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Experiences with Health Insurance and Health Care in the Context of Welfare Reform

Kimberly Danae Narain and Marian Lisa Katz

Studies have shown that in the wake of welfare reform there has been a drop in the health insurance coverage and health care utilization of low-income mothers. Using data from 20 telephone interviews, this study explored the health insurance and health care experiences of current and former welfare participants living in Los Angeles County. This study found that half of these women had been uninsured at some point. Many of these lapses in health insurance coverage were linked to employment transitions and lack of knowledge regarding eligibility for different safety net programs. This study also found that satisfaction with access to health care was high among the insured respondents; however, barriers to care remained for many individuals, including appointment scheduling issues, limited scope of health insurance coverage, narrow provider networks, lack of care continuity, and perceived low quality of care. Better linkages between social programs assisting with health insurance coverage and improved knowledge among program clients may reduce health insurance cycling in this group. New rules for Medicaid managed care, currently being considered by the Centers for Medicare and Medicaid Services, have the potential to improve access to health care and the quality of care for these individuals.

KEY WORDS: *Centers for Medicare and Medicaid Services; disparities; health insurance; Medicaid; Temporary Assistance for Needy Families*

The [Personal Responsibility and Work Opportunity Reconciliation Act \(PRWORA\)](#) (P.L. 104-193), often referred to as welfare reform, passed in 1996. This legislation resulted in a shift of how aid is delivered to needy families. PRWORA gave rise to the Temporary Assistance for Needy Families (TANF) program. The main pillars of PRWORA, designed with the intent to limit dependency and increase employment among needy families, are a cash benefit limit of five years and mandatory sanctions for noncompliance with work requirements. Another change prompted by this legislation was the uncoupling of Medicaid and welfare eligibility, and individuals leaving TANF for employment were granted a year of transitional Medicaid coverage, irrespective of their earnings level ([Schott, 2012](#)). Some individuals have voiced concern that welfare reform may have negative implications for access to health care and health outcomes among low-income mothers. Reductions in income resulting from benefit sanctions or case closures, loss of health insurance coverage due to separate Medicaid/TANF eligibility determination processes, and mandated work hours

in the setting of work schedule volatility and minimal schedule flexibility may limit access to health care. This reduced access to health care may lead to worse health outcomes in this population ([Kaplan et al., 2005](#)). Understanding how the population affected by welfare reform has fared in terms of access to health care and health outcomes is important because health is a significant predictor of economic stability ([Corcoran, Danziger, & Tolman, 2004](#)).

[Hartley, Seccombe, and Hoffman \(2005\)](#) used qualitative methods to explore the ways in which welfare reform affected the health and well-being of individuals leaving welfare for employment and found several barriers to obtaining health care. They interviewed 83 individuals in Oregon, before and after expiration of their transitional Medicaid coverage. During the second interview they found that many individuals had become uninsured in the interim between the first and second interviews, due to lack of knowledge of Medicaid eligibility criteria, difficulty signing up for Medicaid, challenges in remaining financially eligible for Medicaid, and inability to afford private health

insurance. Consequently, many uninsured individuals went without needed health care. In several cases these actions led to worsening health status and the incurring of medical debt. For individuals with health insurance coverage, coinsurance and insurance carve-outs were considered barriers to receiving health care (Hartley et al., 2005). This study illustrates that in the wake of welfare reform many individuals leaving welfare for employment had knowledge deficits, faced administrative burdens, and experienced economic volatility that created barriers to health care receipt, with negative economic and health implications.

The work of Hartley et al. (2005) reflects the health care experiences of individuals who left welfare voluntarily for employment, a relatively better off group of individuals compared with those who have had their benefits reduced or terminated involuntarily. Individuals who exceed TANF time limits, or “time out,” are less likely to be employed, work fewer hours, earn less, and have less education than individuals who leave welfare voluntarily for employment (Hetling, Patterson, & Born, 2010). Timed-out individuals also typically have worse health status than individuals who leave welfare voluntarily (Hildebrandt & Stevens, 2009). The combination of low human capital, low income, and poor health status makes timed-out individuals particularly vulnerable to changes in access to health care. Consequently, it is important to explore how members of this group have fared in the wake of welfare reform. Our research builds on the work of Hartley et al. by using semistructured interviews to explore the health insurance and health care experiences of a different segment of the population navigating health care in the context of welfare reform, including former recipients of CalWORKs (California’s TANF program); CalWORKs recipients currently receiving benefits for both themselves and their children; and CalWORKs recipients who have lost benefits for themselves but who continue to receive benefits for their children, as a consequence of either having had their benefit sanctioned or timing out. Specifically, we explore the perspectives of members of these populations regarding facilitators and barriers to obtaining health care and the implications of these factors for their health care utilization and health outcomes.

