 |
| City (Boston) | | | | | | |
| Chicago | 2.017** | 1.194 | 3.406 | 0.404*** | 0.245 | 0.666 |
| San Antonio | 1.799* | 1.023 | 3.164 | 0.095*** | 0.054 | 0.166 |
| Education (no degree) | | | | | | |
| HS diploma/GED | 0.487** | 0.300 | 0.790 | 0.469** | 0.288 | 0.765 |
| College degree | 0.251*** | 0.117 | 0.539 | 0.274*** | 0.132 | 0.571 |
| Health (excellent/very good) | | | | | | |
| Good | 0.871 | 0.557 | 1.362 | 0.837 | 0.541 | 1.295 |
| Fair/poor | 0.800 | 0.425 | 1.509 | 1.059 | 0.626 | 1.792 |
| Health prob can't work | 1.034 | 0.481 | 2.221 | 5.014*** | 2.651 | 9.484 |
| Health need can't afford | 6.916*** | 3.951 | 12.106 | 1.088 | 0.570 | 2.079 |
| Employment change (stayed FT employed) | | | | | | |
| Got FT employment | 2.046* | 1.065 | 3.930 | 2.329** | 1.282 | 4.231 |
| Lost FT employment | 1.734 | 0.726 | 4.140 | 3.071** | 1.518 | 6.213 |
| Stayed < FT employed | 6.155*** | 3.769 | 10.054 | 10.292*** | 6.320 | 16.762 |
| Welfare change (stayed off welfare) | | | | | | |
| Moved off welfare | 1.259 | 0.662 | 2.396 | 2.930*** | 1.674 | 5.129 |
| Moved on welfare | 0.570 | 0.217 | 1.494 | 4.128*** | 1.836 | 9.282 |
| Stayed on welfare | 6.134** | 1.740 | 21.628 | 36.406*** | 11.267 | 117.643 |
| Marital change (stayed married) | | | | | | |
| Got married | 1.244 | 0.515 | 3.007 | 2.736* | 1.165 | 6.424 |
| Left marriage | 1.618 | 0.725 | 3.612 | 2.374* | 1.061 | 5.311 |
| Stayed single | 2.128** | 1.239 | 3.657 | 3.292*** | 1.852 | 5.851 |
| Constant | 0.346 | | | 2.452 | | |
| Log-likelihood | −2177.626 | | | −2177.626 | | |
| Wald chi$^2$ | 701.442 | | | 701.442 | | |
| Pseudo-$R^2$ | 0.379 | | | 0.379 | | |

*Note*: Reference categories in parentheses; *significant at $p < .05$; ** $p < .01$; *** $p < .001$.

these changes vary by the type of insurance examined. For example, relative to those with no welfare access over time, those who moved off welfare (RRR = 2.930, $p < .001$), moved on to welfare (RRR = 4.128, $p < .001$), or stayed on welfare (RRR = 36.046, $p < .001$) were all more likely to be on Medicaid compared to having private/employer-based health insurance.

At first glance this might seem to provide some evidence of the successful de-linking of welfare and public health insurance benefits because experiencing

welfare transitions had similar effects as having stable welfare access. Nevertheless, the increase in relative risk ratios across categories clearly indicates that those who *moved on to* welfare over time were more likely to have Medicaid relative to those with no welfare access, and those with *stable* welfare access were by far the most likely to have access to public health insurance compared to private/employer insurance. Although this appears to be good news for welfare recipients, unfortunately I also find that those who stayed on welfare (RRR = 6.134, $p < .01$) were also more likely than those with no welfare access across time to be uninsured compared to having private/employer-based health insurance. These contradictory effects illustrate the diversity of low-income women's experiences—while some women on welfare are able to access public health insurance, others find themselves uninsured. This suggests that de-linking may have actually negatively affected at least some low-income women who previously would have automatically qualified for Medicaid when qualifying for TANF benefits.

Full-time employment changes had similar effects. For example, relative to those who stayed employed full time across waves, those who found full-time work (RRR = 2.329, $p < .01$), lost full-time work (RRR = 3.071, $p < .01$), or stayed less than full-time employed over time (RRR = 10.292, $p < .001$) were all more likely to be on Medicaid compared to having private/employer-based health insurance. As might be expected, the increase in relative risk ratios across categories indicates that those who *lost* full-time work were more likely to have Medicaid relative to those with stable full-time employment, and those with *no* access to full-time work over time were by far the most likely to have public health insurance compared to private/employer insurance.

