Using Individual and Small Group Interviews to Better Understand the Inverse Relationship between Low Health Uninsurance Rates and Poor Health Metrics in Kentucky

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Executive Summary

This study examines barriers to health care access and utilization in Kentucky, using individual and small group interviews with a total of 73 people representing all regions of the state and four insurance types: employer-based insurance, Medicaid, Medicare, and Marketplace. Through discussions with Kentuckians, we sought to understand how they think about their health and the health care system and what factors influence their health behaviors, including decisions around seeking or avoiding care. Findings point to multiple, compounding factors that cause many individuals to avoid seeking care until they absolutely need it to function. Barriers to access include health care workforce shortages, long wait time for appointments, and transportation challenges. Costs play a significant role in individuals' decisions about when to seek care. In addition, mistrust of the health care system stemming from previous negative experiences with doctors or insurance and a cultural norm against seeking care (particularly in rural Kentucky and Appalachia) cause many to avoid or delay care, which may, in turn, negatively affect health outcomes.

Background and Purpose

Kentucky's uninsurance rate stands at 5.6 percent, the lowest in four years (Johnson, 2025), making Kentucky one of the states with the highest insured rates in the country (Carter, 2023). Despite its highly insured population, Kentucky remains in the bottom third of The Commonwealth Fund's 2025 health system performance rankings, alongside fellow southern states Alabama, Georgia. Tennessee, Texas, and Mississippi (Radley et al., 2025). This ranking takes into account both health outcomes and health care utilization, suggesting that while Kentucky is a highly insured state, the state has poor health outcomes. Thus, Kentucky offers a unique opportunity to investigate factors related to low health care utilization and poor health outcomes among the insured.

Previous research has identified numerous barriers to health care access and utilization, including cost (TAI 2024), transportation challenges (Smith et al. 2023), administrative burdens (Herd and Moynihan 2018), and health care workforce shortages in rural locations (Center, 2025; Howard et al., 2022). In addition, personal beliefs, cultural attitudes, and levels of trust in the health care system may influence whether individuals use their insurance, seek care when needed, or follow medical advice (Metzl, 2019, Wallace et al., 2022).

Through discussions with Kentuckians across the state, we sought to understand how Kentuckians think about their health and about the health care system, including their perceptions and attitudes surrounding insurance and health care providers. Further, we sought to identify how various cost- and non-cost related barriers influence Kentuckians' decisions regarding health care access and utilization.

Methods

We undertook a qualitative study consisting of individual and small, 2-3 person group interview, consisting of individual and small group interviews (2-3 people per interview) with a total of 73 participants. All interviews were conducted online between October 2024 and May 2025. Participants were recruited from three distinct geographic regions: 1) Appalachia, which is Eastern KY, 2) non-Appalachian rural Kentucky, which consists of the Western and southern parts of the state, and 3) the Urban Triangle, consisting of Louisville, Lexington, Frankfort, and northern KY, which is considered suburban Cincinnati. Appalachian Kentucky is entirely rural and is culturally distinct from non-Appalachian rural parts of the state. Additionally, participants were recruited for a mix of gender identity, level of involvement with the health care system, income, educational attainment, and dis/abilities. To be included in the study, participants were required to speak conversational level English, be between 18 and 75 years old, and be able to participate in online interviews. Potential participants were excluded if they worked in a health care system, for a health insurance payer, in advertising or market research. In addition, participants were excluded if they were uninsured, insured through more than one type of insurance coverage (e.g., Medicaid and Medicare), or insured through the VA program or Tri-Care.[1] As an incentive, each participant who completed the interview and filled out a demographic questionnaire received a $50 Amazon gift card. Figures 1 and 2 illustrate the distribution of participants by region, insurance type, and demographic category. Each interview lasted between 60 and 120 minutes and involved questions about participants' health behaviors and their experiences with and perceptions of the health care system, including personal, community and structural factors influencing health and access to medical care in Kentucky.

Coding was conducted by the two primary researchers on the project, both of whom also conducted the majority of the interviews.[2] The codebook was developed through an iterative process in which the researchers independently coded some interviews, then met to compare codes and align their coding decisions. The researchers allowed for emergent codes to be added as needed, and each interview was reviewed in its entirety at least two times.

