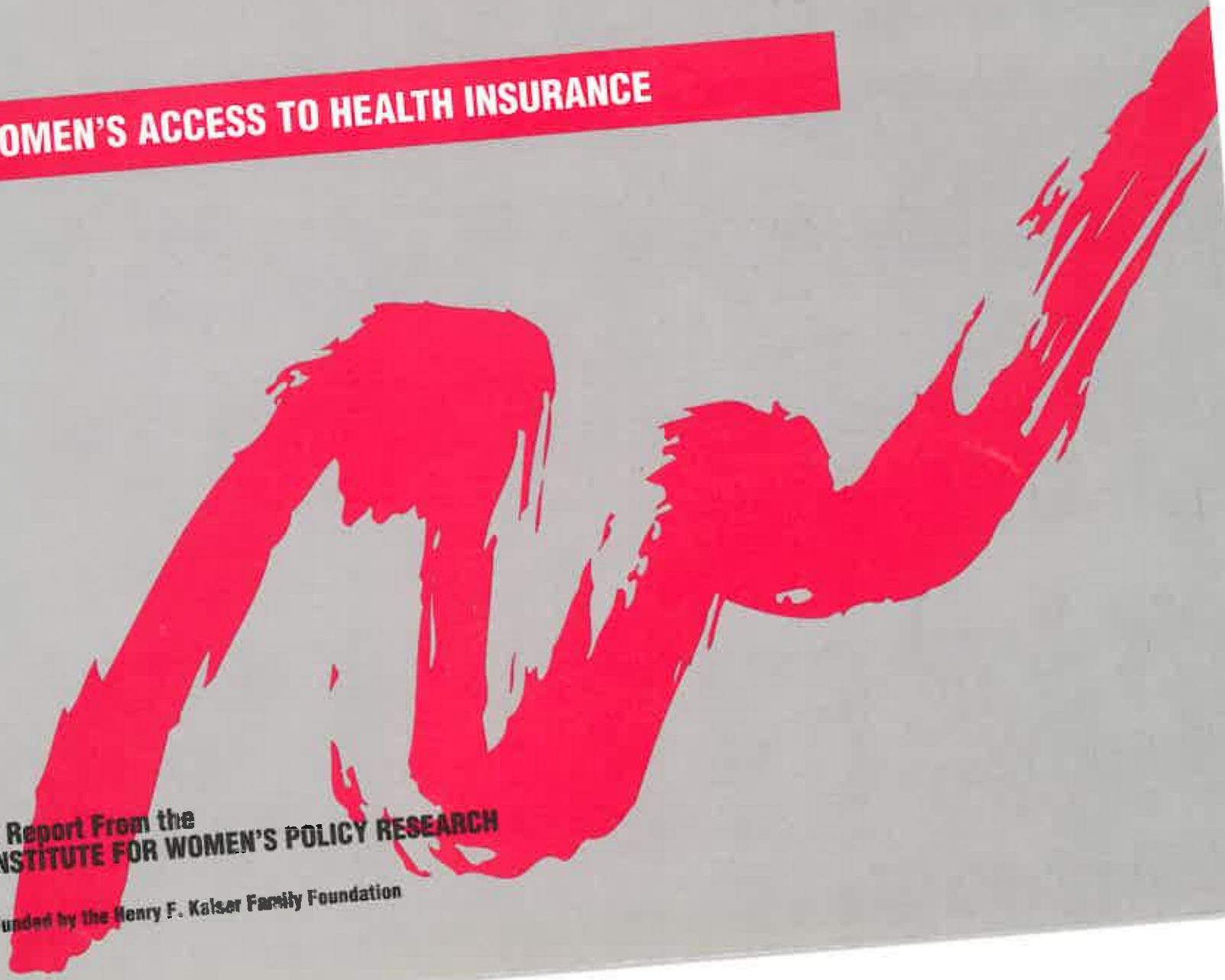
WOMEN'S ACCESS TO HEALTH INSURANCE



A Report From the
INSTITUTE FOR WOMEN'S POLICY RESEARCH

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The Institute is national and international in scope and is committed, in all aspects of its endeavors, to expanding access, strengthening relationships, and fostering partnerships among women in various sectors and of different racial and ethnic backgrounds. IWPR works to build a network of individuals and organizations that conduct and use women-oriented policy research and to facilitate the dissemination of information, ideas, and points-of-view across the boundaries separating scientific disciplines, advocacy specialties, and advocacy and science.

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EXECUTIVE SUMMARY

Women have a unique relationship to the health care system in the United States that needs to be taken into account in health care reform.

Compared with men, women use more health care services and pay more for them as a proportion of their income. They are also responsible for facilitating their families' use of health care and for ensuring the health of infants and children.

Yet many women have no health insurance: 12 million women of working age (18 to 64), or 15 percent of these adult women, have no insurance of any kind. Many of these women are medically underserved as a result.

It has been traditional for women to obtain health insurance indirectly through their husbands' jobs, even when they themselves also work in the labor market. More and more women are slipping through the cracks of this traditional arrangement and more will continue to do so. As people marry later and divorce more, more are unmarried for longer portions of their lives. Already 2 out of 5 adult women do not live with husbands and the majority of women, even of married women, do not receive their health insurance through their husbands. And increasing numbers of men have jobs that do not provide health insurance, especially for other family members; access to dependent care coverage is falling for all workers.

Given these changes taking place in family structures and employment, women increasingly need secure access to insurance. Because of their decreased likelihood of obtaining insurance through marriage, it is important to look at how women obtain access to health insurance through their own employment.

As the conditions of men's employment increasingly come to resemble women's (with the expansion of the service sector and the growth of part-time and contingent jobs), and as more men become single parents for portions of their lives, examining the barriers women face in accessing health insurance is increasingly relevant for men as well as women.

It has been traditional for women to obtain health insurance indirectly through their husbands' jobs. Yet, today, the majority of women, even married women, do not receive their health insurance coverage through their husbands.

Women who are not married are twice as likely as married women to lack health insurance.

Young women especially lack health insurance . . . yet 70 percent of all births occur to women under age 30.

ABOUT THE STUDY

This study analyzes data from the January and March 1991 Current Population Surveys, monthly household surveys conducted by the U.S. Bureau of the Census. The study focuses on adult women of working age, 18 to 64, examines the factors affecting their access to health insurance, and assesses the impact of the proposed Health Security Act on women's health insurance coverage. It compares and contrasts the experiences of women and men whenever relevant. Funding for the research was provided by the Henry F. Kaiser Family Foundation.

FINDINGS FOR ALL ADULT WOMEN

Women have less access to health insurance through their own employers than men do: 37 percent for women versus 55 percent for men. Women have more indirect access to coverage through their spouses than men do and more access to public programs such as Medicaid and Medicare. Overall, men are slightly less likely to have health insurance than are women.

Women are fortunate to have access through more sources than men, but greater reliance on indirect coverage through a family member leaves them vulnerable to life cycle events such as leaving the parental home, divorce, widowhood, or the retirement or job loss of a spouse.

- Young women especially lack health insurance. Five million young adult women (under age 30) have no insurance, yet 70 percent of births are to women under 30.

- The marriage factor is even more important than anticipated: women who are not married are twice as likely as married women to lack health insurance. Marriage to a fully-employed man is also crucial to health insurance access. A woman whose husband works less than full-time full-year is no more likely to have health insurance than a woman whose husband does not work at all.

- Single mothers are also more likely to be uninsured, despite the existence of the Medicaid program which targets low-income single mothers and children.

As other researchers have found, being a member of a minority race or ethnic group and

having low educational attainment and low family income are all associated with lack of insurance. Over 4 million women of color lack health insurance.

FINDINGS FOR EMPLOYED WOMEN

Women generally have more marginal places in the labor market than men and so have less health insurance from their own employers than men do: they are more likely to work part-time, have shorter job tenure, and lower earnings. But everywhere in the labor market — even in large firms, in the higher paying occupations and industries, and in full-time stable work — women have less direct insurance from employers than do men.

- Only 1 in 8 women working fewer than 25 hours per week has direct employer-provided health insurance, 2 in 5 women in the first year on the job, and only 1 in 4 working in small firms with fewer than 25 employees.
- Nearly 8 million of the 12 million uninsured women are employed, yet they do not have access to health insurance through their jobs.

Despite men's greater access to health insurance through their own employers, even more working men than working women are uninsured: 12 million of the 14 million uninsured men are employed.

For both women and men, the six industries that are least likely to provide insurance through employment and that have the highest proportions of workers who are uninsured are: agriculture/forestry, construction, retail trade, business/repair services, personal services, and entertainment services.

These differences by gender, age, marital status, race/ethnicity, conditions of employment, and other factors not only raise questions about fairness between individuals, they also point to the undesirable society-wide outcomes that result from our current system of voluntary employer contributions to health insurance costs.

Is it acceptable that women are least likely to have health insurance during their child bearing years? Is it acceptable that so many working women and men lack health insurance?

Over 4 million women of color lack health insurance.

Women have less access to health insurance through their own employers than men do. Nearly 8 million of the 12 million uninsured women are employed.

Under the Health Security Act, 50 percent of all working women (18-64), and 40 percent of men in the same category would gain coverage through their own employment.

FINDINGS ON THE IMPACT OF THE HEALTH SECURITY ACT

Our findings on the impact of the proposed Health Security Act, particularly the workplace guarantee that would ensure that all employers contribute to health insurance for workers who work at least 10 hours per week, are striking:

- Fully 29 million working women, or 50 percent of all working women ages 18-64, and 27 million working men, or 40 percent of all working men ages 18-64, would gain coverage through their own workplace; the majority of these have coverage through other sources but many are currently uninsured.

- Nearly 20 million of the 26 million uninsured working age adults would gain new health insurance coverage through their own employers — 8 million uninsured working women and 12 million uninsured working men — 3/4 of all uninsured adults.

The following uninsured would gain coverage directly from their own employers because of the workplace guarantee:

- 6 million uninsured women earning less than $12,000 annually and 7 million uninsured men earning at the same level (put another way, 2/3 of all workers who would become insured for the first time through their own employer earn less than $12,000);

- 3 million uninsured women working in large firms, those with 100 or more employees, and 4 million similarly situated men;

- 3 million uninsured women working in small firms with fewer than 25 employees and even more — 6 million — similarly situated men;

- More than 2 million uninsured women working in retail firms of all sizes, 1 million of them in the larger firms with 100 or more workers;

- Nearly 1 million uninsured women working in large (100 or more employees) professional services firms;

- 1 million uninsured women working in personal services, most in small firms, and 2.5 million uninsured men working in construction firms, most in small firms.

ALTERNATIVE WORKPLACE GUARANTEES

If small firms with fewer than 25 employees were dropped from the workplace guarantee and the employer responsibility to contribute, the portion of the uninsured who would gain health insurance through their own employer would fall from 3/4 of all the uninsured to 2/5. If all firms with fewer than 100 employees were dropped, the share of the uninsured who would gain coverage would fall to 1/4.

In addition to increasing coverage for the uninsured, a workplace guarantee provides new direct coverage to many workers who currently have access indirectly through a spouse or a parent. Having direct access to employer-provided health insurance can protect many women from losing insurance as the result of reaching adulthood, family break-up due to divorce or separation, or the retirement or job loss of the insured. Having greater access to insurance from their own employers can thus provide greater security to women undergoing transitions in their family arrangements.

Under the Health Security Act, which also guarantees universal access beyond the workplace through ensuring access to nonworkers through health alliances and by providing subsidies to those with low incomes, workers also do not have to fear loss of insurance when they change jobs, experience unemployment, or leave the labor market for a period of time.

Nearly 20 million of the 26 million uninsured working age adults would gain new health insurance coverage through their own employers under the Clinton plan — 8 million working women and 12 million working men — three-quarters of all uninsured adults.

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INTRODUCTION

Women have a unique relationship to the health care system, which is evident both in how they use the system and in the problems they face in accessing it. This study conducted by the Institute for Women's Policy Research (IWPR) focuses on how women get access or fail to get access to health insurance. It examines three types of issues that affect women's access: differences in women's situations across the life cycle; differences based on social and economic status; and differences based on the extent and characteristics of their employment. The study provides information about how women's access varies by age, marital status, race, ethnicity, education, family income, labor market attachment, and job and employer characteristics. Where relevant, it compares women's access to men's. It identifies which women (and men) fall through the cracks and are uninsured. The study further estimates how many of those women and men who are currently uninsured or at risk of being uninsured would be covered directly through their employers if the Clinton Administration's proposed Health Security Act were implemented.

We focus on women's access to health insurance for several reasons. Although women are a majority of the population, their specific needs are often overlooked in public policy debates because male life-cycle and employment patterns are used as the norm. Women's use of the health care system and their access to it differ from men's. Recent studies show that women use health care services more than men do (Horton, 1992:93) and spend a greater portion of their income on health care (Women's Research and Education Institute, 1994). In addition to having significant personal health needs, women facilitate use of the health care system by other family members. In particular, they are responsible for the family planning and pre- and post-natal care crucial to the birth and rearing of healthy children.

The way women obtain health insurance differs from men as well. Because women's relations to family and work still differ from men's (basically women do more family care and men do more paid work), women are more likely than men to have indirect access to

Women's use of the health care system — and their access to it — differs from men's.

Although women are a majority of the population, their specific needs are often overlooked in public policy debates because male life-cycle and employment patterns are used as the norm.