California has a relatively more robust safety net than other states. Since 2011 families have been eligible for up to 48 months of cash assistance

(California Department of Social Services [CDSS], 2014). At the end of 48 months nonexempt adults are no longer eligible for cash benefits and time out. The case can be converted to a child-only safety net case in which cash benefits are received exclusively for minor children. Between the 2013 and 2014 fiscal years CalWORKs had 560,453 cases, and 7 percent of these were safety net cases (CDSS, 2014).

A patchwork of programs in Los Angeles County provides health insurance coverage to individuals. Guardians of minor children with incomes up to 138 percent of federal poverty level (FPL), families receiving CalWORKs or food stamps, and pregnant women with incomes up to 200 percent of FPL are eligible for Medi-Cal (California’s Medicaid program). The Access for Infants and Mothers Program provides health insurance coverage to pregnant women with incomes ranging from 200 percent to 300 percent of FPL (Department of Public Social Services, 2014). As of July 2011, childless adults with incomes up to 138 percent of FPL became eligible for Medicaid coverage through the Low Income Health Program, a temporary bridge to health insurance coverage for this group until Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) took effect (California Department of Health Care Services, 2014).

METHOD

The institutional review board of the University of California, Los Angeles, approved this study. The inclusion criteria for this study were age older than 17 years, having a minor child, not having Medicare, and English fluency. Recruitment took place in two different ways. The first recruitment strategy was designed to target timed-out individuals. The Los Angeles County Department of Public Social Services (DPSS) identified timed-out individuals, currently receiving safety net benefits, in their database and randomly selected 240 individuals from this group. These individuals were subsequently mailed a letter that contained a phone number that they could call to receive more information about the study. (One letter was returned as undeliverable to DPSS.) Individuals who called the phone line reached a voice recording that instructed them to leave their contact information. Each individual was contacted and screened for study eligibility, and eligible individuals were scheduled for an interview.

The second recruitment strategy focused on attracting individuals who had not timed out and was carried out with the assistance of Crystal Stairs, Inc. (CS). CS coordinates subsidized child care for families participating in CalWORKs. A research assistant spent the afternoon in the CS lobby, disseminating study flyers and taking down the contact information of potential participants. Fourteen people provided their contact information and were subsequently screened for participation in the study. Eleven and 9 participants were recruited using the first and second recruitment strategies, respectively, for a total of 20 participants. The response rate for the first recruitment strategy was roughly 5 percent (11 out of 239). The nature of the second recruitment strategy prevented calculation of a response rate.

Twenty interviews were conducted between July 29 and August 16, 2014. Informed consent was obtained prior to each interview. We used a phenomenological framework to conduct our interviews. The phenomenological approach to interviewing focuses on participant experiences and explores the participant's point of view. This style of interviewing involves the use of open-ended questions, to probe individuals to reconstruct their experiences and to reflect on the meaning of those experiences (Seidman, 2013). The interview guide covered five domains: health insurance coverage, encountering the health care delivery system, personal health, health behaviors, and demographics. These domains were drawn largely from literature review (Aday & Andersen, 1974; Hartley et al., 2005; Hughner & Kleine, 2004). Each individual received a \$30 Target gift card after completing the interview. All interviews were tape recorded and professionally transcribed.

We used the thematic analysis method for analyzing the interview data. Thematic analysis entails becoming familiar with the data; generating initial codes; and searching for, reviewing, and defining the themes (Braun & Clarke, 2006). We conducted a theoretical thematic analysis. This type of analysis involves generating a detailed analysis of specific aspects of the data, rather than a rich description of all available data. To become familiar with the data, two individuals spent time reading through all of the transcripts independently. After reading the transcripts they independently coded the themes, using a structural coding method. *Structural coding* is a question-based method of coding that involves

applying a content-based phrase, representing a topic of inquiry, to a segment of the data that relates to a particular research question (Saldaña, 2009). Two cycles of independent coding were conducted. Each coding cycle was followed by review of all the coded transcripts and a meeting between the two coders to discuss and resolve any coding discrepancies. Following completion of the coding, a meeting was held to compare thoughts regarding patterns in the descriptions of experiences that were relevant to the research questions. The content of each candidate theme was reviewed to ensure internal consistency and identifiable distinctions across them. Five themes were chosen: the value of health insurance, maintaining Medicaid enrollment, factors underlying health insurance loss, consequences of health insurance loss, and barriers to health care among the insured. Under the "barriers to health care among the insured" theme, five subthemes were selected: coverage limitations, disruptions in care continuity, appointment conflicts, quality-of-care concerns, and health not being a priority.

