Life Course Transitions
and Instability in Health Insurance Coverage

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
/Public Policy and Sociology/
in The University of Michigan
2013

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ACKNOWLEDGEMENTS

I would first like to thank the members of my dissertation committee for all of their guidance, for teaching me how to be a researcher, and for supporting me in my pursuit of an applied policy research career. I am deeply grateful to Sheldon Danziger for his steadfast mentorship since the day I set foot on campus. He has provided invaluable advice to me throughout the doctoral program, invested many hours reading drafts of my work and discussing research with me, and shared with me his indignation for economic inequality. Many thanks to Yu Xie for welcoming me as one of his quantitative methodology mentees, for being open to discuss just about any research topic (as long as the data and methodology are well-matched to the research question), for providing thoughtful comments on my work, and for sharing with me his passion for research. I am very grateful to Sarah Burgard for being a source of encouragement throughout this process, for providing valuable feedback on my work, for pushing me to think more deeply, and for never letting me forget my sociological roots. Many thanks also to Helen Levy, for being willing to engage in repeated discussions about the nuts and bolts of my chapters, for sharing her vast knowledge of health insurance policy and research, and for consistently providing helpful comments and encouragement. To my committee collectively, thank you for believing in and investing in me.

There are numerous additional faculty, staff, and students from the University of Michigan who helped me along my way. Mary Corcoran has provided excellent advice as
well as personal support since I entered the program. Luke Shaefer has been another important and encouraging mentor for me here, generously sharing his wisdom about the SIPP dataset, the research process, career choices, and anything else I wanted to talk about. I would also like to acknowledge Barbara Anderson, who trained me in the building blocks of demography; Jim House, who taught me about health inequality and provided a strong model of a policy-oriented sociologist; Pamela Smock, who co-authored Chapter 2 and reminded me to see the big picture; and Teresa Sullivan, who gave me an opportunity to study inequality in credit and debt. I have also had an extraordinary group of graduate and post-doctoral colleagues at Michigan whose friendship and support have been crucial to my academic progress. Although too many to list here exhaustively, several I would like to particularly acknowledge include Erica Blom, Patricia Chen, Margaret Gough, Caroline Hartnett, Elyse Jennings, Sasha Killewald, Kenzie Latham, Kathy Lin, Rachael Pierotti, David Ratner, Patrick Wightman, Geoff Wodtke, and Elizabeth Young. Additionally, among my honorary graduate student colleagues are Brian Davis, Jerry Lavery, Will Stroebel, Eileen Twohy, and Anusha Vable, other friends toiling away in their own doctoral programs in other fields and at other universities who have shared their notes and reflections with me.

Past and future mentors and colleagues at other institutions have also influenced my intellectual development, my growth as a researcher, and my graduate school ambitions and progress. At Grinnell College, my sociology professor, Chris Hunter, introduced me to the fascinating study of the social world, which ultimately led to my defecting from the physical to the social sciences. My statistics professor, Tom Moore, provided a stellar introduction to the methods that would become the tools of my trade. In
my first post-college research position at Child Trends, my bosses, mentors, and friends, Tamara Halle and Marty Zaslow, opened up to me the vast field of applied policy research and nurtured my fledgling research skills. At Iowa State, professors Ken Koehler and Mike Larsen spent hours answering my many questions and patiently helped my classmates and me grow beyond mere “baby statisticians.” My advisor at Iowa State, Fred Lorenz, taught me by example how to carefully apply statistical methods to sociological research and supported me as I pursued my first research study. Thanks also to my new colleagues in the Research and Data Analysis Division of the Washington State Department of Social and Health Services, for showing me the light at the end of the tunnel, for inviting me to come home, and for giving me the opportunity to apply my research skills to programs and policies with direct implications for the socioeconomic and health inequalities I have been studying.

