



May 2006

An Ethnographic Look at Healthcare Choices of the Working Poor

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Recommended Citation

Pulos, Nicholas, "An Ethnographic Look at Healthcare Choices of the Working Poor" 01 May 2006.
CUREJ: College Undergraduate Research Electronic Journal, University of Pennsylvania,
<http://repository.upenn.edu/curej/16>.

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Abstract

This study looks at the effect of U.S. healthcare policies on the working poor. Following up on previous research that looked at risk factors involved in the take-up rate of insurance, this paper addresses how those risk factors contribute to an individual's decision to purchase health insurance. The author argues that the working poor are an especially important group to study because they are often too wealthy to afford public insurance, but cannot afford to purchase private insurance *carte blanche*. Using ethnographic data collected at a small business in Philadelphia, the author concludes that while certain risk factors are significant, more enlightening, the working poor are generally uninformed about health insurance in general. Though being uneducated about healthcare and health insurance is probably not unique to this group, they are most affected by this lack of knowledge because of their precarious position in the U.S. healthcare system.

Keywords

healthcare, health insurance, take-up rate, working poor, ethnography, urban studies, Eric Schneider, Eric, Schneider

**An Ethnographic Look at Healthcare
Choices of the Working Poor**
Nicholas Pulos

1.0 Introduction

Once the largest uninsured demographic, there are virtually no uninsured elderly today thanks to Medicare. When Medicare and Medicaid were introduced in 1965 they represented the government's first large public health insurance program. With an overall goal of covering the elderly and poor respectively, these programs have been relatively successful. When they were created, the government assumed that people who were not poor or elderly were insured through employment-based health insurance. As the economy has changed and healthcare costs have risen, fewer workers are covered today than ever. Despite the government's previous success, virtually no healthcare reform has taken place in over forty years to accompany this change in the economy.

The current system of employment-based health insurance is archaic. Medicare and Medicaid are merely patches to cover up gaping holes in the system. Today there are 46 million uninsured Americans. These people neither receive insurance through an employer nor qualify for one of the government's two major public health insurance programs. Yet many of the uninsured are employed. They may work for small businesses which do not offer health insurance, or through part-time employment do not qualify for their employer's insurance plan. These uninsured Americans rely on a combination of charity, bad debt, and out-of pocket healthcare.

The people that overwhelmingly fall victim to this system have been called tweeners because they make too much to qualify for public insurance, but are not wealthy enough to purchase private insurance *carte blanche*. Thus they fall between two systems of health insurance. These people not only have to make the toughest decisions about their healthcare, but would be most affected by major policy change (Pulos, 2005).

This paper looks at the factors involved the tweener's decision to purchase insurance and the consequences of that decision. Though there is much literature regarding the uninsured, little is written about this specific group. Last semester a similar study was conducted using the Community Tracking Study-Household Survey. That study also looked at tweeners, but it could only show statistical relationships rather than factors in decision making. This study uses interviews from workers at a small business in Philadelphia, which does not offer insurance, to determine what variables factor into an employee's decision to purchase insurance.

This research set out to settle some of the arguments and contradictions in previous literature such as the importance of age and education. It became clear in the interviews, however, that tweeners were in general uninformed about health insurance and healthcare delivery. Those who were well informed however, fared the best, and found a way to stay afloat in America's fragmented system of healthcare coverage.

2.0 Background

The Gap in Healthcare Coverage

Most Americans receive health insurance for themselves and their dependents through their employers. This system of providing health insurance through employment grew rapidly during World War II when, in an effort to control inflation, wages were capped by the War Labor Board. As employers tried to find ways to attract and retain to employees, health insurance was added as a benefit to increase workers "incomes," without increasing their wages. Further reinforcing this system, the Internal Revenue Service decided that health insurance benefits were a business expense and therefore not taxable. Employment-based coverage became the norm in the United States, benefiting virtually all workers and their families.

Although most people still receive their healthcare through employment, businesses are by no means obligated to offer health insurance to their employees. Sered and Fernandopulle (2005) discuss that while this system used to work well for blue-collar workers who had union contracts as well as white-collar workers who remained with the same companies for years, the nature of the economy has changed—necessitating a change in healthcare practices. Workers no longer remain in the same job for extended periods of time, and temporary employees are often hired for positions that had previously been filled by full-time workers. Both of these conditions cause many workers today to remain ineligible for benefits despite their constant participation in the workforce.

Decline in Employment-Based Coverage

Only 70 million of the 120 million workers in the United States under 65 years of age are insured through their employer (Collins et al., 2005). The fact that an increasing number of workers do not obtain health insurance from their employer suggests that employers avoid offering insurance because of the rising costs of healthcare coverage. Health insurance premiums have steadily increased at a rate faster than the rise in wages. In 2004, private health insurance premiums increased 11.2%, five times the rate of growth in workers' wages and inflation (Survey, 2005). While insurance premiums have regularly increased more than inflation and wages for the last fifty years, little has been done to slow the rate of growth. Statistically, those most at risk of being uninsured are low-wage workers, and those employed by small businesses. Often times these employees are ineligible for employment-based health coverage or their employers simply do not offer coverage.

Even if an employer offers health insurance, however, this does not guarantee that workers will join the plan. When Cooper and Schone (1997) looked at the change in

employment-based coverage from the years 1987-1996, they observed that while the proportion of workers obtaining health insurance through their employer was falling, the number of employers offering coverage was actually increasing. These findings suggest that the decline in employment based coverage is due to a decline in the “take-up rate of insurance.” In 1987, 93% of workers offered employment-based insurance accepted the offer. In 1996 this number dropped to 89%. By 2001, less than 80% of workers who were eligible for employment-based health insurance were covered by their employer (Collins et al., 2005).

Reasons for eligible workers not joining their employers’ plans vary. Of those who choose to turn down employment-based health insurance, about 17% are covered by a spouse or other family member, 13% are covered by public insurance, and the rest go without coverage. The decision to go without coverage seems to be strongly linked to income. While 86% of high-wage workers participated in their employers’ coverage, only 64% of eligible low-wage workers decided to join in 2001. Cooper and Schone (1997) anticipated these findings in their 1997 paper when they noted that the differences in take-up rates between low-wage and high-wage workers were statistically significant, and that these disparities increased between 1987 and 1996. Cooper and Schone also found that factors other than income may contribute to a worker’s decision to purchase employment-based insurance. Workers under 25 were least likely to have employment-based insurance coverage than those in other age groups in both time periods. And while differences in take-up rates between black Americans and white Americans were not statistically significant, Hispanics did have a significantly lower take-up rate. Nevertheless, Collins et al. (2005) conclude that, “affordability concerns are likely the principle reason that low-income workers decline coverage and become uninsured.”