Traditionally, women have relied on their husbands' jobs to provide them with health insurance. But, as women continue to marry later, divorce more, and have more children outside of marriage, increasing numbers of women will not have access to health coverage through spouses.

employment-based health insurance (access as a dependent covered by a worker's policy) and less likely than men to have direct access through their own employment. Women also have less direct coverage through their employers because they work fewer hours (on average) and in different industries and occupations than do men. Even when they work in the same industries and occupations, they are still less likely to be covered directly by employers. Women are more likely than men to be eligible for publicly provided insurance because of their greater responsibility for children as single parents and because of their disproportionate poverty.

Traditionally, women have relied on their husbands' jobs to provide them with health insurance. This dependence on indirect coverage places women at increased risk of being uninsured over significant and growing portions of their lives. Already the majority of women do not receive their health insurance indirectly through husbands and, if current trends continue, this majority will only grow larger in the future. As women continue to marry later, divorce more, and have more children outside of marriage, increasing numbers of women will not have access to health coverage through spouses. Currently, two out of five adult women do not live with husbands.[1] Even within marriages, women can no longer be sure that their husbands will receive insurance through their employers.

Provision of coverage to other family members at reasonable cost is particularly problematic, as jobs decline in industries such as manufacturing that have traditionally provided more generous benefits and increase in sectors that provide fewer full-time regular jobs with only limited fringe benefits (Callaghan and Hartmann, 1991). Public insurance does not fill the gap in coverage for women without direct or indirect employer-based coverage. We find that 12 million working-age women do not have health insurance of any kind; a disproportionate share of these, more than four million, are women of color. Women increasingly need direct access to health insurance.

[1] The median age at marriage for women has increased from 21 in 1970 to 24 in 1992. Divorced persons per 1,000 married persons with spouse present also increased from 60 in 1970 to 179 in 1992 (Saluter, 1992: Tables B and D). Between 1962 and 1992, the proportion of women over age 18 who were unmarried increased from 29 percent to 41 percent (Saluter, 1992 and earlier reports). Single parent families are now 27 percent of all families with children over 18, up from 12 percent in 1970. (U.S. Bureau of the Census, 1992; DaVanzo and Rahman, 1993).

The proportion of adults obtaining insurance through employment has been falling throughout the 1980s, as employment has grown in the types of jobs that are less likely to provide insurance and as coverage for dependents has declined as well (Smith, et al., 1992). Although men continue to have more direct coverage through their own employers than women do, men increasingly have access problems that resemble those of women.[2] We find that 14 million working-age men have no health insurance. A surprisingly high number of men rely on indirect coverage through their wives' employers because they lack insurance on their own jobs. Men, however, are much less likely than women to gain health insurance through a spouse because women are less likely to have employer-based coverage, especially insurance that covers other family members. Like women (though not in such large numbers), men are increasingly likely to become single parents for portions of their lives, yet single fathers are less likely than single mothers to have public insurance, because they are less likely to be poor.

Given the changes underway in family structure and employment, both women and men are increasingly likely to lack secure access to insurance. Examining women's lack of direct access to health insurance through employment can lead to the design of reforms to the health care system that would benefit both women and men. Since women's places in the labor market are generally more marginal than men's, any employment-based system that meets women's needs will also ensure access for men.

Differential access that is not related to rational, or socially acceptable, criteria is of concern. For example, in an employment-based system, it is not surprising that a non-worker rarely has access to direct employer paid coverage. But, if young women, women workers, workers of color, lower-paid workers, workers who work fewer hours, and workers in particular size firms, all have less access

Even when women work in the same types of jobs as men, they still are less likely to be covered directly by employers.

Although men continue to have more direct coverage through their own employers than women do, men increasingly have access problems that resemble those of women.

[2] The proportion of men with direct access to employer-based insurance has fallen 5 percentage points between 1988 and 1992, while women's direct access has not increased. Not surprisingly, as men's direct access has fallen, so has women's indirect access (from 29 percent to 26 percent, or 3 percentage points). As a result of declines in direct and indirect employer-based coverage, overall, there has been an increase, for both men and women, in the proportions who have no health insurance of any kind (See U.S. Bureau of the Census, 1991a, Table 43; U.S. Bureau of the Census, 1993a, Table 24).

Because the failure of many employers to provide insurance affects women disproportionately, women have a greater stake in the outcome of the current debate over employer responsibility.

to insurance, the system as a whole may be viewed as disproportionately affecting certain groups unfairly. In addition, the results of differential access to insurance also raise concerns about unfavorable outcomes for society. Is it acceptable that women are the least likely to have health insurance during their child bearing years?

Despite almost complete reliance on employer-provided coverage, the United States is alone among industrial countries in allowing employers absolute latitude as to whether, how, and to whom to provide health insurance coverage (Field and Shapiro, 1993:31). The failure of many employers to provide insurance affects women disproportionately. Women have a greater stake in the outcome of the current debate over employer responsibility, since they currently have less access to direct employer-provider coverage.

For all of these reasons, we believe it is especially important to examine women's access to direct employer-provided coverage and to understand the difficulties women face in obtaining insurance through their own employment.

STUDY DESIGN

To improve our understanding of both the existing barriers women face in accessing health insurance and the resulting lessons for health care reform, this IWPR study first explores current sources of health insurance coverage for all adults. It looks at how these sources vary by factors related to the life cycle, social and economic status, and employment characteristics, and contrasts the experiences of women to those of men whenever salient. This study then asks how well the nearly 80 million working-age women are served by the current system of employer-provided insurance and whether reforms to this system can enable them to obtain the coverage they need. Finally, the study explores how workers, firms, and industries would be affected if more firms of different sizes were required to provide insurance coverage through a workplace guarantee. We did not attempt to estimate possible job losses or gains due to guaranteed coverage. There are great difficulties in estimating these effects, and estimates ranging from large job losses to small net gains have appeared recently (Krueger, 1993; O'Neill and O'Neill, 1993; Rasell, Baker, and Tang, n.d.).

The study undertakes two major tasks: 1) to explore women's access to health insurance and the factors that affect their access; and 2) to estimate the numbers of workers who would gain access to direct employer-based insurance if a Clinton-style workplace guarantee were enacted.[3]

[3] We should note that the data used in our analysis, drawn from the Current Population Survey (see Appendix), provide information on the source from which an individual actually obtains her or his insurance coverage; they do not provide information on the sources available to the individual. A person may have access to insurance through her or his employer, but choose another source (or choose to remain uninsured) due to the cost or inadequacy of the employer's plan (or because the worker values other things more than health insurance). For example, our data show that 69 percent of women in retail trade do not obtain insurance through their own employers. This does not mean that the retail trade firms that employ these women do not offer insurance to their employees. More insurance coverage may be offered by employers than is chosen by workers. If an individual refuses coverage offered by her or his firm, there are two probable explanations: either the coverage is expensive to the individual or it is inferior to a plan offered elsewhere. Firms that provide substandard or more expensive insurance are, in a sense, discouraging their employees from choosing such coverage, thereby passing on their responsibility to other employers or to the public. The data used in our analysis indicate the industries and types of firms that are more likely to offer coverage that is up to market standards and therefore chosen by their employees. Those firms whose plans are not currently chosen would experience increased costs under a plan that requires contributions from all employers since they do not now pay for coverage that is not chosen (under the Clinton plan, for example, they would have to pay 80 percent of the cost of the insurance excluding subsidies). Since our study estimates how many workers would gain access to direct employer-based health insurance (and sheds light on cost shifting among firms), the measure we use here, insurance chosen rather than insurance offered, is the appropriate one.

Three types of issues affect women's access to health insurance: women's different situations across the life cycle; differences based on social and economic status; and differences based on the extent and characteristics of their employment.

We use data drawn from the January and March supplements to the 1991 Current Population Survey (CPS) for this analysis. From these data we are able to gather information on individual characteristics such as gender, age, marital status, presence of children by family type, race and ethnicity, education, family income, work experience and employment characteristics, as well as source of health care coverage in 1990. We are also able to gather information on the individual's spouse, if married, and the spouse's employment and health insurance status.

The first task of our study is to explore which adults and adult workers have or fail to have health insurance coverage. This analysis of life cycle factors, social and economic factors, and employment characteristics includes all persons aged 21 to 64 with the exception of the analysis of age and family type, which considers younger adults as well — all persons aged 18 to 64. The analysis of employment characteristics is based on individuals with at least one week of employment in 1990. As part of this task, we develop statistical estimation models (using logistic regression analyses) that allow us to examine the independent impact of each characteristic on the likelihood that a woman has a certain type of health insurance coverage, when other factors are held constant. The results of this analysis are only briefly reported here (for more detail on these results, see the full technical report).

The second study task involves estimating the number of workers who would gain access to direct employer based insurance with the implementation of a Clinton-style workplace guarantee. This analysis is limited to workers aged 18 to 64 who reported that they usually had 10 hours of employment per week (10 hours of employment is proposed as the threshold that triggers the guarantee in President Clinton's plan). The analysis also provides estimates of the current sources of insurance (or lack of insurance) for those who would newly gain direct employer-based insurance. It explores the effect of the guarantee by industry, firm size, and earnings level, and estimates changes in the coverage of workers if the guarantee proposed in the President's plan were made less universal. It concludes with an assessment of how well this employer-based reform can meet women's need for greater and more secure access to health insurance. For more detail on the study's data and methods, see the Appendix in this report and the full technical report of our study (forthcoming from IWPR).

GENDER DIFFERENCES IN SOURCES OF INSURANCE COVERAGE

Overall, women are more likely than men to have insurance coverage. Our findings show that in 1990, 15 percent of women between the ages of 18 and 64, or 12 million women, are uninsured compared to 19 percent, or 14 million men (see Figure 1).[4] Women are less likely to have insurance through their own employers (direct employer-based insurance) than are men. While 55 percent of men aged 18-64 are insured through their own employers, only 37 percent of women in this age group have direct coverage. In contrast to men, women are more likely to receive insurance through other sources. For example, 28 percent of women aged 18-64 receive insurance indirectly through an employer other than their own (generally their spouses'), while only 10 percent of men are covered indirectly.[5] Women are also more likely to have a publicly funded source of insurance: 11 percent of women ages 18 to 64 are covered through the public sector while only seven percent of men are publicly insured. Women's higher rate of Medicaid coverage (eight percent for women versus three percent for men) accounts for the difference (not shown).[6]

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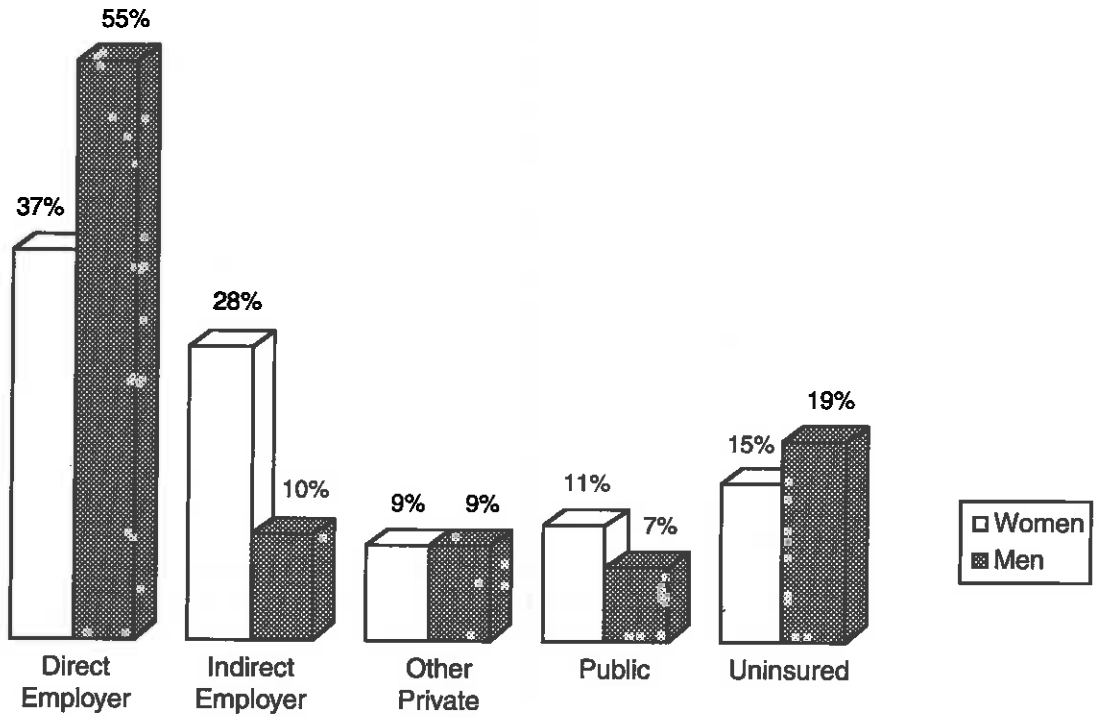
[4] A study of uninsured Americans using the 1987 National Medical Expenditure Survey had the same findings (US Department of Health and Human Services, 1989:6).

[5] Increasingly co-habitating individuals who are not married can be covered though their partners' employers. In our sample, however, less than one percent of respondents reported that an individual other than their spouse or child was insured under their plan. Therefore, throughout the report, we refer to adults receiving indirect employer-based insurance as being covered through their spouses' plans. While this is almost uniformly true for our sample, we realize that individuals in unmarried heterosexual and homosexual couples also may receive indirect insurance coverage and that this also has implications for health care reform.

[6] Parents eligible to receive Aid to Families with Dependent Children (AFDC), most of whom are single mothers, are automatically eligible to receive Medicaid. Other poor families with children (who are also disproportionately headed by single mothers) are increasingly eligible. Access to poor adults without children is more restricted.

Figure 1. Sources of Health Insurance of Persons Ages 18-64, by Gender, 1990

- **Women have less access to health insurance from their own employers (direct-employer based) than do men.**
- **Considering all sources, men are slightly less likely to have health insurance than are women.**



Source: IWPR analysis of data from the March 1991 Current Population Survey.

