# WOMEN'S ACCESS TO HEALTH INSURANCE

TESTIMONY

Access to Health Care in Underserved Communities Under Health Care Reform

Hearings of the Committee on Finance
U.S. Senate

April 21, 1994

by

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I am Heidi Hartmann, Director of the Institute for Women's Policy Research; I am a labor economist and hold the Ph.D. degree from Yale University. I want to thank you, Chairman Moynihan, Senator Bradley, and other members of the Committee on Finance for the opportunity to testify before you today. It is a pleasure to share our new research findings with you at this important hearing on underserved populations and health care reform.

My testimony today is based on our forthcoming report on women's access to health insurance, which presents findings from the first thorough study of the factors that affect women's access and lack of access to health insurance. It shows that certain groups of women fall through the cracks of our current health care system. These women do not have access to health insurance either through their employers, spouses, or the public system, nor can they purchase insurance themselves. Without health insurance, these women are chronically underserved. Our forthcoming report also assesses how well President Clinton's proposed Health Security Act would address women's inadequate access to health insurance.

Among the groups of women particularly at risk of having no insurance are women of child bearing age, single women and single mothers, women with low educational attainment and low income, women of color, and women undergoing transitions in marital or employment status. In addition, women who work part-time, in low wage jobs, in small firms, and/or in certain industries that employ women disproportionately are especially likely not to have health insurance provided by their employers and to be uninsured as a result.

Our study, conducted by a team of five IWPR researchers, relies on data collected by the Census Bureau in its monthly Current Population Survey of 60,000 households which are representative of the nation's population. Our team used the public use tapes from January and March of 1991, the most recent time period for which data on job tenure are available. The study was supported by the Henry F. Kaiser Family Foundation as part of the Kaiser Health Reform Project.

We focus on women's access to health insurance for several reasons. Women are a large proportion of the population, the majority in fact, yet their specific needs are often overlooked in public policy debates. Women also have a unique relationship to the health care system. Recent studies show that women use health care services more than men do and spend a greater portion of their income on health care. In addition to having significant personal health needs, women facilitate use of the health care system by other family members, and, in particular, 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 tend to differ from men's (basically women do more family care and men do more paid work), women are more likely to have *indirect* access to employment-based health insurance (access as a dependent covered by a worker's policy) and less likely to have *direct* access through their own employment. In other words, traditionally women have relied on their husbands' jobs to provide them with health insurance. We believe this traditional reliance 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 this majority will only grow larger in the future. As women continue to marry later and divorce more, increasing numbers of women will be unmarried for longer portions of their lives and will not have access to health coverage through husbands. In addition, as the proportion of child births occurring outside marriages continues to increase, women increasingly need direct access to health insurance. Even within marriages, women can no longer be sure that their husbands will receive insurance through their employers, especially insurance that provides coverage to other family members at reasonable cost, as jobs decline in industries such as manufacturing that have traditionally provided generous benefits and increase in sectors that provide fewer full-time regular jobs with only limited fringe benefits at best. The proportion of adults obtaining insurance through employment, both directly and indirectly, has been falling since at least 1988. Given the changes underway in family structure and employment, women have an *increased* need for secure access to insurance.

For 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. Figure 1 shows that women are much less likely to have direct employer-provided insurance than men, 37 percent versus 55 percent. Women's greater access to indirect coverage (28 percent for women versus 10 percent for men) makes up the difference, while women's greater access to public insurance means that overall a somewhat smaller proportion of women are uninsured than men (15 percent of adult women versus 19 percent of men). Women are

fortunate in having access to more sources of insurance than men, but their greater reliance on indirect coverage through their spouses leaves many women vulnerable to life cycle events such as leaving the parental home, divorce, widowhood, or the retirement or job loss of a spouse.

Overall, we identified three types of issues that affect women's access to health insurance: life cycle factors, factors related to social and economic status, and factors related to the extent and type of employment women have.