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[1] Dual-eligible participants were excluded because we wanted to separately examine how different insurance types influence decisions around health care access and utilization. During the interviews, we found out that two participants were insured through both Medicare and Medicaid. We kept both transcripts in the study because they speak to various barriers to health care, though their data will be excluded from analyses specific to insurance type. VA and Tri-Care participants were excluded because this coverage is more comprehensive than conventional insurance and thus presents fewer barriers to care.

[2] Two interviews were conducted by a third researcher on the project due to scheduling demands.

Figure 1. Participants by Geographic Region and Insurance Coverage Type

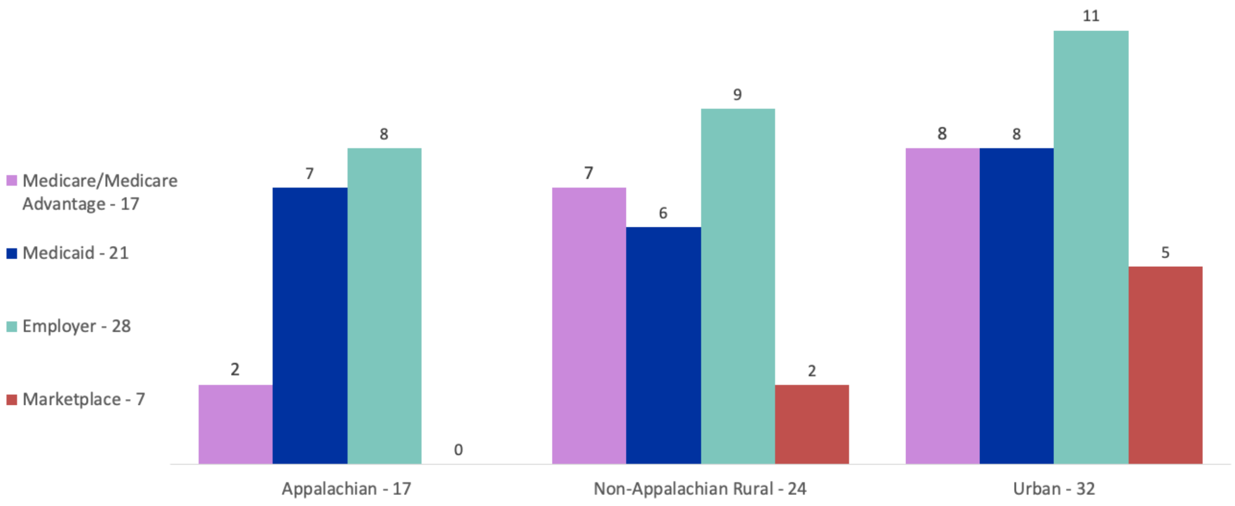
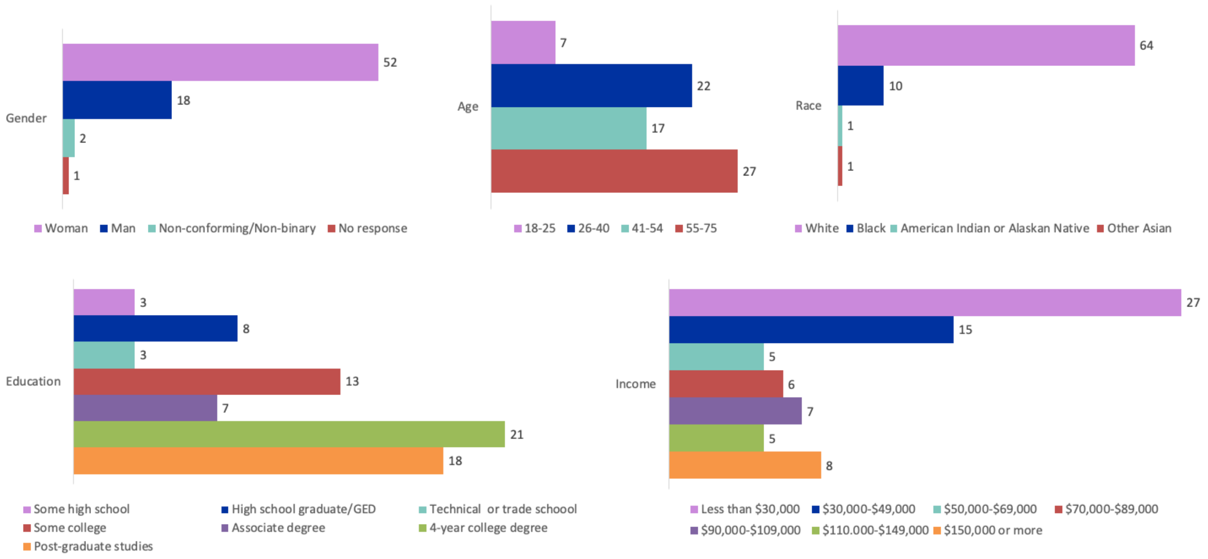


