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# findings brief

## Subgroups of Working Uninsured Require Different Enrollment Strategies

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Today, more than 41 million Americans are uninsured. Perhaps the most perplexing aspect of this problem is that many of them are employed.

Barriers to obtaining employer-sponsored insurance (ESI) are not well understood, but new research has shed light on the characteristics of the working uninsured.

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Linda J. Blumberg, Ph.D., of the Urban Institute and her colleagues Amy Davidoff, Ph.D.; Len Nichols, Ph.D.; and Bowen Garrett, Ph.D., found that many specific factors influence whether insurance is offered or taken up among this population. They also discovered that policies to reduce the number of employed individuals who lack coverage are most likely to be effective if targeted at specific subgroups of workers and employers.

The project had three goals: 1) to identify differences between insured and uninsured low-income workers; 2) to determine the effects of reform in the small-group health insurance market and whether intended goals were met; and 3) to identify differences between uninsured workers in large firms versus those in small firms.

The findings paint a picture of the working uninsured that policymakers can use to craft a coverage approach geared toward that population. For example, the researchers' analysis of the National Health Interview Survey indicated that the working uninsured are predominantly white and have citizenship. Typically, they are uninsured for long periods of time: More than half had been without coverage for three or more years at one time or another. However, the Hispanic population and non-citizens are disproportionately represented among both lower- and higher income workers—a find-

ing that may indicate that these individuals are segregated into labor markets with language barriers, lack of geographic access to insurance agents, or few employers that offer insurance.

“If one were to focus on the largest group of uninsured, one would focus on non-Hispanic white citizens, and might seek to implement fairly mainstream policy solutions,” says Blumberg. “However, a focus on Hispanics, and particularly Hispanic non-citizens, might lead to a different set of policy directions.”

Contrary to popular belief, the researchers also found that most uninsured workers do not fit the profile of “low-demand” workers (i.e., single, young, childless, with no health problems). Adults with no dependent children make up almost half of low-income uninsured workers, but unfortunately are not eligible for the recent coverage expansions that focus on parents of children eligible for public programs.

“It is now well established that about 78 percent of the uninsured in the United States are workers or their dependents,” says Blumberg. Given this and the fact that nearly 70 percent of individuals with health insurance receive it through a workplace, she says, focusing analytical and policy effort on the working uninsured is a high priority.



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“Identifying categories of low-income uninsured workers within each state should be helpful to policymakers at the state and federal levels,” Blumberg adds.

### Methods

The researchers studied the working uninsured on the basis of their income level, health status, and employer size using a state-level comparison and comparative survey methodology. They also analyzed the effects of small group insurance market reforms on the working uninsured.

The researchers used both descriptive and multivariate statistical analysis, and drew data from three major national surveys: the Current Population Survey (CPS), the National Survey of America’s Families (NSAF), and the National Health Interview Survey (NHIS). The choice of survey instrument is key when studying the working uninsured. The CPS, NSAF, and the NHIS produce different results when used alone or in combination, and each has unique advantages for addressing specific questions.

The CPS is most commonly used for analyses of insurance and labor force issues; the NHIS is an excellent source when relating insurance to health status; and the NSAF has a large sample of low-income families and the ability to generate 13 state-specific estimates for this significant population.

Using all three surveys, Blumberg and colleagues conducted an extensive comparative analysis of low-income uninsured workers. However, they used only the NHIS for a separate analysis of the characteristics of all working uninsured individuals, and drew only on the NSAF to study state variation in uninsurance rates among low-income workers.

### Characteristics of Insured and Uninsured Low-Income Workers

Nationally, the uninsured are more likely than the insured to be low-income, Hispanic, non-citizens, in fair or poor health, and employed in small firms. They are also more likely to have job tenure of less than one year and to work in agriculture, retail, or construction industries. However, this profile varies among states. For instance, national uninsurance rates are especially high—35 percent—among low-income workers (those with income less

than 200 percent of the Federal Poverty Level or FPL). However, the rate varied among the 13 states that were studied, ranging from 21 percent (Massachusetts) to 47 percent (Texas). Because low-income workers have special policy significance, the researchers used the 1999 NSAF to analyze the distribution in state rates, as well as the state-specific profiles of low-income workers (non-institutionalized, under age 65).

“We found that, in states with relatively high rates of uninsured, low-income workers, there is also a disproportionately high number of workers with some of the national high-risk characteristics,” says Blumberg. For example, 19 percent of low-income workers in states with high uninsurance rates were in fair or poor health, compared to only 11 percent in states where uninsurance rates were low. “This implies that states with low rates of coverage may find the costs of providing insurance higher than other states do,” she adds.

