URBANALLIANCE

2026

HEALTHCARE REPORT

Understanding access, barriers and service needs of ALICE households in Connecticut

This report was prepared by Urban Alliance (UA), a collective impact organization based in East Hartford, Connecticut. Urban Alliance's mission is to create opportunities for individuals and families to achieve lasting change through the collaborative work of churches and community-based organizations.

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This research was made possible through funding from the Connecticut Health Foundation, an independent, private foundation dedicated to improving health outcomes for people of color and ensuring that all Connecticut residents have access to affordable, high-quality health care. Through strategic grantmaking, public policy, and leadership development, the Foundation works to advance equitable, lasting changes that improve lives across the state.

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Suggested Citation: Sanderson, J., Rodriguez, R., Santiago, R. (2026). *2026 Healthcare report: Understanding access, barriers, and service needs of ALICE households in Connecticut*. Urban Alliance.

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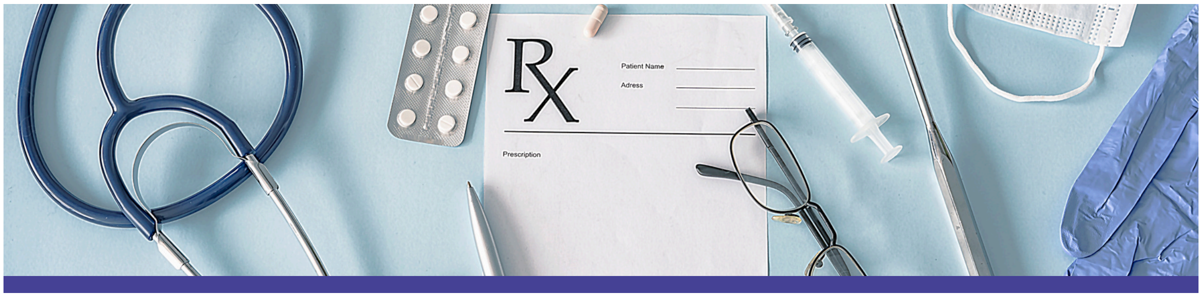


Summary

ALICE (Asset-Limited, Income-Constrained, Employed) households represent a growing population in Connecticut—working families who earn above the federal poverty threshold but lack sufficient income to afford a basic household survival budget, including healthcare. This mixed-methods study examined the barriers these households face in accessing and utilizing health insurance and healthcare services. Quantitative survey data were collected from 350 ALICE households, assessing demographics, health insurance literacy, healthcare utilization, and financial and emotional stress related to medical care. In-depth qualitative interviews with 16 survey participants explored lived experiences, decision-making around insurance and care, and the trade-offs imposed by financial constraints.

Findings reveal that ALICE households experience multifaceted barriers to healthcare access. Despite moderate confidence in navigating health insurance, 66% reported that care is too expensive, 41% reported medical debt, and 54% had cut back on essentials such as food to afford care. Chronic conditions and ongoing health needs amplified both financial and logistical burdens, while the complexity of insurance plans and eligibility gaps limited meaningful access to services. Qualitative findings highlighted the emotional toll of delayed or foregone care, anxiety over unpredictable medical costs, and challenges interpreting plan benefits.

These results underscore that for ALICE households, employment or nominal insurance coverage does not guarantee access to care; economic vulnerability, structural barriers, and plan complexity create persistent inequities. Policy and system reforms that reduce out-of-pocket costs, simplify insurance navigation, and address eligibility and provider network gaps are critical to improving health outcomes and equity for ALICE households.

Introduction

ALICE (Asset-Limited, Income-Constrained, Employed) describes households that earn more than the Federal Poverty Level but still fall short of the income needed to afford a basic household budget for housing, childcare, food, transportation, health care, and technology in their local area. ALICE is intended to identify the “working but struggling” segment of the population that is invisible to traditional poverty measures, yet is at high risk of financial instability.

Recent reports show that Connecticut has a large and growing ALICE population. In 2023 (the most recent statewide ALICE reporting period), approximately 11% of Connecticut households were living below the federal poverty threshold, and an additional 29% qualified as ALICE. This group was earning above the poverty level but still struggling to cover costs like housing and childcare (United for ALICE, 2025).

Roughly 40% of Connecticut households, about 580,000 households, were unable to afford a basic “survival” budget in their county or planning region. Those figures translate to roughly 1.4 million total households in the state, with about 563,000–581,000 households below the ALICE Threshold (United for ALICE, 2025).

The ALICE framework uses a “Cost of Basics” or survival budget, that is calculated for each county/region. In Connecticut, reporting this survival budget is substantially higher than the federal poverty line. For example, ALICE reporting has documented survival-budget benchmarks such as an annual survival-level cost of roughly $38,000 for a single adult, and well over $100,000 for some four-person household survival budgets in higher-cost parts of the state. This mismatch between wages and local costs is a primary driver of growing financial hardship among residents who are employed but unable to get ahead.

ALICE households (the 29% earning above the poverty level but still struggling to cover costs) cut across many demographic groups. They include single adults, working parents, seniors on low fixed incomes, and people with some postsecondary education who nevertheless earn too little to meet local costs. Racial and gender disparities persist with Black and Hispanic households and single-female–headed households disproportionately represented among those below the ALICE threshold.

Geographically, the highest concentrations of hardship are in many of Connecticut’s cities (e.g., Bridgeport, New Haven, Hartford), but recent reporting also shows that increases in financial stress are occurring rapidly in suburban and some rural areas as costs rise and wages stagnate.

Barriers to Health Insurance and Healthcare Access Among ALICE Households

Building upon the overview of ALICE households presented in the previous section, it is important to examine how economic constraints translate into challenges in accessing essential services such as health insurance and healthcare. While ALICE families are employed and often exceed the federal poverty threshold, their financial vulnerability places them in a precarious position where basic health needs remain difficult to meet. Existing research highlights that despite being a critical segment of the workforce, ALICE households encounter a range of obstacles—from unaffordable premiums and high out-of-pocket costs to restrictive eligibility rules, workplace constraints, and competing financial priorities that limit their ability to secure timely and adequate care. The following review synthesizes these findings to illustrate the multifaceted barriers to healthcare faced by ALICE households.

Cost and Underinsurance. One of the most consistently cited barriers for ALICE households is the cost of health insurance and associated out-of-pocket expenses. Although many are employed and may have access to employer-sponsored or marketplace insurance, premiums, deductibles, and co-payments often remain prohibitively expensive (Buchmueller & Levy, 2020; University of Washington Center for Women's Welfare, 2024).

As a result, many ALICE families are underinsured, with coverage that does not adequately protect them from financial hardship related to healthcare expenses. This underinsurance frequently results in delayed or forgone care, particularly for preventive services and chronic disease management (United For ALICE, 2025).

Eligibility Gaps and the Benefits Cliff. ALICE households often fall into the "coverage gap" created by income thresholds for public health insurance programs. Because they earn above the eligibility limit for Medicaid, they are excluded from many safety-net benefits. Yet their incomes remain insufficient to cover the high cost of private insurance without subsidies (Fitzpatrick, 2015; United For ALICE, 2025). This benefits cliff results in a paradox: working households are disqualified from programs designed to assist low-income populations but cannot afford adequate alternatives (United Way of Southeastern Connecticut, 2024).

Workplace and Scheduling Constraints. The nature of employment among ALICE households contributes to additional access barriers. Many ALICE workers are employed in low-wage, hourly, or service-sector jobs with limited benefits, irregular hours, and little schedule flexibility. These conditions make it difficult to attend medical appointments during typical office hours or to take unpaid leave without financial consequences (Boyens, Karpman, & Smalligan, 2023; United For ALICE, 2025). Consequently, even insured individuals may struggle to obtain consistent care.