Figure 2. Demographic Data



Findings and Emergent Themes

Barriers to Health Care Access

Widespread Provider Shortages: Many participants described long wait times, overburdened local systems, and the need to travel—sometimes out of state—for even basic or preventive care. Accessing specialty care was seen as a significant challenge outside of major cities like Louisville or Lexington. In more remote areas, participants noted that entire communities often rely on just one or two doctors or clinics: "There's not enough doctors to begin with, and then… they have to see more people" [N1-1580] and "We have no specialists in this area… if you're needing a specialist, you're going to be driving at least an hour" [N3-2214]. Several participants emphasized how geography and transportation compound these issues, especially in Appalachia and other rural parts of the state. Indeed, one Appalachian participant aptly said, "Geography works against us. Transportation is a huge issue" [A2-148] while a non-Appalachian, rural participant commented, "If the hospital can't help you, they'll transfer you to Louisville via ambulance or helicopter. That's a huge burden" [N3-1554]. The lack of access was described not only as a health burden, but as a logistical and emotional one, as health care often requires missed work, long drives, and significant family disruption.

Dental Care as a Hidden Crisis: Participants also highlighted dental care as a particularly neglected part of Kentucky's health infrastructure. Tooth loss, difficulty accessing appointments, and the absence of fluoride in [likely small or private] water systems were mentioned. One participant—originally from New York—described visible differences in the oral health of Kentuckians: "You really didn't see people with like a whole bunch of missing teeth and then come down here and it's like, wow. These women weren't kidding when they were with, like a full set of teeth. It's something to brag about on dating sites" [U4-225]. Others noted the lack of dentists in their area and the difficulty scheduling appointments as evidenced by this quote, "There's a shortage of dentists in the area… If I commit to a six-month dental cleaning, I've got to schedule my life around it" [A3-2200]. Others linked the poor dental outcomes to a lack of public investment: "Tooth loss is such an issue in Kentucky… I feel like some of the political leanings of our state, where we don't offer the things as we should" [U3-1583]. Many participants discussed the problems with dental work that they have had, as well as mentioned having teeth removed as a normalized part of routine care.

Wait Times for Appointments: Participants reported significant wait times (from several months to one year) to see a provider. These delays were especially common for participants seeking care from specialists or dentists and when seeking to establish primary care. In many cases, participants reported deterioration of their health while waiting to see a provider. One participant [A2-1639] waited approximately one year to get his wisdom teeth taken out, experiencing pain and multiple infections during that time. Another participant reported experiencing significant pain and disability while waiting for a spinal surgery: "It's like, good Lord, I can hardly walk now. It's like I had to wait forever" [U1-221].

Transportation Challenges: Transportation was a significant barrier for participants who don't drive or have access to a car. While subsidized services like MediCab are available, participants described these services as inconvenient and unreliable. As one participant noted: "... you kinda have to schedule it well in advance. And they may or may not be on time, and you may have to go to the appointment two hours early" [N2-351]. According to participant A2-1127, "The biggest problem is if they drop you off, getting them to come back in a timely manner to get you 'cause you could be there for quite a while." In more than one case, the transportation service sent the wrong type of vehicle, causing the participants to miss their appointments. Similarly, more than one participant described times when they were left at their appointments and had to either walk home or find alternative transportation.