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Eleven individuals were timed out of CalWORKs, one individual had her portion of the welfare cash benefit removed due to being sanctioned, seven individuals were receiving welfare cash benefits for both themselves and their children, and one individual was not receiving any welfare cash benefit at all. Fifteen respondents self-identified as black, four reported being biracial, one self-identified as white, and four reported Hispanic ethnicity (race and ethnicity were not mutually exclusive). Thirteen individuals were 30 years old or older. Seventeen individuals reported having either a high school diploma or a GED. Compared with data from a national survey of current TANF recipients from 2010, this interview cohort had an overrepresentation of black women (75 percent versus 32 percent) and an underrepresentation of non-Hispanic white women (5 percent versus 32 percent) and individuals reporting Hispanic ethnicity (20 percent versus 30 percent). A larger proportion of this cohort was employed compared with the national sample (45 percent versus 22 percent) (Office of Family Assistance, 2012). Five individuals in the sample reported at least one chronic physical illness and five individuals reported a current or previous mental health diagnosis. Nine

individuals rated their health as good and 11 individuals rated their health as either fair, poor, or could be better. Eighteen out of 20 individuals reported health insurance coverage at the time of the interview.

Results

The organization of these results draws on the Andersen behavioral model of health services use. The model explains health services use in terms of predisposing characteristics (demographics, social structure, and health beliefs), enabling factors (financing and organization), need (perceived and objective), health behaviors (personal health practices, process of medical care, and use of personal health services), and health outcomes (perceived health, evaluated health, and consumer satisfaction) (Andersen, 2008). The first section describes a predisposing factor, the belief regarding the value of health insurance. The next two sections discuss different aspects of the enabling factor: health insurance coverage, the process of acquiring health insurance, and the factors underlying health insurance loss. The fourth section discusses the impact of health insurance loss on health care utilization and health outcomes. The final section addresses aspects of medical care and health behavior. Interview respondents will be referred to by their first and last initial.

The Value of Health Insurance

Understanding the value of health insurance is central to developing a comprehensive understanding of the health insurance coverage in this group. When knowledge of program eligibility criteria is high and individuals are eligible for benefits, health insurance uptake may be low if the perceived value of health insurance is low. This statement from KC, a healthy 26-year-old single mother of two, illustrates how health insurance is viewed as a buffer standing between illness and economic hardship:

Because illnesses come like a thief in the night, you never know. One day you're fine and you can wake up in the morning and you're feeling terrible. And you may have strep throat. You might need an antibiotic. So those antibiotics may be \$100 or more. It's just, like, man, I really didn't have that to spare but I need it or else I'm going to be more sick. And if I'm

more sick, I can't make it to work, so health insurance is something to never really take for granted.

This statement from HC, a timed-out mother with a chronic thyroid condition, highlights how health insurance takes on a particular salience for individuals with chronic diseases:

With my thyroid and just with the consistent care that I do need, and the medication that comes along with it, I definitely wouldn't be able to afford it. We'd all be dead because there's no way that I would have been able to pay for it.

Health insurance seems to be particularly valuable to individuals who lack the means to purchase health care out of pocket and whose earnings depend on them being physically present at work.

Maintaining Medicaid Enrollment

The administrative burden imposed by separation of eligibility determination processes for TANF and Medicaid has been postulated as a cause of declining health insurance coverage in the wake of welfare reform (Ku, 1997); however, this phenomenon was not reported in this study population. Although respondents reported inconvenience associated with the amount of the paperwork required to apply for Medicaid, none of them reported that the process was too burdensome to complete. This statement from HC illustrates the sentiment:

It's more just a pain in the butt, because it's like the same information over and over. Yeah, it's not that hard, I've had to fill out the paperwork so much that it's just like clockwork, it's just the same information over and over, do you own a car, do you own anything, do you have anything we take from you, are you lying to us, the same thing every year.

The joint application for social services like Medicaid and food stamps may be partially responsible for the high Medicaid participation rate observed in this group. The response from MW, a timed-out single mother of four, when asked about the protocol for maintaining health insurance, highlights how the joint benefit application may be facilitating Medicaid uptake in this group.