Geographic and Provider Access. Beyond affordability, geographic and provider-related barriers affect ALICE households. Limited provider networks, particularly in plans with lower premiums, reduce access to specialists and in-network services (Cohen, & Martinez, 2020).

In rural or underserved urban communities, lack of nearby providers or reliable transportation exacerbates these challenges. These structural barriers can make insurance coverage less meaningful in practice.

Administrative Complexity and Awareness. Complexity in navigating insurance options also poses a barrier. Understanding plan structures, eligibility rules, and network limitations can be overwhelming, particularly for households juggling multiple jobs and responsibilities. ALICE households often lack the time, resources, or support systems needed to make fully informed insurance choices, leading to gaps in coverage or enrollment in inadequate plans (Pestaina, Long, Salaga & Wallace, 2025; United For ALICE, 2025).

Trade-offs and Competing Needs. Finally, ALICE households frequently face difficult trade-offs among basic needs. With limited budgets, spending on housing, childcare, and food often takes precedence over healthcare. Studies in Connecticut show that even modest healthcare costs can push families into financial crisis, forcing them to delay treatment or avoid medical visits altogether (Connecticut Office of Health Strategy, 2024). These trade-offs underscore the precariousness of healthcare access for ALICE families, even when they are nominally insured.

Research demonstrates that ALICE households face multi-layered barriers to accessing health insurance and healthcare, including unaffordable costs, eligibility gaps, underinsurance, employment-related constraints, provider shortages, and competing financial priorities. These barriers collectively increase the likelihood that ALICE households will delay or forgo necessary care, with potential consequences for both individual health outcomes and broader public health.

Addressing these challenges requires policy reforms that target affordability, expand eligibility for public assistance, improve workplace protections, and enhance navigation support for families caught in the gap between poverty and financial stability.

Research Purpose

The purpose of this study is to explore and document the barriers that ALICE (Asset-Limited, Income-Constrained, Employed) households in Connecticut face in accessing health insurance and healthcare services. While previous reports have established the prevalence of ALICE households and highlighted general challenges related to affordability and coverage, there is limited empirical research that integrates both quantitative and qualitative perspectives from these households themselves. By combining survey data with in-depth interviews, this project seeks to capture the scope and complexity of barriers—including financial constraints, eligibility gaps, employment-related limitations, access, and competing household priorities—that hinder equitable healthcare access. The mixed-methods approach aims not only to quantify the extent of these challenges in Connecticut, but also to provide nuanced insights into how families experience and navigate them in daily life. Ultimately, this research is designed to generate actionable evidence that can inform policy, community interventions, and resource allocation to reduce disparities and improve health outcomes among working households that fall below the ALICE threshold.

Methods

This study employed a mixed-methods design to investigate barriers to accessing health insurance and healthcare among ALICE households in Connecticut. Data collection was conducted in two phases: a quantitative survey administered at community events, followed by qualitative in-depth interviews with a subset of survey participants.

Survey Data Collection

Quantitative data were gathered through a structured survey distributed at community-based events in urban centers in Connecticut. These events were selected in partnership with local organizations that serve ALICE households to ensure accessibility and broad representation. The survey instrument included questions addressing household demographics, insurance coverage status, healthcare utilization, health knowledge about health insurance, perceived barriers to accessing care, food security, anxiety, and household service needs. A total of 1700 surveys were collected in total and 350 were ALICE households. Participation was voluntary and respondents were provided with modest incentives (e.g., gift cards, small gifts) to encourage participation.

Standardized measures included:

USDA U.S. Household Food Security Survey Module (2-Item Short Form): The 2-item short form of the survey module was developed by researchers at the National Center for Health Statistics. It has been shown to identify food-insecure households and households with very low food security with reasonably high specificity and sensitivity and minimal bias compared with the original 18-item measure. The tool has a sensitivity of 97% and a specificity of 83% when compared to the USDA's Household Food Security Scale. Residents were given a score ranging from 0-6, which corresponds to at-risk and not at risk for food insecurity (Rabbitt, Reed-Jones, Hales, Suttles, & Burke, 2025).

Generalized Anxiety Disorder Scale (The GAD-2): This 2-item measure that assesses anxiety symptoms associated with generalized anxiety disorder. Items are scored using a zero to three scale indicating the frequency of each of the symptoms. Scale scores range from 0 to 6 and place residents in two categories, at-risk and not at risk (Kroenke, Spitzer, Williams & Löwe, 2007).

Health Insurance Literacy Measure (HILM): This validated self-report instrument was developed by Paez et al. (2014) to assess adults' ability to choose and use private health insurance. Grounded in an extensive conceptual framework and consumer testing, the HILM captures both knowledge and confidence related to navigating health insurance tasks. Two subscales were included in this study including Confidence in Choosing Health Insurance which evaluates consumers' perceived ability to compare plans, understand trade-offs, and select coverage that meets their needs and Confidence in Using Health Insurance which measures confidence in understanding plan documents, calculating out-of-pocket costs, and making informed decisions when seeking care. Items are rated on Likert-type scales, with higher scores indicating greater health insurance literacy. Psychometric testing across a diverse national sample demonstrated strong internal consistency, construct validity, and factor structure. The HILM is widely used in research and practice to assess consumer readiness, identify literacy gaps, and evaluate interventions aimed at improving health insurance decision-making and use.

In-depth Interviews

To complement the survey data and capture more detailed perspectives, follow-up qualitative interviews were conducted with 16 individuals who had completed the survey and expressed willingness to participate in additional research. Participants were purposively sampled to reflect diversity in age, gender, household composition, and insurance status. Semi-structured interview guides were developed to explore personal experiences with navigating health insurance systems, decision-making around healthcare utilization, and the trade-offs made when faced with financial or logistical barriers. Interviews lasted between 30 and 60 minutes and were conducted either in person or virtually, depending on participant preference. All interviews were audio-recorded, with participant consent and transcribed verbatim for analysis.

Sample interview questions included:

I. General Background and Context

- Can you tell me a little about your household and who makes up your family?
- What is your current employment situation? Do you or other family members work full-time, part-time, or multiple jobs?
- Do you currently have health insurance? If so, through what source (e.g., employer, Medicaid, ACA marketplace, etc.) If not, tell me about the reasons you do not have insurance.

II. Accessing Health Insurance

- How easy or difficult has it been for your family to get health insurance coverage? Please explain.
- Can you share about the process of enrolling in a health insurance plan?
- Have you ever gone without health insurance? If so, can you share what that experience was like?
- What factors influenced your decision when choosing your current insurance plan (e.g., cost, coverage, provider network)? What factors influence your decision to not have health insurance?

III. Affording Health Insurance

- How affordable is your current health insurance plan, including premiums, deductibles, and out-of-pocket costs?
- Are there times of the year or circumstances when paying for insurance becomes especially difficult? Please describe.
- Have you ever delayed or skipped getting insurance due to cost? Tell us about that.
- Do you feel like the value you receive from your insurance is worth what you pay for it?

IV. Using Health Insurance to Meet Health Needs

- Has your health insurance been helpful in covering your family’s health care needs? Please explain.
- Can you describe a time when your insurance helped you or your family get the care you needed? Have there been times when your insurance didn’t cover a service you needed? What did you do in those situations?
- Have you ever delayed or skipped getting health care or meeting with a doctor? If so, what caused that?
- To what degree do you feel like you understand how to use your insurance (e.g., copays, referrals, coverage rules)? Please provide an example.
- Have you ever had to advocate for yourself or your family to get coverage or services? Please share an example.

