



**Health Insurance and the  
Transition to Adulthood**

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## 1. Introduction

One of the many tasks that young adults must confront for the first time is finding their own health insurance. Most teenagers are covered as dependents on a parent's private insurance policy; Medicaid covers a substantial fraction as well. But at some point eligibility for these sources of coverage runs out and young adults have to find health insurance on their own. This passage may be a rocky one: data from the Census Bureau show that in 2004, thirty percent of people between the ages of 18 and 24 were uninsured, more than in any other age group (DeNavas-Walt et al. 2005, table 7). Why is the transition from childhood to adult health insurance coverage so difficult? Has this transition, like so many of those facing young adults, become more drawn-out over time?

This chapter analyzes the trajectories of young adults' health insurance coverage and the reasons so many young adults experience gaps in coverage. There are a number of possible explanations for these gaps. One explanation is that health insurance markets suffer from adverse selection as in a classic Rothschild and Stiglitz (1976) model of the insurance market. In this scenario young adults, who are relatively healthy, cannot buy insurance at actuarially fair prices, so they remain uninsured. On the other hand, young adults might not buy health insurance even at a fair price simply because they are financially immature. This financial immaturity may manifest itself in many ways – most important for health insurance, perhaps, is young adults' relatively weak attachment to the labor force. Health insurance coverage in the US is closely linked to employment, with health insurance more likely to be provided as a fringe benefit of a long-term, full-time job (Farber and Levy, 2000). Of course, these are exactly the jobs that young adults may take some time to find (see Yates [2005] for details). Gaps in coverage for young adults may simply be the result of a drawn-out transition to stable employment.

These two explanations are not mutually exclusive; each may contribute to low coverage rates among young adults. But they have different implications for public policy. If financial immaturity explains young adults' failure to obtain coverage, then policies aimed at making coverage available to them, such as increasing the maximum age of eligibility for dependent coverage, may be less effective than policies like Medicaid expansions that effectively spread a safety net under young adults. On the other hand, if adverse selection in health insurance markets explains why adults are not covered, then policies to address market imperfections may effectively increase rates of insurance among young adults without further expansion of public programs. Determining why rates of coverage are so low among young adults will therefore help to inform public policy toward the uninsured.

This chapter analyzes the health insurance trajectories of young adults and the nature of gaps in coverage in this population. I begin by estimating descriptive life-cycle profiles of health insurance coverage for men and women from childhood through age 35. I also estimate the flows between different types of coverage (private, public, none) in order to shed light on the dynamics of gaps in coverage: where do all those uninsured young adults come from? Next, I investigate the extent to which other characteristics of young adults can explain their low rates of health insurance coverage. I find that employment and other characteristics including school enrollment and marital status explain about half of the unusually low rates of coverage among young adults. While this does not mean that these other characteristics *cause* young adults to be uninsured – rather, it means that they all happen at the same time – the overall picture that emerges is one in which lack of health insurance is part of a more general lack of financial maturity. This is not the whole picture, however, since coverage rates among young adults

remain significantly lower than for individuals at other ages even after controlling for employment and other markers of financial maturity. The residual effect of young adulthood on coverage may be due to differences by age in other characteristics that I have not measured, such as risk preferences, or may be due to adverse selection in health insurance markets.

I also investigate whether the transition to adult health insurance has changed over time and, in particular, whether this transition has occurred later for more recent cohorts. Given the close link between employment and health insurance, the changing nature of the labor market facing young adults – for example, the increased job churning documented by Henry Farber in this volume – may mean that it takes young adults in more recent cohorts longer to get their own insurance. I analyze nearly twenty years’ worth of data on health insurance coverage to see whether the experience of young adults born in the 1980s has been different from that of cohorts born in the 1960s and 1970s. This analysis shows that more recent cohorts of young adults are more likely to be uninsured and that the age at which their risk of being uninsured peaks occurs later. Moreover, these changes are the result of a delay in obtaining “adult” insurance coverage (in one’s own name or through a spouse) for later cohorts, rather than any decline in public coverage or coverage by a parent’s policy. In other words, the “changing timetable for adulthood” discussed by Furstenburg et al. (2005) appears to apply to health insurance, too.

## **2. Background**

About one in six Americans had no health insurance in 2005 (DeNavas-Walt et al. 2006). Most health insurance coverage is obtained through employment, and workers in “good” jobs – long-term, full-time jobs – are much more likely than short-term or part-time workers to have insurance on the job (Farber and Levy 2000). Not surprisingly, the uninsured tend to be poorer than the insured (Institute of Medicine 2001). They are also younger: in fact, half of all uninsured adults are between the ages of 18 and 34 (author calculations based on DeNavas-Walt et al. 2006, table 8). Even though young adults have the highest rates of uninsurance of any age group, very little research has focused on their health insurance coverage.<sup>1</sup> An exception is Collins et al. (2006), who document the high rates of uninsurance among young adults, especially those who are low-income or do not go on to college after leaving high school. The Institute of Medicine (2001) also notes young adults are overrepresented among the uninsured and attributes this to “social, economic and demographic factors” such as family income, employment in small firms, and low-wage jobs, although they do not test the extent to which these factors do, in fact, explain higher rates of uninsurance among young adults.