These findings are organized according to three problem areas that women face in obtaining access to health insurance: (1) women's differential situations across the life cycle (including factors such as age, marital status, and husband's employment status); (2) differences in access based on social and economic status (including race, ethnicity, education, and family income); and (3) differences in access based on the extent and type of women's employment (including work attachment and job and employer characteristics).

We find that there is considerable variation in the sources of coverage among women. The data presented below show how different subgroups of women receive their health care coverage and indicate who is falling through the cracks in the current system. The situation of women is compared with that of men whenever pertinent. Tables 1 through 3 present the data illustrating how women's and men's access to health insurance varies.

Women's Access Across the Life Cycle

Figure 2 illustrates the proportions of women who lack health insurance in relation to several factors reflecting changes over the life cycle.

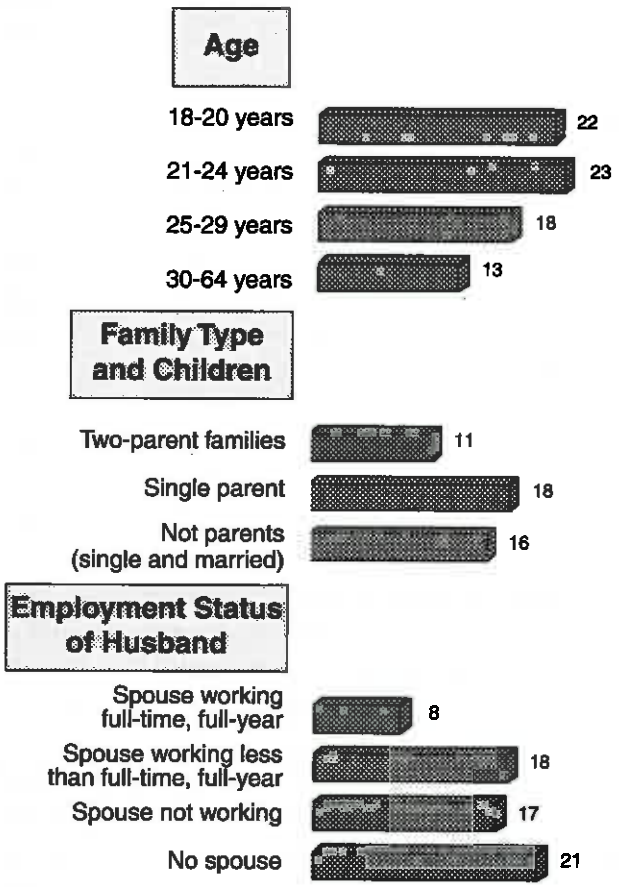
Age: *Women are least likely to have health insurance during their prime childbearing years.*

Young adults, 18-20, obtain most of their health insurance indirectly through their parents and lose this coverage as they leave home and school (see Figure 3). Women in their twenties are especially unlikely to have access to indirect insurance through parents or a spouse's job. Young adults under age 25, whether male or female, often do not have strong job attachment and so are less likely to have employer-provided insurance. They experience more frequent job changes as well as more unemployment. Both women and men are more likely to be insured as they grow older.

Women under the age of 30 are the most likely to be uninsured (see Figure 2). Five million young adult women have no insurance. Lack of coverage for women in this age range is especially troublesome because these are

Figure 2. Why Do Women Lack Insurance? Life-Cycle Factors

Percent of Women in Each Category Who Are Uninsured



- Women under 30 are the least likely to have health insurance.
- Women who are single mothers are especially unlikely to have health insurance.
- Married women whose spouses work less than full-time, full-year, are just as likely to lack health insurance as women whose husbands do not work at all and women who are not married.

Source: IWPR analysis of data from the March 1991 Current Population Survey.

the years when many women begin childbearing; 70 percent of all births in 1990 were to women under age 30 (U.S. Bureau of the Census, 1993b: Table 93).

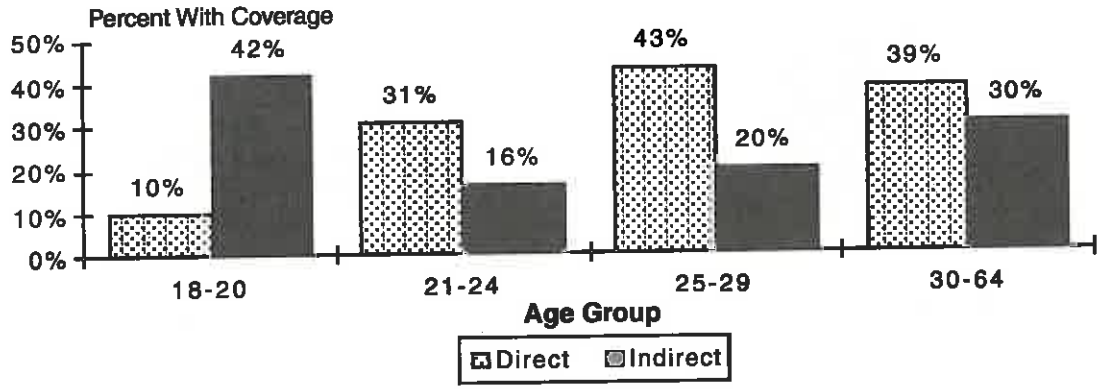
Both the women themselves and their children are likely to suffer if health care is difficult to obtain. Later first marriages and high rates of divorce and remarriage mean that many women experience life-cycle transitions during these years, and increasing rates of birth outside marriage mean that women need direct access to insurance.

Marital Status: *Women who are not married or whose spouses are absent are especially likely to lack health insurance.*

Only 10 percent of married women with spouses present lack insurance, as compared with 21 percent of all other women (see Figure 4). Married women with spouses present are the most likely to have health care insurance because they have very high rates of indirect employer-based coverage (see Table 1a). Married women with absent spouses and separated women are the least likely to have

Five million young adult women have no health insurance.

Figure 3. Direct and Indirect Employment-Based Coverage for Women Ages 18-64 by Age Group, 1990



Source: IWPR analysis of data from the March 1991 Current Population Survey.

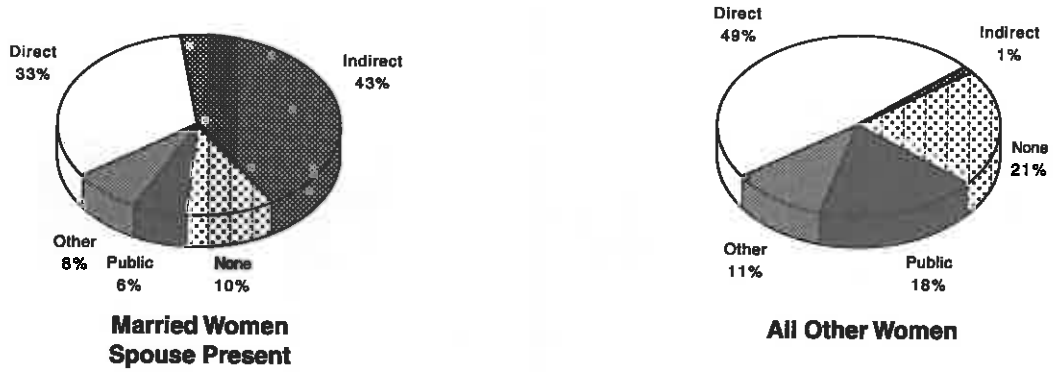
Women's dependence on indirect coverage through their husbands' jobs places them at increased risk of being uninsured over significant and growing portions of their lives.

insurance: 24 percent of such women are uninsured. Married women with absent spouses and separated women have much lower rates of direct insurance coverage than their divorced or never-married counterparts, perhaps because the former groups were recently covered indirectly through their spouses and have not made the transition to employment-provided insurance or to a public insurance program. Interestingly, men with these nonmarried statuses are more likely to be uninsured than are women, even though they have more direct employer coverage, largely because their access to public insurance is limited and because they purchase less other private insurance (see Table 1b).

Presence of Children: *Many single parents are uninsured even though Medicaid targets poor single parents.*

Among women with children, 18 percent of single mothers lack insurance compared with 11 percent of mothers in two-parent families (see Figure 2). The highest rate of direct-employer coverage is found among women

Figure 4. Women Ages 21-64 with Sources of Health Insurance, by Marital Status, 1990



Source: IWPR calculations based on the March 1991 Current Population Survey.

Table 1a: Factors Affecting Women's Access to Health Insurance (Women Ages 21-64)[a]

Factors	Total		Percent Distribution				
	Number (In thousands)	Percent [b]	Direct %	Indirect %	Private %	Public %	Uninsured %
Life-Cycle Factors							
BY AGE							
18-20 years	5,303	100	10	42	12	14	22
21-24 years	7,324	100	31	16	15	15	23
25-29 years	10,436	101	43	20	7	13	18
30-64 years	55,225	100	39	30	9	9	13
BY MARITAL STATUS							
Married, Spouse Present	45,622	100	33	43	8	6	10
All Other	27,363	100	49	1	11	18	21
Married, Spouse Absent	690	100	23	0	26	27	24
Separated	2,623	100	35	0	9	32	24
Divorced	8,213	100	58	0	7	16	19
Widowed	2,824	99	41	0	18	20	20
Never Married	13,013	100	47	3	12	16	22
BY EMPLOYMENT STATUS OF SPOUSE, IF PRESENT							
Works Full-Time, Full-Year	32,920	100	34	48	7	3	8
Works Less Than Full-Time, Full-Year	8,029	99	34	29	9	9	18
Does Not Work	4,673	100	27	25	12	19	17
BY PRESENCE OF CHILDREN & FAMILY TYPE [c]							
Single Parents	8,622	100	36	1	7	38	18
In Two Parent Families	24,608	101	30	47	6	7	11
Not Parents (Single and Married)	45,058	99	41	23	11	8	16
Social and Economic Factors							
BY RACE							
White, Non-Hispanic	54,754	100	40	31	10	7	12
Afro-American, Non-Hispanic	8,799	99	39	10	5	25	20
Hispanic	5,859	100	28	19	5	17	32
Other Races, Non-Hispanic	2,624	100	33	22	12	15	18
BY EDUCATION							
Less than High School	11,796	101	19	20	7	27	28
High School	30,414	99	37	30	8	10	14
Some College	15,799	99	42	28	11	7	11
College or More	14,975	100	54	26	10	3	7
BY FAMILY INCOME [d]							
Less than $15,000	14,900	100	18	4	11	35	32
Between $15,000-$24,999	11,593	101	41	19	10	10	20
At least $25,000	46,492	100	45	37	8	3	7
All Adult Women (21-64)	72,985	101	39	27	9	11	15

Notes: a Except as otherwise noted.
b Percents may not add to 100 due to rounding.
c Ages 18-64
d Family income pertains to the 1990 calendar year.

Source: IWPR analysis of data from the 1991 March Current Population Survey.

ok to skip Table 1a+b

Table 1b: Factors Affecting Men's Access to Health Insurance (Men Ages 21-64)[a]

Factors	Total		Percent Distribution				
	Number (In thousands)	Percent [b]	Direct %	Indirect %	Private %	Public %	Uninsured %
Life-Cycle Factors							
BY AGE							
18-20 years	5,164	100	11	43	14	8	24
21-24 years	7,111	101	35	8	17	7	34
25-29 years	10,331	101	56	6	7	6	26
30-64 years	52,609	99	62	8	7	7	15
BY MARITAL STATUS							
Married, Spouse Present	43,648	101	65	12	7	6	11
All Other	26,403	99	47	2	11	8	31
Married, Spouse Absent	637	101	42	0	10	7	42
Separated	1,701	100	51	0	8	9	32
Divorced	6,021	101	57	0	7	9	28
Widowed	544	101	52	0	7	20	22
Never Married	17,500	100	44	3	13	8	32
BY EMPLOYMENT STATUS OF SPOUSE, IF PRESENT							
Works Full-Time, Full Year	17,019	100	63	22	5	3	7
Works Less Than Full-Time, Full-Year	14,808	100	67	8	7	6	12
Does Not Work	11,821	100	65	2	7	11	15
BY PRESENCE OF CHILDREN & FAMILY TYPE[c]							
Single Parents	1,351	100	56	0	6	11	27
In Two Parent Families	24,546	100	65	11	6	6	12
Not Parents (Single and Married)	49,318	99	50	10	10	7	22
Social and Economic Factors							
BY RACE							
White, Non-Hispanic	53,535	100	62	9	9	6	14
Afro-American, Non-Hispanic	7,371	100	46	6	5	13	30
Hispanic	5,920	100	42	5	4	8	41
Other Races, Non-Hispanic	2,335	101	53	7	11	9	21
BY EDUCATION							
Less than High School	11,966	100	38	7	6	14	35
High School	26,320	101	59	8	7	7	20
Some College	14,544	101	59	10	11	6	15
College or More	17,221	101	72	8	10	3	8
BY FAMILY INCOME[d]							
Less than $15,000	10,620	101	20	1	11	21	48
Between $15,000-$24,999	10,932	99	49	5	8	9	28
At least $25,000	48,498	100	69	10	8	3	10
All Adult Men (21-64)	70,051	101	59	8	8	7	19

Notes: a Except as otherwise noted.
b Percents may not add to 100 due to rounding.
c Ages 18-64
d Family income pertains to the 1990 calendar year.

Source: IWPR analysis of data from the 1991 March Current Population Survey.

who have no children, while the highest rate of indirect coverage is found among women in two parent families (see Figure 5). Although few fathers are single parents, an even higher percentage of single fathers (27 percent) than single mothers lack health insurance (Table 1b). This is probably because single fathers are more likely than their female counterparts to be working at jobs that make them ineligible for public health care coverage.