You do have something that you do, which is called a recertification or your yearly. It's like when you first apply. You have to do that every 12 months. And it's just for them to get updated on information and they always need to know, do you still need Medi-Cal? If you don't need Medi-Cal no more, you just might want to get cash or the food stamps, or if you want to drop the cash.

Joint application processes for Medicaid and other social services like Supplemental Security Income have been associated with high rates of Medicaid uptake (Ku, MacTaggart, Pervez, & Rosenbaum, 2009).

Factors Underlying Health Insurance Loss

Although the current level of health insurance coverage in the study population was high, half of the study population had been uninsured at some point. Transient lapses in health insurance coverage are not unique to this study cohort. Nationally, nondisabled, nonelderly adults (primarily low-income parents) have the lowest level of continuous Medicaid enrollment, in a year, of all other categorically eligible groups (Ku et al., 2009). One of the frequently cited reasons for becoming uninsured was loss of employment. This response from JZ, an unemployed single mother of three, given when asked about a coverage gap experienced two years ago, illustrates this scenario: "Between the time of being unemployed to getting on the DPSS system, I had no health insurance. I wouldn't have been able to afford it within that timeframe." This population is likely to be employed in the highest employment turnover sectors, making it likely that they will experience a higher number of employment transitions and consequently more gaps in health insurance coverage (Brodkin & Marston, 2013).

Another frequently cited reason for losing health insurance was falling into a safety net program eligibility gap. Individuals fell into an eligibility gap when they lost guardianship of their children, when they were postpartum, when they had a temporary change in their income level, and when they traveled to different states. This statement from BM, a newly uninsured 24-year-old single mother of an infant, describes falling into the program eligibility gap when she was postpartum: "Well, since I'm a government recipient, I guess I

won't meet the qualifications. They said you have to be pregnant; they cover you a little after you have your child, and then that's it."

Actually, BM was receiving CalWORKs benefits for herself and her child, so she qualified for Medicaid; however, she did not seem to be aware of this at the time of the interview. When asked about how things would change because she lost her health insurance, she gave the following response: "Well, I'm just going to pray that nothing happens to me that I really need to see a doctor." Based on this statement, BM had no concrete plans for securing health insurance in the immediate future. This scenario simultaneously illustrates how a lack of communication across social services programs and a lack of knowledge on the part of the individual can manifest in a health insurance coverage lapse. Lack of knowledge of available health insurance options was also evident when we asked individuals about their plans for maintaining health insurance coverage in the future. GG, a 39-year-old mother of two living with chronic abdominal pain, gave this response that suggested lack of knowledge of the Medicaid expansions under the ACA:

Well, DPSS allows the adults, the caregiver of the children, to receive Medi-Cal as long as the children are on DPSS, so again like I said, I have two children, two boys, one's 16 and one is 14, he's about to be 15, and when we're no longer on DPSS, I will not receive Medi-Cal anymore.

Other studies have highlighted lack of knowledge and confusion regarding the ACA in similar cohorts (Bergeron, 2014).

Consequences of Health Insurance Loss

These transient periods of health insurance loss were not without consequence. Individuals reported fiscal challenges, forgoing medical care, and health status declines during these periods of health insurance loss. When asked about how not having health insurance affected her RJ, a 36-year-old mother of two toddlers, gave this response that highlights how in a setting of limited means health care may be sacrificed:

It definitely made me think twice like, OK, if I did go to urgent care and have to pay this amount of money, but that was only maybe a

time or two where I probably should have gone and didn't because of lack of resources.

The consequences of health insurance loss were most significant among individuals with chronic medical conditions. TH, the 39-year-old mother of three with bipolar disorder, lupus, chronic obstructive pulmonary disease, and arthritis, gave the following response when asked how her time without health insurance affected her:

I think it made me more depressed. It may have aggravated a few problems I had. And in turn, once you develop another symptom, they give you another pill. So I think that some of the problems that I'm having still to this day were brought on by all the extra stress that I was going through in the beginning.

This statement illustrates how transient lapses in health insurance coverage can have both short- and long-term health consequences. A few individuals coped with periods of health insurance loss by seeking out care from free clinics, and a limited number reported paying out of pocket for health care, but the most common coping strategy was forgoing health care, which may have dire consequences. Uninsured individuals are less likely to receive preventive care, have less well managed chronic illness, and ultimately have higher health care expenditures (Institute of Medicine, 2002).