I could not have undertaken dissertation research without the financial support of a number of institutions. At the University of Michigan, I received funding from the Department of Sociology, the Gerald R. Ford School of Public Policy, the National Poverty Center, the Population Studies Center, and Rackham Graduate School. My work on Chapter 2 in particular was supported by a grant from the National Poverty Center, using funds received by the U.S. Census Bureau, Housing and Economic Statistics Division, through Contract 50YABC266059/TO002. For my work as a whole, I received generous support from the National Science Foundation through a multi-year Graduate Research Fellowship.

Last but certainly not least, I want to thank my family for their constant love and support. A big thanks to both my parents, Patricia and William Lavelle, for always telling
me I could do anything that I wanted to do, and for sharing their love of learning and commitment to social justice with me. My older brother, Peter, and his partner, Nu-Anh, both recent PhD recipients themselves, imparted their wisdom and humor about graduate school to me and set a great example. My older brother, Patrick, his wife, Jessica, and my two little nieces, Dylan and Cara, have provided much-needed recreation on multiple weekends after conferences in DC and longer holidays. Special thanks to my fiancé, Matt Paul. He has been my biggest supporter throughout graduate school and my most ardent fan, encouraging me when I doubted myself, helping me celebrate each incremental success, and making the process tremendously more fun and enjoyable.
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ABSTRACT

The piecemeal system of health insurance coverage in the United States is not structured to easily adapt to normal life course transitions. The typical routes by which individuals and families access insurance coverage are frequently threatened in times of change, and alternative, affordable sources of coverage are often difficult to come by. This dissertation examines the linkages between life course transitions and instability in health insurance coverage in the late 1990s and early 2000s. The three substantive chapters consider the extent to which divorce, job loss, and the transition to adulthood threaten the stability and continuity of health insurance, and how these linkages can be modified through changes in public policy. In Chapter 2, “Divorce and Women’s Risk of Health Insurance Loss,” I document that many women experience a significant risk of health insurance loss in the months following divorce, and that overall coverage rates remain depressed for more than two years after divorce. Chapter 3, “Job Loss and Health Insurance in the Great Recession: Did the COBRA Subsidy Work?,” considers the difficulty of maintaining insurance coverage following job loss, and evaluates the effects of temporary policy change which reduced the price of purchasing COBRA through a former employer. Although workers with access to the subsidy purchased COBRA at moderately higher rates, many still experienced gaps in coverage after job loss. In Chapter 4, “Health Insurance in Young Adulthood: Less Instability Since the Affordable Care Act?,” I assess changes in the level and stability in health insurance coverage of
young adults following the Affordable Care Act’s expansion of parental dependent coverage up to age 26. I find that the policy change increased overall coverage rates for young adults primarily by filling gaps in coverage for those with higher-SES parents, rather than increasing coverage for the chronically uninsured. Looking forward, the full implementation of the Affordable Care Act in January 2014 may both enable greater access to health insurance for low-income individuals and families who currently face chronic barriers to coverage and enhance the security of health insurance over the life course.
CHAPTER 1

Introduction

Health insurance in the United States is not structured to easily adapt to normal life course transitions. The typical routes by which individuals and families access insurance coverage are frequently threatened in times of change, and alternative, affordable sources of coverage are often difficult to come by. This dissertation examines the linkages between life course transitions and instability in health insurance coverage. Specifically, the three substantive chapters consider the extent to which divorce, job loss, and the transition to adulthood threaten the stability and continuity of health insurance, and how these linkages can be modified through changes in public policy. Collectively, the studies have broader implications for demographers studying population dynamics and the linkages between life course transitions and social and health policies; for sociologists probing the ways in which the social systems and structures we collectively create lead to the often unequal distribution of valued resources; and for policymakers wanting to cover the uninsured.

Health Insurance in the U.S.