V. Impact on Overall Well-Being

- How does health insurance—or the lack of it—affect your family’s financial stability? How?
- In what ways does your insurance situation affect your peace of mind or stress levels?
- Are there health services or care you wish you or your family had access to but don’t because of insurance limitations? Or lack of health insurance.

Results

This study used a mixed methods approach including both survey data and in-depth qualitative interviews of ALICE households. Demographic data for participants completing surveys and interviews will be reviewed. An overview of themes emerging from the qualitative data will be shared.

Quantitative Survey Data

Demographics of ALICE Households Completing Survey

Eligibility for inclusion in analyses included having a household member working, meeting the ALICE income threshold using United Way's online ALICE calculator, and not currently having have Husky A or D health insurance. A total of 350 income eligible households completed the survey, after participants with Husky A and D were removed from analyses a total of two hundred seventy-nine (n = 279) remained.

The majority of participants were females (n = 209, 75.7%). Most described themselves as Black (n = 128, 46.7%) or Latino/a (n=108, 38.7%) totaling 85.4% of participants. There was a fairly equal age distribution across age groups with, with most falling into the 41-54 (n=79, 29%) and 55-64 (n=62, 22.9%) age groups. On average HH 's reported 1.5 adults and one child. Resident HHs were more likely to have children compared to national averages (45.8% have children vs. 40.3% nationally). Additionally, the majority come from food insecurity households (n=203, 75.5.0%) and one quarter were at-risk for an anxiety disorder (n=87, 33.9%). See Tables 1-4.

In CT, about 29% of households are considered ALICE — (Asset Limited, Income Constrained, Employed) — earning above the poverty level but still struggling to cover costs like housing and child care.

Table 1. Demographics of ALICE Households Completing the Survey

Gender	***n***	***%***
Male:	67	24.30%
Female:	209	75.70%
Ethnicity	***n***	***%***
Black/African American:	128	46.70%
White/Caucasian:	17	6.10%
Asian:	10	3.60%
Latino/a:	108	38.70%
West Indian:	3	2.90%
Other:	4	1.10%
Age	***n***	***%***
18-25 years:	19	7.00%
26-40 years:	85	31.30%
41-54 years:	79	29.00%
55-64 years:	62	22.80%
65+ years:	27	9.90%
Employment	***n***	***%***
Household member working:	279	100%

Household	***Ave. # Persons***	
Adult:		2.00
Children:		1.00
% of HHs with children:		45.80%
Health Insurance	***n***	***%***
No insurance:	*41*	15.40%
Employer-sponsored	110	41.40%
Medicare	62	23..3%
Individual-Marketplace/Other:	53	19.90%
Internet Access	***n***	***%***
Yes:	208	83.20%
No:	42	16.80%
Chronic Health Condition		
Yes:	108	43%
No:	141	57%
ALICE Threshold	***n***	***%***
Household met ALICE income threshold:	279	100%

Table 2. Generalized Anxiety Disorder Screener

	n	***Nearly Every Day***	***More than half of days***	***Several days***	***Not at all***
Feeling nervous, anxious or on edge	256	15.6	21.9	26.6	35.9
Not being able to stop or control worrying	234	13.7	19.2	24.4	42.7

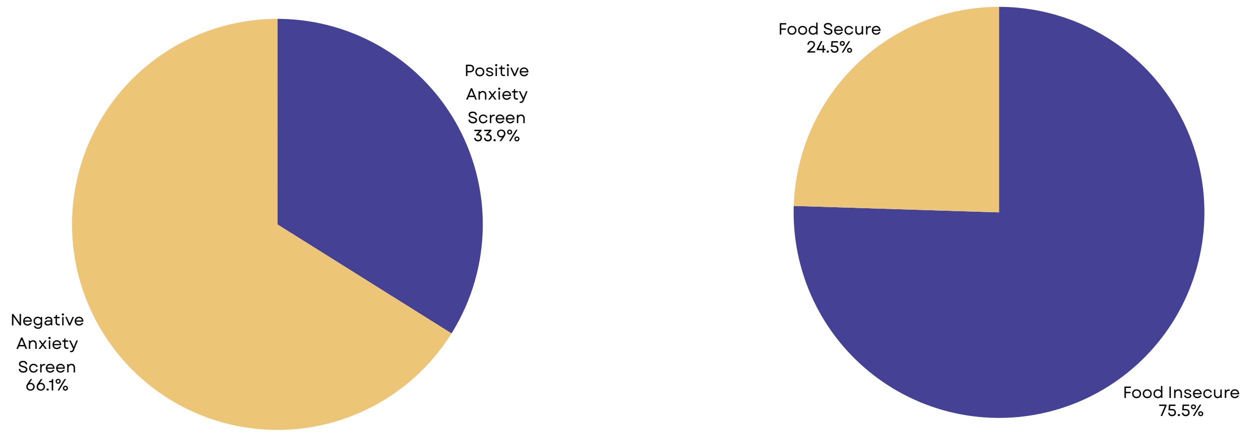
Table 3. USDA Food Insecurity Screener

	n	***Never***	***Some-times***	***Often***
We worried whether our food would run out before we got money to buy more.	268	23.5	53	23.5
The food that we bought just didn't last and we didn't have money to get more.	268	23.7	53.3	22.4

Table 4. Positive Food Insecurity and Anxiety Screener

	n	***%***
At Risk for an anxiety disorder	87	33.9
At Risk for food insecurity	203	75.5

Figure 1. Positive Food Insecurity and Anxiety Screener

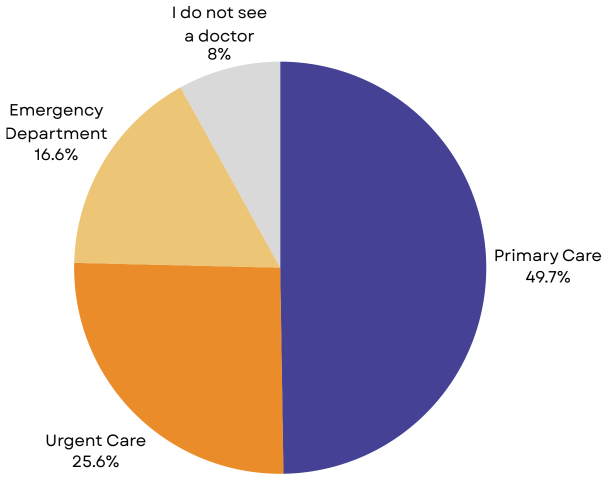


Healthcare Consumption

Descriptive analyses were conducted to examine where ALICE households most often seek medical care when they need to see a doctor. Nearly half of respondents reported primarily using a primary care provider (*n* = 99, 49.7%). Urgent care centers were the next most frequently reported option (*n* = 51, 25.6%), followed by emergency departments (*n* = 33, 16.6%). A smaller proportion of respondents indicated that they do not see a doctor when care is needed (*n* = 16, 8.0%). See Table 5 and Figure 2.

