Nearly 43 million Americans were uninsured in 1999. The large number of individuals living without insurance remains a major health and public policy concern. Although these individuals have less health care access and service use, the uninsured do have some sources of care. A health care system, or “safety net,” for the poor, comprising public hospitals, community health centers, local clinics, and some primary health care physicians, exists in all communities. However, the capacity of these systems and their sources of financial support vary widely.

States’ uninsured rates, marketplace competition, Medicaid payment policies, and state and local financial support all exert pressure on the safety net. As a result, access for the uninsured can vary considerably across states and communities. Cunningham and Kemper (1998), after controlling for personal and health characteristics, find considerable differences across communities in the extent of unmet need and delays in obtaining care among the uninsured.

This brief examines the extent to which differences in the safety-net environment account for differences in the uninsureds’ access to and use of health care. After grouping states according to the vulnerability of various aspects of their health care safety nets, we examine whether low-income uninsured adults get less care and have poorer access in states where the safety net is weaker. We then explore whether utilization and access gaps between the uninsured and the insured are narrower in states with stronger safety nets. The brief focuses on low-income adults, who are more likely to be uninsured and therefore dependent on the safety net, and on residents of metropolitan areas, where most states’ safety-net resources are concentrated. It draws on representative samples of the population from 13 states—Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin—using data from the Urban Institute’s National Survey of America’s Families.

The analysis reveals that differences across states in some measures of care access for uninsured adults are consistent with differences in the levels of safety-net vulnerability. More striking, however, is the finding that substantial gaps in service use and care access between the uninsured and the insured are evident in all states and that the vulnerability of a state’s safety net does not affect these gaps. Uninsured adults’ access to care appears to be no worse where the safety net is more threatened and no better where it is under less pressure.

Defining the Safety Net

The structure of the safety net varies by state (Norton and Lipson 1998). In some jurisdictions, state, county, and other publicly owned systems provide most uncom-
pensated hospital and emergency care. In others, a mix of public and privately owned systems provide the bulk of support to the uninsured. In every state, community health centers as well as county and city health departments also provide subsidized or free care to those who cannot pay, although the extent of such services varies. Some states rely more heavily on direct state and local funding in caring for the uninsured, while others largely depend on the ability of providers to pass costs along to third-party payers.

A number of financial stresses appear to be adversely affecting all safety-net providers, but providers in some areas appear to be under more pressure. In particular, providers in states with high uninsured rates, such as California, Florida, and Texas, are likely to see higher demand for care from individuals who cannot pay than do those in states with low uninsured rates, such as Massachusetts, Minnesota, and Wisconsin.

The growth of managed care may also affect some states’ safety nets, as downward pressure on payments by plans tightens provider budgets. Such pressure is less likely in states where fee-for-service insurance remains prevalent, such as Alabama, Mississippi, and Michigan. Safety-net providers in these states are more likely to be able to finance charity care through cross-subsidies from third-party insurers. In contrast, in states where managed care is well established, such as California and Minnesota, intense marketplace competition among managed care plans could cause the surplus revenues from privately insured patients to shrink. As surpluses decline, fewer providers may be willing to serve indigent patients. Furthermore, if plans are able to negotiate more favorable contracts with other providers, higher-cost, lower-margin safety-net hospitals may not be able to compete. Similarly, increased competition in states with large numbers of for-profit hospitals could make it harder for all hospitals, particularly low-margin safety-net hospitals, to provide free or subsidized care.

Medicaid managed care can also increase competition and erode the uninsured safety net. Under Medicaid managed care, Medicaid patients, particularly healthier, less costly ones, may be attracted away from safety-net hospitals to other hospitals. Even if safety-net providers can compete effectively for managed care patients, they may be hurt by managed care’s impact on their payment rates. Some state Medicaid programs protect safety-net providers from the effects of managed care, but the extent of such protections varies widely.

States’ safety nets also depend on disproportionate share payments (DSH)—direct Medicaid subsidies to hospitals that provide a large share of care to the low-income population. As with other sources of funding, state use of these programs varies considerably. Alabama, California, Mississippi, and Texas receive relatively high DSH payments, while Florida, Minnesota, Washington, and Wisconsin receive limited DSH support. Some states also rely on other kinds of financing. For example, in New Jersey, New York, and Massachusetts, state charity-care pools provide additional support to hospitals that provide high levels of charity care.