Kronick and Gilmer (1999) agree that the reason fewer people are purchasing employment-based insurance is that there is an increasing proportion of workers for whom medical expenditures consume a substantial part of their income. From 1979-1984, per capita health expenditures were less than five percent of income for half of all workers and ten percent or more of income for about one-fifth of workers. This number changed in the early nineties when per capita expenditures were less than five percent for only one-quarter of the workers and more than ten percent for a third of all workers. Thus, Kronick and Gilmer argue, health insurance has become unaffordable for an increasing number of workers.

The Affordability Issue

The relationship between wage and the take-up rate of employment-based coverage is certainly important, but Bundorf and Pauly (2002) suggest that affordability is not a good predictor of insurance coverage. Looking at affordability in the normative sense (determining affordability by looking strictly at the poverty level), they note that of individuals whose families have an income of twice the poverty level or less, 36% are uninsured, while 44% are privately insured. If affordability is viewed as the burden a family faces when purchasing insurance, it would seem that families in this income group would have similar purchasing patterns. Burndorf and Pauly conclude that using a normative standard, “many people who cannot afford health insurance actually purchase coverage and many people who can afford coverage remain uninsured.” (Bundorf and Pauly, 2002) A more behavioral definition of affordability leads to similar results. Here, health insurance is defined as affordable if the majority of people in similar circumstances obtain health insurance. Using this new definition, they find that coverage was “affordable” to more than half of the uninsured in 2000. Though their model is hardly concrete,

Bundorf and Pauly's results are useful in showing that an individual's decision to purchase insurance is not as simple as relating cost to income.

Decision Making?

Bradley Herring (2005) offers a suggestion for why people in similar economic situations differ in their healthcare choices. He argues that looking at the absolute cost of health insurance is erroneous and that economists should look at the cost of insurance relative to the costs associated with being uninsured. Thus, the amount of charity care that an individual is likely to receive may factor into their decision about whether or not to purchase healthcare. Charity care is uncompensated care generally given by hospitals to patients who the hospital deems unable to pay for their medical care. Of course the effect of this charity care in determining healthcare coverage diminishes as income rises. Herring finds that while the low-income uninsured pay for one-third of their medical care, the high-income uninsured, on average, pay for almost half of their medical care (Herring, 2005). The amount of charity care that one may receive in a given year, however, is unknown at the start of the year. Therefore, in order for a person to make a healthcare decision for an upcoming year, they must estimate the amount of free care they are likely to receive. Rask and Rask (2000) first suggested this hypothesis in their 2000 paper. They used the 1987 Medical Expenditure Survey to find that the presence of a public hospital had a negative affect on having private health insurance for those with incomes between 100% and 400% of the poverty level.¹ The statistics from the Community Tracking Study back up Herring's findings. In the study, 72.3% of people who are uninsured reported no cost-related difficulties in obtaining care, and that access to charity care is a "strongly significant predictor of

¹ The authors acknowledge the opportunity for variable bias in the experiment if public hospitals are more frequently located in poorer neighborhoods. To account for this they created a propensity score for hospitals and found that there did not appear to be a "large systematic component in the location of public hospitals" (Rask and Rask, 2000). This allowed the authors to draw conclusion about the impact of public hospitals on the take-up rate of insurance.

lower out-of-pocket spending for uninsured families” (Herring, 2005). From a policy perspective this result has interesting implications. Herring concludes that increasing the availability of charity care, to a level at which out-of-pocket expenses decrease by ten percent, would lead to an increase in the number of people without private insurance by almost a million.

Pulos (2005) looks at demographic variables to explain differences in the take-up rate of insurance. He finds that education is perhaps the best predictor of the decision to purchase private insurance. Census income is still significant in his model, but perhaps not as important as education. He suggests that the limited significance of income stems from the fact that the sample only contains people between 100% and 200% of the poverty level. This narrow range of incomes may make income appear less significant than in a broader sample. Nevertheless, from the coefficients generated in the three-stage least squares regression, one additional year of education has the same effect on the purchase of insurance as almost \$7300 in additional income. For those in the study, this represents a nearly 30% increase in income. Pulos also notes that while this result may seem obvious, in his sample, education is not a statistically significant indicator of income.² Though years of schooling appear to be important, Pulos argues that education is probably a proxy for other differences in demographics (ie. middle class upbringing). In this case, people may value insurance differently based on whether or not they had it as a child.

Pulos also argues that one’s general health also factors into their decision to purchase private insurance. Using a three-stage least squares regression, he finds that those in poorer health are more likely to purchase insurance despite the fact that having private insurance indicates better health. This suggests that having private insurance is beneficial to one’s health.

² When census income was the dependent variable in a regression run with highest grade completed, the coefficient on education was actually negative, with a t score of $t=-1.40$, corresponding to a probability of $p>.16$. Pulos suggests that this is a result of using such a narrow range of incomes.

Thus he concludes that should policy change occur it should come in the form of increasing the availability of private insurance rather than expanding public insurance to the uninsured.

Another variable which may factor into the decision to purchase insurance is quality. Sered and Fernandopulle concede that when low-wage workers are offered employment-based health insurance, the price is often astronomical, but perhaps more enlightening, "...the insurance packages now offered to low-wage employees increasingly tend to include stripped-down policies with spotty coverage or severe limits. The insurance plans provided to low-wage workers often lack coverage for prescription drugs, dental care, vision services and care of dependents" (Sered and Fernandopulle, 2005). As premiums increase, the employers offer plans that are more affordable, at the expense of more comprehensive care. Long and her colleagues found evidence to support Sered and Fernandopulle's observations when they looked at access to care for low-income mothers. They found that private insurance for low-income families was similar in terms of use and access to that of Medicaid (Long et al., 2005).

Similar conclusions were found by Freeman and Corey (1993) using earlier data from the Health Interview Surveys of 1983, 1984, and 1986. Looking at people in poverty, those on Medicaid utilized healthcare services almost twice as much as the uninsured. More surprisingly, however, they found that poor people with private insurance and without insurance had the same average number of visits to their physician. They also found that the hospitalization rates of these people with private insurance were more similar to the uninsured than to those on Medicaid. They concluded that for people in poverty, economic barriers in the form of co-payments and deductibles (out-of-pocket expenses) prevent private insurance from being any more valuable than no insurance at all. This seems to contradict Pulos (2005) which argued that private insurance was more efficient than public insurance in terms of healthcare delivery.