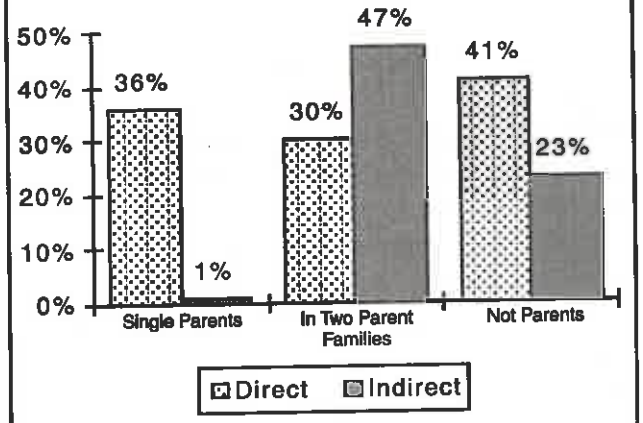
Spouse's Employment Status: *Women whose husbands work less than full-year full-time are just as likely to be uninsured as women whose husbands do not work at all.*

Women whose spouses work full-time, year round are the only group more likely to depend on indirect employer-based insurance (48 percent) than on insurance through their own employer (34 percent; see Table 1a). These women are nearly twice as likely to obtain their insurance indirectly through their spouses' employer as are wives of part-time or part-year workers.

Despite their lack of indirect coverage, women whose husbands work less than full-time, full-year are no more likely than other women to receive insurance through their own employers and only slightly more likely to receive insurance from a public source. The result is that women whose husbands do not work full-time full-year are more likely to be uninsured: 18 percent of these women are uninsured, compared with 8 percent of women whose husbands work full-year full-time and 17 percent of those women whose husbands do not work (see Figure 2).

The great disparities in insurance rates between married women whose husbands

Figure 5. Direct and Indirect Employment-Based Coverage for Women Ages 18-64 by Presence of Children & Family Type, 1990



Source: IWPR analysis of data from the March 1991 Current Population Survey.

Single mothers are especially more likely to be uninsured, despite the existence of the Medicaid program which targets low-income single mothers and children.

Women of color are disproportionately uninsured: African American women lack indirect employer-based coverage (insurance through husbands), while Hispanic women are the least likely to receive health insurance through their own employers.

work full-time year-round, other married women, and unmarried women indicate that our system does not work for all women.

Access Based on Social and Economic Factors

Race and Ethnicity[7]: *Hispanic women are most likely to be uninsured; white women are least likely.*

Thirty-two percent of Hispanic women have no insurance compared with 20 percent of African American women, 12 percent of white women, and 18 percent of women of other races (Asian and Pacific Islander, American Indian, and Aleut; see Figure 6). Four million women of color lack health insurance.

About 39 percent of African-American and 40 percent of white women receive insurance directly through their own employers (see Figure 7). Thirty-one percent of white women depend on indirect employer based coverage. Few African American women have indirect-employer based insurance (10 percent), likely because marriage rates for African American women are lower (Saluter, 1992) or because their spouses are less likely to be employed overall or specifically in jobs that provide health insurance (U.S. Bureau of the Census, 1993a). Instead, African American women rely more heavily on public insurance programs (25 percent; see Table 1a). Hispanic women are the least likely to receive health insurance through their employers (28 percent). Although Hispanic women have significantly higher rates of indirect coverage than African American women, their lower rates of receipt of public and other private insurance reduce their overall rate of coverage.

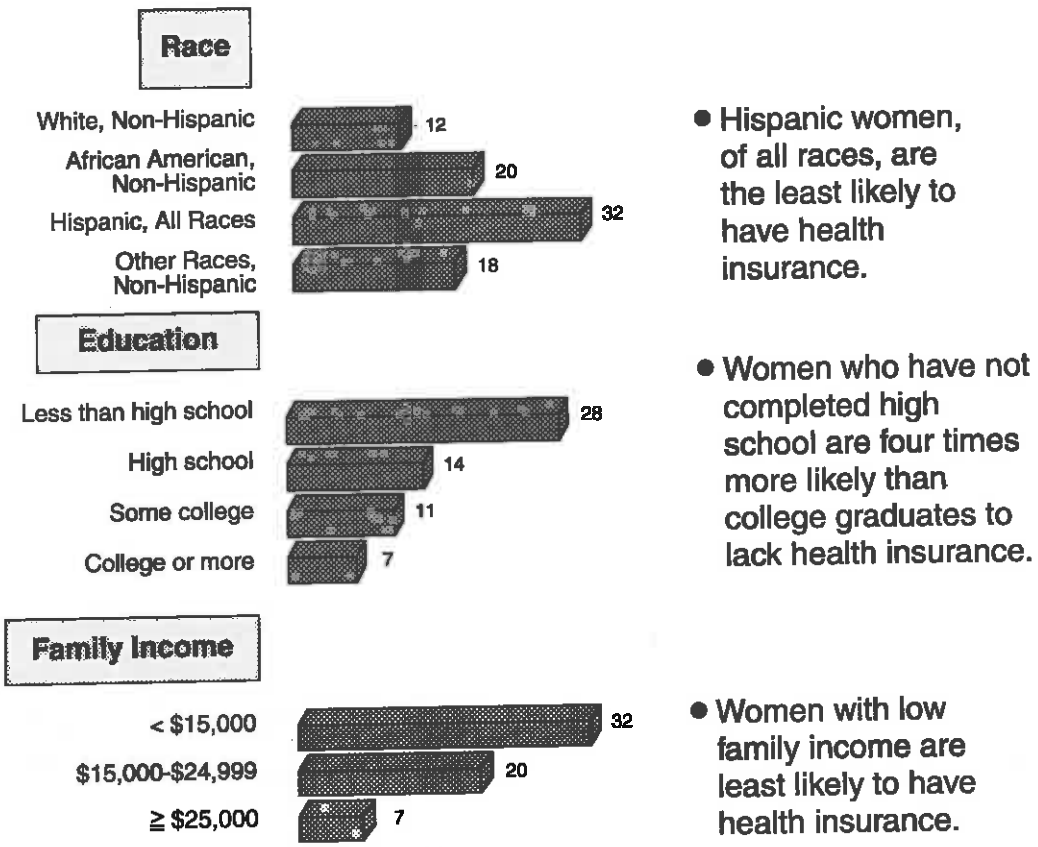
Education: *Women without a high school diploma are least likely to have insurance; public insurance does not make up the gap in the lack of direct and indirect employer-based coverage.*

The proportion of women who have health insurance through their own employers increases from 19 percent for those who have not completed high school to 54 percent for those who have at least a college degree (see Figure 8). Women with more education are also more likely to have indirect employer-based coverage; because women with higher education are likely to marry men with higher

[7] In our report, the term African American refers to non-Hispanic African Americans, and white refers to non-Hispanic whites. Hispanics are of all races.

Figure 6. Why Do Women Lack Insurance? Social and Economic Factors

Percent of Women in Each Category Who Are Uninsured



- Hispanic women, of all races, are the least likely to have health insurance.
- Women who have not completed high school are four times more likely than college graduates to lack health insurance.
- Women with low family income are least likely to have health insurance.

Source: IWPR analysis of data from the March 1991 Current Population Survey.

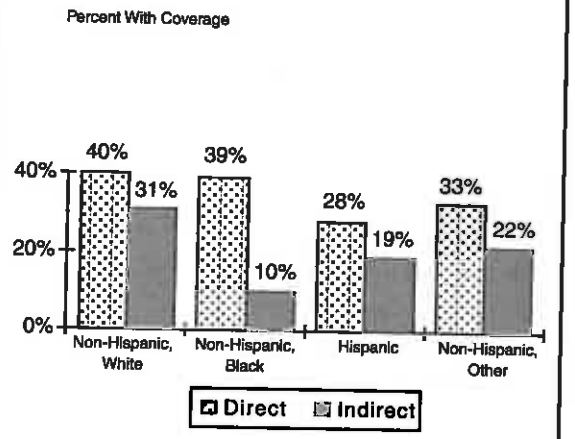
educational attainment who also have higher incomes (see Kalmijn, 1991) and more insurance, these women have more opportunities to receive indirect coverage or to purchase independent private coverage.

Twenty-eight percent of women who have not completed high school have no health insurance coverage, twice the proportion of high school graduates and four times the proportion of college graduates (see Figure 6). Women without high school diplomas rely on public insurance programs more than women with higher educational attainment, but not in great enough proportions to close the gap in insurance coverage (Table 1a).

Family Income: *As family income increases, women are more likely to have both direct and indirect employer-based insurance; public insurance does not make up the gap in insurance coverage for low-income women.*

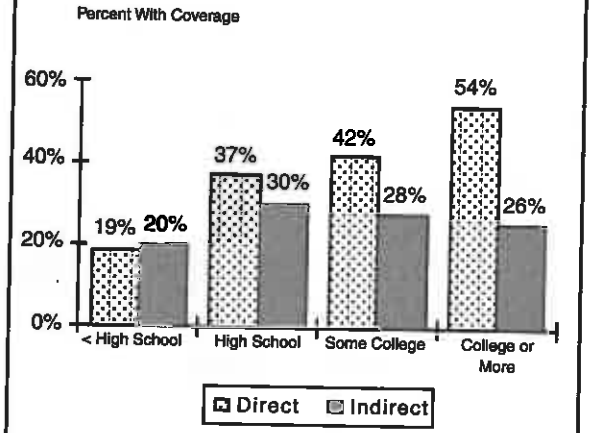
At low family income levels, few women have direct or indirect employer-based health insurance. Only 18 percent of women with

Figure 7. Direct and Indirect Employment-Based Coverage for Women Ages 21-64 by Race & Ethnicity, 1990



Source: IWPR analysis of data from the March 1991 Current Population Survey.

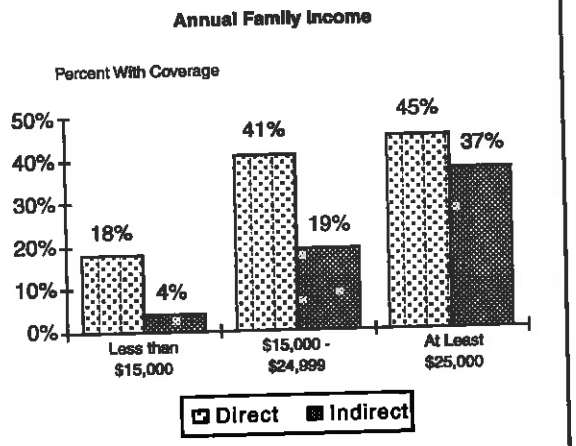
Figure 8. Direct and Indirect Employment-Based Coverage for Women Ages 21-64 by Education, 1990



Source: IWPR analysis of data from the March 1991 Current Population Survey.

family incomes under $15,000 have health benefits through their own employers, as compared with 41 percent of women with family incomes between $15,000 and $24,999, and 45 percent of women with family incomes of at least $25,000 (see Figure 9). A similar pattern exists with indirect employer-based insurance coverage. While only 4 percent of women with family incomes under $15,000 have indirect coverage, 19 percent of women in the $15,000-$24,999 income range, and over 37 percent of women with family incomes of $25,000 or more have this benefit.

Figure 9. Direct and Indirect Employment-Based Coverage for Women Ages 21-64 by Annual Family Income, 1990



Source: IWPR analysis of data from the March 1991 Current Population Survey.

Low-income women have a relatively high probability of being completely uninsured even though they are more likely than higher-income women to receive public insurance. About one in three women with a family income under $15,000 is uninsured, compared to one in fourteen women with family incomes greater than $25,000 (see Figure 6).

Significantly, women with family incomes between $15,000 and $25,000, the range in which the median single mother family falls,[8] also have fairly low insurance rates. On average, about one out of five of these women are uninsured, showing the relative failure of the current system to serve low-income workers and their dependents in general and the particular problem faced by single mother families.

Access Based on the Extent and Characteristics of Employment[9]

Women's access to insurance through their own employment is greatly affected by the

The U.S. is alone among industrial nations in allowing employers absolute latitude as to whether, how, and to whom to provide health insurance coverage.

[8] In 1990 the median income for a single mother family household was $18,069. For all households the median income was $29,943 (U.S. Bureau of the Census, 1991b: Table 1).

[9] The employment-related data on insurance coverage refer to workers aged 21 to 64 who worked at least one week in 1990, unless otherwise noted.

Women who work part-time are more likely to be uninsured than women who work full-time.

nature of the jobs they hold — their hours of work, occupation, earnings, and the industry and firm size of their employers, among other factors. The impact of some of these factors is shown in Figure 10 in which women's rates of direct employer-based coverage are compared with those of men. Men have higher rates of coverage from their own employers than do women, in nearly all circumstances.[10]

About half of all working women do not have health insurance through their own employers. Among women aged 21-64, 49 percent do not have direct employer-based coverage; among women aged 18-64, 52 percent lack such coverage. For men, the proportion without direct coverage is about two-fifths.

These differences point to work-related dimensions that need to be targeted in health care reform, particularly by reformers wanting to approach universal access through an employment-based system.