Once again, though, a closer examination reveals a more complicated story. Although those with no full-time employment over time (relative to those with stable full-time work) were more likely to have Medicaid (as described above), they were also significantly more likely to be uninsured at T2 (RRR = 6.155, $p < .001$). This once again illustrates a diversity of experience among low-income women; while some low-income women who lack full-time employment are able to qualify for Medicaid, others are at risk of being uninsured. Perhaps more concerning, I also find that relative to those with stable full-time employment, women who found new full-time work were also at greater risk of being uninsured at T2 compared to having private or employer-based insurance (RRR = 2.046, $p < .05$). Thus, finding full-time employment did not guarantee access to health insurance benefits for these low-income women.

Similar effects were also observed for marital changes. Relative to those who stayed married across waves, those who became married (RRR = 2.736, $p < .05$), left a marriage (RRR = 2.374, $p < .05$), or stayed unmarried over time (RRR = 3.292, $p < .001$) were all more likely to be on Medicaid compared to having private/employer-based health insurance. Although marital disruptions did not appear to significantly affect low-income women's risk of being uninsured, relative to those who stayed married, those who stayed single

over time were more likely to be uninsured at T2 compared to having private/employer-based health insurance (RRR = 2.128, $p < .01$). As noted above, these findings also illustrate a diversity of experience among low-income women; while some single low-income women are able to qualify for Medicaid, others are at greater risk of being uninsured.

In addition to the effects of welfare, work, and family changes on women's access to insurance over time, I also find evidence that public health insurance programs play an important role in providing insurance to low-income women with health problems and protecting them from having unmet health needs. For example, low-income women who indicated that they had a health problem that affected their ability to work were more likely to have Medicaid compared to private/employer-based insurance (RRR = 5.014, $p < .001$). Public health insurance programs appeared to be particularly important for younger women (RRR = 0.952, $p < .001$) and those with children (RRR = 1.296, $p < .001$). The consequences of being uninsured were also significant. The results show that low-income women who indicated that they had a health need they could not afford to address were significantly more likely to be uninsured at T2 (RRR = 6.916, $p < .001$). I also find that relative to those in Boston, low-income women living in Chicago (RRR = 0.404, $p < .001$; RRR = 2.017, $p < .01$) and San Antonio (RRR = 0.095, $p < .001$; RRR = 1.799, $p < .05$) were significantly less likely to have Medicaid and more likely to be uninsured.

## CONCLUSIONS

Taken together, these findings illustrate the inadequacies of a patchwork health insurance system in the United States. Despite a 20% decline in the proportion of women living in poverty at Wave 3, the proportion of women uninsured only declined 2% (see Table I). The fact that 27.9% of the women sampled were uninsured at Wave 3 suggests that in the decade following welfare reform an eroding private/employment-based health insurance model supplemented by a narrowly defined residual system of public health-care benefits has been insufficient for meeting the needs of low-income women. This type of system is particularly inadequate at addressing the complexity of women's lives, the relationship between the state, market, and family, and the way changes in each of these arenas affect low-income women's access to health insurance over time.

The data presented show that low-income women have experienced a great deal of aggregate and individual-level change over the last decade. But while welfare reform may have been successful in encouraging more low-income women to enter the labor force, this has not guaranteed greater quality of life for these women. For example, the assumption that low-income women who gain access to full-time work over time are able to meet their needs for health insurance in the private market is not supported in this analysis. Instead, I find that at least some low-income women who are newly employed

full time are at *increased* risk of being uninsured due to loss of public health insurance benefits and an inability to secure private or employment-based benefits. In this way, a positive life change, like finding a full-time job, may actually have negative consequences for low-income women and their families.

In addition, the results also illustrate the importance of examining change in women's lives. Although I observed similar effects across many categories of welfare, work, and family change, there are clear patterns in the consequences of these effects. Changes in low-income women's lives appear to be most consequential for their access to public health insurance programs. But stable characteristics like underemployment, welfare access, and singlehood were more likely to affect women's risk of being uninsured. These same results also show the importance of recognizing the diversity of experiences among categories of women—while being underemployed, on welfare, or single for extended periods of time increases *some* women's access to Medicaid, for other low-income women it increases their risk of being uninsured. Thus, as inequalities in the larger society continue to grow, so also will inequalities among low-income women—leaving some with access to public health insurance programs and others with few or no health insurance options.

Divergence in state policy approaches simply reinforces these inequalities. The fact that women in Chicago and San Antonio are less likely to have public health insurance and more likely to be uninsured illustrates how the protective benefits of public programs for some women may be limited due to state-specific rules and regulations. The results provide evidence that state policy contexts play a critical role in shaping low-income women's access to health insurance and options for care.