Regardless of the quality of care that these patients receive, given the findings of both Freeman and Long, it is not surprising that low-wage workers have a lower take-up rate of employment-based insurance.

The results of the RAND Health Insurance Experiment, which looked at how increased co-pays and deductibles affected overall health, suggest that decreased use of services is not necessarily bad. In one of the largest, randomly controlled health experiments ever, researchers assigned different health plans to random families to see the effect that co-pay had on use of medical services. The deductibles ranged from completely free care to the patients paying 95% of their medical bills. The researchers found that the greater proportion of their medical bills people had to pay, the less healthcare services they used. While this result is not all that surprising, what was of interest to the researchers was the extent to which people increased their use of healthcare services when on free care. The fully insured purchased 40% more healthcare than those who had to pay the entire bill themselves. This increased use of services, however, had no effect on the overall health of the subjects. In fact, those who were covered under the free care policy actually had more “work loss days” (sick days), implying they were sicker. Researchers generally agreed that this had more to do with spending extra time getting treated for illnesses than that patients who had free care were actually in worse health. (Newhouse, 1993). This increased use of services is generally known as the “moral hazard” associated with receiving free care. If the results of the RAND Health Insurance Experiment are correct, then increased deductibles and co-pays do not negatively affect the general health of patients as Freeman and Corey suggest. In fact cost shifting from the insurance company to the consumer may decrease medical care costs in general by decreasing the use of services without compromising health.

Who are the Uninsured?

Both Long and Freeman and Corey look at the quality of care for those in lower income groups. This is useful from a policy perspective since the employment-based insurance of low-wage workers is more of a concern than for higher-wage workers. It should not be assumed, however, that all uninsured people are poor. When the California Healthcare Foundation set out to identify the non-poor uninsured (those with incomes more than 200% the poverty line), they found that almost half had a yearly income of \$40,000 or more, and perhaps more surprisingly that 92% had bought some sort of insurance other than health insurance. Only 12% of respondents reported fair or poor health, and more than half reported having received medical care within the last year. Consistent with the results that Long, Freeman and Corey, and Kronic and Gilmer found when looking at low-income individuals, the number one reason for not purchasing insurance among the non-poor was cost. Alarming, 75% of those surveyed overestimated the cost of insurance, and when informed of the actual cost of insurance plans nearly half expressed interest.

While previous studies have examined healthcare choice on a large scale, few have taken a closer look at the actual choices individuals make. The California Healthcare Foundation came closest in doing a comprehensive study of the uninsured, but my study aims to look at the working poor, both insured and uninsured. This study will examine insurance “choice” for tweens by looking at a small group of individuals and asking them questions both about their current healthcare and about how they think about healthcare in general. Previous research leaves the door open for a study to be done to find out how people decide whether or not to purchase insurance. While statistical analysis can show what factors are significant, it cannot show the underlying thought that make these factors important. By using in-depth interviews of

a small group of tweeners, I will be able to better identify the thought processes of tweeners and connect them back to the factors that previous research has shown to be important.

3.0 Methodology

For the purpose of this study, tweeners are defined as those individuals for whom private health insurance is obtainable, but not affordable. Previous research has focused on people between 100%-200% of the poverty level (Pulos, 2005). For this study, the sample is thirteen employees from a small bakery (95 employees) in Philadelphia. All interviewees will be asked to self-report their approximate income from 2005 and their number of dependents. These two numbers allow poverty level to be calculated for each individual.

2005 HHS Poverty Guidelines

Persons in Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$ 9,570	\$11,950	\$11,010
2	12,830	16,030	14,760
3	16,090	20,110	18,510
4	19,350	24,190	22,260
5	22,610	28,270	26,010
6	25,870	32,350	29,760
7	29,130	36,430	33,510
8	32,390	40,510	37,260
For each additional person, add	3,260	4,080	3,750

SOURCE: *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375

Though being in tweener range was important for Pulos (2005) by focusing on a specific group within the CTS-HS, having respondents be slightly above or below this range in this study will not significantly affect the research. The range was more a tool for statistical analysis than an absolute definition of tweeners.

This research will not provide an accurate view of the United States as a whole, but it will provide a more qualitative look at an individual's decision to purchase insurance. The goal of this research is to settle some of the arguments in the literature such as the importance of education, age, and willingness to purchase insurance.

The specific bakery observed in the study was chosen as the site for the interviews because its employees are, by definition, tweeners. They are too wealthy to qualify for public insurance, but few have private insurance since, like many small businesses, the bakery does not offer employment-based insurance to all of its employees. To qualify for employment-based insurance an employee must be a supervisor. Of those interviewed, only three were eligible. For

those who do qualify for this benefit, the cost is still significant. The bakery offers the choice of receiving the benefit or an increase in salary.

The thirteen employees interviewed represent the totality of the non-elderly morning shift at the bakery and are familiar with the interviewer. Though none of the interviewees were prompted with a list of sample questions, several knew of the researcher's project before the interview. Interviews were conducted in February and March of 2006 and respondents were asked about their healthcare for 2005. Prior to each interview, respondents were asked to fill out an informed consent form (Appendix 1). Then there were three lines of questioning that each interview covered:

1. Demographic information
2. Healthcare delivery information
3. Open-ended questioning about healthcare experience/thought processes

The responses to these questions were tape-recorded upon interviewee consent. At the conclusion of the one hour interview respondents were compensated ten dollars for their time.

The first two sets of questions were based strictly on the questions used in the Community Tracking Study-Household Survey (CTS-HS) (2000). Previous research has made the case for these questions to be of importance in determining demographic characteristics and assessing healthcare delivery. The wording of these questions was identical to that of the CTS-HS to provide consistency in case the researcher wished to compare the findings of this study to those of previous studies involving tweeners. These questions have also been proven to elicit the types of answers that the researcher is looking for. The third line of questioning was more provocative and took up the majority of the interview time. For a complete look at the interview guide see Appendix 1.

The purpose of this last set of questions was to have respondents elaborate on how they feel the healthcare system works, what they actually want out of a healthcare system, and how they make healthcare decisions. In the end this set of questions should tell the researcher the following about the working poor:

1. Why they choose to purchase or not to purchase healthcare
2. How confident they are that they could get healthcare if they needed it
3. How their childhood experiences with healthcare affect their choices as adults
4. The threshold value for purchasing insurance (either the price at which they would buy it or the price at which they would drop it depending on their current status)
5. How knowledgeable they are about the current healthcare system
6. How they view the healthcare system (ie. marginalized by it, pleased by it, unaffected by it)

Each interviewee was also shown a list of health insurance quotes which showed various plans that they were eligible for on the open market. This was used as an aid to assess each interviewee's willingness to purchase insurance.