Work Attachment

Hours of Work Per Week: *Direct insurance coverage from employers is much lower for part-time than full-time workers. Men with low weekly work hours are more likely to have direct employer coverage than their female counterparts.*

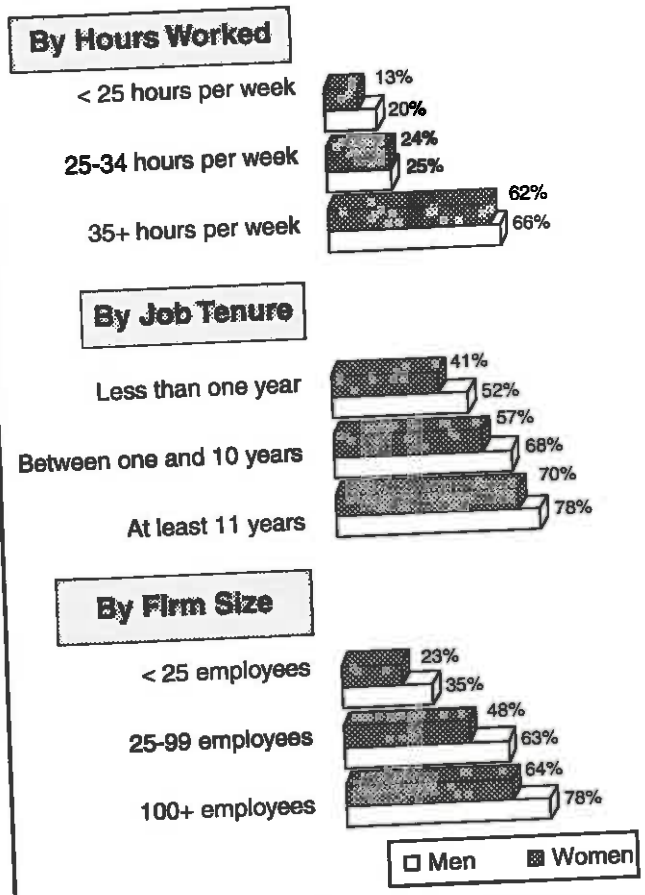
The amount of direct employer-based coverage decreases precipitously with a decline in the number of hours worked (see Figure 10). Sixty-two percent of women working 35 hours or more per week have direct employer-based health insurance. In contrast, only 24 percent of women working between 25 and 34 hours per week and 13 percent of those working fewer than 25 hours have direct employer-based health coverage. Other kinds of insurance do not compensate for these differences. As a result, women who work part-time are also more likely to be uninsured than women who work full-time (see Table 2a).

Compared with women, men who work fewer than 25 hours per week are more likely to have direct employer-based insurance: about 20 percent compared with only 13 percent of women have this benefit (see Figure

[10] We reiterate here that the CPS data does not tell us which employers offer insurance, but rather whether workers use insurance offered by their employers. For instance, a married woman may be eligible to receive insurance through her employer, but because of cost or the level of insurance benefits, she may choose to be covered by her husband's employer instead.

Figure 10. Direct Employer-Based Coverage for Employees Ages 21-64 by Gender, Hours Worked Per Week, Firm Size, and Job Tenure

Percent with Health Insurance from Own Employer



In nearly all circumstances, men have more access to health insurance through their own employers than do women.

- The more hours worked per week, the more likely workers are to have health insurance from their own employers.
- The more years on the job, the more likely workers are to have health insurance from their own employers.
- The larger the firm, the more likely workers are to have health insurance from their own employers.

Source: IWPR analysis of data from the March 1991 Current Population Survey.

Table 2a: Work-Related Factors Affecting Women's Access to Health Insurance (Employed Women Ages 21-64)

Factors	Total		Percent Distribution				
	Number (in thousands)	Percent [a]	Direct %	Indirect %	Private %	Public %	Uninsured %
Work Attachment Factors							
BY HOURS PER WEEK[b]							
Fewer Than 24	7,754	100	13	47	15	9	16
Between 25-34	5,734	99	24	35	13	9	18
At least 35	40,491	101	62	16	7	4	12
BY JOB TENURE[c]							
Less than 1 year	3,234	101	41	24	10	7	19
Between 1 and 10 years	10,604	100	57	23	7	3	10
At least 11 years	3,879	101	70	17	7	1	6
BY UNEMPLOYMENT[b]							
Those who reported unemployment	7,776	100	35	22	9	11	23
Those who did not report unemployment	46,202	100	53	23	8	4	12
Job Characteristics							
BY OCCUPATION[d,e]							
Executive, Professional, & Technical	16,698	100	63	21	8	2	6
Sales	6,321	101	36	29	13	7	16
Administrative Support (incl. Clerical)	15,061	100	58	23	7	3	9
Service Occupations	9,184	101	27	25	11	11	27
Farming, Forestry, & Fishing	554	100	16	18	28	11	27
Blue Collar Occupations	6,084	100	54	17	5	7	17
BY ANNUAL EARNINGS[b,f]							
Low Wage Workers (<$15,000)	27,584	99	29	30	11	9	20
Moderate Wage Workers ($15,000-$24,999)	14,109	100	71	16	5	1	7
High Wage Workers (≥$25,000)	11,798	100	78	12	5	1	4
All Women Workers (21-64)	53,978	100	51	23	8	5	13

Notes: a Percents may not add to 100 due to rounding.
b Refers to 1990 calendar year.
c Refers to job held in January 1991. A smaller data sample consisting of matched data from the January and March 1991 Current Population Surveys was used for this analysis.
d Refers to longest job held in 1990.
e Excludes civilian workers formerly in the armed forces.
f Excludes those who worked without pay.

Source: IWPR analysis of data from the 1991 March Current Population Survey.

Table 2b: Work-Related Factors Affecting Men's Access to Health Insurance (Employed Men Ages 21-64)

Factors	Total		Percent Distribution				
	Number (In thousands)	Percent [a]	Direct %	Indirect %	Private %	Public %	Uninsured %
Work Attachment Factors							
BY HOURS PER WEEK[b]							
Fewer Than 24	2,389	100	20	14	23	12	31
Between 25-34	2,504	102	25	11	19	8	39
At least 35	58,452	101	66	8	7	3	16
BY JOB TENURE[c]							
Less than 1 year	3,019	101	52	11	9	5	24
Between 1 and 10 years	11,429	100	68	9	6	2	15
At least 11 years	6,461	100	78	6	9	1	6
BY UNEMPLOYMENT[b]							
Those who reported unemployment	10,600	100	41	9	8	6	36
Those who did not report unemployment	52,745	100	67	8	8	3	14
Job Characteristics							
BY OCCUPATION[d,e]							
Executive, Professional, & Technical	18,203	101	75	8	8	2	8
Sales	6,676	100	60	11	13	2	14
Administrative Support (incl. Clerical)	3,601	100	72	7	7	2	12
Service Occupations	5,619	100	53	7	8	5	27
Farming, Forestry, & Fishing	2,586	101	25	11	24	6	35
Blue Collar Occupations	25,823	100	61	7	6	3	23
BY ANNUAL EARNINGS[b,f]							
Low Wage Workers (<$15,000)	17,408	101	30	10	13	8	40
Moderate Wage Workers ($15,000-$24,999)	14,867	101	65	9	7	4	16
High Wage Workers (≥$25,000)	30,733	99	81	6	6	1	5
All Men Workers (21-64)	63,345	101	63	8	8	4	18

Notes:
a Percents may not add to 100 due to rounding.
b Refers to 1990 calendar year.
c Refers to job held in January 1991. A smaller data sample consisting of matched data from the January and March 1991 Current Population Surveys was used for this analysis.
d Refers to longest job held in 1990.
e Excludes civilian workers formerly in the armed forces.
f Excludes those who worked without pay.

Source: IWPR analysis of data from the 1991 March Current Population Survey.

ok to skip Tables 2a+b

Short job tenure also affects men's rates of direct employer-based coverage, but at all tenure levels men have more coverage than women.

10). Men and women working between 25 and 34 hours per week have about the same level of coverage, but 66 percent of men working 35 hours or more have direct coverage compared with 62 percent of women.

These data indicate that while part-time work does decrease the likelihood that a person has insurance through her or his own employer, other factors, including gender, access through a spouse, occupation, and industry, are also likely important. For example, women who work part-time are more likely than their male counterparts to access health insurance through their spouses (compare Tables 2a and 2b).

Job Tenure: *Women working on the job for less than one year are much less likely to have insurance through their employer than women who have been at their jobs for over 10 years; the impact of short job tenure is less dramatic for men.*

Only 41 percent of women (about two out of five) who have been at their job less than one year have direct employer-based insurance (see Figure 10). In contrast, 70 percent of women workers who have been with their employers for over 10 years are covered directly by their employers.

The low rate of coverage during the first year of employment may be due to employers' delaying health benefits until the end of a probationary period. In addition, a sizeable portion of people who have worked less than a year may be in jobs with high turnover that do not regularly provide insurance coverage.

Short job tenure also affects men's rates of direct employer-based coverage, but at all tenure levels men have more coverage than women. Slightly over one-half of men who have been on a job less than a year have employer-provided health insurance, compared with 78 percent of those who have worked for more than 10 years (see Figure 10).

Unemployment: *The likelihood that a woman has insurance through her employer drops significantly if she experiences a period of unemployment during the year.*

Only 35 percent of women workers who spent some time unemployed were insured through their employers, a much smaller pro-

portion than the 53 percent of continuously working women who received this benefit (Table 2a). Men who experienced unemployment fared only slightly better, with 41 percent having health insurance directly from their own employer (Table 2b). The fact that individuals who experience a period of unemployment have lower rates of insurance is significant in light of federal provisions (COBRA) that allow certain unemployed workers and their dependents to continue obtaining coverage through their former employer. These provisions, which require former workers to pay the full cost of any continued insurance, apparently do not meet the needs of the unemployed for access to health insurance.

Job Characteristics

Occupation: *Women in most occupations are less likely to have direct employer-provided insurance than are their male counterparts; the gender gap is greater in lower-status occupations.*

The higher the occupational status, the higher the percentage of employees covered directly by employers. Women in most occupations are less likely to have direct insurance than their male counter-parts, however. Three-fourths of men in executive, professional, and technical occupations receive insurance directly through their employers as compared with about 63 percent of women in these occupations (see Tables 2a and b). In many lower status occupations, the gender gap is even larger. While 60 percent of men in sales occupations receive insurance directly through their employers, only 36 percent of women have this benefit, 24 percentage points fewer. These disparities in coverage may be due to a number of the employment characteristics we discuss here, including variation in industry, hours worked, and job tenure. Some of these differences may also be due to gender bias in the workforce. Some may be due to women choosing insurance through their husbands' jobs.

Earnings: *The lower women's earnings, the less likely they are to obtain direct employer-provided benefits; the gap is not made up by indirect employer-provided insurance or by publicly provided insurance.*

The proportion of women insured through their own employers increases from 29 percent for women earning less than $15,000 per year to nearly 80 percent for women earning

The gender gap in health coverage is greater in lower-status occupations.

Women who are self-employed are more likely to be uninsured than women who are wage and salary earners.

$25,000 or more (see Table 2a).[11] Women with earnings less than $15,000 are more likely to depend on indirect employer-based coverage. Access to indirect coverage and other public or private insurance does not fill the gap. As a result, about 20 percent of women earning less than $15,000 are uninsured, compared with seven percent of women earning between $15,000 and $25,000 and four percent of those earning $25,000 or more.

Employer Characteristics

Class of Employer: *Women workers in the public sector are the most likely to have employer-provided coverage; women who are self-employed are the least likely.*

The type of employment a woman holds strongly influences whether she has direct employer-based insurance. Women employed in the public sector are the most likely to have direct employer-based insurance. Sixty-six percent of public sector employees have this benefit in contrast to 51 percent of female employees in the private sector (see Table 3a). Self-employed women are much less likely to have insurance than are wage and salary workers in the public or private sector: only 12 percent of self-employed women have direct employer-based coverage. Self-employed men are more likely to have direct coverage (31 percent; see Table 3b).

Firm Size: *Women who work in small firms are less likely to receive direct employer-provided health benefits than women and men in large firms or than their male counterparts in small firms.*

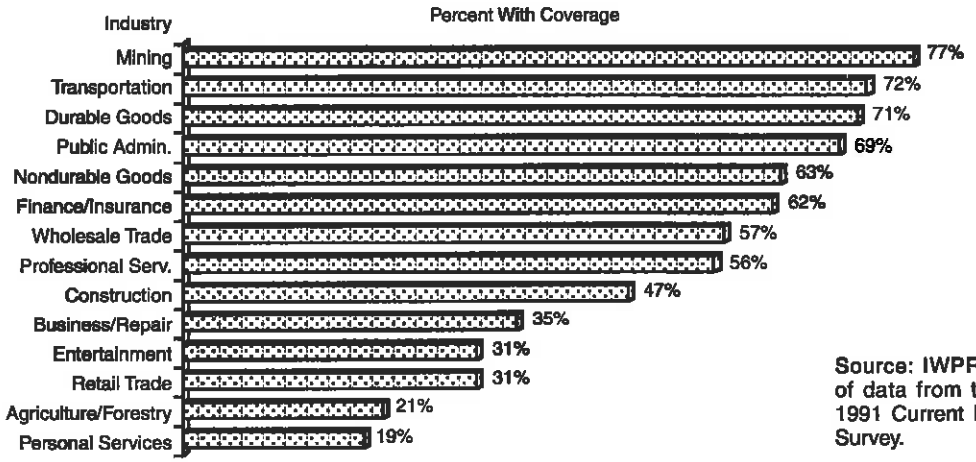
Women who work in large firms are the most likely women to obtain health benefits from their employers (see Figure 10).[12] About 65 percent of women who work in firms with 500 or more employees receive health insurance directly from their employers (Table 3a).

In medium-sized firms (25 to 99 employees), 48 percent are directly covered. In contrast, only 23 percent of women working in firms with fewer than 25 employees are insured through their own employers. Women in small firms are more likely to depend on

[11] Previous work by IWPR demonstrates that in all industries, low wage workers are less likely to have employer provided health benefits (Hartmann, 1991).