Table 5 & Figure 2. Where do you go for healthcare when you need to see a doctor

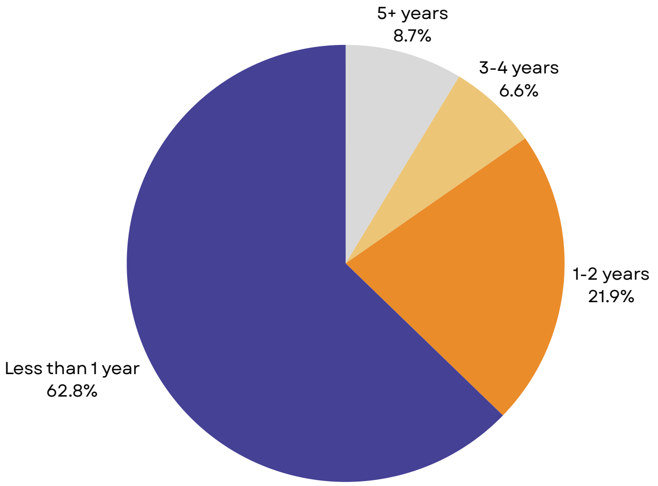
	n	***Yes %***
Primary Care	99	49.7
Urgent Care	51	25.6
Emergency Department	33	16.6
I do not see a doctor	16	8



Descriptive analyses examined the length of time since respondents' most recent visit with a primary care provider. Over one-third of respondents reported having seen a primary care provider within the past year (*n* = 123, 37.2%). Approximately one fifth indicated their last visit occurred 1–2 years ago (*n* = 43, 21.9%), while smaller proportions reported visits 3–4 years ago (*n* = 13, 6.6%) or 5 or more years ago (*n* = 17, 8.7%). See Table 6 and Figure 3.

Table 6 & Figure 3. When was the last time you saw your primary care physician?

	n	***Yes %***
5+ years	17	8.7
3-4 years	13	6.6
1-2 years	43	21.9
Less than 1 year	123	37.2



Confidence Accessing Health Insurance and Navigating Healthcare

Survey data explored residents' confidence accessing health insurance plans using the Health Insurance Literacy Measure (Paez, et. al., 2014). Descriptive analyses examined respondents' knowledge and confidence related to selecting and affording health insurance. Overall, respondents reported moderate levels of confidence across items related to navigating health insurance options. Participants indicated some familiarity with comparing health insurance plans on Access Health CT (*n* = 203, *M* = 2.61), though responses were distributed across the scale, suggesting variability in understanding. Similarly, respondents reported moderate confidence in knowing what questions to ask in order to choose the best health plan (*n* = 196, *M* = 2.87). Confidence was also moderate regarding knowing where to go for help when having difficulty affording health insurance (*n* = 206, *M* = 2.79), with a substantial proportion indicating agreement or strong agreement. Collectively, these findings suggest that while many ALICE households possess some foundational knowledge about navigating health insurance, notable gaps remain that may benefit from targeted education and support. See Table 7.

Table 7. Confidence Accessing Health Insurance

	n	*M*	*SD*	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*
I know how to compare health insurance plans on Access Health CT.	203	2.61	1.8	21.7	23.2	27.1	28.1
I know what questions to ask so I can choose the best health plan.	196	2.87	2.4	19.4	18.4	33.7	28.6
I know where to go for help if I have trouble affording health insurance.	206	2.79	1.1	17	18.9	32	32

Descriptive analyses assessed ALICE households' confidence in understanding and managing health insurance–related costs. Overall, respondents reported moderate confidence across items assessing their ability to anticipate and navigate out-of-pocket expenses. Participants indicated moderate confidence in their ability to estimate what they would pay for health care over the course of a year (*n* = 200, *M* = 2.58). Similarly, respondents reported moderate confidence in figuring out their share of health care costs after the health plan has paid its portion (*n* = 198, *M* = 2.61). Confidence was also moderate regarding knowing how to determine what services are and are not covered prior to receiving care (*n* = 201, *M* = 2.60). Response distributions across items suggest that while a meaningful proportion of ALICE households expressed agreement or strong agreement with these statements, a substantial number reported uncertainty, indicating ongoing challenges in navigating the financial aspects of health insurance. See Table 8.

Table 8. Confidence Navigating Health Insurance

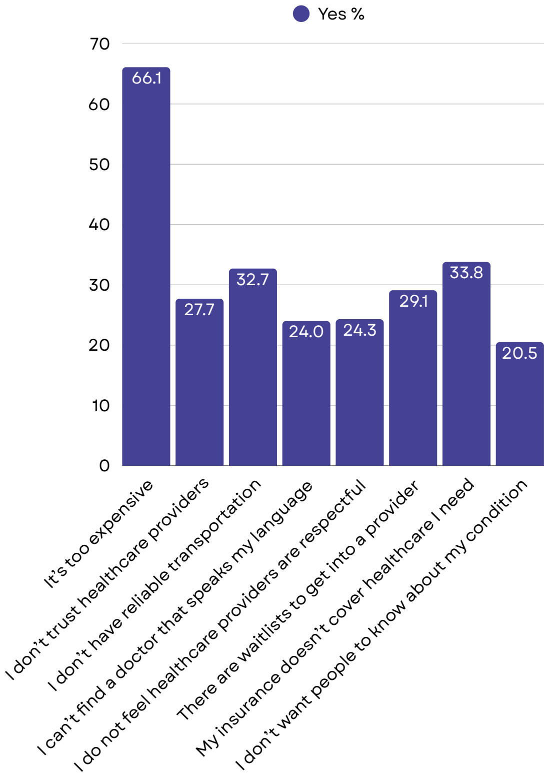
	n	*M*	*SD*	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*
I know how to estimate what I will pay for my health care each year.	200	2.58	1.1	20.7	24.2	31.3	23.7
I know how to figure out my share of the cost for care, after the health plan pays theirs.	198	2.61	1.1	21.2	23.2	29.3	26.3
I know how to find out what is and is not covered before I receive a health care service.	201	2.6	1.1	21.9	21.9	30.3	25.9

Barriers to Accessing Health Care Services

Descriptive analyses examined perceived barriers to accessing health care among ALICE households. The most frequently reported barrier was the cost of care, with over two-thirds of respondents indicating that health care is too expensive (*n* = 160, 66.1%). Insurance-related limitations were also common, as one-third reported that their insurance does not cover the care they need (*n* = 67, 33.8%). Transportation challenges were reported by nearly one-third of respondents (*n* = 66, 32.7%), and waitlists for providers were identified as a barrier by 29.1% of respondents (*n* = 57). Trust-related and relational barriers were also notable, with more than one-quarter reporting a lack of trust in health care providers (*n* = 57, 27.7%), and approximately one-quarter indicating difficulty finding a provider who speaks their language (*n* = 49, 24.0%) or feeling that providers are not respectful (*n* = 46, 24.3%). Additionally, concerns about privacy and stigma were reported by one-fifth of respondents (*n* = 40, 20.5%). See Table 9.

Table 9 and Figure 4. Barriers to Accessing Health Care

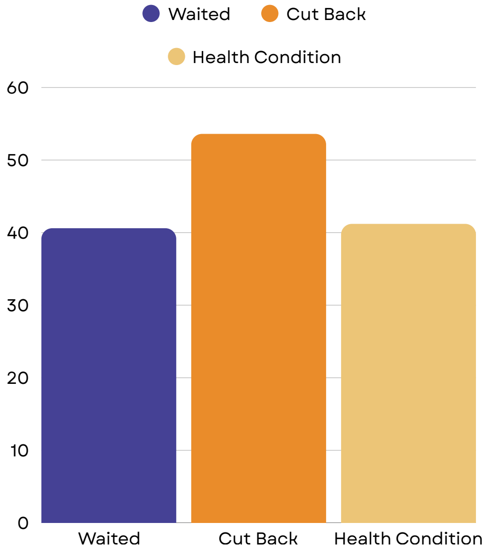
	n	*Yes %*
It’s too expensive	160	66.1
I don’t trust healthcare providers	57	27.7
I don’t have reliable transportation	66	32.7
I can’t find a doctor that speaks my language	49	24
I do not feel healthcare providers are respectful	46	24.3
There are waitlists to get into a provider	57	29.1
My insurance doesn’t cover healthcare I need	67	33.8
I don’t want people to know about my condition	40	20.5



Descriptive analyses highlighted the financial burden associated with accessing health care among ALICE households. Over two-fifths of respondents reported delaying care due to the cost of seeing a health care provider (*n* = 99, 40.6%). More than half indicated that they had to cut back on other essential areas of life, such as food, in order to afford medical care (*n* = 133, 53.6%). Additionally, a substantial proportion of respondents reported having medical debt (*n* = 101, 41.1%), underscoring the pervasive financial strain associated with health care expenses. See Table 10.