None of the research to date on the transition to adulthood has examined health insurance coverage as an outcome. This is surprising because it seems like an excellent marker of adulthood since it is closely tied to other frequently studied outcomes like the stability of employment. The fact that the transition to adulthood is acknowledged to be difficult on many dimensions raises the question: is the transition to adult health insurance coverage special? That is, high rates of uninsurance among young adults may simply reflect the fact that the transition to adulthood is a difficult one, and this difficulty is manifested in many different ways: unstable employment, lack of health insurance coverage, and in some cases failure to leave the parental nest. One reason that the young are so likely to be uninsured may not be their youth per se but rather that they have other characteristics that make them less likely to be insured. The most

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<sup>1</sup> Glied and Stabile (2000) and Glied and Stabile (2001) analyze the health insurance coverage of young men, but the youngest men in their analyses are already 25.

obvious of these is a weak attachment to the labor force. We know that the transition from school to stable employment can take a surprisingly long time: for example, Yates (2005) documents that the median worker takes nearly a year after first leaving school to start a job that will last for at least one year. For the median high school dropout, it takes more than three years. It is unclear whether young workers' high mobility represents pointless churning between dead-end jobs or productive search that ultimately yields a good match; see Neumark (2002) for a review of this issue. But the consequences of high job mobility for health insurance coverage are unambiguous: nonworkers are much more likely than workers to be uninsured. Even among workers, previous research has shown that employers of workers in low-tenure jobs are much less likely to provide health insurance (Farber and Levy 2000). If young adults spend some time unemployed while looking for a job, move between short-term jobs, or are more likely to be in low-tenure jobs, they will be less likely to have employer-sponsored insurance. Even a job that will ultimately prove to be a stable job that provides health insurance has to start out as a new job.

On the other hand, getting health insurance for young adults may present a unique set of difficulties beyond those presented by the other milestones of adulthood. Markets for health insurance may suffer from imperfections that lead young adults, who are relatively healthy, to face prices for insurance that are actuarially unfair, resulting in lower demand for coverage. This could occur either because of information asymmetries in the insurance market or because of regulation-induced distortions in the market. In the first scenario, the market for insurance might suffer from a classic adverse selection problem in which insurance companies have less information than consumers about risk and therefore the low-risk individuals (in this case, young adults) are not fully insured (or in this case, uninsured) (Rothschild and Stiglitz 1976). In the second scenario, insurance markets might function efficiently in the absence of regulation, but community rating requirements that limit insurers' ability to vary premiums across individuals induce the same result as information asymmetries: young adults face actuarially unfair prices and therefore don't buy insurance. This could also be caused by the *de facto* community rating that employers appear to practice (Pauly and Herring 1999). Cardon and Hendel (2001), the only paper that tests directly for adverse selection in health insurance markets, finds no evidence of adverse selection.<sup>2</sup>

Understanding whether high rates of uninsurance among young adults are due to financial immaturity or to problems in the health insurance market has important implications for public policy. If financial immaturity explains young adults' failure to obtain coverage, then policies aimed at making coverage available to them, such as increasing the maximum age of eligibility for dependent coverage, may be met with a blank stare reminiscent of adolescence. Mandates or further expansions of public coverage, both of which take the decision about coverage out of the hands of the young adults, may be necessary to cover them in this case. On the other hand, if adverse selection in health insurance markets explains why adults are not covered, then policies that allow young adults to buy stripped-down insurance policies with high deductibles ("bare bones" insurance) may effectively increase rates of insurance among young adults without more intrusive government interventions.

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<sup>2</sup> Tests for adverse selection generally have low power to distinguish between adverse selection and moral hazard. See Chiappori and Salanie (2000) on empirical tests for adverse selection in general and Abbring et al. (2003) on the difficulty of distinguishing between the two phenomena.

### 3. Data

The data for the analysis come from two different sources: The Survey of Income and Program Participation (SIPP) and the Annual Social and Economic (ASEC) Supplement to the March Current Population Survey (CPS).

My analysis of the SIPP uses data from the 1996 and 2001 panels. After restricting the sample to account for item and wave non-response, as detailed in the Data Appendix, my sample includes 33,443 individuals ages 15 to 35. The outcome of interest is health insurance coverage: whether the individual has any and if so, whether it is from a parent's private policy, a spouse's private policy, one's own private policy, or a public program (Medicaid or SCHIP). An individual with none of these is uninsured.

My analysis of changes across cohorts relies on the ASEC Supplement to the March CPS in 1989 through 2006. In any one year, the March CPS includes about 40,000 to 60,000 respondents ages 15 to 35. Although the structure of the survey and the wording of the questions differ from the SIPP (see the Data Appendix for details), the CPS also collects information that allows me to construct a measure of health insurance coverage similar to the one based on the SIPP: parental coverage, own coverage, spouse's coverage, public coverage, uninsured.

### 4. Results

#### *4a. Life-cycle profiles of health insurance coverage through age 35*

How does health insurance coverage evolve as youth mature into adults? Figures 1 and 2 show the distribution of health insurance coverage by age for men and women, respectively, from birth through age 35. Coverage through a parent's policy is the main source of insurance for both boys and girls, covering almost two-thirds of all children through age 17. After age 17, the probability of parental coverage drops, and by age 24 only a negligible fraction of adults are still covered by their parents. Figure 3 presents trends in parental coverage separately for those who are still in school full-time and for those who are not. Parental coverage is heavily dependent on enrollment status, and the decline in parental coverage starts about four years later for those who remain enrolled in school full-time, at age 21 rather than age 17. Interestingly, the declines in parental coverage for non-students begin at age 16, before the typical maximum age of eligibility for non-students (18 or 19), suggesting that this constraint may not bind very tightly.