## Life Cycle Factors

Women need more health care during young adulthood, the peak child bearing years, yet, as can be seen in Table 1, women under 30 are substantially more likely to be uninsured. Young adults, 18-20, obtain most of their health insurance indirectly through their parents, which they then lose as they leave home and school. Women in their twenties are especially unlikely to have access to indirect insurance through parents or a spouse's job. The lack of insurance in this age range is especially troublesome, as 70 percent of all births in 1990 were to women under age 30. 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 job change as well as more unemployment. Our study shows that uninsurance falls for both women and men as they age and that, at all ages, men have more direct insurance than women. Men also are more likely than women to lack insurance at all ages (because, in comparison with women, they have less access to insurance through spouses' jobs and less access to public insurance).

Table 1 also shows that married women with spouses present have the most insurance, because of their high access to indirect insurance (still, less than a majority, 43 percent, of married women receive their insurance through their spouses). Women in all other marital status categories (married with absent spouse, separated, divorced, widowed, or never married) are twice as likely to be uninsured. And women most likely to be experiencing marital transition (those in the spouse absent and separated categories) have the highest rates of uninsurance (24 percent, not shown on table). We also found that married women whose spouses work less than full-time, full-year are just as likely to have no insurance (18 percent) as those whose spouses do not work at all, whereas only 8 percent of those with spouses employed full-time, full-year lack insurance (not shown on table).

Among women with children, those who are single parents are especially likely to be uninsured (18 percent lack insurance compared to 11 percent of mothers in two-parent families), even though Medicaid targets poor single mother families. The highest rate of direct employer-provided insurance is found among women who have no children (41 percent).

The great disparities in insurance rates between married women whose husbands work full-time year-round, other married women, unmarried women, young women, and single mothers indicate that our system is based on assumptions that do not work for all women. We must question the adequacy of a social system that leaves women who need health care most, specifically those in the child-bearing years, the least likely to have health insurance.

### Race, Education, and Family Income

Social and economic factors also greatly affect which women have access to health insurance. As shown in Table 1, women of color are approximately twice as likely as non-Hispanic white women to lack insurance, with Hispanic women being nearly three times as likely as white women to be uninsured. African American women have especially low access to health insurance through husbands (only 10 percent compared to 31 percent for white women).

Women with low levels of education and low family income are also disadvantaged by our current system. Women with less than a high school diploma are twice as likely to be uninsured as high school graduates and women with low family income (less than $15,000) are more than five times more likely than women in moderate and higher income families to be uninsured (32 percent versus 6 percent). It is clear that public insurance does not close the insurance gap for women in low-income families. In the $15,000 - $25,000 income range, the range in which the median single mother family falls, about one in five women lack insurance (not shown on table). Like insurance coverage generally, women's direct coverage (through their own employer) increases with educational attainment and family income. Nearly three times as many college graduates as high school dropouts have direct employer-provided health insurance.

It is clear that the current employer-based system fails to serve women in low-income families and women of color.

### The Extent and Type of Women's Employment

Women's access to insurance through employment is greatly affected by the nature of the jobs they hold -- their hours of work, years on the job (tenure), earnings, and the firm size and industry of their employers, among other factors. Among women workers, women have less access to direct employer-provided health insurance at least partly because they are disproportionately located in industries or types of employment in which employers traditionally do not provide insurance. Women also have less direct employer provided health insurance even when they work in the same types of jobs as men do.

Table 2 shows that for virtually all the work-related characteristics studied, men have more direct insurance than women while women have more indirect insurance and less uninsurance than men. Direct employer provided insurance is rare among women working part-time, fewer than 35 hours per week, but women with these low work hours are fortunate to have substantial indirect access through their spouses' jobs. While men working low hours have more direct access, they have very little indirect access through their wives' jobs and are thus more likely than women overall to be uninsured. Workers in the first year on the job, both female and male, have less direct insurance than those with longer job tenure, as do those who report having had some unemployment. While it is not surprising that workers who show less work attachment have less direct employer-provided insurance, it is surprising that women workers have even less coverage than similarly situated male workers. For women, then, transitions in employment present special difficulty in getting direct insurance.