Finally, local revenues are important to safety-net providers. Often city or county governments fill in the gaps when all other sources of revenue have been exhausted. In Florida (Miami and Tampa), lawmakers increased local taxes in the early 1990s to support care to the poor. In contrast, the level of local support for the Harris County, Texas, hospital district (Houston) has been an ongoing issue (Meyer, Legnini, Fatula, and Stepnick 1999).

Based on case studies conducted for the Urban Institute’s Assessing the New Federalism project in 1997, Norton and Lipson (1998) concluded that despite the array of stresses on the safety net, providers were able to maintain their commitment to the low-income uninsured, even in areas experiencing the greatest financial pressure. They concluded that the safety net was holding steady because (1) few communities experienced all of the potentially adverse factors at the same time, (2) most safety-net providers responded quickly to pressures as they arose, and (3) states and localities also responded promptly to the needs of safety-net institutions. Safety-net providers responded to threats by joining or developing managed care plans, increasing efficiency, reducing costs, improving the quality of care or service to patients to compete with other providers, developing new ways to manage care for the uninsured, and effectively lobbying for financial support at the federal, state, and local levels.

Assessing State Vulnerability

This analysis divides 13 states’ safety net systems into three categories—most vulnerable, somewhat vulnerable, and least vulnerable—using an approach developed by Norton and Lipson (1998). Norton and Lipson’s original measure of vulnerability incorporated information on uninsurance rates, the percentage of commercial managed care penetration, the percentage of hospitals that are for-profit, the penetration of Medicaid managed care, and federal and state support for inpatient care. While using the same basic approach, several measures were added that resulted in some changes in the assignment of states (table 1).

California, Florida, and Texas are classified as having the most vulnerable safety nets in this study. These three states have the highest adult uninsurance rates, relatively high commercial managed care penetration, and/or a high share of for-profit hospitals. California also has a high percentage of enrollees in Medicaid...

Based on case studies conducted for the Urban Institute’s Assessing the New Federalism project in 1997,
managed care and the lowest capitation rates in the nation (Holahan and Shimer 2000). In 1997, none of these states had programs other than basic Medicaid that provided insurance to low-income adults. Compared with other states, federal DSH payments are moderate in California and Texas and low in Florida. Recent research also reports problems in sustaining local government support for providers in Texas (Meyer et al. 1999).

Massachusetts, Minnesota, Washington, and Wisconsin have the least vulnerable safety nets. These states have relatively low uninsurance rates, and in 1997, all but Wisconsin provided subsidized insurance coverage to low-income adults. Each of these four states has fairly large Medicaid managed care programs, but none has been particularly aggressive in seeking cost savings.

The safety nets of the remaining six states—Alabama, Mississippi, New York, New Jersey, Colorado, and Michigan—are somewhat vulnerable. These states fall in the middle category for different reasons. While Alabama and Mississippi have relatively high rates of uninsurance, they have low private managed care penetration, virtually no Medicaid managed care, and high federal disproportionate share payments. Alabama and Mississippi also have a high number of Federally Qualified Health Centers (FQHCs) per capita and the highest number of public hospital beds per low-income person among the 13 states. FQHCs are nonprofit, tax-exempt, or public facilities in medically underserved areas, and they represent a large share of community health centers serving the poor regardless of ability to pay. New York and New Jersey have moderate uninsurance rates, high disproportionate share payments and a history of supporting safety net institutions with bad debt and charity-care pools. Colorado has a moderate uninsurance rate, high levels of market competition, and moderate Medicaid managed care, but no specific program covering low-income adults and only moderate levels of disproportionate share payments. Michigan has a relatively low uninsurance rate, but no statewide programs providing subsidized insurance for low-income adults and an extensive program of Medicaid managed care.

The outcome measures examined here are having a usual source of care other than an emergency room, seeing a doctor, and having confidence in the ability to obtain care. The sample is low-income adults (incomes below 200 percent of the federal poverty level) living in urban areas. Limiting the sample to low-income individuals, who are more likely to use the safety net, keeps the economic situation of the sample fairly homogeneous, except for insurance status. We estimate regression models that control for differences in demographic characteristics, such as age, gender, family structure, race and ethnicity, education, income, self-reported health status, and presence of a disability. The models include a dummy variable for insurance status (full-year uninsured versus full-year insured), dummy variables for each state, and state-insurance interaction terms. The insurance status variable together with the state-insurance interaction terms allow us to measure state-by-state differences in access for the uninsured; they also permit comparisons between the insured and uninsured within each state.