[12] In 1990, only 35 percent of firms with fewer than 25 employees offered health benefits to their employees, as compared to 89 percent of firms with more than 25 employees (Smith et al., 1992: 65).

Figure 11. Direct Employment-Based Coverage for Female Employees Ages 21-64 by Industry, 1990



Source: IWPR analysis of data from the March 1991 Current Population Survey.

indirect employer-based coverage, and they are more likely to be uninsured.

In contrast to the 23 percent of women in firms with fewer than 25 employees who receive direct employer-based coverage, 35 percent of men in these firms have this benefit (see Figure 10). Because men in small firms have higher rates of coverage than women, firm size by itself cannot explain the gender-based differences in rates of direct employer-based insurance.

Industry: *The likelihood that women obtain health insurance through their employers varies by industry, with workers in personal service industries the least likely to obtain this benefit; three out of 10 women in this industry have no insurance at all.*

Over two-thirds of female workers in public administration, mining, durable goods manufacturing, and transportation, communications, and public utilities receive direct employer-based health insurance (see Figure

In nearly all workplace settings, men have more access to insurance through their own employers than women do.

Table 3a: Employer-Related Factors Affecting Women's Access to Health Insurance (Employed Women Ages 21-64)

Factors	Total		Percent Distribution				
	Number (in thousands)	Percent [a]	Direct %	Indirect %	Private %	Public %	Uninsured %
BY CLASS OF EMPLOYER[b,c]							
Private Sector Wage and Salary	39,814	100	51	22	8	5	14
Public Sector Wage and Salary	9,976	99	66	18	5	4	6
Self-Employed	3,884	100	12	41	23	6	18
BY FIRM SIZE[b]							
Fewer than 25 Employees	14,732	99	23	33	16	6	21
Between 25 and 99 Employees	6,560	100	48	23	7	6	16
100 or More Employees	32,687	100	64	18	5	4	9
Between 100 and 499	8,169	99	60	19	5	5	10
Between 500-999	3,334	101	65	17	6	4	9
At least 1,000	21,184	99	65	17	5	4	8
BY INDUSTRY[b]							
Agriculture/Forestry	705	101	21	23	26	8	23
Mining	168	100	77	9	9	0	5
Construction	741	100	47	26	9	2	16
Durable Goods Manufacturing	3,573	99	71	13	3	3	9
Nondurable Goods Manufacturing	3,625	100	63	15	4	4	14
Transportation, Comm. and Public Utilities	2,413	99	72	13	4	3	7
Wholesale Trade	1,515	101	57	21	9	3	11
Retail Trade	9,427	100	31	27	12	8	22
Finance, Insurance and Real Estate	4,663	100	62	22	7	2	7
Business/Repair Services	3,035	100	35	29	10	8	18
Personal Services	3,206	100	19	27	14	11	29
Entertainment Services	545	101	31	30	18	6	16
Professional and Related Services	17,827	101	56	24	8	4	9
Public Administration	2,534	100	69	15	4	7	5
All Women Workers (21-64)	53,978	100	51	23	8	5	13

Notes: a Percents may not add to 100 due to rounding.
b Refers to longest job held in 1990.
c Excludes those who worked without pay.

Source: IWPR analysis of data from the 1991 March Current Population Survey.

Table 3b: Employer-Related Factors Affecting Men's Access to Health Insurance (Employed Men Ages 21-64)

Factors	Total		Percent Distribution				
	Number (In thousands)	Percent [a]	Direct %	Indirect %	Private %	Public %	Uninsured %
BY CLASS OF EMPLOYER[b, c]							
Private Sector Wage and Salary	45,593	102	67	7	6	3	19
Public Sector Wage and Salary	9,020	100	74	6	3	11	6
Self-Employed	8,711	100	31	16	27	3	23
BY FIRM SIZE[c]							
Fewer than 25 Employees	19,587	101	35	13	18	4	31
Between 25 and 99 Employees	8,456	100	63	8	5	3	21
100 or More Employees	35,301	100	78	5	4	4	9
Between 100 and 499	8,700	101	74	6	4	3	14
Between 500-999	3,130	100	79	6	5	1	9
At least 1,000	23,471	101	80	5	3	5	8
BY INDUSTRY[b]							
Agriculture/Forestry	2,413	100	23	11	25	5	36
Mining	673	101	81	4	4	1	11
Construction	7,284	101	43	12	11	3	32
Durable Goods Manufacturing	9,212	100	80	5	3	2	10
Nondurable Goods Manufacturing	5,122	101	80	5	3	2	11
Transportation, Comm. and Public Utilities	5,907	101	76	6	5	2	12
Wholesale Trade	3,194	100	71	9	5	2	13
Retail Trade	8,252	101	49	9	12	4	27
Finance, Insurance and Real Estate	3,049	99	70	9	8	2	10
Business/Repair Services	4,439	100	49	11	11	3	26
Personal Services	1,306	102	46	10	12	5	29
Entertainment Services	841	100	45	8	16	5	26
Professional and Related Services	7,673	100	69	8	10	3	10
Public Administration	3,982	101	68	6	2	20	5
All Men Workers (21-64)	63,345	101	63	8	8	4	18

Notes: a Percents may not add to 100 due to rounding.
b Refers to longest job held in 1990.
c Excludes those who worked without pay.

Source: IWPR analysis of data from the 1991 March Current Population Survey.

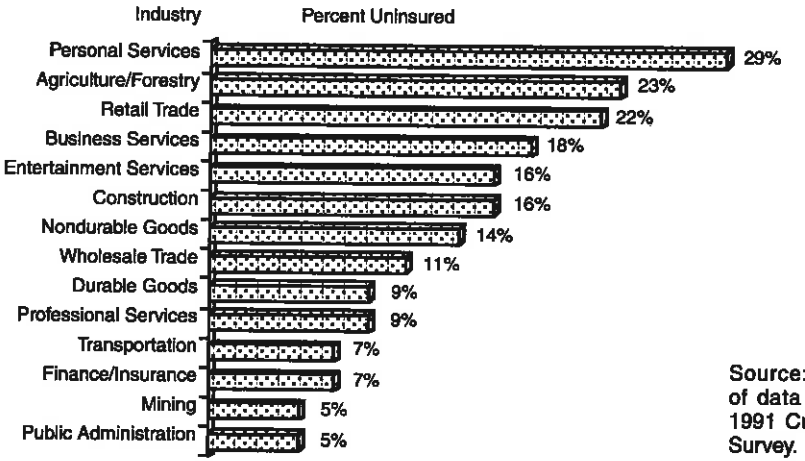
ok to skip 3a+3b

11). In contrast, only 35 percent of women employees in business and repair services, 31 percent of those in retail trade and in entertainment services, 21 percent of those in agriculture/forestry/fisheries, and 19 percent of those in personal services, have such coverage. More than one-quarter of women employees in these low coverage industries depend on indirect employer-based coverage (see Table 3a). Nonetheless, between 22 and 29 percent of women workers in retail trade, agricultural industries, and personal services have no insurance at all (see Figure 12).

In nearly every industry, women are less likely to have insurance through their own employers than their male counterparts (compare Tables 3a and 3b). It is possible that the mix of occupations (a preponderance of female-intensive occupations) and the smaller number of hours women work on average reduce the availability of coverage.

Women are also more likely to have a spouse with insurance and therefore are more likely to have the option to choose to be covered indirectly. But many women in low-wage

Figure 12. Percent Uninsured for Female Employees Ages 21-64 by Industry, 1990



Source: IWPR analysis of data from the March 1991 Current Population Survey.

industries such as personal services (which includes beauty shops and laundry, cleaning, and garment services) appear unable to rely on indirect coverage through a spouse and as a consequence have a higher likelihood of being uninsured.

Factors Related to Access Considered Simultaneously

We used logistic regression analysis, a type of multivariate analysis, to determine the relative importance of factors that explain why employed women fail to receive coverage directly from their employers, indirectly from other family members (mainly spouses), or not at all. Logistic regression controls simultaneously for the effects of many of the factors described above. This technique allows us to look for effects masked by other variables and to determine which factors remain important. Our logistic regression analysis (summarized in Appendix Table A 1) confirms the important influences already discussed, and further highlights some important racial and ethnic differences.

The regression analysis confirms that the employment-related factors that decrease the odds that an employed women is covered directly by her employer are the following: having less than a high school diploma; receiving low earnings; working part-time; working in a small firm; and working in agricultural or retail industries, or business, entertainment, and personal services.

The factors that decrease the odds that employed women are covered indirectly through a family member's employer reflect their relation to men. Our findings show that working women who are not married or women who are married to a spouse working part-time or in a small firm are less likely to have indirect, employer-based coverage, or any coverage. Of working women, they are the most likely to be uninsured.

The regression analysis also shows the interactive effects of race and gender. Previously, we saw that white women are most likely and Hispanic women least likely to have health insurance. Similar patterns hold for men. Nearly as high a proportion of African American women as white women has direct employer-based coverage. This seeming equality in direct employer-based coverage between white and African American women disappears when workers only are considered

and the kinds of jobs held and various personal characteristics of the workers are taken into account. With these factors statistically controlled, African American women as well as other women of color are significantly less likely than white women, with similar characteristics, to obtain direct employer-based coverage and are more likely to be uninsured. The same lack of employer-based coverage and higher likelihood of being uninsured are observed for minority men. These findings indicate that minorities tend to find jobs with fewer fringe benefits even after controlling for pay, hours, and industry of employment.

This gap in direct coverage is not made up by greater indirect coverage or public insurance. And even though men have more direct employer-based coverage than women of their own race/ethnicity group, racial and ethnic differences are greater among men than among women. African American and Hispanic men, especially, fall farther behind white men in obtaining health insurance from their employers than do African American and Hispanic women compared with white women.

Our regression analysis shows that race and ethnicity, gender, marital status, the characteristics of women's jobs, and the characteristics of their husbands' jobs all have independent effects on the likelihood of having employer-provided health insurance or on being uninsured.

IMPACT OF THE HEALTH SECURITY ACT

Our study points to many gaps in coverage in the current health care system. Therefore, we considered the impact of health care reform on coverage for both women and men, modelling the effect of the President's Health Security Act, specifically the proposed guarantee of workplace coverage. Guaranteed coverage for all employees through the workplace overcomes such barriers to health insurance access as low wages, short job tenure, low hours of work, and industries with traditionally low coverage rates.

Using data from the March 1991 Current Population Survey pertaining to 1990, we estimate how many employees, both male and female, not covered by their own employer would become directly insured under the workplace guarantee in the Clinton plan (which requires employers to provide coverage for all those working at least 10 hours per week). Next we examine the resulting changes in the source of insurance coverage for men and women affected by the Clinton plan, estimating the numbers of workers who would be newly eligible to receive direct coverage who currently have other coverage or are uninsured. We also explore how the new access to direct coverage varies by firm size, industry, and earnings levels. This analysis allows us to address how the responsibility of coverage would likely shift among employers and the impact that exempting small firms from the guarantee would have on the number of employees who would receive coverage through their own employers.

Impact on the Extent and Source of Insurance Coverage of Men and Women Workers

We estimate that 29 million women, or 50 percent of all working women ages 18 to 64, would be affected by the workplace guarantee and would gain access to direct coverage through their own employers (see Table 4a). Among newly eligible female workers, only 27 percent (8 million) would gain new coverage while 46 percent would switch from indirect coverage. The remainder would switch from other types of coverage, including public plans and other private insurance. Some 27 million men, or 40 percent of all working men, would be affected by the workplace guarantee and

Guaranteed coverage for all employees through the workplace would overcome current barriers to health insurance access such as low wages, short job tenure, low hours of work, and industries with traditionally low coverage rates.

would be newly eligible for direct employer-based health care coverage. Among newly eligible male workers, 44 percent (12 million) would gain new coverage because they are currently uninsured, while 25 percent would switch from indirect coverage through a spouse (or parent). This new direct access would reduce the risk of insurance loss from life cycle transitions in living arrangements that women (and men) currently experience. Nonworking adults married to those working for employers who are not currently providing insurance would also be newly covered indirectly through their spouses' employment (we were not able to estimate this number).

Some working women and men, approximately 1.2 million women and fewer than 400,000 men who work fewer than 10 hours per week, would still not have access to direct employment-based coverage when the 10 hour screen is applied (see Table 4b). In addition, many Americans, primarily those not working, will still need to obtain insurance through

Table 4a: Employed Workers Who Would Gain Access to Direct Employer Coverage Through the Clinton Plan (Ages 18-64)

Current Source of Insurance	Number of Affected Workers[a] (In thousands)		
	Women	Men	Total
All Sources	**28,805**	**26,852**	**55,657**
With Existing Coverage	**21,130**	**14,921**	**36,051**
Employer-Based Indirect Coverage	13,208	6,648	19,856
Other Private Plan	4,882	5,677	10,559
Public Plan	3,040	2,596	5,636
Without Coverage (Uninsured)	**7,675**	**11,931**	**19,606**

Note: [a] To be counted as newly gaining direct employer-based coverage (an affected worker) under the Clinton Plan in these estimates, a worker must work 10 hours per week and must not already have insurance through his or her own employer.

Source: Estimates based on IWPR analysis of data from the March 1991 Current Population Survey.

other payment means. Our data indicate that of the 26 million men and women currently without insurance, 20 million would gain new coverage through their own employers because of the workplace guarantee in the Clinton Administration's plan (see Figure 13), leaving 6 million people of working age (2 million men and 4 million women, ages 18-64) ineligible to receive direct employer-based coverage (see Table 4b). As noted above, some of these individuals may be eligible for indirect coverage as a currently uninsured spouse or parent gains access to direct coverage through their employers. And, under the Clinton plan, which guarantees universal access, others, such as the unemployed, would purchase insurance as individuals, receiving subsidies according to their family income level, or would participate in an expanded public program.