Health insurance in the United States, some form of which was held by approximately 85 percent of the population in 2012, comes from a complex blend of public and private sources (Cohen and Martinez 2012). Unlike in most other developed
countries, employers are the primary providers of insurance, covering just over half of the population (DeNavas-Walt, Proctor, and Smith 2012). Americans over 65 are nearly universally insured through the publicly-funded Medicare program, which also covers a small fraction of the disabled non-elderly (those who qualify for Social Security Disability Insurance). Public sources of insurance coverage—including Medicare, programs which target low-income families and children (Medicaid, CHIP, and other state programs), and insurance for military personnel, veterans, and their families—collectively insure one-fifth of the non-elderly population (Kaiser Family Foundation 2012b). An assortment of non-employer private plans provide the remainder of insurance coverage, such as group policies purchased through trade unions, professional associations, and universities, and non-group policies purchased on the private market.¹

Paired with the rapidly rising costs of health care and the growing volatility in family and work lives, this piecemeal system results in large numbers of uninsured persons at any point in time and high volatility in health insurance coverage over the life course. Health care costs have risen substantially over the past decade, offsetting nearly all income gains for the median-income family (Auerbach and Kellermann 2011). These cost increases have made health insurance coverage more difficult to access, both inside and outside of employment relationships. Employee contributions to health insurance premiums have risen faster than wage growth, contributing to decreased take-up rates of employer-provided insurance, particularly among low-wage, young, and minority

¹ The non-group market, also known as the individual market, is where individuals without group (typically employer-based) coverage purchase private health insurance. When individuals secure health insurance through a group (of fellow employees, for example), the health risks in the group are pooled, giving individuals in the pool more even premium costs. Non-group health insurance policies purchased on the private market tend to be priced higher (with occasional exceptions for the youngest and healthiest individuals) and often carry less comprehensive benefits.
workers (Cooper and Schone 1997; Gabel, Hunt, and Kim 1998; Gruber and Washington 2005). Premiums for coverage purchased on the non-group market have risen substantially as well (AHIP 2007, 2009). As such, the number of uninsured persons has increased over the past decade, and this increase accelerated during the recent recession (Kaiser Family Foundation 2012a). By 2012, more than 47 million Americans were uninsured (Cohen and Martinez 2012).

The risk of being uninsured is not spread evenly across segments of the population. Rather, insurance coverage in the U.S. is a heavily stratified resource, with coverage levels varying greatly by income and educational attainment. Only 28 percent of nonelderly adults without a high school diploma hold private health insurance coverage, compared to 85 percent of college graduates (Kaiser Family Foundation 2012b). And about one in three poor nonelderly Americans is uninsured, roughly six times the rate at which those with incomes greater than four times the poverty line lack health insurance (Kaiser Family Foundation 2012b). A major contributing factor to disparities in insurance coverage is the highly regressive tax exemption of premiums for employer-sponsored health insurance—by far the largest expenditure of the federal government—which disproportionately benefits higher-income workers (Gruber 2010). Nearly three-quarters of workers in high-wage occupations receive health insurance benefits, compared to about one-quarter of workers in low-wage occupations (BLS 2011).

The uninsured are also not a static population. Rather, those lacking coverage at any one point in time reflect the snapshot of a dynamic process in which many people gain and lose insurance coverage over time. Short and Graefe (2003) document that in
any given year, half to two-thirds of the uninsured cycle into or out of coverage. Insurance instability is an issue of concern because even short gaps in insurance coverage expose individuals and their families to substantial financial risks and pose a barrier to receiving medical care when needed.