Taking local characteristics into account, state and federal policymakers can better target interventions to reduce the number of uninsured. For instance, in a state with a high percentage of non-citizens, a policy expanding Medicaid coverage to more recent immigrants may have greater success if it is accompanied by an outreach campaign to allay the common, but inaccurate, belief that Medicaid enrollment can interfere with future granting of citizenship.

### Low-income workers and the non-group insurance market

As a mechanism for reducing the number of uninsured, policymakers are considering issuing tax credits or premium subsidies to workers to buy insurance in the non-group (individual) insurance market. However, this policy option is limited in several ways. First, the researchers found a strong relationship between non-group coverage and health status. Sick or high-risk individuals are not likely to purchase non-group coverage if tax credits or subsidies are not sufficient to cover the higher premiums associated with those populations.

Further, people tend to make decisions about non-group insurance participation at the family level. Generally, an individual will not enroll if his or her family members face barriers to participation, such as high premi-

ums due to health status. Thus, if subsidies or tax credits are structured so that the subsidies for single coverage are high relative to premiums, but subsidies for family coverage are not as generous relative to premiums, it is unlikely that any of the family members will enroll. As Blumberg and Davidoff note, policymakers should not assume that some family members will enroll even if others do not.

Finally, only 40 percent of workers with incomes above 400 percent FPL who do not have access to employer coverage participate in the non-group market. The vast majority of these individuals are left uninsured as a consequence. Given that this population, by definition, does not face income constraints to purchasing coverage, even relatively generous subsidies to the low-income population should not be expected to lead to significantly more than a 40 percent take-up rate.

### Small Group Market Reform Effects

Between 1993 and 1996, reform policies increased risk pooling across small firms. Policymakers hoped that increased pooling would improve access to, and insurance coverage for, high-risk workers in small firms. Market reforms had some, but not all, of the effects desired by proponents. The researchers found that reforms had a modest, positive effect on ESI coverage for high-risk workers in small firms. However, this positive effect was relative to small negative effects on coverage for low-risk workers in small firms.

These findings indicate that the degree of pooling occurring under small group market reforms was insufficient to protect high-risk workers. Also, based on the results for low-risk workers in small firms, it seems that a fundamental failure of the reforms is that they could not affect the higher premiums faced by all small firms relative to large firms. Increasing risk pooling across only small firms does not address their higher administrative costs or risks associated with insuring a particular firm.

“These barriers may be more effectively addressed by a broader spreading of risk across the population of all workers in firms of varying sizes,” says Blumberg. “Researchers and policymakers should study and consider such alternatives.”

### The Uninsured in Large Firms

The researchers note that there is potential to neglect the uninsured in large firms because policymakers focus so much on those in small firms. But while workers in the largest firms are less likely to be uninsured, they still account for more than a quarter of the nation's uninsured. Because this group is different from their counterparts in small firms, policies might be more successful if targeted by firm size.

“The uninsured in large firms are younger, less likely to be Hispanic, and less likely to be non-citizens,” says Blumberg. “They are more likely to be unmarried and to be highly educated, and are more likely to have ESI available to them; Forty-six percent decline an ESI offer and are uninsured.” Finally, says Blumberg, these individuals are more likely to work part-time; have job tenure of less than one year; and work in the retail industry or in technical, sales, or administrative support occupations.

The researchers looked at the characteristics associated with whether a large-firm worker has an ESI offer, and, if so, whether the worker enrolls. They found that, in large firms, non-citizen employees have the same propensity as citizen employees to enroll, but are less likely to receive offers. This finding suggests that non-citizen workers are more likely to be uninsured because they lack jobs that offer insurance. Income level affects take-up, but whether a person enrolls in insurance is most strongly related to his or her opportunity to do so.

In large firms, employees' education level is an important factor affecting the probability of accepting an ESI offer, but not for having the offer to begin with—a distinc-

tion between large firm and small firm models. Interestingly, in large firms, being young significantly decreases the probability of being insured, but being young in small firms does not have this effect. Finally, in large firms (compared to small firms), uninsured workers are more often part-time employees or have been employed less than one year.

“Policies aimed at offering large-firm workers coverage at the start of employment, or making them eligible for a public subsidy until employer insurance is available, could be effective in reducing the uninsured among this vulnerable subpopulation,” adds Blumberg.

### Conclusion

Perhaps the most important lesson that can be drawn from the project is that subpopulations of the working uninsured require different approaches to enrollment. Policymakers should consider how to better target low-income workers, adult employees without children, Hispanic and non-citizen employees, and workers in large firms.

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### Endnotes

- 1 Urban Institute analysis of the 1999 National Health Interview Survey.
- 2 The Kaiser Commission on Medicaid and the Uninsured. *Changes in Insurance Coverage: 1994–2000 and Beyond*. Washington, DC: The Henry J. Kaiser Family Foundation, August 2002.