Characteristics of the employer also affect the likelihood of having direct insurance coverage. In small firms and in the six industries that provide the lowest rates of coverage, men have more direct coverage than women have (except in construction). Differences between men and women in direct coverage are especially large in personal services and retail trade, and in the business/repair and entertainment services. Even women's greater indirect access still often leaves them with very high rates of uninsurance -- particularly in small firms, and in personal services, retail trade, and agriculture. Those working in agriculture have the lowest rates of insurance through a spouse, likely reflecting the lack of alternative types of employment in rural areas that could provide access to health insurance.

Figure 2 illustrates differences in direct coverage for women and men by weekly work hours, years on the job, and firm size. Only 1 in 8 women working less than 25 hours per week has employer-provided health insurance, 2 in 5 women in the first year on the job have direct coverage, and only 1 in 4 of those working in small firms does.

In our study we also used multivariate statistical techniques to consider the effects of all these variables simultaneously, checking for effects that might be masked by other variables and determining which factors remain important. This analysis generally confirmed the importance of the variables discussed, showing most to be statistically significant determinants of health insurance coverage for women (and men).

## Impact of the Health Security Act

Our study points to many gaps in coverage in the current health care system. Therefore, we also considered the impact of health care reform on coverage for both women and men, modelling the

effect of the President's Health Security Act, especially the proposed employer mandate. An employer mandate, particularly one covering all employers and all their employees, overcomes a number of barriers to insurance coverage. Women workers would overcome such barriers to health insurance access as low wages, short job tenure, low hours of work, and firms with 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 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 burden of coverage would likely shift among employers and the impact that exempting small firms would have on the number of employees who would receive coverage.

We estimate that 29 million more women, or 50 percent of all working women, would have access to direct coverage from their own employer than now do so. 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 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 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, would still not have access to employment-based coverage, when the 10 hour screen is applied. In addition, many Americans, primarily those not working, will still need to obtain insurance through other payment means. Our data indicate that of the 26 million men and women currently without insurance, 20 million would gain direct coverage leaving 6 million working age men and women (ages 18-64) ineligible to receive direct employer-based coverage (see Figure 3). 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 the employer mandate. 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 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 (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.

When we consider which employers would newly be required to contribute 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 3). 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). In these 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.

For men compared to women, more of their new access is concentrated in the smaller firms. This is especially true for the construction industry. Among those construction workers who would become newly eligible for direct coverage, about 75 percent work in small 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 employees.

A profile of the currently uninsured workers who would gain direct access to health insurance for the first time under a Clinton-style mandate shows that out of 7.7 million currently uninsured women workers, 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 3).

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 3).

Thus, when women and men are considered together, nearly 80 percent of those who would become newly insured under a Clinton-style employer mandate earn less than $24,000 per year, and nearly 2/3 earn less than $12,000 per year. An employer mandate would bring health insurance coverage to substantial numbers of low-earning uninsured workers. In addition, nonworking dependents in their families would also become eligible for coverage through a mandate that requires coverage for dependents as well as workers (as the Clinton plan does).

Finally, we considered the effect on coverage for the uninsured if smaller firms are exempted from an employer mandate. Using the 10 hour screen from the Clinton plan, our estimates show that, out of all 26 million uninsured adults, 20 million uninsured workers would gain new direct insurance coverage under a universal mandate, compared to only 10 million if firms with fewer than 25 workers were exempted, and only 7 million if firms with fewer than 100 employees were exempted (see Figure 3). These data indicate that plans which exempt certain firms from the employer mandate fail to cover many workers as well as nonworkers. If universal access is guaranteed, as it is in the Health Security Act, then the burden of covering workers in exempted firms will fall elsewhere in the system, for instance on the federal government.

* * * * *

In conclusion, our study shows that many women have inadequate access to health insurance in our current system. 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.

Women have less direct access to health insurance through employment than men, 37 percent versus 55 percent or 29 million versus 42 million, and for many groups of women, neither indirect access through men nor public insurance makes up the difference. Many young women, women in transition out of marriages, and women whose husbands have employment that does not provide health

insurance are at greater risk of being without insurance of any kind. 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 now provide health insurance to their workers. These differences not only raise questions about fairness, but 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, for example?