At about the same age that parental coverage drops off, young adults begin to obtain their own private health insurance policies. Rates of own private coverage for both men and women increase sharply between the ages of 17 and 23, at which point women's coverage levels off while men's continues to increase until leveling off around age 28. Spouses are an important source of coverage for women starting in their early 20s and throughout the rest of their adult lives. Men rely on spousal coverage as well, but it is a less important source of coverage for them than it is for women, never covering more than 15 percent of men and covering less than 10 percent of men under the age of 30.

The male-female differentials in own private and spousal coverage offset one another so that overall, the age profiles of coverage by private insurance in one's own name or through a spouse are nearly identical for men and women. Looking at private coverage from any source – whether the policy is held by oneself, a spouse, or a parent – shows that the increases in own and spousal coverage come just a few years later than the declines in parental coverage. The result is a pronounced dip in the probability of private health insurance coverage for both men and

women between the ages of 18 and 27. For men, this dip is exacerbated by a drop in the probability of public coverage that also occurs around age 18, presumably as a result of Medicaid program rules. Thirteen percent of eighteen year old boys have public insurance; by the time they are 21, only four percent do. The decline in public coverage for women is much more gradual and does not really begin until age 22.

The net effect of these phenomena is an increase in the probability of being uninsured between the ages of 18 and 30 that is larger for men than for women, shown in Figure 4. At age 17, about 20 percent of men or women are uninsured. By age 22, 37 percent of men and 30 percent of women are uninsured. By age 30, the fraction of women who are uninsured has dropped to 16 percent and remains relatively flat through the remainder of women's working lives. For men, the fraction uninsured drops to about 18 percent by age 32 and remain reasonably flat thereafter.

The risk of being uninsured is even higher if instead of looking at a point in time we look at the probability of being uninsured at some point in a given window. Figure 5 shows the probability over a two-year period (six survey waves) that the respondent reports being uninsured at least once. More than half of all young men between the ages of 18 and 25 will be uninsured at some point in the next two years, and two-thirds of young men will be uninsured at some time between the ages of 21 and 23. For women the risk is slightly lower; the age range in which the median woman will be uninsured at some point is only 19 to 23, and the maximum risk of being uninsured at some point in a two-year window is 58 percent at age 22 (as opposed to 65 percent at age 21 for men).

These results confirm that young adults are more likely than children or older adults to be uninsured at a point in time. How long do young adults' spells without insurance last? If young adults' spells without insurance are all very short – say, four months or less – then they mean something different than if they typically last a year or more. In fact, the median remaining spell length for someone who is uninsured when first observed in the SIPP is about 16 months for all young adults (Figure 6). Children have shorter median remaining spell length: 4 to 12 months, depending on the child's age, and older adults have slightly longer spells. But the median spell without insurance for young adults lasts more than a year.

#### *4b. Differences in insurance coverage by socioeconomic status*

Socioeconomic status (SES) is an important determinant of insurance coverage for children. Figure 7 shows the distribution of health insurance coverage for different groups of children ages 0 to 18 defined by their parents' education<sup>3</sup>. The probability of having private coverage through a parent's insurance policy increases with education; fewer than 20 percent of the children of high school dropouts have this insurance, while almost ninety percent of the children of college graduates do. In contrast, children of less educated parents are much more likely to have public coverage. Almost half (43 percent) of children of high school dropouts have public coverage compared with only two percent of the children of college graduates. But this difference in public coverage is not enough to offset the different in private insurance; nearly

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<sup>3</sup> Unfortunately, it is not possible to see what happens to these different groups as they become young adults because at that point they start moving out of their parents' homes, and parents' education is available in the SIPP only for children living with their parents.

one-third of the children of high school dropouts are uninsured, compared with less than six percent of children with at least one parent with a college degree.<sup>4</sup>

#### *4c. Flows into and out of insurance*

Figures 1 and 2 suggest that coverage rates among young adults are so low because they lose parental coverage or lose public coverage and don't pick up the slack for themselves. Examining year-to-year transitions using the panel aspect of the SIPP data confirms that this is in fact what is happening. Figures 8 and 9 present a summary of flows into and out of insurance for men and women, respectively. The line running over the bars is the increase in the fraction uninsured that will occur in the upcoming year. For example, the peak of 0.125 at age 19 in Figure 8 reflects the fact that the fraction of men who are uninsured will increase by 12.5 percentage points between age 19 and age 20. The bars show where that increase will come from: the white and gray bars above the horizontal axis represent the flow out of different types of insurance. For example, the chart shows that between ages 19 and 20, ten percent of men in the sample will lose parental coverage and become uninsured. Four percent will lose public coverage and become uninsured. 2.6 percent will lose their own private coverage and become uninsured. At the same time, a few – about four percent – will gain insurance. This is shown in the black bar below the horizontal axis. The sum of these flows into and out of insurance is the net change in insurance coverage.

The analysis in Figures 8 and 9 is pretty much what one would expect given how the distribution of coverage evolves with age. Young adults lose parental and private coverage in large numbers in their late teens; several years later, they begin getting their own insurance coverage (primarily private coverage, though this is not shown in the figure). The spike in the fraction without any coverage that is evident in Figure 4 occurs because of the lag between these two sets of events.