An Urban-Rural Divide: Participants consistently emphasized disparities between accessing care in rural vs urban areas. While urban residents can “just get in the car” and find care, rural residents described needing to weigh the cost, time, and stress of even a basic appointment. Indeed, participants described traveling 30 minutes to 3 hours to their appointments in larger cities. Several shared stories of providers or specialists leaving their communities for better-paying jobs in urban centers, leaving an already underserved populations with even fewer options: “We’ll get a good specialist for less than six months, and then all of a sudden they just disappear… they’re moving to bigger towns” [A2-346]. Rural participants often also noted that the doctors in their area are medical students or students fresh out of medical school and so are either only in the area for a short period *or* they are unable to provide the best quality of care.

Administrative Burdens Related to Health Insurance: Across insurance types, participants described difficulties accessing benefits. These difficulties can be described as administrative burdens, or the hurdles individuals must overcome to utilize benefits for which they are eligible (Herd and Moynihan, 2018). In dealing with their insurance, participants reported significant learning costs (associated with understanding programs and services), as well as compliance costs (i.e., time and resources devoted to complying with administrative rules). Participants found it especially difficult to find dentists willing to accept Medicaid, as noted by this individual: “So, it's like incredibly difficult to find a list of providers that actually take Medicaid to begin with and then when you do find that list of providers that do take Medicaid, the next question is, are you taking new patients? And that's always a no as well. And then if you magically find one who says yes to both of those questions, then you have to ask. Oh well, do you actually have a dental hygienist on staff that can do cleanings?” Rather than deal with the hassle of finding a dental provider, the participant said, “I just try to be really good about brushing my teeth” [U2-469].

Participants also described spending significant amounts of time on phone calls and paperwork with doctors’ offices and insurance companies to resolve pre-authorizations and denials. As one participant explained, “If I want something to get done, I have to follow up. I have to initiate phone calls. I can't just trust that you know that this prior authorization's gonna happen and that everything's gonna fall into place. You know, I might have to be on the phone everyday with two different entities for two weeks to make sure, for instance, that my MS medication is approved” [U4-361]. In many cases, participants reported having to go for weeks without needed medication while seeking approval from insurance.

To some participants, administrative rules appeared to be veiled attempts to delay or deny care. To get authorized for an MRI, one participant was required to document having previously received physical therapy. However, the insurance company initially rejected her documentation: “We just kept going back and forth and back and forth, and I had proof, like, I had, you know, documentation. And they said they couldn't take the documentation, and I had to do it differently, and... I think they were just stalling. I think they were trying to hope that I would just go away” [U3-320].

Cost-Related Barriers to Health care Utilization

Costs were the most common barrier to care mentioned by participants. These include the cost of insurance premiums and out-of-pocket costs such as co-pays and deductibles, as well as the costs of medical care not covered by insurance. In addition, participants reported indirect costs, such as transportation costs and lost wages from time off work. Finally, participants reported *fear* of costs, stemming from anticipation of costs they believe they might incur in the future. While some participants can afford these costs, others find them incredibly burdensome. For example, participant U3-357 reported that the co-pays for her employer-provided insurance are so high that she has to decide between health care and groceries. In many cases, participants reported skipping or delaying care due to the costs of health care. For example, participant U4-366 opted not to get a cardiac stress test, even though it was medically necessary, when the hospital demanded upfront payment of $3000.

Beyond the effects on participants' bank accounts, the costs of health care impose psychological stress on individuals, especially during major health crises. For instance, participant U3-352 was diagnosed with a rare cancer at age 28 and reported that the financial cost was among her biggest worries: " … when something happens to you or a child or anything like that. … you shouldn't have to worry about money, like, that should be the last thing you have to worry about. And that probably stressed me out more than anything else that I was going through."