These findings also have important implications for public policy. If Republican opposition to the 2010 Patient Protection and Affordable Care Act can be stayed, the reforms scheduled to be implemented promise to extend health-care coverage to 32 million Americans, while cutting the federal deficit by $124 billion (Kaiser Family Foundation, 2010a,b). Some of the reforms included will benefit women generally, while others aim to help low-income families in particular (National Women's Law Center, 2010; Zimmerman and Legerski, 2010). For example, Medicaid eligibility will be expanded to include individuals who in the past may have been disqualified from participation by eliminating the categorical requirements for eligibility and expanding the income threshold to 133% of the federal poverty level (FPL) (Kaiser Family Foundation, 2010a). Requirements for employers to provide health insurance may also benefit low-income women who are employed in companies with 50 or more employees, but may be less beneficial for those employed less than full time and/or in small companies. Nevertheless, establishment of insurance exchanges and non profit co-ops, as well as availability of premium and cost-sharing subsidies for families with incomes up to 400% of the FPL promise to help reduce gaps in coverage for low-income women like those represented in this sample (Collins et al., 2008; Holahan et al., 2007; Kaiser Family Foundation, 2010a). Further expanding health insurance options for low-income

women, the reform law also allows states to create a health insurance plan just for uninsured individuals with incomes below 200% of the FPL (Kaiser Family Foundation, 2010a). The law also includes incentives for states to develop "community-based collaborative care network programs" to support, coordinate, and integrate services for low-income uninsured and underinsured populations (Kaiser Family Foundation, 2010a:2).

Despite all the effort to expand eligibility and create new avenues for obtaining insurance, because the Affordable Care Act builds on and reinforces the public-private health insurance system, there are still concerns that normal life changes may result in health insurance disruptions (Sered and Proulx, 2011; Short et al., 2011). For example, because eligibility for new programs will likely be based on the previous year's taxable income, this poses challenges for families encountering immediate and substantial income and family changes. Thus, the newly established state health exchanges may play a critical role in providing options for individuals seeking temporary health coverage as they go through life transitions (Jacobs et al., 2011).

The results of the analyses presented here are limited to low-income women living in low-income neighborhoods in Boston, Chicago, and San Antonio. The change measures were created using reports of women's welfare, work, and family statuses at each wave. Despite the utility of using measures of change to understand women's access to insurance over time, because the measures created do not include changes between waves, they ultimately represent conservative estimates of change. It is highly possible that at least some women experienced even greater numbers of changes between waves than the statistics presented in these analyses reveal. Although it would be ideal to construct measures that take into consideration the full extent of changes these women experienced over time, this level of detailed data was simply not available for all variables at all waves.

The present analysis is also limited in its ability to identify the exact causal mechanisms responsible for changes in women's insurance status over time. Future research should qualitatively examine how women make work, family, and welfare decisions based on their needs for health insurance in order to help illuminate the findings and identify important causal mechanisms. Such a qualitative investigation would not only give low-income women voice in expressing the challenges they encounter as they negotiate their relationship between the state, market, and family, it would also allow scholars to develop better explanatory models and policymakers to devise better public policy solutions to the barriers low-income women face in securing adequate health insurance over the life course.

Understanding how change shapes women's health insurance status over time has important public policy implications. It would also be worthwhile to examine the effects of these welfare, work, and family changes on women's health over time. Despite contemporary efforts to curtail low-income women's access to social supports, evidence that welfare, work, family, and health insurance changes affect women's health outcomes may provide compelling

evidence for expanding women's long-term access to stable social programs and forms of health insurance.

An exploration of the nuances of state policy characteristics on low-income women's access to insurance is another area of research needing further development. The states are often described as "laboratories of democracy" in that they allow us to observe the outcomes of state-level experimentation in social policy and program development. What were the specific policy characteristics of Massachusetts, Illinois, and Texas that created such significant variation in women's access to various forms of insurance and economic well-being over time? Future research should explore how state-level policy characteristics, such as specific policy requirements and program sanctions, affect women's outcomes over time. The benefit of such an analysis lies in the potential to develop effective public policies at both the state and federal levels that will improve women's access to various forms of health insurance and assist in their well-being and independence from exploitive work, family, and state relationships.

Finally, given the passage of federal health-care reform, it will be imperative to monitor the effects of new policies on women's health and access to care over the next decade. Despite promises to expand coverage to millions of Americans, who will remain uninsured? Will mandating health insurance coverage, expanding Medicaid eligibility, creating high-risk pools, and regulating the private health insurance market be sufficient for meeting the needs of all low-income women? What new forms of vulnerability might be created? As specific reforms are implemented, it will be vital to track the effects of each policy on women's health and access to care in order to inform future policy decisions.

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