_Growth and Change in Life Course Transitions_

Considering life course transitions is essential to understanding the dynamic composition of the uninsured population and for considering and evaluating policy responses designed to expand insurance coverage and facilitate access to medical care. Because of the piecemeal system of insurance coverage in the U.S., normal life course events frequently jeopardize the continuity of health insurance coverage, increasing the likelihood that individuals experience gaps in coverage (Quadagno 2004; Jacobs et al. 2011). Such events may include changes in income level, which modify the affordability of insurance coverage; changes in employment relationships, which may establish or sever access to group health insurance coverage; marital transitions, which may change both income level and establish or sever access to group health insurance coverage; and the transition to adulthood, which may eliminate various options for coverage (e.g., dependent coverage through a parent’s employer, or Medicaid/CHIP received as a child). This dissertation examines health insurance as it relates to three common life course events—marital transitions, job transitions, and the transition to adulthood. Each has undergone important demographic changes in recent years which have implications for the distribution and continuity of health insurance coverage, and the overall insured rate in the population.
In the second half of the 20th century, patterns of marriage and divorce changed dramatically, resulting in people spending more time outside of marriage. For decades, the age of marriage has been rising (Cherlin 2010). By 2011, the median age at first marriage was 28.7 years for men and 26.5 years for women (U.S. Census Bureau 2012b). Rates of marital disruption rose significantly in the 1960s and 1970s, peaked in the 1980s, and have now plateaued at a high level; roughly half of all marriages are estimated to end in marital disruption (Goldstein 1999; Raley and Bumpass 2003). About one in five adults has ever been through a divorce, and nearly one million divorces occur each year (Kreider and Ellis 2011). Whites and college-educated people are more likely to ever marry, and also have a lower probability of divorce (Cherlin 2010). Because the shared economic resources within marriage can help facilitate access to health insurance coverage indirectly and because some spouses receive health insurance directly through a spouse’s employer, the changing demography of marriage and divorce has important implications for health insurance coverage.

Also over recent decades, the U.S. labor market and that of other industrialized countries has witnessed the decline of stable long-term employment and the growth of temporary, contingent, and non-unionized jobs, particularly among less-educated workers (Smith 1997). While holding a single stable job throughout adulthood may have once been the norm, Americans born at the end of the baby boom held an average of eleven jobs between the ages of 18 and 44 (BLS 2012). The majority of jobs now last less than five years, even at middle age (BLS 2012). Part of the decline in job security is associated with the changes in the structure of the labor market, including the decline in manufacturing and unionized labor, the growth of the service sector, and the outsourcing
of some jobs to other countries (Lee and Mather 2008). Because the majority of health insurance coverage is tied to employers, the decline in job security has important implications for the stability of health insurance coverage.

Young adulthood is the phase of the life course in which individuals transition from dependence on parental resources to independence and acquisition of adult resources. Demographers have found that the timing of this transition has shifted later for young adults in the U.S. and other industrialized countries. Compared to even a decade ago, young people are taking longer to move away from home, to achieve economic independence, to get married, and to have children (Danziger and Rouse 2007; Berlin, Furstenburg, and Waters 2010). Because young adults are taking longer than in the past to secure stable, well-compensated jobs (particularly those from disadvantaged backgrounds), they are also taking longer to secure their own health insurance coverage (Levy 2007; Furstenburg 2008).

*Three Papers on Life Course Transitions and Instability in Health Insurance Coverage*

To investigate the linkages between life course transitions and the stability and continuity of health insurance, I analyze longitudinal data from the Survey of Income and Program Participation (SIPP). The SIPP follows a nationally representative sample of individuals for up to five years, collecting monthly data on health insurance coverage and other key variables. Because of its large sample size, the data capture a large number of life course transitions such as divorces, job losses, and college graduations. Additional information on the SIPP is provided in the substantive chapters.

Chapter 2, “Divorce and Women’s Risk of Health Insurance Loss,” which is co-authored with Pamela Smock, examines how women’s health insurance coverage
changes after divorce. Past research has shown that single women have lower rates of health insurance coverage than married women, but the extent to which marital transitions are associated with changes in insurance coverage was previously unknown. Likely for this reason, recent policy debates surrounding health care reform have not acknowledged among the panoply of deficiencies of the current health care system that divorce jeopardizes health insurance coverage. This chapter finds that women experience a significant risk of insurance loss in the months following divorce, and that overall coverage rates remain depressed for more than two years after divorce. Health insurance loss has the potential to compound the well-documented decline in economic well-being many women experience after divorce and may threaten their health as well. Given the sustained high rates of divorce in the U.S., this issue affects tens of thousands of women each year.