To some extent, this stress stems from the complexity of the health care system and participants' uncertainty and confusion about whether they will get billed for something down the road. Even if that bill never materializes, the anticipation of costs can affect individuals' well-being and health care decision-making. For example, one participant (U1-469) who recently enrolled in Medicaid, reported avoiding getting a mammogram (for which she is overdue) because of a misperception that she would be responsible for the bill: "I was not able to get a mammogram last year. So, I guess I'm late for that because of health care costs. Although I guess that is a little bit my fault because I haven't checked to see what the cost would be with Medicaid . . . I'm kind of assuming it would be expensive."

Cultural Barriers to Health and Health care Utilization

Cultural Norms and Beliefs Around Seeking Care: Many participants described a widespread mindset in which people avoid preventive care and only seek medical attention when symptoms are severe or life-threatening. This norm was often passed down across generations: "If it is not an emergency or you are not going to die… you don't go" [N3-1554] and "Honestly, the doctor is for sick people. If you're going to go in and see, you're going to get sick if you're not" [A3-87]. Others noted that health simply wasn't discussed in their family or communities. Care was seen as something you postponed, endured, or handled privately. "One generation removed, that was something you didn't discuss. You didn't talk about your health" one Appalachian, Medicaid participant commented [A2-148]. For some participants, avoidance of health care stemmed from mistrust of the health care system: "You can't trust doctors… that's in our culture" [N3-991]. For others, avoiding care was tied to fear of diagnosis, as going to the doctor meant learning something that you didn't want to hear, or facing the potential cost and complexity of treatment. Finally, participants described a cultural identity, particularly in Eastern Kentucky, built around toughness, self-reliance, and enduring hardship without complaint. This mentality is likely due to the region's occupational history of coal mining as one participant stated, “My grandpa was a coal miner for so many years… going to the doctor, like it’s bad” and went on to say “It’s just kind of like a tough mentality that people in Eastern Kentucky are supposed to adapt to” [A3-1626].

Dietary Choices: Participants described poverty as a foundational barrier to health in Kentucky, restricting both access to care and the ability to make long-term, health-promoting decisions. Many interviewees reflected on how economic strain shaped daily dietary choices. Participants expressed a desire to eat healthier foods, but noted that fresh and nutrient-dense options were often too expensive or inaccessible. These economic constraints made highly processed or sugar-heavy foods, which some noted are aggressively marketed to the region, more common in households: “I would love to eat a different way, but financially I can’t do that all the time […] I think in the Appalachia community, soda is very… Everyone drinks it. They allow kids to drink it from an early age” [A3-12]. Some individuals described this as a generational pattern, where poor dietary habits were passed down.

Tobacco Use: Tobacco use emerged as one of the most frequently mentioned concerns, cited by participants across age groups and regions. Many saw tobacco as both a cultural norm and a structural challenge, tied to Kentucky’s agriculture history and shaped by long-standing economic and policy factors. Several participants pointed to the historical importance of tobacco farming in Kentucky, which continues to shape social norms today. Despite declining rates of cigarette use among younger people nationwide (Ahmed et al. 2024), tobacco remains widely accessible and visible in public spaces, particularly in rural areas and in the absence of a statewide smoke-free law. Some individuals described how the normalization of smoking influenced their personal behaviors. Several began to smoke in college or in high school, in part because tobacco use was socially accepted and cigarettes were relatively inexpensive. Indeed, one participant mused, “I started smoking cigarettes because it was kind of prevalent in Lexington and Kentucky in general… It’s very normalized compared to other states” [N2-349]. Participants also expressed concern about the broader health impacts of tobacco use, especially cancer and cardiovascular disease.

Attitudinal Barriers: Perceptions of the Health care System

Beliefs that Insurance and Medical Care are Profit Driven: Many participants described insurance companies and the broader medical care system as excessively profit-driven and intentionally opaque. Several noted the inflated and inconsistent pricing structures, especially for insured versus self-pay patients. As one urban, employer-based insurance participant put it, “If you are self-pay, your costs are significantly lower. So the only reason that a surgery is $100,000 is because of the insurance company” [U3-353]. Others expressed frustration with the billing practices that appeared arbitrary or exploitative. One participant described receiving an itemized bill where a service was discounted by $400 for insurance, but they were still charged extra, asking, “Why do I owe anything?” [N3-300].