Barriers to Health Care among the Insured

The majority of insured respondents felt that overall they had good access to health care. Although the majority of respondents felt that their access to health care was adequate, some recurrent barriers to health care were brought up.

Coverage Limitations

Several respondents reported dissatisfaction with gaps in their health insurance coverage. Dental coverage was the most frequently cited gap in coverage, although gaps in prescription medication, vision, and mental health coverage were also mentioned. When asked if she is able to see a mental health provider as often as she would like, TH, the 39-year-old single mother of three with bipolar disorder quoted earlier, gave this response that highlights some of the perceived limitations in mental health coverage:

Not as frequently as I like because they've put a cap on it. I can only see her at most twice in a week, but that's in a severe situation. Medi-Cal sent me a letter stating that they would prefer I only go twice a month.

To cope with these health insurance coverage restrictions TH has begun meditating and paying out of pocket for acupuncture. This statement from CM, a timed-out single mother of two, illustrates some of the frustration with the health insurance coverage carve-outs:

You know, I don't think it's fair. Like, I had to go to see a psychologist at my school rather than the hospital that I receive care at because it's not covered. It's just, like, rules that I don't understand that should be addressed, like, you know, if you offer Medi-Cal—if you offer Kaiser and if I have Medi-Cal, I should be able to see [a psychologist] there too, why is mental health not covered? Or even dental, like, they just allowed us to have dental insurance and I go to the dentist and I need all this work done and because, you know, they cut my dental, my teeth are damaged, you know, from years of not going, even though I still brush.

This statement demonstrates how the initial coverage gap can result in pent-up demand for services and possibly worse and more expensive health outcomes down the line.

Disruptions in Health Care Continuity

Another frequently cited barrier to health care was loss of health care provider continuity. Loss of continuity primarily resulted from changes in the health care provider network. When asked about whether or not she had a usual source of care, HC, a timed-out single mother with hyperthyroidism, gave the following response:

Mine changes because the doctors all of a sudden will be, like, "Oh, we don't take CareFirst anymore," of course they don't bother to tell you that until you show up for your appointment. They had even scheduled the appointment and after I had done some blood work for them and I came in, they didn't bother to cancel my appointment.

HC did not receive follow-up on her lab results and did not seek out another primary care physician until she needed a referral to a gynecologist.

Appointment Conflicts

A few respondents reported having difficulty scheduling their medical appointments. In the following statement, DH, a 38-year-old timed-out single mother of one minor and four adult children, recounts the struggle of trying to schedule an appointment with her last physician:

I would have to go down to the clinic just to make an appointment and I would tell them, “Why aren’t you guys picking up the phone?” and then I would be there and see the phone ringing and they wouldn’t pick it up.

Consequently, DH reported only seeking care in the event of an acute medical issue. BM, a 24-year-old single mother of one, expressed similar sentiments when she was asked if she is able to see a medical provider as often as she would like:

I kind of don’t because the lines and the phone, trying to call for an appointment is just too much. You have to stay on the line forever or we have to go down there, wait in line. It’s just, like, a process that’s not even worth it.

What is illustrated in both of these statements is how the inability to schedule an appointment easily can lead to either delaying or forgoing the receipt of health care.

For this population the process of care may present significant challenges for accessing health care despite the perceived need for it. The extent to which these issues have been exacerbated by the growth in Medicaid managed care is unclear. Studies have not linked Medicaid managed care with declining access to care or patient satisfaction in the general population; however, studies have shown that racial and ethnic minority patients are less satisfied with Medicaid managed care than white, non-Hispanic patients (Weech-Maldonado et al., 2003).

Health Care Quality Concerns

Some respondents expressed concerns regarding the quality of care they received. DH, a 38-year-old single mother of five, gave this statement while discussing why she switched her primary care provider:

Yeah, and she really didn’t help her patients, to me, and I was there for a while before I changed her. I was just trying to give her the benefit of the doubt, but after so long I was just, like, no. I can’t take it anymore.

When asked about her experiences obtaining health care after transitioning from employer-sponsored health insurance coverage to Medicaid, BM, a 24-year-old single mother of one who is a full-time student, gave this response that underscores the perception of disparate treatment described by some of the Medicaid recipients:

Say, for instance, if there’s an emergency or something, if you know you’ve got [non-Medi-Cal] health coverage, then you are going to want to go to the doctors and offer to pay them with the health care you have, because I also felt that you get treated differently as well, too. Because there was a time when I had to go to the emergency room and I was on Kaiser, and I was treated good, and then there was a time when I presented my Medi-Cal card when I had to go to emergency, and it felt like they were just trying to hurry up and get me out [of] there, like they didn’t really care.