Our study shows that reform that includes an employer mandate would address many of the problems in health insurance access that women currently face. The failure of many employers to provide insurance disproportionately affects women. Women have a greater stake in the outcome of the debate over employer responsibility, since they currently have less access to direct-employer provided coverage. An employer mandate like that proposed in the Clinton Administration's Health Security Act would bring direct coverage to 21 million women and 15 million men who now have other sources of insurance as well as *new* direct coverage to 20 million working adults, or three-fourths of all adults who are now totally uninsured. Among adult women aged 18 to 64, an employer mandate for those working more than 10 hours per week would provide new direct coverage to 8 million, or two-thirds of all uninsured women, according to our estimates. Among adult men, 12 million, or more than four-fifths of all uninsured men, would be newly eligible for direct employer-provided health insurance according to our estimates. 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 mandate, the proportion of the uninsured who would gain new direct coverage would fall dramatically. When all firms 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.

As discussed above, an employer mandate would provide new direct coverage to many workers who are currently uninsured or who have access only indirectly through a spouse or a parent. Having direct access can protect many women from losing insurance as the result of reaching adulthood, family break-up due to divorce or separation, or the 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 goes beyond an employer mandate by also guaranteeing universal access, 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.

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.

## Table 1: How Do Women Get Their Health Insurance?

(Women Ages 21-64) a

| Characteristics | Total | | Percent Distribution | | | |
|---|---|---|---|---|---|---|
| | Number (in thousands) | Percent b | Direct % | Indirect % | Other % | Uninsured % |
| **BY AGE** | | | | | | |
| 18-20 | 5,303 | 100 | 10 | 42 | 26 | 22 |
| 21-24 | 7,324 | 100 | 31 | 16 | 30 | 23 |
| 25-29 | 10,436 | 101 | 43 | 20 | 20 | 18 |
| 30-64 | 55,225 | 100 | 39 | 30 | 18 | 13 |
| **BY MARITAL STATUS** | | | | | | |
| Married, Spouse Present | 45,622 | 100 | 33 | 43 | 14 | 10 |
| All Other | 27,363 | 99 | 48 | 1 | 29 | 21 |
| **BY PRESENCE OF CHILDREN & FAMILY TYPE c** | | | | | | |
| Single Parents | 8,622 | 100 | 36 | 1 | 45 | 18 |
| In Two Parent Families | 24,608 | 101 | 30 | 47 | 13 | 11 |
| Not Parents (Single and Married) | 45,058 | 99 | 41 | 23 | 19 | 16 |
| **BY RACE** | | | | | | |
| White, Non-Hispanic | 54,754 | 100 | 40 | 31 | 17 | 12 |
| Afro-American, Non-Hispanic | 8,799 | 99 | 39 | 10 | 30 | 20 |
| Hispanic | 5,859 | 100 | 28 | 19 | 21 | 32 |
| Other Races, Non-Hispanic | 2,624 | 100 | 33 | 22 | 27 | 18 |
| **BY EDUCATION** | | | | | | |
| Less than High School | 11,796 | 100 | 19 | 20 | 33 | 28 |
| High School | 30,414 | 99 | 37 | 30 | 18 | 14 |
| Some College | 15,799 | 100 | 42 | 28 | 19 | 11 |
| College or More | 14,975 | 100 | 54 | 26 | 13 | 7 |
| **BY FAMILY INCOME d** | | | | | | |
| Less than $15,000 | 14,900 | 100 | 18 | 4 | 46 | 32 |
| Between $15,000 - $30,000 | 17,319 | 101 | 43 | 22 | 18 | 18 |
| More than $30,000 | 40,766 | 100 | 45 | 38 | 11 | 6 |
| **ALL ADULT WOMEN (21-64)** | **72,985** | **101** | **39** | **27** | **20** | **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.