Table 10 and Figure 5. Financial Burden of Health Care (n=279)

	n	***% Yes***
Have you waited to see a healthcare provider because of the cost?	99	40.6
Have you ever had to cut back in other areas of life (i.e., food) because of the cost of medical care?	133	53.6
Do you have medical debt?	101	41.1

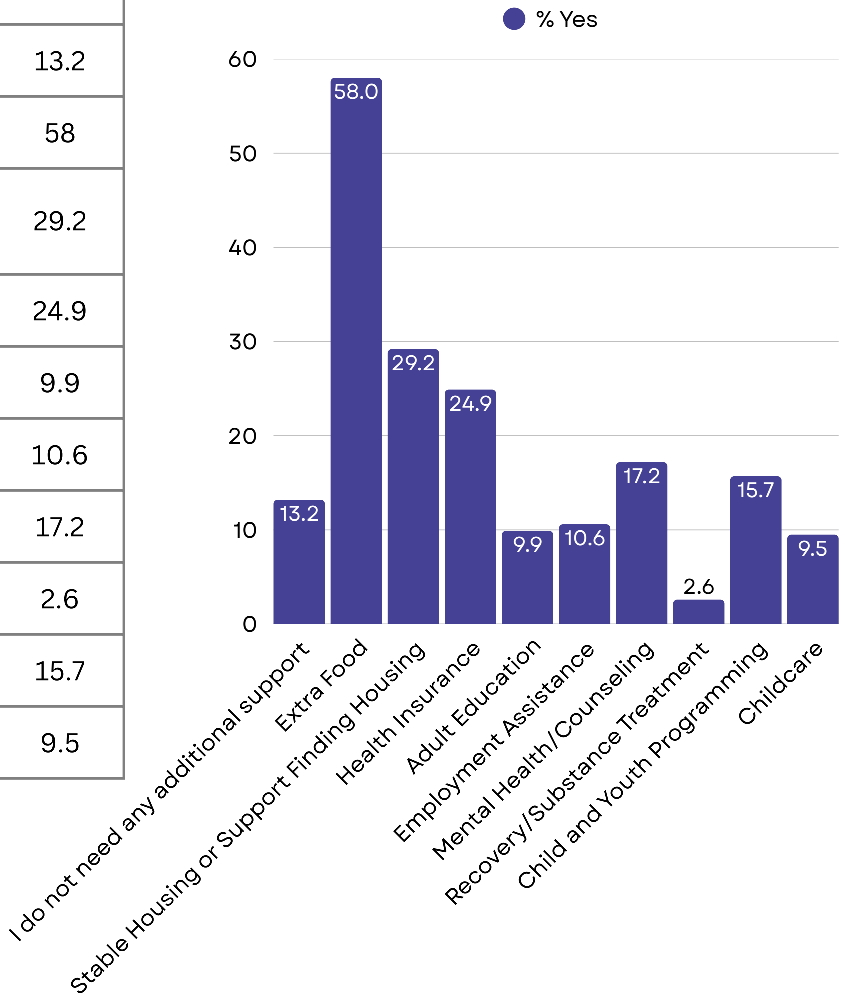


Household Service Needs

Descriptive analyses examined additional service needs reported by ALICE households. The majority of respondents indicated a need for at least one form of additional support, with only a small proportion reporting no need for additional services (*n* = 36, 13.2%). The most frequently identified need was extra food support, reported by more than half of respondents (*n* = 159, 58.0%). Nearly one-third indicated a need for stable housing or assistance with finding housing (*n* = 80, 29.2%), and approximately one-quarter reported a need for health insurance support (*n* = 68, 24.9%). Mental health or counseling services were identified by 17.2% of respondents (*n* = 47), and child and youth programming was reported by 15.7% (*n* = 43). Smaller proportions reported needs related to employment assistance (*n* = 29, 10.6%), adult education (*n* = 27, 9.9%), childcare (*n* = 26, 9.5%), and recovery or substance use treatment (*n* = 7, 2.6%). See Table 11.

Table 11 and Figure 6. Household Service Needs (n=273)

	n	***% Yes***
I do not need any additional support	36	13.2
Extra Food	159	58
Stable Housing or Support Finding Housing	80	29.2
Health Insurance	68	24.9
Adult Education	27	9.9
Employment Assistance	29	10.6
Mental Health/Counseling	47	17.2
Recovery/Substance Treatment	7	2.6
Child and Youth Programming	43	15.7
Childcare	26	9.5



Qualitative Survey Data

Demographics of Interview Participants

The majority of residents completing the survey were females (*n* = 13, 75.7%). Most described themselves as Black (*n* = 4, 25%) or Latino/a (*n*=11, 68%) totaling 93% of participants. There was an equal age distribution across age groups with most falling into the 26-40 year group (*n*=8, 50%). On average, households had 2 adults and 1 child, and 43.8% of households had children under 18 years of age. All respondents reported someone working in their household and met the ALICE income threshold. See Table 12.

Table 12. Demographics of ALICE Interview Participants)

Gender	***n***	***%***
Male	3	24.30%
Female	13	75.70%
Ethnicity	***n***	***%***
Black/African American	4	25.00%
White/Caucasian	1	6.00%
Asian	0	0.00%
Latino/a	11	68.00%
West Indian	0	0.00%
Age	***n***	***%***
18-25 years	1	6.00%
26-40 years	8	50.00%
41-54 years	2	12.00%
55-65 years	3	19.00%
65+ years	2	12.00%

Household	***Ave. # Persons***	
Adult		2.00
Children		1.00
% of HHs with children		43.80%
Health Insurance	***n***	***%***
No insurance	*2*	12.00%
Private insurance	11	68.00%
Medicare	3	19.00%
Employment	***n***	***%***
Household member working	16	100%
ALICE Threshold	***n***	***%***
Household met ALICE income threshold	16	100%

Overview of Qualitative Interview Themes

We used a deductive qualitative coding approach to identify themes within the data. A preliminary codebook was developed prior to analysis, based on the study's conceptual framework and relevant literature. Transcripts were uploaded into ATLAS.ti software, which facilitated systematic organization, coding, and retrieval of text segments. Two coders independently applied the predefined codes to the data within ATLAS.ti and met regularly to compare interpretations and resolve discrepancies, ensuring consistency and analytic rigor. In addition, AI-assisted analysis tools were used to support coding verification, pattern recognition, and theme refinement, helping to triangulate human coding and highlight potential areas for further exploration. After coding was completed, codes were grouped and synthesized into broader themes aligned with the predetermined domains. This deductive process, supported by ATLAS.ti and AI-assisted tools, ensured that thematic findings were systematically linked to the study's research questions and theoretical foundations. Using this approach, the following themes emerged.

Based on interviews with 16 participants, five core themes emerge that can be further analyzed using a deductive approach. Here are the key themes identified:

Theme 1. Participants shared varied experiences enrolling in health insurance.

Participants frequently discussed their experiences obtaining health insurance, including the ease or difficulty of enrollment. Some found the process straightforward. For example, when describing the enrollment process, one participant shared, “Actually, it was fairly easy. We do it right at work. You can even do it online, so it was not difficult at all for me to enroll.”