We also estimate models to assess the importance of differences in vulnerability across states. In these models, we include dummy variables to identify the three sets of states and interactions between insurance status and these vulnerability dummies. Unless otherwise noted, differences are significant at the 5 percent level in a two-tailed test.

**The Safety Net’s Effect on Three Outcome Measures**

Figures 1 through 3 show the differences among the three groups of states in the likelihood of having a usual source of care, a doctor visit, and confidence in the ability to obtain care when needed (full results are shown in table 2). In each figure, the states are grouped by safety-net vulnerability and are shown from least vulnerable to most vulnerable.

**Usual Source of Care**

The uninsured in the most vulnerable states are less likely to have a usual source of care than are the uninsured in the other two groups (figure 1). (The difference between the least and somewhat vulnerable groups combined and the most vulnerable group is significant at the 10 percent level). Less than 60 percent of the uninsured...
in all three of the most vulnerable states have a usual source of care, with the percentage falling as low as 49.4 percent in California and 51.2 percent in Texas. In contrast, in all four least vulnerable states, the likelihood of having a usual source of care is more than 60 percent. The results for states in the somewhat vulnerable group vary. More than 60 percent of the uninsured have a usual source of care in Alabama, Colorado, and New Jersey; less than 60 percent do in New York, Mississippi, and Michigan.

Notably, a state’s vulnerability does not affect the magnitude of the access-to-care gap between the uninsured and the insured. The gap is at least 20 percentage points in all 13 states. The insured are at least 30 percent more likely than the uninsured to have a usual source of care in all states and more than 50 percent more likely in California, Michigan, and New York. Because both the insured and the uninsured are less likely to have a usual source of care in the most vulnerable states, however, the gap in access between them is not significantly larger than in the other two groups of states.

**Seeing a Doctor**

Figure 2 shows the percentage of low-income insured and uninsured adults with a doctor visit. In the three states with the most vulnerable safety-net systems, 36.9 percent of the uninsured on average had a doctor visit; the results ranged from 33.8 percent in California to 39.3 percent in Texas. In contrast, in the four least vulnerable states, 42.1 percent of the uninsured had a doctor visit. However, the difference between the most and least vulnerable groups (42.1 percent and 36.9 percent) was not statistically significant. The larger difference between the somewhat vulnerable and least vulnerable groups (46.5 percent and 36.9 percent) was significant at the 10 percent level. Again, more variation was evident within the somewhat vulnerable group, with the New Jersey and New York uninsured having almost a 50 percent likelihood of having a doctor visit, compared with 38.4 percent in Colorado and 39.1 percent in Michigan.

As with having a usual source of care, although the differences between the uninsured and the insured in every state are striking, they do not vary with the vulnerability of the safety-net system. The insured were more than 40 percent more likely than the uninsured to have a doctor visit in all 13 states; they were at least 50 percent more likely in 12 of the 13 states, and 75 percent more likely in four states: California, Florida, Massachusetts, and Michigan. Nevertheless, despite significant state-by-state differences in the likelihood of a doctor visit among insured adults (with a visit less likely, on average, in the most vulnerable states), the vulnerability of the safety-net system does not
worsen the relative position of the uninsured. Indeed, the uninsured are no worse off relative to the insured in the most vulnerable states than in the other states.

**Confidence in Obtaining Care**

Overall, vulnerability of the safety net did not affect adults’ confidence in their ability to obtain care when needed (figure 3). In the most vulnerable states, 72.6 percent of the uninsured were confident they could get care, compared with 80.3 percent in the least vulnerable states, but the difference between the two groups was not statistically significant. Some differences in confidence between individual states were significant. For example, 68.3 percent of the uninsured in California reported confidence in their access to care, versus 82.3 percent in Massachusetts.

The gaps between the uninsured and the insured are less dramatic for confidence than for the other measures. Still, the uninsured are significantly less likely than the insured to be confident in their ability to obtain care in all states. Almost all the insured in Michigan and Minnesota (more than 95 percent) reported having confidence, compared with about three-quarters of the uninsured in both states. In contrast, California had the lowest rate of confidence among the uninsured. In that state, however, the insured are also less likely to have confidence than the respondents in other states. Overall, the states’ safety-net vulnerability does not significantly affect the magnitude of the uninsured-insured gap. The least vulnerable states do no better than the most vulnerable in closing the confidence gap between the insured and uninsured.