4.0 Data

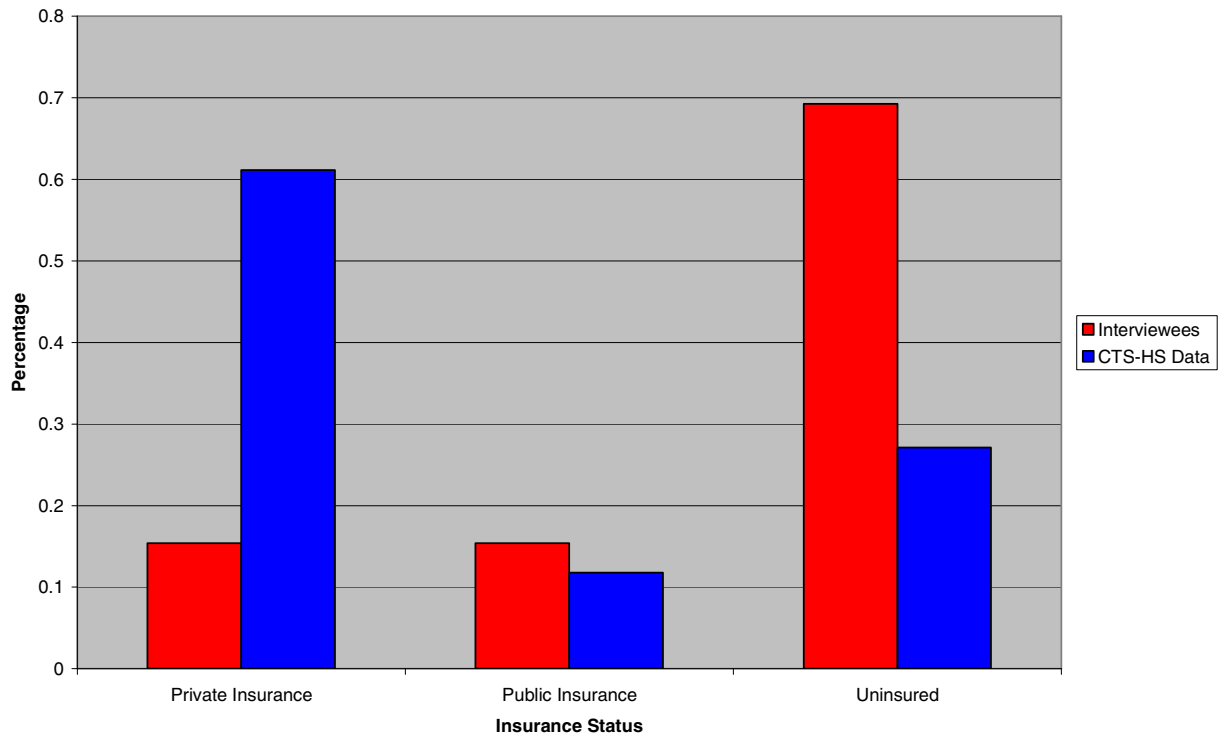
The following chart shows a statistical summary of the data taken in the interviews regarding demographics and general healthcare delivery.

Variable	Observations	Mean	Std. Deviation	Min	Max
Age	13	32.3077	11.6861	59	19
Male	13	0.8462	0.3755	0	1
Highest Grade Completed	13	13	2.0412	10	16
Census Income	12	21,583.33	9967.75	6,000	38,000
White	13	0.3846	0.5064	0	1
Black	13	0.3846	0.5064	0	1
Hispanic	13	0.2308	0.4385	0	1

Eligible	13	0.2308	0.4385	0	1
Excellent Health	13	0.0769	0.2774	0	1
Very Good Health	13	0.3846	0.5063	0	1
Good Health	13	0.3846	0.5063	0	1
Fair Health	13	0.1538	0.3755	0	1
Poor Health	13	0	0	0	0
Very Satisfied	13	0.0769	0.2774	0	1
Somewhat Satisfied	13	0.3077	0.4804	0	1
Neither Satisfied nor Diss.	13	0.0769	0.2774	0	1
Somewhat Dissatisfied	13	0.3077	0.4804	0	1
Very Dissatisfied	13	0.2308	0.4385	0	1
Overnight	13	0.0769	0.2774	0	1
Total Nights	13	0.2308	0.8321	0	3
ER Visits	13	0.6923	1.0316	0	3
Dr Visits	13	0.9231	0.7596	0	2
Surgery	13	0.1539	0.3755	0	1
Flu Shot	13	0.1539	0.3755	0	1
Unmet Medical Needs	13	0.3846	0.5064	0	1
Put-Off Needed Care	13	0.6923	0.4804	0	1
Private Insurance	13	0.1538	0.3755	0	1
Public Insurance	13	0.1538	0.3755	0	1
Uninsured	13	0.6923	0.4803	0	1

There are several differences between this data and the data Pulos (2005) from the CTS-HS. The first is that racial proportions in this study are more evenly distributed than they are in the CTS-HS. In the CTS-HS, more than 50% of respondents were white and only 15% were black. In this study however, nearly 40% of interviewees were white, the same proportion as black, and the rest of respondents were Hispanic. The proportion of uninsured is much greater in this study than in the CTS-HS most likely because the sample is taken from a business which does not provide employment-based health insurance.

Qualitative Data v. CTS-HS Data



In the CTS-HS, 30% of respondents were uninsured, whereas nearly 70% of respondents in this study were uninsured. The fact that such a large proportion of the interviewees were uninsured is probably the reason a much higher percentage of respondents said they were “very dissatisfied” with the healthcare received than prior studies. Roughly 23% of interviewees said that they were “very dissatisfied” with their healthcare as opposed to less than 7% in the CTS-HS. Nevertheless, this statistical summary confirms that Metropolitan Bakery was a good site for conducting interviews with tweeners since the average income in this study was \$21,583.33 compared to \$21,683.40 in the CTS-HS. This observation encourages the researcher that a reasonable sub-sample has been identified.

5.0 Examining the Hypotheses

Do Tweeners Exist?