## Table 2a: How Do Employed Women Get Their Health Insurance?

(Employed Women Ages 21-64)

| Characteristics | Total | | Percent Distribution | | | |
|---|---|---|---|---|---|---|
| | Number (in thousands) | Percent a | Direct % | Indirect % | Other % | Uninsured % |
| **BY HOURS PER WEEK b** | | | | | | |
| Less Than 24 | 7,754 | 99 | 13 | 47 | 23 | 16 |
| Between 25-34 | 5,734 | 99 | 24 | 35 | 22 | 18 |
| At least 35 | 40,491 | 101 | 62 | 16 | 11 | 12 |
| **BY JOB TENURE c** | | | | | | |
| Less than 1 year | 3,234 | 100 | 41 | 24 | 16 | 19 |
| Between 1 and 10 years | 10,604 | 100 | 57 | 23 | 10 | 10 |
| At least 11 years | 3,879 | 100 | 70 | 17 | 7 | 6 |
| **BY UNEMPLOYMENT b** | | | | | | |
| Those who reported unemployment | 7,776 | 100 | 35 | 22 | 20 | 23 |
| Those who did not report unemployment | 46,202 | 100 | 53 | 23 | 12 | 12 |
| **BY ANNUAL EARNINGS b** | | | | | | |
| Lower Wage Workers (< $15,000) | 27,584 | 100 | 29 | 30 | 21 | 20 |
| Higher Wage Workers (> $15,000) | 25,907 | 100 | 74 | 14 | 7 | 5 |
| **BY FIRM SIZE d** | | | | | | |
| Less than 25 Employees | 14,732 | 100 | 23 | 33 | 23 | 21 |
| Between 25 and 99 Employees | 6,560 | 101 | 48 | 23 | 14 | 16 |
| At least 100 Employees | 32,687 | 100 | 64 | 18 | 9 | 9 |
| **BY INDUSTRY d,e** | | | | | | |
| Agriculture/Forestry | 705 | 100 | 21 | 23 | 33 | 23 |
| Construction | 741 | 100 | 47 | 26 | 11 | 16 |
| Retail Trade | 9,427 | 100 | 31 | 27 | 20 | 22 |
| Business/Repair Services | 3,035 | 100 | 35 | 29 | 18 | 18 |
| Personal Services | 3,206 | 100 | 19 | 27 | 25 | 29 |
| Entertainment Services | 545 | 100 | 31 | 30 | 23 | 16 |
| **ALL WOMEN WORKERS** | **53,978** | **101** | **51** | **23** | **14** | **13** |

Notes: a Percents may not add to 100 due to rounding.
b Refers to 1990 calendar year.
c Refers to jobs held in January 1991. A smaller data sample consisting of matched data from the January and March Current Population Surveys was used for this analysis.
d Refers to longest job held in 1990.
e Six industries with lowest rates of direct employer coverage.

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

## Table 2b: How Do Employed Men Get Their Health Insurance?

(Employed Men Ages 21-64)