Others faced significant barriers, such as complex application procedures or that they were not able to apply for certain programs due to income limits. For example, one participant shared, “They said I have to update my income... I need to go get some paycheck pay stuff, send it to them... I struggled until finally, I got those based off last month after a series of trials."

Some shared that it was challenging to know which plan was best for them. For example, one shared, "I just feel like I don't know which is a good plan, which is a not so good plan for my family.” When describing the enrollment process, one participant shared, “It was quite difficult and quite confusing, because, you know, some of the language I was not familiar with... it was just really confusing for me." This highlights the challenges faced by individuals who are not familiar with the terminology and processes involved in enrolling in health insurance. Participants expressed a desire for more accessible information and assistance regarding health insurance options and healthcare services.

Some shared that accessing correct and up-to-date information was a challenge when enrolling in an insurance plan. For example, one participant shared, "At the beginning, it was kind of hard, because I had to wait for their open enrollment process. I didn't know I wasn't provided with the correct information at first, but then I was able to get access to it."

One participant mentioned difficulties switching plans. "So right before, right after I retired, you know, insurance is only good for three days after that. So between that time and the time that I was able to get Medicare, I delayed my appointments because I wasn't sure if I was going to be able to pay." This quote illustrates the anxiety and hesitation individuals feel about seeking care when they are uncertain about their coverage as they transition from one plan to another.

Theme 2. Financial burden was the primary barrier associated with meeting healthcare needs.

The financial burden associated with health insurance and medical care emerged as a prominent theme among participants in the study. Many individuals voiced their concerns regarding the escalating costs of healthcare, which included high deductibles, copayments, and out-of-pocket expenses. These financial pressures often forced families to make difficult decisions about whether to seek necessary medical care, impacting their overall health and well-being. Cost was a factor in determining if they would purchase a health insurance plan. For example, one participant stated, “So right after college, I came straight here. I didn't really have a car. And I mean, I can't apply for Husky, because Husky, you need to make less than $2,000 a month. And which I do make $2,000 a month. So I can't apply for any health insurance here, and everything else they want you to pay $300 out of pocket. So I refuse.” Participants frequently highlighted the challenge of managing high deductibles, which required them to pay a substantial amount out of pocket before their insurance coverage kicked in. This upfront cost created a barrier to accessing care, as many individuals found themselves weighing the necessity of treatment against their financial capabilities.

The fear of incurring significant medical bills often led to delays in seeking care, with some participants admitting to postponing appointments or avoiding necessary procedures altogether due to cost concerns. For example, one participant shared, “I try to avoid it, because I, at this moment in my life, I'm still trying to get, like, a better finance situation, so trying to add, not trying to add more bills." This reflects the mindset of individuals who may delay seeking medical attention due to financial constraints, prioritizing their budget over their health.”

Additionally, the burden of copayments for doctor visits and medications added to the financial strain. Many families reported that these recurring expenses could quickly accumulate, making it difficult to budget for healthcare alongside other essential living costs. This situation was particularly challenging for those with chronic conditions requiring ongoing treatment, as the cumulative costs could become overwhelming.

The financial impact of insurance costs was a significant concern for many families, with participants expressing anxiety about their ability to afford both routine and emergency medical care. This anxiety was compounded by the unpredictability of healthcare needs, as unexpected illnesses or accidents could lead to sudden and substantial financial obligations. The stress of managing these costs often took a toll on participants' mental health, as they grappled with the constant worry of how to pay for necessary care. For example, one participant shared, ""Yeah, actually, I was kind of a little nervous when I went to the urgent care. When it came I was, like, nervous, but luckily, like, it worked out. My bills worked out, but I was a little nervous that I would have to, like, either take from my savings or be a little late on the other bill to pay for the urgent care bill."

In summary, the financial burden of healthcare, characterized by high deductibles, copayments, and out-of-pocket expenses, poses a significant challenge for individuals and families. This financial strain not only affects their ability to access necessary medical care but also contributes to broader concerns about health equity and the overall well-being of communities. Addressing these financial barriers is crucial to ensuring that individuals can prioritize their health without the fear of crippling debt.

53.6% of survey participants reported they had to cut back in other areas such as food or utilities because of medical costs.

41.1% of survey participants reported medical debt.

40.6% of survey participants reported waiting to access medical treatment due to cost.

Theme 3. Many experienced anxiety due to financial strain and delayed care.

The theme of emotional burden and anxiety related to meeting health needs emerged prominently in the interviews, revealing the significant psychological toll that navigating the healthcare system can impose on individuals and families. Participants frequently expressed feelings of stress, frustration, and helplessness as they grappled with the complexities of health insurance, the financial implications of care, and the challenges of accessing necessary services.

Many individuals reported experiencing anxiety over the uncertainty of their healthcare coverage and the potential costs associated with seeking treatment.

The fear of incurring unexpected medical bills often led to a reluctance to pursue necessary care, resulting in postponed appointments and untreated health issues. This cycle of avoidance not only exacerbated physical health problems but also contributed to a growing sense of emotional distress. Participants also highlighted the overwhelming nature of managing chronic conditions, which required ongoing treatment and frequent interactions with healthcare providers. The logistical challenges of coordinating care, understanding insurance benefits, and navigating complex medical terminology added layers of stress to their daily lives. This emotional burden was particularly pronounced for those who lacked support systems or resources to help them navigate these challenges.

For example, one participant shared, “This adds to the stress level, right? Like, every couple of days I get a reminder that I have this medical bill pending, but I don't pay it. I have to pay the mortgage first. I have to pay the bills first, right? And then this pay period, now I'm going to have to figure out how much can I now dedicate to that, um, so, you know... It wasn't in my budget. So now I'm like, okay, I have that in mind, but when they're sending these constant reminders, you're like, um, I know you need your money, but I don't have it currently.”

Moreover, the stigma associated with financial struggles and the fear of being perceived as a burden to family or friends further compounded participants' emotional distress. Many expressed a desire for more comprehensive support, including clearer communication from insurance providers and access to community resources that could alleviate some of the pressures they faced.

In summary, the emotional burden and anxiety associated with meeting health needs are significant issues for individuals navigating the healthcare system. Addressing these challenges through improved support, clearer communication, and more accessible resources is essential to enhancing the overall well-being of those affected. By recognizing and validating these emotional experiences, healthcare providers and policymakers can work towards creating a more compassionate and supportive environment for individuals seeking care.

Theme 4. Many found it difficult to understand their health insurance plan.

Participants in the study consistently highlighted the intricate nature of health insurance plans, emphasizing the challenges posed by the specialized jargon and terminology used by insurance companies. This complexity often resulted in significant confusion regarding coverage options and benefits, which in turn hindered individuals' ability to effectively navigate their healthcare needs.

Many respondents expressed frustration with the language surrounding health insurance, noting that it was often filled with technical terms that were not easily understood. "It was quite difficult and quite confusing, because, you know, some of the language I was not familiar with... it was just really confusing for me."

This quote emphasizes the challenges individuals face in understanding the terminology and processes involved in enrolling in health insurance. This lack of clarity made it difficult for individuals to fully grasp what their plans covered, leading to uncertainty about their rights and responsibilities when seeking care. For instance, participants reported feeling overwhelmed by the details of their policies, which included various deductibles, copayments, and exclusions that were not clearly explained.

Moreover, the complexity of insurance plans often resulted in individuals being unaware of the full range of services available to them. This lack of understanding could lead to missed opportunities for necessary care or unexpected out-of-pocket expenses when seeking treatment. Participants noted that they frequently had to rely on customer service representatives for clarification, which could be time-consuming and frustrating. For example, one participant shared, “I think using insurance is complicated, honestly, but so far, it's been good for the times I've had to use it... I learned that if you kind of don't, if you go in there for one thing and ask questions about another, they charge you for that." This highlights the confusion and unexpected costs associated with health insurance.