To be a tweener is to fall between two systems of healthcare coverage. People in this group do not make enough money to easily afford private insurance, but make too much money to qualify for public insurance. Though all stressed the financial burden that purchasing health insurance would bring, John, a 27 year old Hispanic male, provides the best example of what it means to be a tweener. With two dependents, John, does not have health insurance for himself or his kids. Being on salary at \$25,000 per year, John makes 155.38% of the federal poverty level. Last year he had to put off going to the doctor for a fever because of the cost of the doctor and cost of missing a day of work. Though he went to the free clinic last year once for a physical, it took all day. When he came down with a fever later in the year he decided to take his chances at the ER where he received a \$200 bill for his visit and prescriptions. He was very dissatisfied with his care because he feels the hospital was prejudiced against him not only for being uninsured but also for being Hispanic. He claims that doctors were condescending and that he waited longer to see a doctor than he would have had he been white. While he says he is in very good health, he worries about his kids being uninsured. He estimates that he paid \$500 for his children's healthcare out-of-pocket. The cost of purchasing insurance is the number one reason he remains uninsured. He estimates he could afford a monthly premium of \$100 for comprehensive insurance for himself and his family. When asked who was responsible for him being uninsured he answered "Uncle Sam." When he applied for public insurance they told him he was not eligible because he "made too much...get your own." This is the essence of what it means to be a tweener. Though he fears having insurance would not completely solve the problem of prejudice in hospitals, it would allow his kids to get the check-ups they need. He thinks about his health and his kids' health everyday, but does not see his situation changing anytime soon.

Insurance Status as Choice versus Consequence

This study assumes that tweeners are actively making decisions about their healthcare and insurance status. In order to confirm this, respondents were asked, “Do you view your health insurance status as a choice?” There was also a follow-up question, “Do you view your health insurance status as an inevitable consequence of your situation.” Surprisingly, more than half of all respondents said that they did not view their insurance status as a choice, but as a consequence of their situation. When asked who was responsible for not being insured, answers varied. Some said that though they did not choose to be uninsured, they themselves were responsible for not being uninsured by choosing the field or putting themselves in a situation which made them unable to purchase insurance. A few blamed the employer or the industry in general for not providing insurance. About one third of respondents blamed the government.

Interestingly, age was perfectly correlated with the choice versus consequence question. Respondents older than 30 said that their insurance status was a choice, while younger respondents, younger than 27 suggested that their insurance status was a consequence of their situation and were more likely to blame others for their insurance status. This result was so highly correlated that respondents whose age range was between 30 and 27 said that it was part choice and part consequence that led them to their insurance status.

There are a few reasons that responses may be highly correlated with age. The first is that as people get older, they lose some of their ideologies that they had growing up. While everyone said that health insurance is a right rather than a privilege, younger respondents were more likely to bring up politics or issues larger than the individual. Carlos, a Hispanic male age 25, who was one of the few respondents eligible for health insurance through Metropolitan Bakery, said that the government was 95% responsible for him being uninsured. He turned

down the bakery's offer to insure him because he said the plan was too expensive (in excess of \$800 per month). Carlos added "...that's why we need Hillary Clinton to be president."

Responses which place blame on sources outside the individual may indicate that tweeners are not actually making decisions about healthcare. After all, if someone is uninsured as a consequence of their situation, then any efforts to become insured would be futile. It is not convincing to me that this is necessarily the case. Despite the fact that all of the young interviewees said that they were uninsured as a consequence of their situation, many suggested that if health insurance was cheaper they would purchase it. In essence tweeners use two factors to determine their insurance status: the relative cost of insurance and their risk, which seems to be a function of age and/or general health.

Age and Willingness to Purchase Insurance

Previous studies have been mixed on whether or not age is a good indicator of insurance status. Cooper and Schone (1997) found that workers under 25 were less likely to have employment-based insurance than older workers. Pulos (2005) and the California Healthcare Foundation (2005) found a more spurious connection. While Pulos found no significant relationship between age and the take-up rate of insurance there was a connection between general health and the purchasing of private insurance. There was also a connection between age and general health which was statistically significant. Therefore while age was not a good indicator of insurance status, age's relationship with general health was an important factor. For respondents in this study, age was of great importance. One of the two respondents who had private insurance, Calvin, was black male age 59, who received insurance through a previous job and now through his wife's employer. He said that though he had no chronic healthcare issues that made health insurance a higher priority for him, when he and his wife were offered

employment-based insurance they jumped at the opportunity because they knew they “wanted healthcare.” He suggested that not having insurance would have a significant effect on his health. He could not imagine what would have happened when he had bronchitis or pneumonia had he not had insurance at the time. Both respondents with public insurance, ages 41 and 48, said that they would find a way to purchase insurance if they became ineligible for public insurance. Eddie, a 40 year old black male said that though he never bought health insurance in the past, his recent hernia made the purchase of health insurance a big priority for him. He said that he was currently seeking health insurance.

Not only were older workers more likely to purchase insurance or express interest in insurance, but younger workers suggested that as they got older, health insurance would become a bigger priority. Clearly this supports Cooper and Schone’s findings while seemingly contradicting Pulos. Age it appears, however, is more of a proxy for general health than an absolute number. Therefore when Pulos (2005), found no statistical relationship for age and health insurance status, it was because people with similar ages but different levels of general health made different decisions. In other words, there is not a normative relationship between age and the take-up rate of insurance. Rather “age” is used by the respondents as a relative term which indicates poor health and decreased mobility. In this study this is best illustrated with Gerald and Eddie. Despite similar ages their view of what is “old” is different and therefore their thoughts on purchasing insurance are different.

Gerald, a 34 year old white male, suggested that while he is healthy now and therefore does not need insurance, one day he will not be so healthy and therefore purchasing insurance would be a higher priority. At 34, however, health insurance was, as expenditure, “near the

bottom.” While Gerald’s opinions on health insurance were not unusual for the younger group when it came to age, he was unique in his approach to making decisions about insurance.

Case Study #1: A Rational Economic Decision?

Upon promotion to manager at the bakery, Gerald was given the option of participating in the bakery’s health insurance plan. Though he does not remember the specifics of the plan, he remembers that his share of the premium would be \$200 per month. He thought about it for a while, but in the end declined the offer. The way that Gerald puts it, it was a financial decision. “I’d rather have \$200 extra dollars at the end of the month.” Last year Gerald estimates that he spent about \$600 on healthcare he received for pneumonia. He was treated by a doctor at a private practice around the corner from his house and had to purchase medications. All of his expenses were out-of-pocket. As soon as he stated how much he spent last year on healthcare, he immediately offered that the amount was half of what he would have paid for insurance through the bakery. It was in his words a “rip-off.” When asked at what price he would be willing to purchase health insurance, he responded no more that \$50 per month. Insurance for Gerald was more for peace of mind than an actual contributor to better health.