#### *4d. Explaining lack of coverage: Is it other characteristics?*

In order to determine the extent to which characteristics of young adults explain their low rates of coverage, I estimate the following linear probability model:

$$Unins_{it} = X_{it} \cdot b + \{(age = 17) \cdot a_{17} + \dots + (age = 35) \cdot a_{35}\} + e_{it}$$

where  $i$  indexes individuals,  $t$  indexes survey waves (6 for each individual), and  $X$  is the vector of control variables.<sup>5</sup> The dependent variable is binary (1 if the individual is uninsured, 0 if s/he has private or public insurance). I estimate the model separately for men and women. First, I estimate the model with only the age dummies for ages 17 – 35 (age 16 is the omitted category) and no control variables; this is equivalent to calculating average rates of no insurance at each age. I will refer to this as the “no covariates” model. Then for each group I estimate the model ten times using the following different sets of control variables:

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<sup>4</sup> It would be interesting to know whether children from low SES families have longer spells without insurance in young adulthood. Unfortunately it is not possible to determine this using SIPP data because data on parental education is available only for children who still live with their parents at some point during the survey, so that we do not know parents' education for a majority of young adults. Young adults' own current educational attainment is a poor proxy for SES because so many of them are still in school.

<sup>5</sup> Standard errors are robust to the presence of multiple observations from each person.

1. A set of dummies indicating whether the person works full time, works part-time, is in school full-time, or none of the above (the omitted category)
2. A set of 9 dummies characterizing the individual's family income relative to the poverty threshold
3. A marital status dummy
4. A marital status dummy, a dummy for being a parent, and an unmarried parent dummy
5. A set of variables reflecting the activity of one's spouse (full-time work, part-time work, full-time school, none of the above [omitted])
6. Dummies for race (black, other nonwhite) and Hispanic ethnicity
7. A set of establishment size dummies for workers
8. A dummy for being a homeowner
9. A dummy indicating whether the individual lives with his/her parents and the interaction between that dummy and a full-time student dummy
10. A set of dummies indicating whether the person works full time, works part-time, is in school full-time, or none of the above (the omitted category) plus an indicator for whether the person has more than one job, and variables reflecting job tenure on the main job;
11. A "kitchen sink" regression including all of the covariates listed above.

I then compare the vectors of age dummies ( $a_{17}, \dots, a_{35}$ ) from the different specifications to see what effect different controls have on the age profile of uninsurance.

For men, some of the covariates – most notably, income and establishment size – do very little to explain the spike in uninsurance or actually go in the wrong direction in terms of explaining the spike.<sup>6</sup> Other covariates, however, explain quite a bit of the age profile of coverage, and all of the covariates taken together reduce the peak in the probability of being uninsured by more than half of its value: the peak at age 23 is 19.4 percentage points higher than age 16 in the model with no controls but only 9.3 percentage points higher than at age 16 in the model with all the covariates. The set of covariates that is most important are the dummies for major activity (full-time school, full-time work, part-time work) plus job tenure for full-time workers (model 10). The age dummies from the no-covariates and all-covariates models are plotted in Figure 10; the dotted lines represent the 95 percent confidence interval around the coefficients from the model with all covariates. The inclusion of covariates clearly matters, and the change in the estimated age profile of coverage is significant: a Hausman test rejects the null hypothesis that the age dummies from the two models are equal with  $p < 0.001$ . But the age dummies remain significantly different from zero even when all the covariates are included in the model, as is evident from the confidence interval in the figure. That is, the spike in uninsurance for young men persists even after controlling for other attributes.

The analysis for women is similar, although the spike is smaller and the amount of it that can be explained by covariates is larger (see Figure 11). Covariates reduce the spike in health uninsurance (relative to age 16) from 13.2 percentage point at age 21 to only 5.6 percentage points. There are also some differences, compared to men, in which covariates matter. Family income, marital status and spouse's employment each explains as much of the spike for young women as the women's own employment information. The general pattern, however, is similar to that for men: covariates reduce the spike, but the probability of being uninsured remains

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<sup>6</sup> Complete results for men from the no-covariates and all-covariates models are reported in Appendix Table 1.

significantly elevated in young adulthood for women even once we have controlled for these other attributes.

To summarize: other characteristics such as employment and job tenure can explain half of the spike in uninsurance in young adulthood for men and slightly more than half of the spike for women. Even controlling for covariates, however, rates of uninsurance among young adults remain significantly higher than those for older adults. How should we interpret these results? Because health insurance and the other covariates like employment and income are simultaneously determined, we cannot place a causal interpretation on the regression results. That is, it would be incorrect to say that young adults have lower rates of health insurance coverage *because* they are less likely to be in full-time, long-term jobs than older adults. It is equally plausible that an attribute we do not observe determines both employment and health insurance coverage. For example, reaching financial maturity might be an independent event that expresses itself in many ways, including getting a stable job and getting insurance coverage, and also perhaps getting married and buying a house.<sup>7</sup> What the regression tells us, rather, is whether health insurance coverage is completely tied up with these other factors or whether *even when we have taken account of the other factors*, young adults are less likely than other adults to be insured. These results suggest that lower rates of health insurance are not just a symptom of the lack of financial maturity, although lack of financial maturity explains about half of them.