The overall sentiment among participants was a desire for more straightforward communication from insurance providers. Many suggested that having access to personalized support, such as consultations with insurance experts, could significantly improve their understanding of their plans. This would empower individuals to make informed decisions about their healthcare and ensure they are utilizing their benefits effectively. For example, one participant shared, “I think if we could go and actually sit down with an insurance consultant, you know, someone who's well-versed in the mentorship process, and just walk us through this, walk me through the steps, or help me understand some of the language that I'm not familiar with, I think that would be a heck of a lot better than just making sure that everything's online." This quote emphasizes the desire for personalized support in understanding health insurance options.

In summary, the complexity of health insurance plans, characterized by confusing jargon and unclear coverage details, poses significant barriers for individuals trying to navigate their healthcare needs. Addressing these challenges through clearer communication and support could enhance the overall experience of managing health insurance.

Theme 5. Participants with chronic health conditions voiced added strain and complexity.

The interviews conducted revealed that individuals living with chronic health conditions encounter a unique set of challenges when it comes to accessing care and managing their health insurance. These challenges are often exacerbated by the need for ongoing treatment and frequent specialist visits, which can create a complex interplay of financial and logistical difficulties.

For many participants, the requirement for continuous medical care meant that they had to navigate a healthcare system that was already difficult to understand. Chronic conditions often necessitate regular appointments with various specialists, each of whom may have different requirements and billing practices. This complexity can lead to confusion regarding insurance coverage, as individuals struggle to determine which services are covered and what their out-of-pocket costs will be. The need to coordinate care among multiple providers can also be overwhelming, particularly for those who may already be managing the physical and emotional toll of their conditions.

Financially, the burden of chronic conditions can be significant. Participants reported that the cumulative costs of ongoing treatments, medications, and specialist visits often exceeded their expectations, leading to financial strain. For example, one participant shared, “Well, with his medications, as they put him on diabetes medication, I would say sometimes it's 100 $200 to refill his medication. So, I think that's a lot.”

High copayments and deductibles associated with their insurance plans could make it difficult to afford necessary care, forcing individuals to make tough choices about which treatments to prioritize. Some participants expressed feelings of guilt or anxiety over their inability to access certain therapies or medications due to cost, which could further impact their health outcomes. For many, ensuring their chronic health conditions are covered, was an important consideration when selecting a health insurance plan. For example, on participant stated, “I feel like most of my, a good portion of my check goes towards the health insurance... just knowing, which is a good plan, which is a not so good plan for my family. Me and my husband both have chronic asthma, so just finding a plan that also deals with the medications for that, that gets very expensive, of course. So just really navigating the whole process, seeing which plans are beneficial."

Logistically, managing a chronic condition often requires meticulous planning and organization. Participants noted that keeping track of appointments, medications, and insurance claims could be a full-time job in itself.

The added stress of ensuring that all necessary paperwork is submitted correctly and on time could lead to missed appointments, or delays in treatment, further complicating their health management. This situation was particularly challenging for those who lacked support systems or resources to help them navigate the complexities of their care.

Moreover, the emotional impact of living with a chronic condition cannot be overlooked. The constant need for medical attention and the associated financial and logistical hurdles can lead to feelings of frustration, isolation, and helplessness. Participants often expressed a desire for more comprehensive support from their insurance providers, including clearer communication about coverage, and assistance in coordinating care among multiple specialists. One participant stated, “There should be much more coverage to protect that person, that when they go to the doctor, the medications are covered, that the coverages that they have is ideal for the sickness that they have.”

In summary, individuals with chronic health conditions face significant challenges in accessing care and managing their health insurance. The need for ongoing treatment and specialist visits compounds the financial and logistical difficulties associated with health insurance, creating barriers that can hinder effective health management. Addressing these challenges through improved support systems, clearer communication, and more accessible care options is essential to enhancing the quality of life for those living with chronic conditions.

Theme 5. Participants offered a number of suggestions for improving the system.

Throughout the interviews, a recurring theme emerged regarding the urgent need for systemic changes within the healthcare and insurance systems to better support families and individuals. Participants expressed a collective desire for reforms that would simplify processes, enhance affordability, and improve the comprehensiveness of insurance coverage. These changes are seen as essential to addressing the myriad challenges faced by individuals navigating the complexities of healthcare.

One frequently mentioned area for improvement was the enrollment process for health insurance.

Many participants described the current system as convoluted and overwhelming, often involving extensive paperwork and unclear instructions. Simplifying this process could significantly reduce barriers to access, allowing families to secure coverage more easily and efficiently. Participants suggested that a streamlined, user-friendly enrollment system could help demystify the process, making it more accessible to individuals from diverse backgrounds, including those with limited health literacy. For example, one participant suggested, "I think if we could go and actually sit down with an insurance consultant... help me understand some of the language that I'm not familiar with, I think that would be a heck of a lot better." This quote underscores the desire for a more user-friendly and supportive enrollment experience

Affordability was another critical concern raised by participants. One participant stated, “I think that I would probably say that every household should be able to afford health care. There should not be a question of, should I or shouldn't I go to get seen.” Many families reported struggling to keep up with rising insurance premiums and out-of-pocket costs, which often led to difficult decisions about healthcare access. Suggestions for making insurance more affordable included implementing sliding scale premiums based on income, expanding subsidies for low-income families, and capping out-of-pocket expenses to prevent financial hardship. Participants emphasized that reducing the financial burden of insurance would not only improve access to care but also enhance overall health outcomes by encouraging individuals to seek necessary treatment without fear of incurring crippling debt. One participant stated, “How do I know what copays I am going to have to pay out of pocket? The deductibles are so high. Now, you know, it's like, do I take the $1000 or the $2000 or the $6000? I remember last year I looked and it was like $8000. How could anybody go and have an insurance that the deductible is $8000 out of pocket? The ideal is that out of pocket should not be that much.”

In addition to affordability, participants called for more comprehensive insurance coverage that adequately addresses a wide range of healthcare needs. Many expressed frustrations with the limitations of their current plans, which often limited or excluded essential services such as mental health care, chronic disease management, limited dental coverage, and specialists. When asked about the ideal health insurance plan, one participant stated, “"It would probably be that it covers all specialist as the need arises, you know, depending on what the need would be with the patient, with me, or anyone in my household...that it would be affordable, that the deductibles would be low, that it would cover our needs, be it mental, physical or emotional..." Expanding coverage to include these critical areas would provide individuals and families with the support they need to maintain their health and well-being. Participants advocated for policies that prioritize holistic care, recognizing that health is multifaceted and requires a comprehensive approach.

Moreover, participants highlighted the importance of transparency in the healthcare and insurance systems. Many expressed a desire for clearer communication regarding what their insurance plans cover, as well as the costs associated with various services. As one participant put it, “I think that insurance can be a little bit more comprehensive. I think that when you are dealing with insurance companies and you're dealing with coverage not everybody understands the lingo.” Improved communication and transparency would empower individuals to make informed decisions about their healthcare, fostering a sense of agency and control over their health journeys.

In summary, the need for systemic changes in the healthcare and insurance systems is a pressing concern among participants. Simplifying the enrollment process, enhancing affordability, and expanding the comprehensiveness of insurance coverage are critical steps toward creating a more equitable and supportive healthcare environment. By addressing these issues, policymakers can help ensure that families and individuals have the resources and support they need to navigate their healthcare effectively, ultimately leading to improved health outcomes and quality of life. These themes can guide further analysis and help in formulating recommendations for improving health insurance access and affordability based on the experiences shared by the interviewees. We will dive deeper into key themes to more comprehensively give voice to the lived experiences of ALICE households.