Because the President's plan requires nearly all firms (all those with fewer than 5000 employees, employing about 85 percent of all

Under the Clinton plan, three-quarters of currently uninsured working adults would gain health coverage.

Table 4b: Workers and Nonworkers Who Would Not Gain Direct Access Through the Workplace Guarantee in the Clinton Plan (Ages 18-64)

	Number of "Unaffected" Adults[a] (in thousands)		
	Women	Men	Total
Workers	**29,117**	**40,632**	**69,749**
Already Have Direct Employer-Based Coverage	27,908	40,277	68,185
No Direct Coverage and Work Fewer than 10 Hours per Week	1,209	355	1,564
Currently Uninsured	186	125	311
Nonworkers	**20,366**	**7,731**	**28,097**
Currently Uninsured	3,855	2,176	6,031
All Uninsured Who Would Not Gain Direct Coverage Through a Workplace Guarantee	**4,041**	**2,301**	**6,342**

Note: [a] "Unaffected" adults are those who do not gain direct coverage: to be counted as newly gaining direct employer-based coverage (an affected worker) under the Clinton Plan in these estimates, a worker must work 10 hours per week and must not already have insurance through his or her own employer.
Source: Estimates based on IWPR analysis of data from the March 1991 Current Population Survey.

workers) to participate in health insurance purchasing cooperatives, or alliances, women and men would be subject to much less change in their sources of health care when they experience transitions such as job change, job loss, leaving their parents' home, marriage, divorce, separation, or widowhood than they typically are now. Whatever the source of the payment for their health insurance (whether by their employer, themselves, or via subsidies or public programs), they would have the option of maintaining access to the same health care plan through an alliance. (Of course, if they have to take on a greater share of the cost because of lack of employment they might choose to switch to a less expensive plan). In addition, women and men would have secure access for their dependents, since all employers, including those large firms not required to participate in the alliances, would be responsible for contributing their share (80 percent under the President's proposal) of the cost of coverage for dependents.

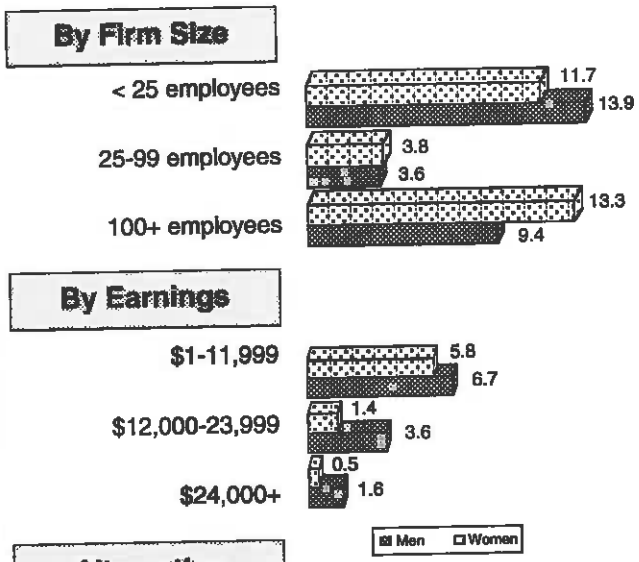
Impact of Guaranteed Coverage by Industry and Firm Size

When we consider which employers would newly become responsible for contributing toward the cost of health insurance for their employees, we observe some surprises. Of the 29 million women who would be newly eligible to receive insurance through their own employers, the largest share, 13 million or 46 percent, are currently working for firms with 100 or more employees, 12 million or 41 percent are working for firms with fewer than 25 employees, and only 3.8 million or 13 percent work for firms employing 25 to 99 employees (see Figure 13). About half of the women newly eligible for direct coverage are employed either in retail trade (8.1 million) or professional service industries (7.9 million; see Figure 14). In these two industries, about half of the gains would be for workers in large firms, those with 100 or more employees. In contrast, in personal services most of the new access to direct employer-based insurance among women workers would occur in small firms, those with fewer than 25 employees (see Figure 14).

For men compared with women, more of their new access is concentrated in the smaller firms. Of all 27 million male workers who would newly gain direct access, 14 million, more than half, are currently working for firms with fewer than 25 employees, 9.4 million or 35 percent are working for firms with 100 or more employees, and 3.6 million or 13 percent work for firms with 25 to 99 employ-

Figure 13. Impact of Health Security Act on Workers Ages 18-64

Number of Workers (in Millions) Gaining Health Insurance from Own Employer



- About two-fifths of workers who would gain health insurance coverage through their own employers work in larger firms with more than 100 employees.
- Nearly two-thirds of the uninsured who would gain health insurance coverage through their own employer earn less than $12,000 per year.
- When small firms are excluded from the workplace guarantees the number of uninsured individuals gaining coverage falls dramatically.

Source: Estimates based on IWPR analysis of data from the March 1991 Current Population Survey.

Two-thirds of all workers who would become insured for the first time through their own employers [because of workplace guarantees] earn less than $12,000.

About half of the uninsured workers who would gain coverage under a universal workplace guarantee are employed in small firms.

ees (see Figure 13). This impact on workers in small firms is the most pronounced in the construction industry. Among those construction workers who would become newly eligible for direct coverage, about 75 percent work in small firms (see Figure 14). Therefore, by requiring small firms to take responsibility for contributing to health insurance, men would benefit more than women.

Impact by Earnings Level

A profile of the currently uninsured workers who would gain direct access to health insurance for the first time under the Clinton workplace guarantee shows that out of 7.7 million currently uninsured women workers gaining coverage, 5.8 million women (75 percent) earn less than $12,000, another 1.4 million (18 percent) earn between $12,000 and $23,999, and only 500,000 women (6 percent) earn over $24,000 (see Figure 13).

Our analysis shows that more of the working men (than women) who would be newly eligible for direct coverage come from the ranks of the uninsured, partly because they are less likely to be able to rely on their spouses' employers or public insurance. Out of these 12 million currently uninsured working men, 6.7 million (55 percent) earn less than $12,000, another 3.6 million (30 percent) earn between $12,000 and $23,999, and only 1.6 million (14 percent) earn over $24,000 (see Figure 13).

Thus, when women and men are considered together, nearly 90 percent of those who would become newly insured under the Clinton workplace guarantee earn less than $24,000 per year, and nearly 2/3 earn less than $12,000 per year. The requirement that employers contribute to health insurance costs for all those working more than 10 hours per week would bring health insurance coverage to substantial numbers of low-earning, currently uninsured workers. In addition, nonworking dependents in their families would also become eligible for coverage through a guarantee that requires coverage for dependents as well as workers (as the Clinton plan does).

Impact of Exempting Small Firms

Finally, we consider the effect on coverage for the uninsured if smaller firms are exempted from the workplace guarantee. Under the Clinton plan, our estimates show that, out of all 26 million uninsured adults, 20 million uninsured workers (three-quarters of the uninsured) would gain new direct insurance coverage under a universal guarantee, com-

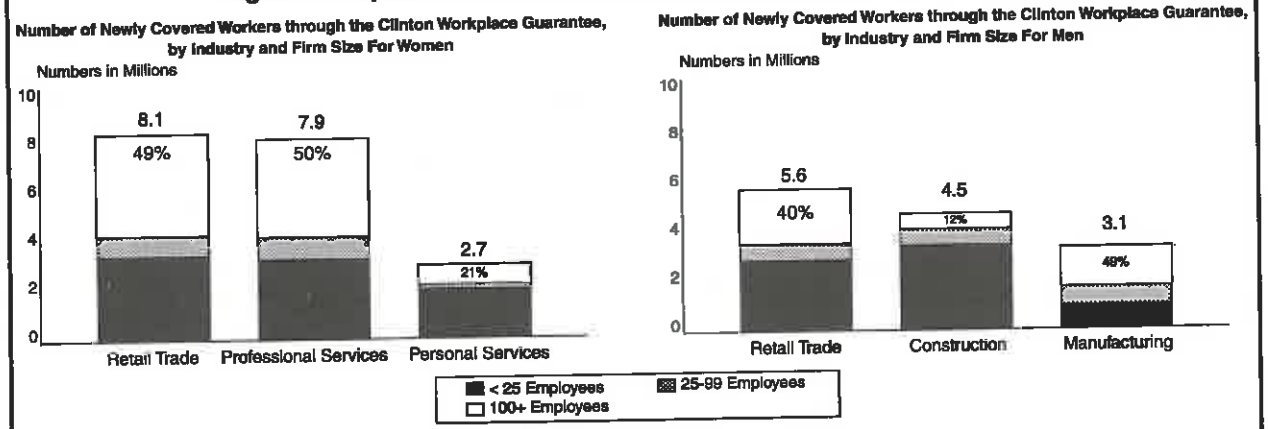
pared with only 10 million if firms with fewer than 25 workers were exempted, and only seven million if firms with fewer than 100 employees were exempted (see Figure 13).

As these figures indicate, about half of the uninsured workers who would gain coverage under a universal guarantee are employed in small firms. Six out of the 12 million currently uninsured male workers and over three million of the eight million uninsured women workers are in small firms with fewer than 25 workers. However, four million uninsured men and three million uninsured women work for firms with over 100 employees. The largest number of uninsured women workers are employed in retail trade, with over one million of them in large firms (see Table 5).

These data indicate that plans which exempt certain firms from providing insurance fail to cover many workers as well as nonworkers. If only firms of 100 or more participate in the workplace guarantee, only about one quarter of the currently uninsured would obtain coverage through employers. The burden of meeting the health care needs of uncovered workers in exempted firms will fall elsewhere in the system, for instance on other employers or on taxpayers who provide support for the public programs that provide health care to the uninsured.

Seven million uninsured women and men work for firms with more than 100 employees.

Figure 14. Impact of the Clinton Plan by Gender, Industry, and Firm Size



Source: IWPR analysis of data from the March 1991 Current Population Survey.

Table 5: Impact of the Clinton Plan's Workplace Guarantee on the Health Coverage of Workers, Ages 18-64, By Firm Size, Industry, and Gender
(millions of workers)

	Total Workers Employed	Number Affected by Clinton Plan[a]	Number of Affected Workers Who are Currently Uninsured			
	All Firms	All Firms	All Firms[b]	Firm Size < 25	Firm Size 25-99	Firm Size ≥ 100
EMPLOYED LABOR FORCE						
Women	57.9	28.8	7.7	3.3	1.2	3.2
Men	67.5	26.9	11.9	6.3	2.0	3.7
Total	125.4	55.7	19.6	9.6	3.1	6.9
SELECTED INDUSTRIES FOR WOMEN[c]						
Retail Trade	11.3	8.1	2.4	1.0	0.3	1.1
Professional Services	18.5	7.9	1.6	0.5	0.2	0.8
Personal Services	3.5	2.7	0.9	0.7	0.1	0.2
Manufacturing[d]	7.4	2.5	0.9	0.2	0.2	0.4
Business/Repair Services	3.2	2.0	0.6	0.3	0.1	0.2
SELECTED INDUSTRIES FOR MEN[c]						
Retail Trade	9.9	5.6	2.5	1.2	0.4	0.9
Construction	7.7	4.5	2.5	1.8	0.4	0.3
Manufacturing[d]	14.8	3.1	1.6	0.5	0.4	0.7
Professional Services	8.0	2.6	0.8	0.3	0.1	0.4
Business/Repair Services	4.7	2.5	1.2	0.8	0.2	0.3

Notes: a To be counted as an affected worker, that is a worker who gains direct employer-based coverage, under the Clinton Plan, in these estimates, a worker must work 10 hours per week and must not already have insurance through his or her own employer.
b Numbers may not add due to rounding.
c Industries selected because, for each gender, they employ the largest number of uninsured workers who would gain workplace coverage under the Clinton Plan.
d Includes both durable and non-durable goods manufacturing.

Source: Estimates based on IWPR analysis of data from the March 1991 Current Population Survey.

CONCLUSION

Many adults have inadequate access to health insurance in our current system. This system can be characterized as relying on three components: employer choice, in which many employers choose not to provide insurance; a "marriage mandate," in which many women must rely on marriage to obtain access to health insurance; and a public component targeted at poor single mothers. Although men in this system are more likely to have direct employer based coverage, they are less able to depend on their spouses for indirect insurance and have almost no access to means-tested public insurance.

IWPR's study shows that the current system leaves many women (and men) falling through the cracks of these imperfect components. The assumption that all nonworking women or women with marginal employment can gain access to insurance through their husbands or parents is not supported by the facts. Many young women, who are especially in need of health insurance because of the likelihood of child birth, single women with children, women in transition out of marriages, and women whose husbands work less than full-time full-year are at greater risk of being without insurance. Low income women, women with low educational attainment, and African-American and Hispanic women also lack insurance in disproportionate numbers.

Our current employment-based system provides less insurance to low earners, part-time workers, and those on the job less than a year; many small firms and both large and small firms in particular industries also do not provide health insurance to their workers. As men's employment patterns more closely come to resemble those of women, men with marginal employment are also at a high risk of being uninsured.

Increasing numbers of men have jobs that do not provide health insurance, either for themselves or for other family members. Access to dependent care coverage is falling for all workers. These differences not only raise questions about fairness among individuals, but also the social outcomes of differential access.

Twelve million working age women do not have health insurance of any kind; eight million are employed, four million are women of color. Five million are young women in their childbearing years.

The assumption that all nonworking women or women with marginal employment can gain access to insurance through their husbands or parents is not supported by the facts.