#### *4e. Analysis of changes in insurance coverage across cohorts*

Next, I turn to the CPS for an analysis of whether the transition to adult health insurance has changed over time. Figure 12 shows the age profile of uninsurance separately for three different cohorts: those born in the 1960s, 1970s and 1980s. The figure shows that each successive birth cohort has an increase of several percentage points in the peak probability of being uninsured. Moreover, the peak occurs a year later for the young adults born in the 70s and 80s than for those born in the 60s, at 22 instead of 21.<sup>8</sup> Figure 13 shows the fraction of each cohort that has coverage from their parents at each age. This figure shows that there has been essentially no change in when young adults lose coverage from their parents' policies. If anything, the two more recent cohorts are slightly more likely to be covered in their early 20s than are children born in the 1960s. Results for public coverage (not shown) show very little change across cohorts in the fraction of young adults with public coverage, so this is not an important factor in the change in coverage across cohorts. The dynamics of losing coverage in young adulthood, then, do not appear to have changed much over time, and it must be changes in gaining one's own coverage as an adult that drive the shift in the probability of being uninsured that is evident in Figure 12. Figure 14 confirms this. On average, each successive cohort gets adult health insurance (private coverage in one's own name or through a spouse) one year later than the last cohort.<sup>9</sup> It appears that 23 is the new 22, which was itself the new 21. These shifts in timing may not be as large as some of those associated with other markers of the transition to adulthood, such as establishing one's own home or having children. But the "changing timetable for adulthood" discussed by Furstenburg et al. (2005) appears to apply to health insurance, too.

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<sup>7</sup> See Dougherty (2006) for evidence that the apparent positive effect of marriage on earnings for men is in fact due to unobserved maturity that is expressed both in higher earnings and in getting married.

<sup>8</sup> Results are not shown separately for men and women because the trends across cohorts for the two groups are similar. The probability of being uninsured is higher for young men than for young women in each cohort.

<sup>9</sup> Again, the patterns across cohorts are similar for men and women so I do not show the results separately.

## 5. Discussion

To recap the results of this analysis:

- (1) There is a sharp peak in the probability of being uninsured in young adulthood, when individuals lose parental or public coverage but have not yet obtained their own adult coverage.
- (2) About half of this peak can be explained by controlling for employment and other characteristics such as job tenure, marital status, and family income.
- (3) The peak is slightly larger and occurs slightly later for more recent cohorts of young adults.
- (4) The change across cohorts is driven by more recent cohorts taking longer to get their own insurance rather than any change in patterns of losing public or parental coverage.

These results leave unanswered a number of questions that should be a high priority for future research. The first is a definitive answer to the question of how important health insurance market failure is in explaining lack of coverage. My results suggest that half of the lack of coverage among young adults is due to employment instability and other characteristics rather than market imperfections; but that still leaves a large potential role for market imperfections. Further evidence on the relative importance of these two explanations will shed light on whether public policy should focus on insurance markets or elsewhere to help ensure young adults' financial security. Another important question that remains unanswered is how much of a threat lack of coverage poses to young adults' health and financial security. How likely are catastrophic health events among uninsured young adults, and what consequences do they have? Understanding the consequences of lack of coverage among young adults will help determine how urgent the search for remedies should be.

Even without answering these larger questions, the results presented in this chapter have implications for public policy. The importance of stable employment to young adults' health insurance coverage suggests that one way to expand coverage for this group would be to facilitate a smoother transition to the labor force and reduce employment instability. As noted above, however, high rates of job mobility for young workers are not necessarily undesirable *per se* and may even be desirable if they result in higher quality job matches. Any gains in coverage in young adulthood associated with reduced mobility would have to be weighed against the possibility of poorer job matches in the long run.

The results also speak to a number of other policies that have been proposed to increase rates of health insurance coverage among young adults. Collins et al. (2006) identifies three such policies: requiring students to obtain coverage through their colleges or universities, extending eligibility for Medicaid and SCHIP beyond age 18; and extending the age of eligibility for dependent coverage on parental policies. Each of these policies would reach some, but not all, uninsured young adults. For example, 17 percent of uninsured twenty-somethings in the SIPP are enrolled in school full-time; an additional 6 percent are enrolled part-time. So a mandate that students obtain insurance would reach these young adults, but not the majority of the uninsured in this age group. Extending eligibility for public coverage to later ages would likely reach a different subset of young adults.

Several states have recently extended the maximum age at which children are eligible for dependent coverage. For example, in 2006, Colorado and New York extended this age to 25 and New Jersey extended it to 30 (see Collins et al. 2006 for details). While these policies may help

an important subgroup of uninsured young adults, the impact of this policy may be smaller than the policy's supporters predict. The age profiles of parental coverage by school enrollment (Figure 3) show that coverage begins to drop off well before the current common maximum ages of 18 for non-students and 25 for students. That is, if these constraints may not currently bind for very many individuals, so that relaxing them may not have much of an effect. Of course, evaluating what happens in states that change their laws will be the acid test of these policies' effectiveness.

It is interesting that two of these three policies involve raising the age at which children are considered adults for purposes of health insurance coverage. An increasing body of research supports the notion that the transition to adulthood is occurring later than it did in the past and also that expectations about adulthood are changing, as discussed by Settersten et al. (2005). The results presented in this chapter suggest that health insurance is affected by this trend as well. Viewed in this light, policies that extend the age of eligibility for Medicaid or parental coverage reflect these changing norms. Current policies and insurance market rules may be predicated on an outdated set of expectations that lag behind the new reality of adulthood in the 21<sup>st</sup> century.