Participants also criticized the administrative burdens of using insurance, citing the need to go back and forth between their provider and insurance to ensure that they are billed correctly. “It felt like pulling teeth just to make sure everything was taken off the way it was supposed to […] you're just playing a game of telephone," said one participant [N3-1554]. Many believe the system prioritizes maximizing profits over delivering quality care, with one person stating, "It feels like a system that's designed to give corporations more opportunities to make money off of me" [A2-1639]. Others voiced deeper concerns about the power of insurers and pharmacy benefit managers in shaping access and pricing: "They're able to lobby those in government […] to make it harder for people that are lower income or in more precarious positions" [N3-349].

Perception of Elitism and Profit-Driven Care: Many participants described a perception that health care providers act with a sense of superiority, driven more by financial incentives than genuine concern for patient well-being. This included feeling rushed, unheard, or dehumanized: "just a number" in a billing system or being "herded through like cattle." Some noted that the training and professional culture of medicine may erode empathy, while others believed systemic pressures from insurance companies distort the provider-patient relationship. As one participant said, "Doctors don't work for their patients, they work for the insurance company" [N3-300]. Most participants complained about the amount of time doctors spent with them as one said, "I get 10, 15 minutes […] they're not really hearing me" [U2-257] and another said, "Why I am I even coming to see you if I can't discuss anything?" [N3-2214]. Others questioned whether doctors are requesting tests because they are in their best interest or if "they are trying to get more money out of me" [N3-2214]. Finally, one participant commented "I think some doctors are just greedy […] they're double- and triple-booked so they can rush you through and make more money" [U3-13].

Perceived Medical Mistakes, Oversights, or Harm: Several participants described experiences they perceived as medical error, misdiagnosis, or outright malpractice ranging from misjudged surgical decisions to missed diagnoses and dismissals that led to preventable suffering. These were not framed as rare outliers but as a shared community experience that led to general feelings of distrust. Indeed, several participants noted the importance of word-of-mouth in Kentucky, as people would discuss which doctors and hospitals to avoid at all costs. For example, one rural participant stated, "When it comes down to our emergency room department here […] just skip going to Madisonville altogether and go somewhere else" [N4-33].

Perceived Bias in the Health care System: Many participants shared experiences that reflect not only individual mistreatment, but also broader patterns of systemic bias in the health care system. These perceived biases, rooted in gender, socio-economic status, race, and weight were not isolated, but often overlapped. For those in rural or marginalized communities, these experiences exacerbated existing structural barriers and reinforced skepticism toward the medical system.

Participants frequently described being treated differently based on having Medicaid or Marketplace insurance. This included being steered towards dental extractions over preventive dental care, receiving less personalized attention, or having doctors deprioritize their care. For example, one participant said, "There's a huge stigma against Medicaid… [The dentist said] 'Medicaid is the worst thing ever. It's worse than charity" [U2-469]. Another participant commented "Doctors […] when they see Marketplace or not a main insurance […] think, 'Oh, well, we can wait'" [U4-366].

Many women described not being taken seriously when presenting symptoms. Some noted that their concerns were dismissed as hormonal or emotional, while similar complaints from men would be treated more urgently. One woman stated, “I get told a lot that it’s just a ‘mommy you’re tired’ issue […] if my husband goes in and says he’s tired, they run tests” [N3-2214]. Another participant described an experience in the emergency room where “The male doctor asked if I wanted anxiety meds […] I don’t think he would’ve said that if I wasn’t a woman” [U3-352].

Black participants described a heightened need to advocate for themselves and noted a lack of providers of color in most areas outside large cities. They reported assumptions about pain, health literacy, or insurance status based on race. One participant described an instance in the emergency room where “they set [my son’s] wrist with no anesthesia […] I told them he’s not a Medicaid recipient, he has full PPO” [U3-13]. Another stated, “I always have to be on guard with the provider […] until I can recognize that they don’t have those internal biases” [N3-1073].