Low levels of patient satisfaction may lead to alienation from the health care delivery system and have implications for the receipt of health care and compliance with treatment recommendations (Kovac, Patel, Peterson, & Kimmel, 2002).

Health Is Not My Priority

A segment of respondents reported having competing priorities that took precedence over their health. Competing priorities included school obligations and seeking housing, child care, and employment. This statement from RR, a timed-out mother of one who was living in a homeless shelter, illustrates the types of complex tradeoffs that have to be made when it comes to addressing health concerns while dealing with socioeconomic instability.

There’s a bunch of stuff that I need to do, but like I said, I’ve been just consumed with our housing and things like that, trying to comply with the rules here. And then sometimes they have things that are going on here and you can’t—for some reason, like this past year,

they've always clashed with my appointments and then I have to say, OK, which is more important? And then I'll choose that instead of my health.

When the decision came down to either addressing immediate material needs or taking care of health, the respondents often decided that the material concerns were more pressing, despite the perceived need for health care.

DISCUSSION AND CONCLUSION

This study is one of the few to explore the experiences of current and former TANF recipients with navigating the health care delivery system in the wake of welfare reform. This study builds on previous work that has focused on individuals leaving TANF for employment by including the perspectives of current TANF recipients, particularly individuals who have had their benefits reduced involuntarily. In summary, this study found that frequent lapses in health insurance coverage were reported despite a high value being placed on health insurance coverage and high levels of perceived need for health care. Many of the lapses in health insurance coverage were explained by employment transitions and fluctuating eligibility for social services programs, in the setting of limited program knowledge. Contrary to what has been found in other studies, the enrollment process for Medicaid did not pose a significant administrative burden to study respondents. The coping strategies used by respondents during health insurance lapses included delaying care and forgoing care, often with fiscal and health consequences for individuals with chronic illness. Satisfaction with access to health care was high among the insured respondents, although barriers to care remained for some. Many of the barriers discussed by respondents were not unique to this study cohort. Barriers to care included health insurance carve-outs, having more pressing obligations, and having concerns regarding the quality of care they received. Several processes of care were also mentioned as barriers to care. These barriers included problems scheduling appointments and lack of care continuity.

This study has several limitations. This study is not able to provide information that is generalizable to the broader population affected by TANF. The generalizability of the study is further

hampered by the low response rate obtained in the recruitment of timed-out study participants and by the use of convenience sampling to recruit individuals who had not timed out. This study also excluded non-English speakers; as a consequence the results of this study do not reflect the ways in which limited English proficiency may complicate navigation of the health care delivery system and does not capture the experiences of many Hispanic individuals, a significant component of the TANF population in Los Angeles County. Last, the study sample is limited to California, particularly Los Angeles County, which has a unique health care delivery system and social services context. Consequently, the experiences and views of individuals in this study sample may not be reproducible in other cohorts. Nonetheless, this study does provide some useful insights that may help to inform policymakers and program administrators.

Lapses in health insurance coverage are still occurring in this population despite a robust health insurance safety net, a streamlined enrollment process for Medicaid, and early adoption of the Medicaid expansion under the ACA. Some of the lapses in health insurance coverage may be prevented by improving communication between health insurance safety net programs and the knowledge base of individuals regarding their available coverage options.

Many insured respondents endorsed barriers to health care stemming from underinsurance. Insurance carve-outs, particularly vision and dental, posed challenges to receiving needed care in this population. Tweaking the federally mandated package of Medicaid services to include these essential services for adults would help ensure access to needed care in this population if enough medical providers were available and willing to meet the service demand (Sommers, Tomasi, Swartz, & Epstein, 2012).

New proposed rules to govern Medicaid managed care organizations have the potential to address many of the barriers to health care raised by individuals in this study population, including discontinuity of care, limited provider networks, and perceived low quality care. The proposed rules currently under consideration by the [Centers for Medicare and Medicaid Services \(2015\)](#) include tighter regulations for maintaining continuity of care, establishing network adequacy standards for the provision of covered services, and efforts to bring quality of care on par with that of private

health insurance providers. Mandating the tracking of patient satisfaction and including rules that focus on ensuring efficient processes for making appointments will also greatly benefit this population. Last, studies should explore why minority populations are less satisfied with Medicaid managed care than nonminority individuals. **HSW**

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HOPE Matters

The Power of Social Work

Elizabeth J. Clark and Elizabeth F. Hoffler, Editors

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