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Figure 1  
Sources of health insurance coverage by age: Men ages 0 to 35  
SIPP, 1996 and 2001 panels

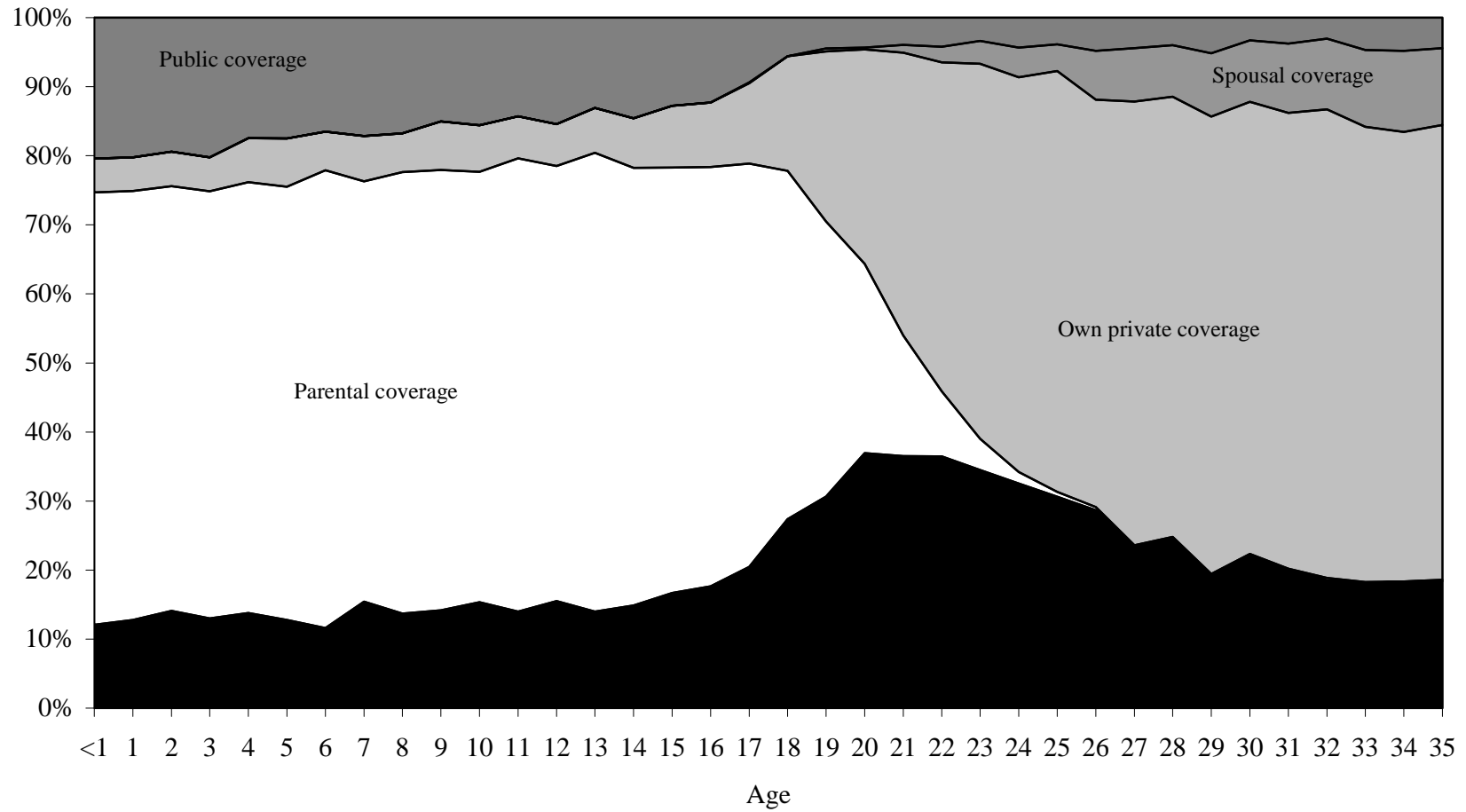


Figure 2  
Sources of health insurance coverage by age: Women ages 0 to 35  
SIPP, 1996 and 2001 panels