None of the other interviewees so blatantly discussed the mathematics of their decision to purchase insurance. Gerald it seems made a rational decision based on the information he was given. He spent \$600 last year on healthcare and therefore is not willing to spend more that \$600 on insurance, assuming that his healthcare costs are constant from year to year. While Gerald was proud of his rationality in the interview, the fact is that he is making an unformed decision. Not only are healthcare costs rising, which would mean he needs to increase his healthcare budget accordingly, but he is incorrectly assessing his risk. Health insurance, though used most often to cover doctors’ visits and prescriptions, is supposed to be a safety net for some high cost

low risk event. Therefore Gerald estimating that he will spend the same amount from year to year, is ignoring the fact that there is a probability that he will fall victim to some catastrophic medical event (ie. hernia). In this case he should increase his threshold for purchasing insurance accordingly. While Gerald was unique in being so “rational” about his decision, he was using incomplete information and therefore was not alone in being a victim of the healthcare system.

Case Study #2: An Informed Healthcare Consumer

A recent injury to Eddie, had a completely different effect on his opinion of health insurance. He said that he is in good health, but at the end of last year suffered a hernia which sent him to the emergency room. With no health insurance, he said that he was anxious during the ride to the emergency room. The injury required him to have surgery and stay in the hospital for three nights. He said that despite not having insurance, he had a good experience at the hospital (besides the food). “I saw a doctor within twenty minutes,” he recalled. He knew he needed medical attention prior to finally pulling a muscle at work, but “couldn’t afford it, both in terms of work and care.” He estimated the cost would be a couple thousand dollars. After leaving the hospital he received a bill for less than \$500. Eddie knew he narrowly escaped a crippling hospital bill. He was unclear what happened to the rest of the bill which he knows was more than \$10,000. While in the hospital administrators tried to find government programs which he could qualify for. He did not know about the outcome of those searches, but was grateful that he did not have to pay for the entire bill which would be more than half his yearly income.

Having a mother who is a nurse and having had healthcare his entire childhood through his step-father’s employment in the military, it would seem Eddie would be particularly predisposed to purchasing health insurance. Instead he said that it allowed him to go a long time

without seeing a doctor by simply consulting with his mother whenever he was sick. He said that not having healthcare was a choice that he made. That if he wanted it, he could afford it and therefore he is totally responsible for his situation. The hernia has made him rethink his priorities. Short of rent, food, and a tax levy which he is required to pay, healthcare is his most important expenditure. He is now actively seeking out private insurance and would be willing to lower his wage by 20% if it allowed him to have health insurance.

What makes Eddie's story so interesting is that he has perhaps made the best decisions about healthcare. His mom being a nurse was essentially a substitute for health insurance. Instead of going to a doctor, he would consult his mother for medical advice. Likewise when he had serious medical problem he went to the hospital and ended up with only having to pay a fraction of the bill. Unlike Gerald, who appears rational but has incomplete information, Eddie has good information and therefore has played the system perfectly. Eddie's hernia indicates to him that it is time to get insurance because for the rest of his life medical care will be a necessity, whereas earlier in his life it was not.

Purchasing insurance was in the end, however, an economic decision for nearly all of the respondents. All of the uninsured respondents ranked cost as the number one reason they did not have health insurance. Vanessa, a 21 year old female of mixed race, when asked why she did not purchase health insurance said that she had no money and that her "salary left no room" for insurance. For Vanessa, health insurance was a relatively low priority. After she paid her student loans, car payments, gas, put aside money for an apartment of her own, and went out to eat, there was no money left for health insurance. Last year she only had to go to the doctor once for a sinus and respiratory infection. She went to a family doctor that she used to go to when she was covered by her parents' health insurance. Her total health expenditures last year were less

than \$100. Vanessa said that purchasing health insurance would make her “feel better,” but probably would not improve her current health. Given that for tweens purchasing health insurance is an economic decision, it is important that tweens can actually estimate their health risks from a financial standpoint. Few interviewed however were able to do this.

Importance of Health Insurance in General

Going along with other trends in the data, the importance of healthcare and age were related. Respondents older than 40 said that healthcare was very important to them. Respondents under 40 years of age generally said that health insurance was less important to them. When asked how important healthcare was to them personally, one young respondent said, “not as important as it should be.” Indeed when asked to list expenditures which were more important to them than health insurance, younger respondents had longer lists. While food and rent were universal responses, cell phones and entertainment were unique among respondents under 40. One young respondent was even as frank as to list “weed” and “beer” as more important expenditures than health insurance.

What the younger respondents had in common that may explain this apathy to health insurance was better general health. Most of the doctor visits for the younger interviewees were related to injuries, while older respondents went to doctors and hospitals for healthcare. Travis, a 24 year old white male and college graduate, said that health to him was extremely important even, “more so than others.” Travis however was not very likely to purchase health insurance, despite having a serious knee injury. Travis was forced to spend \$5,000 last year for a torn ACL that he received playing in the snow. He argued that taking care of oneself is a better substitute for health insurance. If he was more flexible, he claimed he would not have hurt his knee. Though he thinks about his health everyday, health insurance was of little importance to him. He

prefers to spend his money on eating well and yoga than on insurance. Travis has received a payment plan for paying off the \$5,000 medical bill for his recent surgery. Despite the recency of his injury, he had no plans to purchase health insurance. He did admit that as he ages, it will be inevitable that he has to go to the doctor and will then begin to look into insurance. Right now he is in excellent health and “never gets sick.”

What to Look For

Since the bakery does not offer health insurance to most of its employees, workers who are interested in purchasing insurance must look for it on the market. With so many insurance companies offering several different options, consumers must make decisions based on monthly premiums, deductibles, and options. Marcus, a 41 year old black male with three dependents, just got off unemployment. While unemployed he applied for public insurance, which he now receives. His coverage will end, however, when “they” find out he is working again. Other than the brief time during which he was unemployed but not yet on public insurance, Marcus has had coverage through employment. He said he is now actively looking for plans to replace the public coverage he will inevitably lose. When given the choice between a high deductible low premium plan and a high premium low deductible plan, Marcus said he would choose the lower deductible. Though the monthly premium is higher, most interviewees found plans with lower deductibles more attractive. The logic was that a plan with a 5,000 deductible was essentially no better than being uninsured. Besides looking at cost and deductible, most wanted to make sure they could get prescriptions and emergency room visits covered. Some employees, like Marcus, wanted a plan that covers dental. A handful of employees wanted vision covered as well (all wore glasses).