Chapter 3, “Job Loss and Health Insurance in the Great Recession: Did the COBRA Subsidy Work?,” considers the difficulty of maintaining insurance coverage following job loss, and evaluates the effects of a recent, temporary policy implemented to mitigate this risk. Because the majority of Americans receive health insurance through employers, job loss is the most common trigger of health insurance loss in the U.S. Although the federal COBRA law grants workers the option to purchase an extension of their employer-sponsored health insurance coverage following job separation, premiums are financially out-of-reach for many of the unemployed. As part of the American Recovery and Reinvestment Act (ARRA), the stimulus package passed in 2009, Congress established a temporary subsidy to help involuntary job losers purchase COBRA. I find that this subsidy resulted in moderate increases in COBRA utilization and small (non-
significant) increases in continuity of coverage after job loss, with the greatest effects among college-educated workers. Findings have important implications for predicting the success of subsidies for private coverage that will be made available under the Affordable Care Act, and can be instructive for developing future policies intended to help displaced workers maintain insurance coverage.

Chapter 4, “Health Insurance in Young Adulthood: Less Instability Since the Affordable Care Act?,” assesses the health insurance coverage of young adults, and changes in the continuity of coverage during this period of the life course before and after a recent policy change. Young adulthood is a particularly turbulent phase of the life course in terms of geographic mobility, attachment to the labor market, and health insurance coverage. A significant proportion of young adults lose the coverage they had as children, either from their parents’ policies or from public programs like Medicaid and the Child Health Insurance Program (CHIP). As a result, young adults have both the highest uninsured rate of any age group (DeNavas-Walt, Proctor, and Smith 2011) as well as the most frequent gaps in coverage (Collins et al. 2012; Schwartz and Sommers 2012; Short et al. 2012). The Affordable Care Act (ACA; 2010) required that private health plans allow young adult dependents to remain on their parents’ policies up to age 26, permitting parents to cover their children for longer into early adulthood (previous age limits were typically 19 for non-students and 25 for full-time students). I find that the policy change increased overall coverage rates for young adults primarily by filling gaps in coverage for those with higher-SES parents, rather than increasing coverage for the chronically uninsured. Although these dependent coverage provisions of the ACA implemented in 2010 increased health insurance inequality in the short-term, the
implementation of the full set of ACA provisions in 2014 are expected to have a much more equalizing effect.

*Considering Health Insurance Inequality*

This dissertation probes how the structure of current U.S. health insurance system produces inequality in health insurance coverage before and after life course transitions, and how policy changes modify these linkages. For many years, sociologists have studied the way in which social systems and structures produce inequality in major domains such as income (Wright 1979), education (Mare 1981) and occupational status (Blau and Duncan 1967), and more recently have explored how these domains map onto inequality in other resources like wealth (Keister and Moller 2000) and health outcomes (House et al. 1994). Although rarely considered by sociologists to date, health insurance is another valuable resource, the distribution of which both reflects and compounds socioeconomic and health inequalities.

As articulated above, health insurance in the U.S. is unequally distributed by socioeconomic status, with higher-income and more highly educated people having substantially higher rates of coverage, particularly private coverage. My three substantive chapters also highlight disparities in insurance coverage by gender and marital status (unmarried women have substantially lower access to insurance coverage than married women); by employment status and occupation (workers are more likely to have insurance coverage than non-workers, but large numbers of workers still do not receive health insurance through their jobs); and by age (young adults have the lowest levels of insurance coverage of any age group).
Each of the chapters also addresses how instability in coverage during the three life course transitions (divorce, job loss, transition to adulthood) differs by social class. In interpreting the outcomes, it is important to consider who is included in and who is omitted from the comparison at hand. For example, Chapter 2 finds women with moderate family incomes before divorce are most likely to lose health insurance coverage after divorce. However, this finding does not imply they have lower absolute levels of insurance coverage after divorce than lower-income women. Rather, lower-income women are less represented in the risk set of those who can lose insurance after divorce, because they have lower baseline levels of coverage. Chapter 3 explicitly restricts the analysis sample to workers with employer-sponsored insurance in the last month on the job prior to involuntary job loss. Only one-quarter of involuntary job losses met this restriction, so the analysis sample represents a substantially more advantaged group of involuntary job separators compared to the overall population of involuntary job separators, many of whom are chronically uninsured.