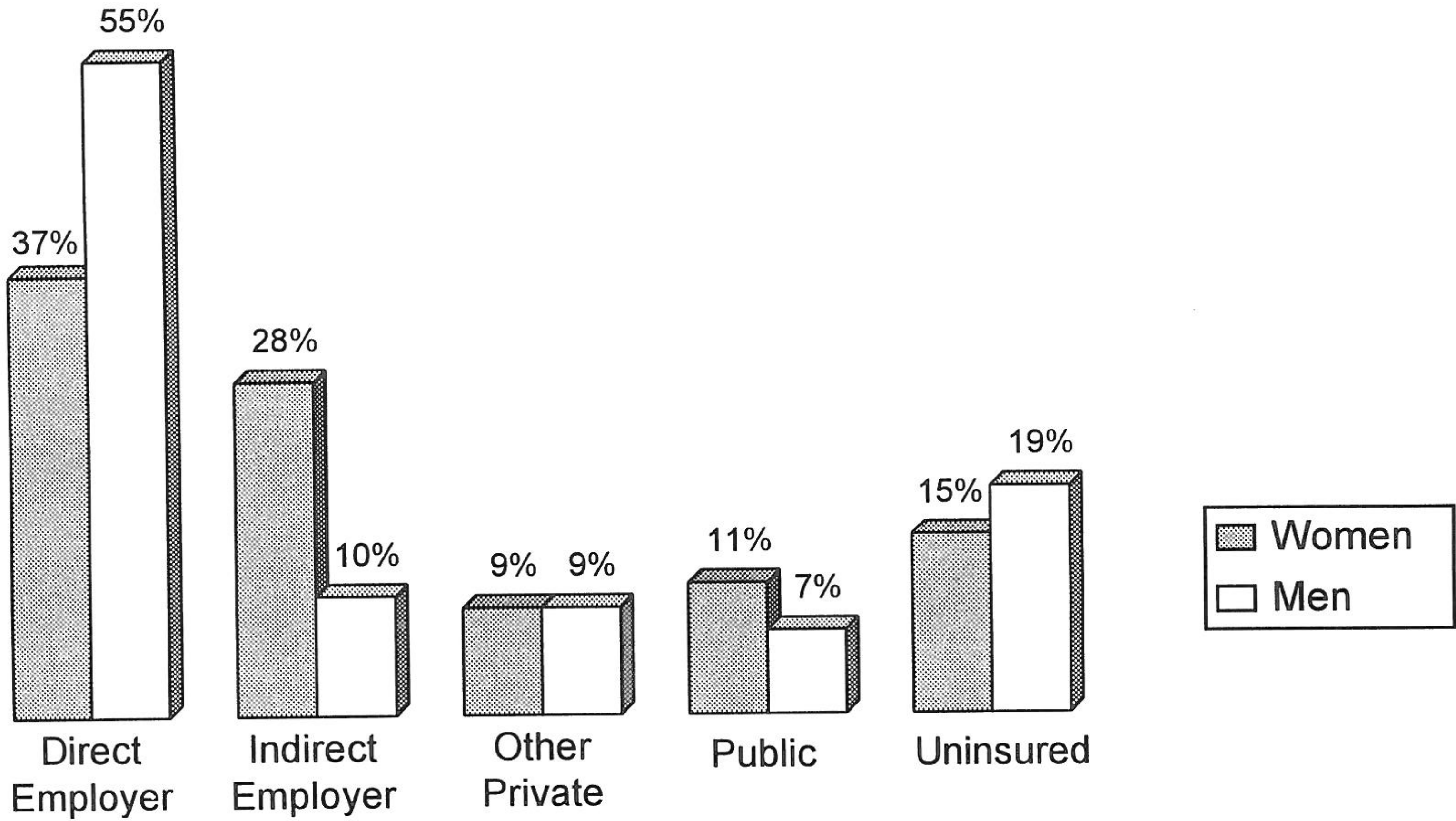
| Characteristics | Total | | Percent Distribution | | | |
|---|---|---|---|---|---|---|
| | Number (in thousands) | Percent a | Direct % | Indirect % | Other % | Uninsured % |
| **BY HOURS PER WEEK b** | | | | | | |
| Less than 24 | 2,389 | 100 | 20 | 14 | 35 | 31 |
| Between 25-34 | 2,504 | 101 | 25 | 11 | 26 | 39 |
| At least 35 | 58,452 | 100 | 66 | 8 | 10 | 16 |
| **BY JOB TENURE c** | | | | | | |
| Less than 1 year | 3,019 | 100 | 52 | 11 | 13 | 24 |
| Between 1 and 10 years | 11,429 | 100 | 68 | 9 | 8 | 15 |
| At least 11 years | 6,461 | 100 | 78 | 6 | 10 | 6 |
| **BY UNEMPLOYMENT b** | | | | | | |
| Those who reported unemployment | 10,600 | 100 | 41 | 9 | 14 | 36 |
| Those who did not report unemployment | 52,745 | 100 | 67 | 8 | 11 | 14 |
| **BY ANNUAL EARNINGS b** | | | | | | |
| Lower Wage Workers (< $15,000) | 17,409 | 100 | 30 | 10 | 20 | 40 |
| Higher Wage Workers (> $15,000) | 45,604 | 100 | 76 | 7 | 8 | 9 |
| **BY FIRM SIZE d** | | | | | | |
| Less than 25 Employees | 19,587 | 100 | 35 | 13 | 21 | 31 |
| Between 25 and 99 Employees | 8,456 | 100 | 63 | 8 | 8 | 21 |
| At least 100 Employees | 35,301 | 100 | 78 | 5 | 8 | 9 |
| **BY INDUSTRY d, e** | | | | | | |
| Agriculture/Forestry | 2,413 | 100 | 23 | 11 | 30 | 36 |
| Construction | 7,284 | 100 | 43 | 12 | 13 | 32 |
| Retail Trade | 8,252 | 100 | 49 | 9 | 16 | 26 |
| Business/Repair Services | 4,439 | 100 | 49 | 11 | 14 | 26 |
| Personal Services | 1,306 | 100 | 46 | 10 | 16 | 28 |
| Entertainment Services | 841 | 100 | 45 | 8 | 21 | 26 |
| **ALL MEN WORKERS** | **63,345** | **100** | **63** | **8** | **12** | **17** |