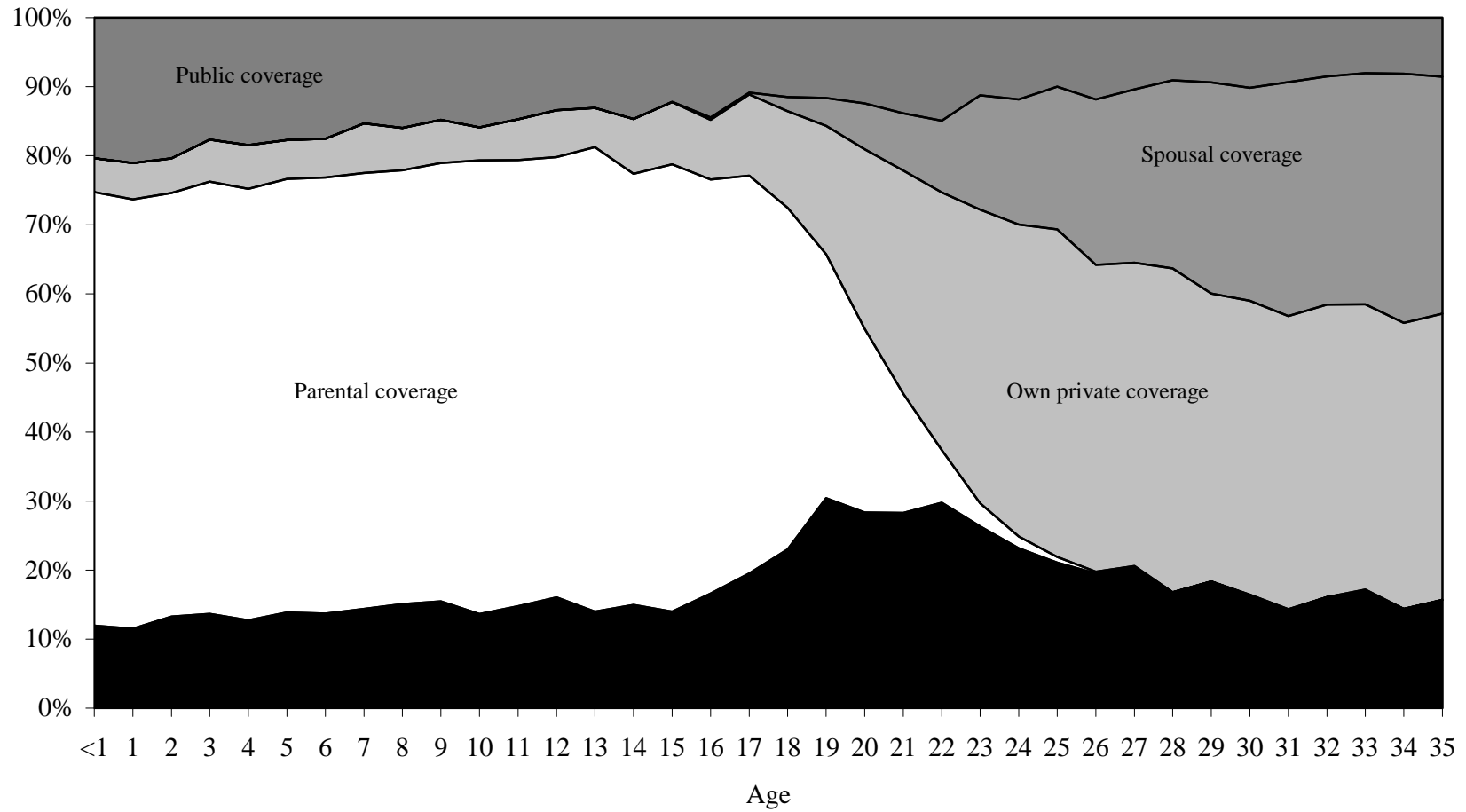


Figure 3  
 Probability of parental health insurance, by age, sex and school enrollment  
 SIPP, 1996 and 2001 panels