Employees were shown a plan offered by Aetna that had no deductible, no coinsurance and \$20 office visits for the individual. Unlike the California Healthcare Foundation study which found that uninsured workers were interested in purchasing insurance when told the actual price, only one employee, Eddie was able willing to pay the actual price. All of the other employees said the most they would be willing to pay for a \$150 plan was between \$50 and \$100. What made the California Healthcare Foundation study different is that they interviewed people who were more than 200% of the FPL. Several interviewees said they would be willing to lower their wage by \$.50 to \$1.00 per hour if the bakery would cover half the cost of the plan. This just reinforces the idea that the employees are unaware about how to make decisions regarding their health. Lowering their wage by \$1.00 per hour is essentially a loss of \$160 in income each month to have the employer contribute only \$75 to their insurance policy! The \$.50 response is more reasonable, but still not equitable. Though interviewees said this, it should be noted that not one of the employees who was offered a plan through the bakery took it.

Policy Change

Given that most of the uninsured respondents were unable or unwilling to pay for health insurance at the current time, they may have to pay for healthcare out-of-pocket for future medical emergencies unless policy change is enacted. The main problem with having to pay for healthcare out-of-pocket is that people are gambling on never having a medical catastrophe which costs them in excess of a paycheck or two. Other than one interviewee, Michael, a 48 year old black male with diabetes, no one budgeted for health expenses. Michael was unique because he has a monthly co-pay of \$20 each month for his medication. The rest of his prescription is covered by public insurance which he receives because of his illness and low income.

Most employees were not so lucky as to have public insurance. Several uninsured respondents indicated that the government or “Uncle Sam” was responsible for them not being covered. About half the respondents mentioned Canada at this part of the interview. Though few could actually talk at length about Canada’s national health plan, most mentioned that it existed without prompting from the interviewer. For the uninsured this seemed a logical plan for America which one respondent said was “the richest nation in the world.”

The State of the Union Address on January 31, 2006, prompted the final question of the interview which asked interviewees about Health Savings Accounts (HSAs). Despite several interviewees implicating the government, none had seen the State of the Union Address or heard of HSAs. When informed of the nature of these accounts and asked whether or not they would contribute to such a program, most said yes. Those on private insurance and public insurance preferred their current plan to HSAs. For the uninsured however, all but one said they would be willing to contribute anywhere from \$50 to \$200 per month. The one uninsured interviewee, a college graduate who would not contribute, said he generally distrusted any policy that the President endorsed. He preferred an Amish system of insurance, where the connected community contributes to pool their risk.³ He did not know how much such a plan would cost.

5.0 Conclusion

The purpose of this study was to investigate how people with financial burdens (tweeners) make decisions about something as important as healthcare. Specifically the goal was to settle some of the arguments made in previous literature. Pulos (2005) defined tweeners as being between 100% and 200% of the poverty level. In this range approximately half of the

³ Again this just shows how uniformed people are about health insurance. The Amish system is based on the same principles as private health insurance. The only difference is that you know the people with whom you are risk pooling in the Amish system. While this may appeal to the consumer, it is in fact more costly since everyone contributing has similar risks.

population purchases insurance and the other half do not. Quantitative research has suggested many hypotheses about how people make decisions about health insurance. These hypotheses however merely show statistical relationships rather than actual decision making on the level of the individual. Previous research has set the stage for a qualitative analysis to establish the relationship between the macro and micro.

One of the potential problems with this study is that there were not enough insured workers at the bakery. When choosing the sample, I had originally estimated that half the employees at the bakery were insured and half were not (as per the definition). In the end, most were uninsured. Nevertheless, the results are useful. Had a site been chosen which offered employment-based insurance, most likely the proportions of uninsured employees would decrease, but at the risk of people not actively making healthcare decisions. This speaks to the importance of having an employer offer health insurance. When an employer offers health insurance, the default is to purchase the insurance and an employee can make a decision not to do so. With companies which do not offer health insurance, the default is to go uninsured. This makes current legislation like the Phair Act, proposed in Pennsylvania, appealing. The Phair Act would require companies with more than 10,000 employees to offer employment-based insurance, thus making insurance the default. In the end this study is about how and why people purchase insurance, and perhaps this is no better shown than in a site where employment-based insurance is not offered.

As John Soto's story illustrates, the workers at the bakery are tweeners. They fall into a hole in the healthcare safety net. For the most part, the workers are too wealthy to qualify for public insurance, but are unable to afford private insurance. They are stuck between healthcare options. While the younger employees tended to see their health insurance status as exogenous,

older workers agreed that their status was a choice which they could change. Which statement is more accurate is relatively unimportant. The fact is that younger workers, who see themselves as being unable to change their insurance status, will not make an effort to become insured. This is what makes the choice versus consequence results so surprising. Previous literature analyzing choice has assumed that people make choices about health insurance. This study suggests that some workers seem their status as an inevitable consequence and therefore are not actually making choices.

It could be argued then that trying to insure these young tweeners should be a low priority given that they are healthy and more inclined to buy cell phones and movies than private health insurance. Also, these young workers are less likely to get sick and are generally in better health than older employees despite not having health insurance. These however are excuses for ignoring the problem rather than solving it. Every single respondent indicated that health insurance is a right that everyone deserves, especially given that America is one of the last developed countries to adopt a comprehensive healthcare plan.

Though government was commonly blamed for the lack of insurance coverage, no respondents had seen the State of the Union Address or heard of The President's plan of HSA . The savings accounts generally appealed to the respondents, save one respondent's distrust in the President generally. What respondents liked about the HSAs is that they were in control of their own money. A general dislike of taxes made a tax exempt HSA attractive. Though most would contribute to such an account, they would not choose it over comprehensive insurance. Similarly, employees universally declined the high deductible, low premium plan shown in the interview despite its lower loading cost (closer to actuarial fair price). This suggests a lack of understanding of the health insurance in general. Employees interviewed saw health insurance

as a vehicle for paying medical bills rather than as a way to protect themselves from losses. Health insurance which pays for high risk medical bills is less efficient and more costly in terms of insurance company profits and administrative costs than high deductible insurance. Perhaps this is why Freeman and Corey (1993) saw economic barriers in the forms of co-payments and deductibles in private insurance. They saw health insurance as a way to pay for medical coverage rather than a way to protect against a catastrophic event.