Notes: a Percents may not add to 100 due to rounding.
b Refers to 1990 calendar year.
c Refers to jobs held in January 1991. A smaller data sample consisting of matched data from the January and March Current Population Surveys was used for this analysis.
d Refers to longest job held in 1990.
e Six industries with lowest rates of direct employer coverage.

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

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

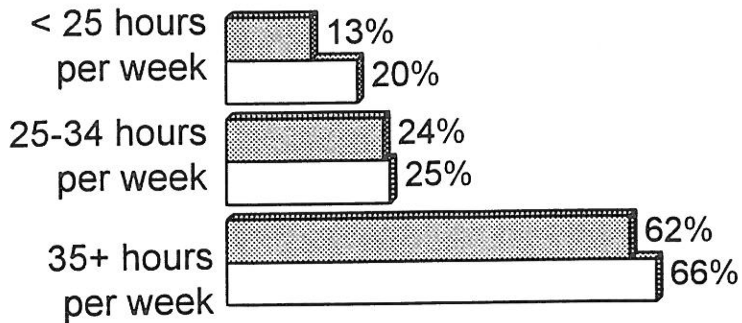
- **Women have less access to health insurance from their own employers (direct-employer based) than do men.**
- **Considering all sources, men have slightly less health insurance than women.**



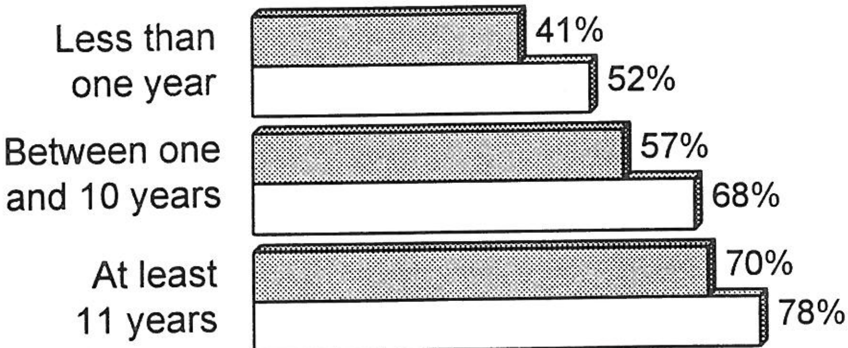

Source: IWPR analysis of data from the March 1991 Current Population Survey.

## Figure 2. Direct - Employer Based Coverage for Employees Ages 21-64 by Gender, Hours Worked Per Week, Firm Size, and Job Tenure

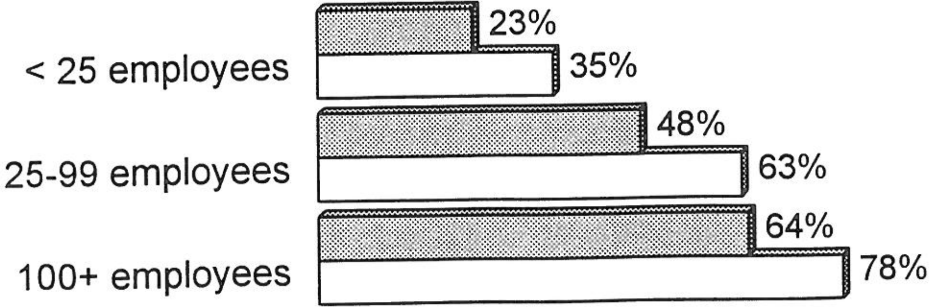
*Percent with Health Insurance from Own Employer*




▸ The more hours you work per week, the more likely you are to have health insurance from your own employer.