Furthermore, more disadvantaged individuals are more likely than others to experience destabilizing life course events like divorce and job loss that may jeopardize insurance coverage. Less-educated women have higher rates of marital disruption compared to others (conditional on marital entry; Cherlin 2010), and less-educated workers have higher levels of job instability (Farber 2011). Everyone experiences the transition to adulthood, but disadvantaged young adults have particular difficulty gaining stable employment and acquiring sufficient resources to support themselves during this life phase (Danziger and Ratner 2010). Partially as a result, Chapter 4 finds substantially
lower rates of insurance coverage and greater levels of insurance instability among young adults from disadvantaged backgrounds.

The unequal distribution of health insurance coverage has the potential to compound existing economic inequalities. This resource helps to pay for routine medical care and protects individuals financially in the event of a major illness or injury. Being without coverage can be financially problematic; uninsured Americans have high levels of financial stress and many carry significant medical debt (Schoen et al. 2011). It may also compound health inequalities. A substantial body of research in sociology, social epidemiology, and public health has found that individuals with more income and education live longer and healthier lives (Adler 2001). Although these researchers have concluded that differential access to medical care is not the main cause of these health disparities (Adler 2001; Schoeni et al. 2008), nevertheless foregoing preventative medical care and lacking access to medical services when health problems arise may potentially exacerbate medical conditions and have negative long-term health ramifications for the uninsured. Indeed, the uninsured tend to experience significantly worse health and die at younger ages compared to their peers (Institute of Medicine 2002). Furthermore, recent quasi-experimental and experimental studies consistently find positive and often significant effects of health insurance on health outcomes, especially for low-income adults, those with chronic health conditions, and other vulnerable populations (Levy and Meltzer 2008; McWilliams 2009; Finkelstein et al. 2011).

**Looking Forward**

The health care system is in the midst of a period of substantial change, brought about by the passage of the recent health care reform law, the Affordable Care Act (ACA;
March 2010). One of the major aims of this law is to achieve near-universal coverage of the population. Multiple provisions of the ACA were designed to further this goal, including the expansion of Medicaid eligibility to those with incomes up to 133 percent of the federal poverty line; and the provision of premium subsidies to help those with incomes up to 400 percent of the federal poverty line purchase private health insurance through new state-run health insurance exchanges. These major provisions, scheduled to go into effect in January 2014, are expected both to enable greater access to health insurance for low-income individuals and families who currently face chronic barriers to health insurance coverage and to enhance the stability of health insurance over time.

Chapters 2 and 3 in this dissertation help to identify current disparities in insurance coverage by marital status, and document pre-health-reform levels of instability in insurance coverage following divorce and job loss. After the new health system is up and running, new studies will be needed to measure how much these disparities have attenuated and the extent to which the reformed health system has reduced the risk of insurance loss following these common life course events. Chapter 4 explicitly examines the changes to young adult health insurance before and after an early policy change (implemented in September 2010) under the ACA that targeted 19- to 25-year-olds. Although this early policy change reduced the instability of health insurance coverage for some young adults, many—particularly those from more disadvantaged backgrounds—continue to lack stable coverage. After the ACA is fully implemented, additional research will be needed to examine how much further young adults’ health insurance instability has been reduced and whether this resource is distributed more equally among young adults from different family backgrounds.