Health Savings Accounts may help to alleviate the problem of large medical bills in the future, but does not solve the problem of informing tweeners about healthcare choices. One of the major hypotheses last semester was that middle class upbringings (as measured by education) may have a great effect on the take-up rate of insurance. This study was inconclusive when it came to education and health insurance status, but it does show the importance of understanding the system. It would not be a stretch to call Eddie's upbringing "middle class" with a mother who was a nurse and step-father in the military. More importantly, because his mother was a nurse, he was particularly well informed about healthcare and healthcare delivery. Despite having the largest hospital bills in the sample, Eddie paid nearly the average amount out-of-pocket. The data in this study can not support the idea that a middle class childhood increases the likelihood of success in the healthcare system, because there were others who were brought up in a middle class household that did not fair so well (ie. Travis). What sets Eddie apart is his knowledge of the system. Eddie's case is a good example of what Herring (2005) found. He argued that people make healthcare decisions by estimating the amount of free care they are likely to receive. While Eddie may not have actively estimated the amount of free care he will receive each year, he definitely knew the free care system enough to make an informed decision. The issue of education and take-up rate of insurance is worth exploring further.

Perhaps Gerry was in fact rational in not purchasing the health insurance plan, but his methodology was nevertheless incorrect. This paper cannot speculate whether tweeners are any more or less informed about insurance and risk assessment than other groups. What sets tweeners apart from other demographics is that they are the group that really has to make sacrifices in order to purchase insurance. Wealthier demographics can purchase insurance carte blanche without having to assess their risk and worrying about actuarially fair premiums. Poorer demographics are reasonably well covered by public insurance systems. Tweeners however have limited resources and making informed and wise economic decisions is crucial. Purchasing a health insurance plan which offers comprehensive coverage is perhaps not cost-effective for most of those interviewed. Most employees were able to afford their out-of-pocket medical costs in 2005. Those who could not afford their medical bills had low-risk catastrophic events. These injuries could be covered by a high deductible insurance plan at very little cost to the employee. Perhaps coupling this with an HSA would be the best way for tweeners to ensure their health. At least with HSAs employees can over-contribute without feeling like they are throwing their money away. State legislature like the Phair Act and federal plans such as Health Savings Accounts are exciting if for nothing else than bringing national healthcare to the forefront of political debate. These plans will have the most effect on tweeners to be sure. How tweeners will make choices in the future and how these plans will contribute to America's healthcare system, however, is anybody's guess.

Appendix 1. Interview Guide

Interview Guide

DEMOGRAPHIC

Name:

Age:

Sex:

Race:

Zip code:

What is the highest grade or year of school you've completed?

What was your income for 2005?

What is your wage currently?

How many dependents do you have?

GENERAL HEALTHCARE

In general, would you say your health is:

- Excellent?
- Very Good?
- Good?
- Fair?
- Poor?

How do you know? (comparison)

All things considered, were you satisfied or dissatisfied with the healthcare you received in 2005?

- Very Satisfied
- Somewhat Satisfied
- Neither Satisfied nor Dissatisfied
- Somewhat Dissatisfied
- Very Dissatisfied

Why?

Give me a specific example:

Are you eligible for health insurance through Metropolitan Bakery? Tell me about the insurance

How many different times did you stay in any hospital overnight or longer during 2005? Ever?

How many total nights did you stay in any hospital overnight in 2005? Ever?

In 2005, how many times did you go to a hospital emergency room? Ever?

Tell me about that time

In 2005, about how many times did you see a doctor? Do not count doctors seen while an overnight patient in a hospital or in the emergency room. Or ever?

Include osteopathic doctors and psychiatrists

Include outpatient hospital visits

Exclude dentist visits, chiropractic visits, and telephone calls to doctors

Not counting the doctors visits you already told me about, how many times did you see a nurse practitioner, physician assistant, or midwife in 2005? Ever?

Where do you get healthcare?

Altogether how many different times did you have surgery in 2005 either in the hospital or in a doctor's office? Ever?

In 2005, did you have a flu shot? A flu shot is usually given in the fall and protects against influenza for the flu season. Why or Why not?

In 2005, was there any time when you didn't get the medical care you needed? Tell the story

And was there any time in 2005 when you put off or postponed getting medical care you thought you needed?

What was the reason for putting off needed medical care? –story?

What type of healthcare insurance did you have in 2005?

If public: Which plan are you covered under (ie. Medicare, Medicaid, VA)

If private: Describe your plan and your premium.

If none: What are some reasons that you don't purchase health insurance. Comparison.

Do you have any chronic healthcare issues that make health insurance a higher priority for you than it might be for other people?

How do you pay for healthcare?

Have you ever been really sick?

PROBING

What constitutes healthcare?

Did you have any other type of insurance in 2005 (ie. homeowners, car, flood...)? Why?

To the best of your knowledge did you have health insurance when you were under 18? How? When did you use?

Do you view your healthcare insurance status as a choice?

Do you view healthcare insurance status as an inevitable consequence of your situation?

Who's responsible?

If Private: What is the maximum amount you'd be willing to spend on health insurance if your rates were to go up?

Comparison: Car payment?

If none: At what price would you be willing to purchase health insurance?

More important expenditure?

Least important expenditure?

If public: Does the thought of purchasing health insurance appeal to you, or does current practice meet your needs?

How bad before you go private?

Suppose I told you that the average premium for someone your age to have coverage that includes _____, costs _____ per month. Would this appeal to you?

If your company offered you the same plan but would pay for half of the premium, how much would you be willing to decrease your monthly wage?

Do you see health insurance as a privilege or a right?

To what extent do you think the following statement is true? "I could get adequate healthcare if I needed it, whether or not I have insurance."

Why?

Explain where you get it.

Does your response to the above question factor into your decision about whether or not your purchase insurance? How?

Is purchasing insurance a decision you actually make?

Do you not really think about it?

How do you decide about insurance?

How often do you think about your own healthcare?

How about the state of this countries healthcare system?

How important is healthcare to you?

Do you think that having (or not having) healthcare would significantly alter your current health?

Would you put money into a Health Savings account?

Appendix 2. Informed Consent Form

Informed Consent

This is a research project on decision making by healthcare consumers in America. Discussions with people who make healthcare decisions for themselves and their families are an important source of information for this project. Interviewees will participate in a tape recorded, thirty- to ninety-minute interview and they will be asked for information about their demographics, current and past experiences with healthcare, and their opinions on several topics regarding healthcare reform and policy. The purpose of the research is to gain a better understanding of the ways in which people make decisions regarding their health. All information is for the use of this project only and no individuals will be identified. All interviewees will be assigned pseudonyms and their assent will be requested orally. Participation in this project is entirely voluntary and interviewees may choose not to answer certain questions or to terminate their participation in the interview.

A copy of this form will be kept on file at the University of Pennsylvania's Office of Regulatory Affairs, which can be reached at 215-898-2614. Questions about the project can be directed to Nicholas Pulos, who can be reached at 610-613-5295

By signing this form I acknowledge that I have read the above Informed Consent form and have received \$10 for my involvement in the project.

Print Name

Date

Signature

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