▸ The longer you are on the job, the more likely you are to have health insurance from your own employer.




▸ The larger the firm you work for, the more likely you are to have insurance from your own employer.

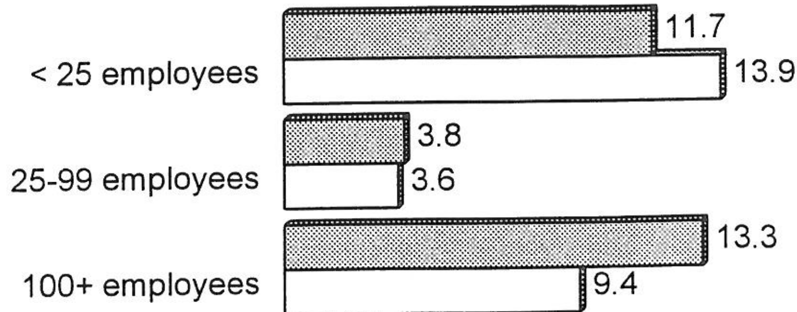
Women  Men

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

## Figure 3. Impact of Health Security Act on Workers Aged 18-64

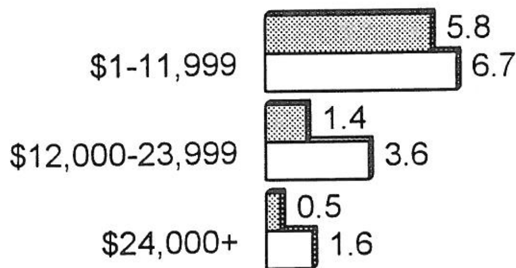
*Number of Workers (in Millions) Gaining Health Insurance from Own Employer*

### By Firm Size




- About one-half of workers who would gain health insurance from their own employers work in small firms with fewer than 25 employees.

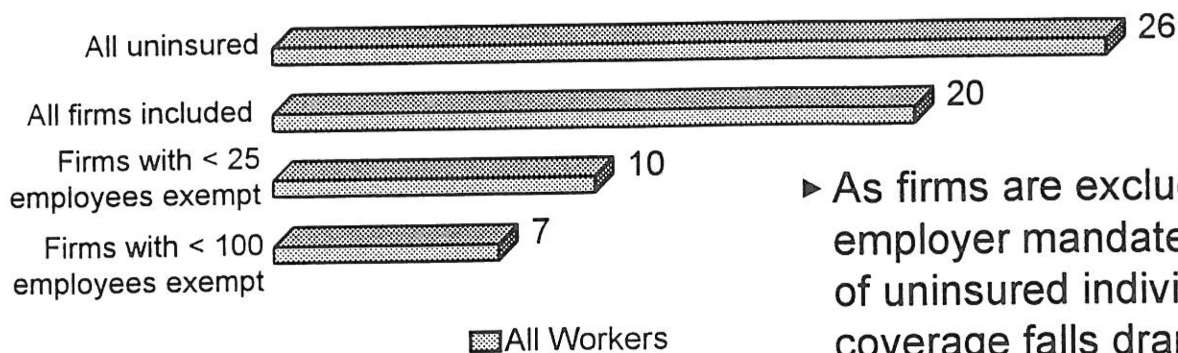
### By Earnings




- Nearly two-thirds of the uninsured who would gain health insurance from their own employer earn less than $12,000 per year.

Women Men

### Alternative Mandates




- As firms are excluded from the employer mandate, the number of uninsured individuals gaining coverage falls dramatically.

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