**Comparing the Low-Income Insured and High-Income Insured**

The vulnerability of a state’s safety net adversely affects access to care, but it does not reduce or increase the gap in access that exists between the low-income uninsured and insured. As a final step, for all three outcome measures, we compare higher-income insured adults (incomes above 200 percent of the federal poverty level) with both low-income insured adults and low-income uninsured adults. This comparison shows whether obtaining insurance would likely increase currently uninsured adults’ access to care to about the same levels shown for high-income insured adults. We would expect safety-net vulnerability to have a much smaller effect on higher-income insured adults, who generally have wide access to health care, than on both

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**FIGURE 2. Predicted Probability of Having a Physician Visit (Low-Income Insured vs. Low-Income Uninsured)**

Source: Regression estimates controlling for demographic characteristics and health.
* Significantly different from the most vulnerable group at the 5 percent level.

**FIGURE 3. Predicted Probability of Having Confidence in Ability to Get Care (Low-Income Insured vs. Low-Income Uninsured)**

Source: Regression estimates controlling for demographic characteristics and health.
* Significantly different from the most vulnerable group at the 5 percent level.
low-income insured and uninsured adults.

As observed for the low-income population, higher-income insured adults in the states with the most vulnerable safety nets were less likely than those in the somewhat or least vulnerable states to have either a usual source of care, a physician visit, or confidence in their ability to get care (figure 4). This finding suggests that the factors that increase pressures on safety-net providers (e.g., managed-care penetration) also affect the broader health care system and access patterns in these states.

High-income insured adults, have higher care use and access than do low-income insured adults but differences are small when compared with use and access for the uninsured. In the most vulnerable states, the gap between low-income and high-income insured adults was only 5 to 7 percentage points for all three outcome measures. In contrast, the difference between uninsured adults and insured adults was more than 30 percentage points in the most vulnerable states for usual source of care and physician visits and about 19 percentage points for confidence. In the somewhat and least vulnerable states, differences between the high-income and low-income insured are even smaller, even where statistically significant. Being in a state with a less vulnerable safety net does not, however, improve the relative position of the uninsured. On the other hand, having insurance virtually eliminates differences in access to care in the least and somewhat vulnerable states, and it nearly eliminates the gap where the safety net is most vulnerable.

**Health Insurance Is the Best Way to Ensure Access**

Our analysis shows some state-by-state differences among the uninsured according to the three measures we examined. With the exception of having a usual source of care, however, the differences are not related to safety-net vulnerability. Indeed, in states where the safety net is under greater stress because of higher uninsured rates among low-income adults, more managed care, less support of hospitals that provide charity care, and other factors, the uninsured do not appear to be significantly worse off than they are in states with less vulnerable safety nets. The health systems of the most vulnerable states appear to have found ways to respond despite the greater pressures.

More striking is the finding that the large gaps observed in care access and use between the low-income insured and uninsured populations are unrelated to the vulnerability of the safety net. The gaps in the most vulnerable states were no larger than in the other two groups of states for any of the measures. A true assessment of the impact of stress factors would need to examine shifts in access as safety-net conditions change. Nonetheless, our findings are consistent with providers’ perceptions that they have managed to cope with demand in states where stresses were high.

The weakness of the safety net does not appear to worsen the uninsureds’ access to care. Conversely, a relatively strong safety net does not appear to improve their position relative to the insured. No matter how the uninsured are supported—whether by third-party payers, the presence of community health cen-

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**FIGURE 4. Health Care Use and Access among High-Income Insured, Low-Income Insured, and Uninsured Adults, by State Safety-Net Vulnerability**

Source: Regression estimates controlling for demographic characteristics and health.

*High income insured significantly different from low income insured at the 5 percent level.
The uninsured appear no worse off in states with the most vulnerable safety nets, that does not mean that the low-income population is not better off in some places. If the low-income population is significantly more likely to be insured within a state, they will have greater use of and access to care. For example, in Massachusetts, Minnesota, Washington, and Wisconsin, there are substantial programs providing insurance to low-income adults, and the low-income population is more likely to be insured. In California, Florida, and Texas, uninsured rates are considerably higher than elsewhere. Although the gaps between the uninsured and the insured show little variation among states, low-income populations clearly will be better off in states where they are more likely to be insured.

Endnotes
1. The sample includes only adults who are uninsured or insured for the entire year, to avoid potential bias in the estimated impact of insurance, or if we included those whose insurance status changed during the year (Marquis and Long 1994/5).

References

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This series presents findings from the 1997 and 1999 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at http://newfederalism.urban.org.

The NSAF is part of Assessing the New Federalism, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.


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