Men also are at high risk of being uninsured. Increasing numbers of men have jobs that do not provide health insurance for themselves or other family members.

Our study shows that reform based on a workplace guarantee would increase access to health care insurance, and reach three out of four uninsured working age adults. Increasing workplace coverage is of great importance to women, who are less likely to have employer based coverage than men, but it is increasingly important to men as well.

A workplace guarantee similar to that proposed in the Clinton Administration's Health Security Act would bring new coverage to many working adults who are now uninsured. Among adult women aged 18 to 64, of the 12 million currently uninsured, an employer requirement to contribute to coverage for those working more than 10 hours per week would provide new direct coverage to 8 million, or two-thirds of the uninsured women workers, according to our estimates. Among adult men, 12 million out of the 14 million uninsured, or 84 percent, would be newly eligible for direct employer-provided health insurance, according to our estimates.

Altogether, some 20 million (or three-fourths) of the formerly uninsured would be eligible for new health insurance coverage through their own employers. In addition, some portion of the uninsured who are not working but are dependents of newly covered workers would also be eligible for health insurance as family members.

If the smaller firms are exempted from an employer requirement to provide health insurance, the proportion of the uninsured who would gain new direct coverage would fall dramatically. When firms of all sizes are included, three-fourths of the uninsured gain direct coverage; if firms with fewer than 25 workers are excluded, the proportion falls to about two-fifths; and if those with fewer than 100 workers are excluded, the proportion getting new coverage falls to about one quarter.

In addition to increasing access to coverage, a workplace guarantee would address some of the inequalities in our current system. Workers would receive coverage regardless of their occupation, industry, or earnings. This increased access would benefit individuals with lower socio-economic status, including women of color, less educated women, and low-income women, who hold more marginal positions in the labor force. Men who hold marginal positions in the work force would also benefit especially.

IWPR's study shows that, under the proposed Health Security Act, of the currently uninsured who would be newly eligible for health insurance coverage through their workplaces, nearly two-thirds earn less than $12,000 per year. A workplace guarantee would also reach many employees in large firms in industries such as retail and professional services who are now not using direct employer-provided insurance, as well as many employees in small firms who currently have a high rate of being uninsured.

In addition, this new direct access would protect women from changes in their insurance status that occurs with life cycle changes. Having direct access can protect many women from losing insurance as the result of a divorce, separation, retirement, or the job loss of the insured spouse.

But our estimates also show that one-third of uninsured adult women would not gain new direct employer-based coverage, either because they do not work or work fewer than 10 hours per week. Since the proposed Health Security Act assures universal access, these women would likely gain access either indirectly through newly insured working family members, through purchasing private insurance (possibly with some subsidy assistance if their incomes are low), or through an expanded program of public insurance.

Under the Health Security Act, workers also do not have to fear loss of health insurance when they change jobs, experience unemployment, or leave the labor market for a period of time. They may, however, be subject to changes in the way they obtain health insurance, if they decide to choose a less expensive plan should their costs increase when they are out of work.

Nevertheless, our research indicates that the Health Security Act, with its workplace guarantee, will greatly increase both women's and men's coverage compared to the current system.

Of all the health care reform proposals currently being debated, only a single payer system, in which all individuals are insured through the same system and in the same manner, provides as much access as the Health Security Act — universal access. Because a single-payer system would likely provide the most secure and stable access to

The workplace guarantee in the Clinton plan would bring new coverage to many currently uninsured workers — two-thirds of all uninsured adult women and more than four-fifths of all uninsured adult men.

When choice is left to individual employers, many people fall through the cracks.

health insurance, it, too, deserves further consideration as an alternative to the current system.

Despite almost complete reliance on employer-provided coverage, the United States is alone among industrial countries in allowing employers absolute latitude as to whether, how, and to whom to provide health insurance coverage. As our research shows, a system where choice is left to individual employers leaves many people underserved. In order to meet the increasing needs of women and men for secure access to health insurance, reform to address current gaps and changing realities is necessary.

APPENDIX: DATA AND METHODS

Data Sources

The data used in this study are drawn from the January and March 1991 supplements to the Current Population Survey (CPS). The CPS is a nationally representative survey that collects monthly data on the economic status and activities of the population of the United States by interviewing approximately 57,000 households. Each household is interviewed once a month for four consecutive months one year, and then re-interviewed 12 months after the first interview. Using probability sampling, each month the CPS introduces new households into the sample and drops an equal number of old households. The March 1991 CPS provides data on work experience, income, and non-cash benefits, including health care, for 1990. The March 1991 CPS, however, does not contain information on job and occupational tenure, two potentially important factors for determining employer-based coverage. These variables are available from the January CPS. In order to include these variables in the study we matched the January and March surveys for the sample of households that was interviewed in both months, approximately one third of the March households.

Sample Size

The sample of men and women aged 18 to 64 from the March 1991 CPS is 95,672 representing 153.5 million men and women in the United States. Linking the January and March 1991 CPS resulted in a sample size that was 36 percent of the original March sample, because only fifty percent of the sample overlapped in the two months, and because we could not adequately trace households that changed composition from month to month. Because of the limited sample size of the matched data, we relied on the March 1991 CPS for most of our analysis. We used the matched data only to examine the relationships between job tenure and occupation and different sources of insurance.

With the exception of two parts of our analysis, the study is based on two sub-samples of the data, limited to women and men ages 21 to 64: a sub-sample of all adults consisting of 89,291 cases and a sub-sample of employed

adults consisting of 73,220 cases (employees were defined as those who had at least one week of work during calendar year 1990). The exceptions are that, first, when we examined the relation between age and health insurance status, we considered the full sample of 18 to 64 year olds, and, second, when we estimated the impact of the Administration's proposed Health Security Act, we considered all employed 18 to 64 year olds, a sample of 78,133.

Measures of Coverage

This study examines whether an individual is uninsured or has one of four sources of health insurance: direct employer-based coverage, indirect employer-based coverage, private coverage from another source, or public insurance. To capture the employer-based variables, we used the responses to two questions included in the March 1991 CPS survey: (1) whether a person had an insurance policy in her or his own name and (2) whether it was through the employer or union.[1] A person was defined as having direct employer-based coverage if he or she answered "yes" when asked if he or she had an insurance plan in his or her name and "yes" that the coverage was through his or her employer or union. A person was considered to have indirect employer-based health insurance coverage if he or she did not have an insurance plan in his or her own name and if the head of household said that he or she had a plan through an employer or union that covered dependents in the household, whether or not the individual thought they were covered by the plan.[2]

If a person received her or his insurance through a non-group private health plan, then we categorized her or him as having an alternative or independently purchased private health plan. We did not distinguish between direct and indirect coverage for those adults with alternative sources of private health care coverage. Adults were categorized as having public insurance if they had any of the following government health care programs: Medicaid, Medicare, CHAMPUS, VA (Veterans Administration), or military health insurance.

[1] We could not use the Census Bureau variable concerning whether an individual was part of a group health plan to determine employer-based coverage because the CPS does not distinguish between those covered directly and indirectly.

[2] The Bureau recodes the answers of dependents who answer differently than the head of household because children are often unaware of their health insurance status.

Finally, those who reported having no health coverage were categorized as being uninsured. The result of this categorization system yielded five categories: four sources of insurance and no health coverage.

About four percent of our respondents were covered by more than one health insurance plan. We handled the problem of multiple coverage by counting only one source of insurance using the following decision rules for determining the preferred source. First, we gave priority to employment-based plans for obtaining health insurance. That is, if an individual received his or her insurance from both an employment-based plan and public plan, the employment-based plan was considered to be the source of coverage.

For those individuals with both direct and indirect coverage from employment-based plans, direct coverage was considered to be the source of coverage. For those individuals with both public insurance and private individually purchased plans, the public plan was considered to be the source of coverage. For those individuals with more than one source of public insurance, Medicaid was given priority over Medicare or other public insurance.

In the multivariate analyses using logistic regression analysis, we limited our analysis of sources of health insurance to three: direct employment-based insurance, indirect employment-based insurance, and no insurance. Only working women between the ages of 21 and 64 were included in the analysis. For more detail on the logistic regression analyses and results, please see the full technical report of our study, forthcoming from the Institute for Women's Policy Research.

Estimating the Impact of Workplace Guarantees

To estimate how many employees would gain health insurance from their own employers under workplace guarantees, we selected those adult men and women, ages 18 to 64, who worked at least one week during 1990. We tabulated this sample universe by their current source of coverage and by whether they worked 10 hours per week or more, the cut off for eligibility under the Clinton plan. Workers newly eligible for workplace coverage were those working 10 hours or more but not insured by their employers. In our analysis, we did not attempt to estimate possible job loss due to guaranteed coverage. Widely differing estimates have appeared in recent

months — ranging from large job losses to small net gains. There are great difficulties in estimating their effects (Krueger, 1993). Our figures implicitly assume no change.

Next, to estimate how new access to direct coverage would be distributed across the different groups of employees, we examined the firm size, industry, and earnings level for newly covered men and women. Then we examined two factors, firm size and industry, simultaneously to give us some sense of which firms in what kind of industry would have to carry new responsibility as a result of the workplace guarantees.

Finally, because of the current debate on which employers would be required to provide coverage, we estimated the number of currently uninsured employees who would gain guaranteed coverage under three different scenarios: first, requiring all employers to cover their employees regardless of the firm size; second, exempting employers with fewer than 25 employees; and third, exempting employers with fewer than 100 employees.

Table A1: Factors which are Statistically Significant in Affecting the Odds of Having Health Insurance for All Working Women Ages 21-64

Increase Odds of Having No Health Insurance

- Less than High School
- Low Earnings
- Working in Small Firm
- Working Part-Time
- Agriculture, Forestry, Fishery
- Construction
- Retail Trade
- Business, Entertainment, Personal Services
- Not Married
- Non-Hispanic Black
- Hispanic
- Non-Hispanic Other Races
- Spouse Working in Small Firm
- Spouse Working Part-Time or Part-Year

Decrease Odds of Having No Health Insurance

- College Education
- High Earnings
- Transportation
- Finance
- Public Administration
- Age
- Spouse Working in Manufacturing
- Spouse Working Full-Time Full-Year

Increase Odds of Having Direct, Employer-based Health Insurance

- High Earnings
- Manufacturing
- Transportation
- Wholesale Trade
- Age
- Not Married
- Spouse Working in Small Firm

Decrease Odds of Having Direct, Employer-based Health Insurance

- Less than High School
- Low Earnings
- Working Part-Time
- Working in Small Firm
- Self-Employed
- Agriculture, Forestry, Fishery
- Retail Trade
- Business, Entertainment, Personal Services
- Non-Hispanic Black
- Hispanic
- Non-Hispanic Other Races
- Spouse Working Full-Year, Full-Time

Increase Odds of Having Health Insurance Indirectly, Through a Spouses's or Parent's Employment

- Some College
- Low Earnings
- Working Part-Time
- Working in Small Firm
- Self-Employed
- Retail Trade
- Business, Entertainment, Personal Services
- Spouse Working in Manufacturing
- Spouse Working Full-Time, Full-Year

Decrease Odds of Having Health Insurance Indirectly, Through a Spouses's or Parent's Employment

- Less than High School
- College Education
- High Earnings
- Agriculture, Forestry, Fishery
- Mining
- Manufacturing
- Transportation
- Not Married
- Non-Hispanic Black
- Hispanic
- Non-Hispanic Other Races
- Spouse Working Part-Time
- Spouse Working in Small Firm

Notes: Only factors which are significant at the 0.05 level are included in the above charts. For a more complete discussion of these results, see the full technical report, available from IWPR..

Source: IWPR analysis of data from the March 1991 Current Population Survey.

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Heidi Hartmann (Ph.D. in Economics from Yale University) is a co-founder of IWPR and is the current Director and President. Formerly, she held several positions at the National Academy of Sciences and served as a professor and Director of Women's Studies at Rutgers University and on the graduate faculty of the New School for Social Research. Her research at the Academy on pay equity helped to establish comparable worth as a remedy for the underpayment of jobs dominated by women. Her work on this and other employment issues is well known in the policy and advocacy communities, and her work in feminist theory is widely read by women's studies scholars. At IWPR she has co-authored reports on family and medical leave, welfare and low wage work, mothers's earnings, pay equity, and contingent work.

Roberta Spalter-Roth (Ph.D. in Sociology from American University) has been on the staff of IWPR since its inception in 1987. As Director of Research, she has overall responsibility for the coordination of IWPR's research program and directs many specific projects. Prior to joining IWPR, she conducted research for more than ten years for the Anti-Poverty Program of the Greater Washington Research Center. Her writing on women's policy issues is widely used in both academic courses and by practitioners across the United States. At IWPR, she has co-authored reports on low wage work, family and medical leave, combining work and welfare, mothers' earnings, and the Pregnancy Discrimination Act. Dr. Spalter-Roth also holds an appointment in the Sociology Department at The American University. She has also served on the faculty at George Washington University.

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Lois Shaw (Ph.D. in Economics from the University of Michigan) has been a consulting economist at IWPR since 1992. She retired in 1991 from her position as Senior Economist at the U.S. General Accounting Office where she conducted research on welfare and pension issues. She was employed for many years at the Center for Human Resource Research, The Ohio State University, as a Research Scientist. She has written extensively on women's employment issues.

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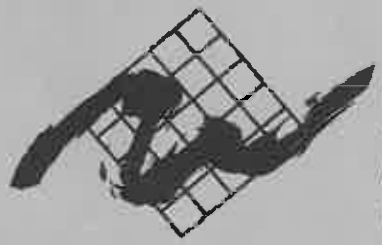

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