Conclusion

This study explored the experiences of ALICE households who did not have Husky A or D accessing health insurance and meeting their health needs. Quantitative surveys were conducted with 279 participants, and in-depth qualitative interviews were conducted with 16 residents. This study gives voice to the experiences and challenges of ALICE households in CT, and offers policy and practice suggestions to improve health care access for ALICE households.

Cost and underinsurance are the primary barriers to care for ALICE households.

Both the quantitative and qualitative findings demonstrate that affordability—not employment or insurance status—is the dominant determinant of health care access for ALICE households. In this study, 66.1% of respondents reported that health care is too expensive, 40.6% delayed seeing a provider because of cost, and 53.6% reported cutting back on essential needs such as food to pay for medical care. Notably, 41.1% reported carrying medical debt, underscoring the cumulative financial impact of out-of-pocket costs. These findings are consistent with national and state-level research showing that ALICE households are disproportionately underinsured, meaning that while they may technically have coverage, high deductibles, copayments, and limited benefits leave them financially exposed (United For ALICE, 2025). Prior studies have similarly found that medical costs are a leading cause of financial hardship among working families and that even modest health expenses can precipitate economic instability (Aborode, et. al., 2025; University of Washington Center for Women's Welfare, 2024).

Financial strain associated with health care contributes to emotional distress, uncertainty, and delayed care.

The data indicate that the financial burden of health care is closely linked to psychological stress and care avoidance. Nearly one quarter of survey respondents (24.9%) screened positive for risk of an anxiety disorder, and more than three quarters (76.0%) were at risk for food insecurity—conditions that interviews revealed were often exacerbated by medical expenses and uncertainty about insurance coverage. Participants frequently described anxiety about unexpected bills, fear of using services even when insured, and the need to postpone care to avoid additional financial strain. These experiences align with prior research demonstrating that cost-related nonadherence and delayed care are common among underinsured populations and are associated with worse health outcomes and increased stress (Kullgren et al., 2013; Coombs, Meriwether, Caringi & Newcomer, 2021). The findings suggest that the emotional toll of navigating health care costs functions as a barrier in its own right, reinforcing cycles of deferred care and worsening health.

System complexity and structural gaps amplify inequities in health care access.

Moderate levels of health insurance literacy observed in the survey highlight how complexity within the health insurance system compounds financial vulnerability. Respondents reported only moderate confidence in estimating annual health care costs, understanding their share of costs after insurance pays, and determining coverage prior to receiving services.

Qualitative interviews further revealed confusion about plan options, unfamiliar terminology, eligibility thresholds, and provider networks, with participants often unsure which plan best met their family's needs—particularly when managing chronic conditions. These findings are consistent with prior literature showing that low health insurance literacy is associated with suboptimal plan selection, higher out-of-pocket spending, and reduced use of preventive care (Pestaina, Long, Salaga & Wallace, 2025; Paez et al., 2014; Loewenstein et al., 2013). Additionally, the "benefits cliff" identified in ALICE research leaves many working households ineligible for public coverage, yet unable to afford adequate private plans, exacerbating disparities in access (Fitzpatrick, 2015). Together, these results point to the need for policy and practice interventions that simplify insurance design, improve transparency, and provide personalized navigation support to reduce inequities for working families living below the ALICE Threshold.

Policy and System Suggestions

Based on the survey and interview findings, three key policy and system-level recommendations emerge that directly address the barriers experienced by ALICE households:

Reduce out-of-pocket costs and strengthen protections against underinsurance.

Policies should focus on lowering deductibles, copayments, and uncovered services for working households who fall above Medicaid eligibility but remain financially vulnerable. This could include expanding income-based subsidies on the ACA marketplace, implementing caps on out-of-pocket spending tied to household income, and requiring more comprehensive coverage of high-use services such as primary care, mental health care, and chronic disease management. Given that 66.1% of respondents reported health care as too expensive, and 41.1% reported medical debt, these protections are critical to preventing health care costs from triggering financial crises and delayed care.

Simplify insurance systems and expand navigation and decision-support assistance.

The findings point to the need for clearer, more accessible insurance information and hands-on support. Policies and system reforms should prioritize plain-language plan descriptions, standardized benefit designs, and proactive outreach to help households understand costs, coverage, and trade-offs. Funding community-based insurance navigators or embedding insurance support within trusted settings (e.g., community organizations, churches, clinics, workplaces) could address the moderate health insurance literacy observed in the survey and the confusion described in interviews. Improving navigation support would help ALICE households select plans that better match their health needs and avoid unexpected expenses.

Address structural gaps related to eligibility, work constraints, and provider access.

Reforms should target the benefits cliff and logistical barriers that disproportionately affect working households. This includes expanding Medicaid eligibility or creating bridge programs for near-ALICE households, aligning eligibility thresholds across assistance programs, and strengthening workplace protections, such as paid sick leave and flexible scheduling. Additionally, policies that expand provider networks, invest in transportation supports, and incentivize providers to serve under-resourced communities would improve the practical usability of insurance coverage. These changes would help ensure that employment does not inadvertently limit access to timely and appropriate health care for ALICE families.

Future Research

Building on these findings, future research is needed to deepen understanding of healthcare access and affordability among ALICE households and to inform effective policy and system-level responses. While this study highlights critical financial, structural, and emotional barriers faced by working families, additional research is necessary to strengthen generalizability, examine variation within the ALICE population, and evaluate interventions designed to reduce healthcare-related hardship. Priority areas for future investigation include expanding statewide, representative data on ALICE households in Connecticut; assessing the impact of healthcare affordability and cost-sharing reforms; examining strategies to improve insurance navigation and reduce plan complexity; and addressing the compounded challenges faced by households managing chronic health conditions and healthcare-related stress. Together, these directions offer a pathway for advancing solutions that promote equitable access to care for economically vulnerable working families.

Statewide, Representative Assessment of ALICE Households in Connecticut: Future research should include a larger, more representative sample of ALICE households across Connecticut, capturing variation by geography (urban, suburban, and rural), industry of employment, household composition, and racial and ethnic identity. A statewide sampling strategy would strengthen generalizability, allow for subgroup analyses, and better inform state-level policy and system reforms aimed at reducing healthcare-related inequities among working families.

Evaluation of Healthcare Affordability and Cost-Sharing Interventions: Given the high prevalence of medical debt and trade-offs between healthcare and basic needs, future studies should evaluate interventions designed to reduce out-of-pocket costs for ALICE households. This includes assessing the impact of expanded subsidies, reduced deductibles, caps on cost-sharing, and alternative benefit designs on healthcare utilization, financial strain, and health outcomes.

Health Insurance Navigation and Plan Complexity: Despite reported moderate confidence in insurance literacy, qualitative findings suggest that plan complexity and benefit ambiguity remain significant barriers. Future research should test and compare insurance navigation supports such as community-based navigators, simplified plan materials, or employer-facilitated education to determine which strategies most effectively improve understanding, reduce delayed care, and alleviate emotional stress.

Mental Health Consequences of Healthcare Insecurity: The emotional toll of delayed or foregone care and unpredictable medical expenses emerged as a critical theme. Future studies should more explicitly examine the mental health impacts of healthcare insecurity among ALICE households and evaluate integrated or community-based approaches that address both financial stress, and mental well-being.

Chronic Conditions and Ongoing Care Needs: Households managing chronic illness face disproportionate financial, emotional, and logistical burdens. Future research should focus on how insurance design, provider network adequacy, and cost-sharing affect care continuity, treatment adherence, and health outcomes for ALICE households with ongoing healthcare needs, with particular attention to cumulative costs over time.

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