In rural areas, participants described a culture of assumed drug-seeking behavior when reporting pain. As a result, many avoided mentioning pain altogether with medical professionals, fearing they’d be judged. For example, “If I bring up the slightest amount of pain… they just shut down immediately” [A2-346]. Similarly, another participant said, “You don’t say you’re hurt […] you say you’re a little sore, or they’ll think you’re here for pills” [A2-346].

Participants who identified as overweight described encounters where their weight was blamed for unrelated issues or where doctors refused to treat them surgically. These experiences left many feeling stigmatized when seeking care. One participant recalled an instance where “I had a fibroid and the doctor said, ‘There’s no way in the world I’d want to operate on someone your size” [N3-991]. Another said, “You go in for a sore throat […] and the focus is, ‘We need you to lose weight” [U3-357] while another participant observed,. “They see a fat person, and they’re just like, that’s your problem—even if it’s totally unrelated” [A2-2237].

Strengths and Limitations

This study draws on a large number of in-depth interviews (*n* = 73), most of which were conducted by just two interviewers, contributing to consistency in data collection. The sample included participants from across Kentucky, representing a range of geographic regions and insurance types, which allowed us to capture both cost- and non-cost barriers to care. The interdisciplinary research team—including communication, political science, public health, and medicine—brought complementary perspectives to the design, analysis, and interpretation, particularly given the political and policy-driven nature of health care access.

A few important limitations should be noted. Although our team members are based in Kentucky, the core research team resides in Louisville (an urban setting). This may have influenced rapport-building during interviews and shaped the lens through which data were interpreted, particularly when working with participants who perceived themselves as culturally or socioeconomically different. However, the feedback from participants in the demographic surveys often noted that the participants felt comfortable during their interviews. Interviews were conducted via videoconference, which may have limited participants’ sense of closeness with the interviewer(s). Recruitment challenges also impacted the sample: online screening spam, out-of-state individuals posing as eligible participants, and high rates of no-shows substantially delayed data collection. Finally, we were unable to recruit as many participants from Appalachian Kentucky as desired, particularly among those with Marketplace insurance. However, we must note that this is an already small and hard-to-reach subgroup, as fewer than 100,000 Kentuckians hold Marketplace coverage.

Conclusions

Multiple, compounding factors impede Kentuckians’ access to and utilization of health care. Nearly all participants reported at least one problem. In deciding whether to seek care, insured individuals must weigh the costs—including those that are known, such as co-pays and deductibles, and those that are unknown, such as bills or the time required to deal with insurance—against the benefits of seeking care. Although many participants have had positive experiences with doctors, most also reported encounters that were rushed or transactional, leading to feelings of being dismissed and unseen. Further, some participants reported extremely negative, even traumatic experiences, which left a lasting impression and contributed to their general mistrust of the health care system. Along with the cultural norm against seeking care (especially in rural Kentucky and Appalachia), these factors likely cause many Kentuckians to avoid care until they recognize that they absolutely need it to function. Even then, barriers to access, including the shortage of providers and long wait times for appointments, mean that Kentuckians who seek care may not be able to get it in a timely manner. Delayed care, in turn, may contribute to the poor health outcomes observed in the state, despite the high insurance rate.

Recommendations for Future Research

Future research should delve more deeply into the factors that influence poor health outcomes. One possibility would be to replicate to this study in a state with a similar rate of uninsurance and a similar rural character, but significantly better health performance, such as Iowa or Michigan. This type of comparative case study could shed light on the extent to which features of health care systems, economic factors, and cultural norms and practices contribute to health care access and utilization and to overall health. Additionally, future research should study individuals who, while currently insured, have previously experienced gaps in health insurance coverage. It would be particularly instructive to examine the extent to which their health behaviors during periods of uninsurance extend into the present and whether their current health status is partially attributable to previous lack of health care. It would also be informative to know how the experiences of Kentuckians compare and contrast with residents of other Southern states. Finally, given passage of the One Big Beautiful Bill Act of 2025 and the ensuing changes in Marketplace and Medicaid coverage, it may be useful to repeat this study in 2-3 years to examine how recent federal policy changes have affected barriers to health care access, utilization, and health.

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Nomenclature used to identify participants:

U=Urban
N=Non-Appalachian Rural
A=Appalachian