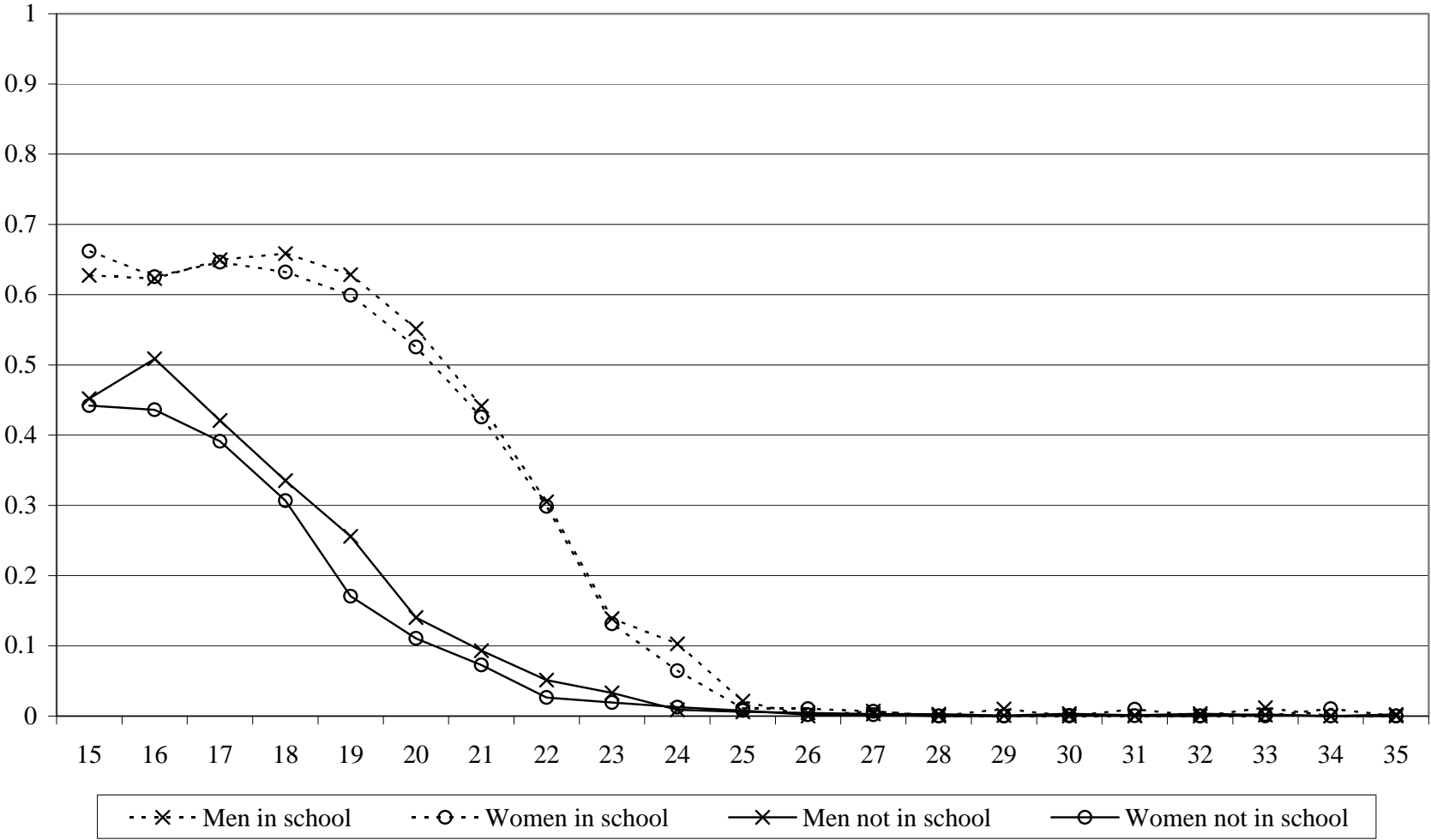


Figure 4  
Probability of no health insurance at a point in time, by age and sex  
SIPP, 1996 and 2001 panels

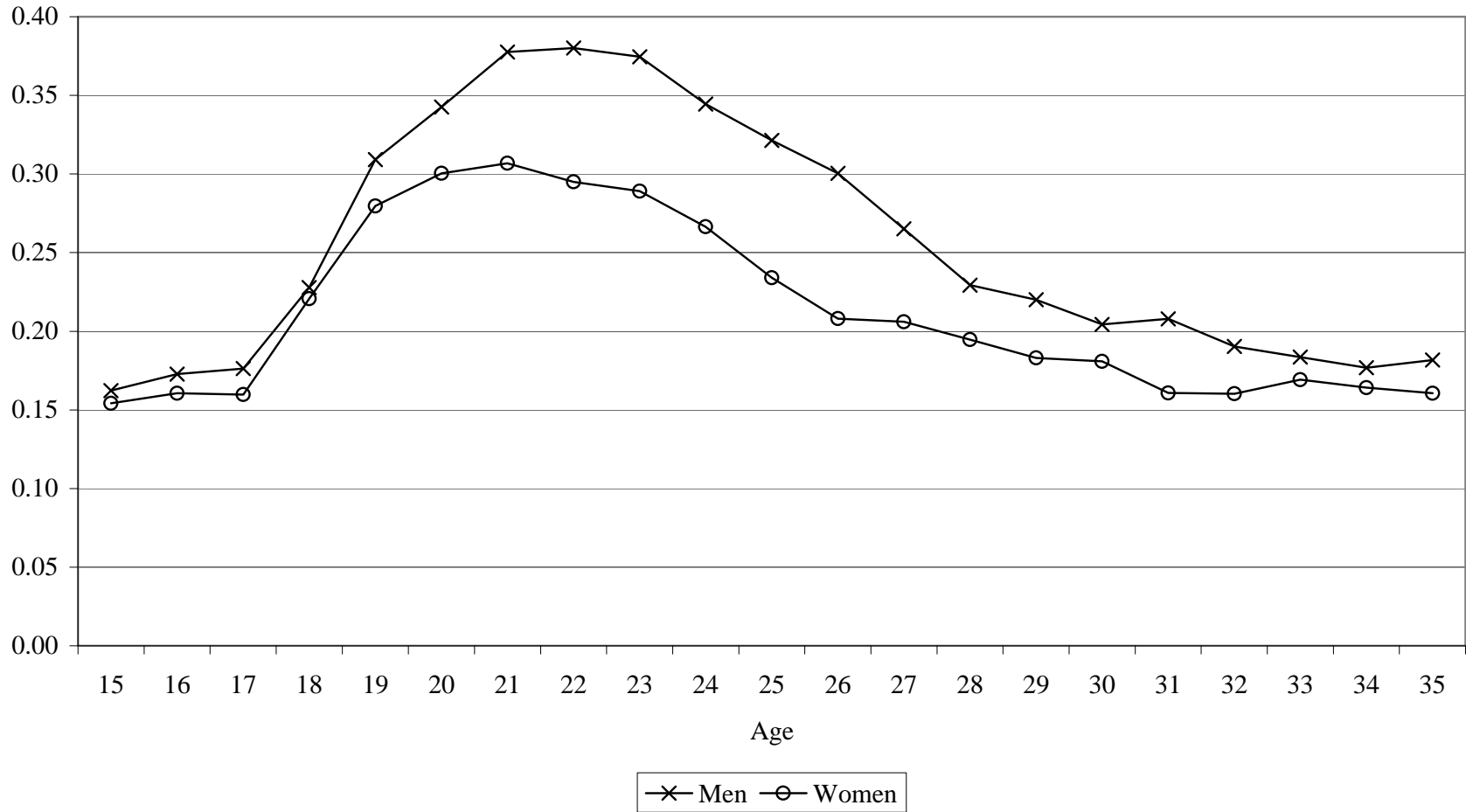


Figure 5  
Probability uninsured at one or more waves in the next two years, by age at wave 1  
SIPP, 1996 and 2001 panels

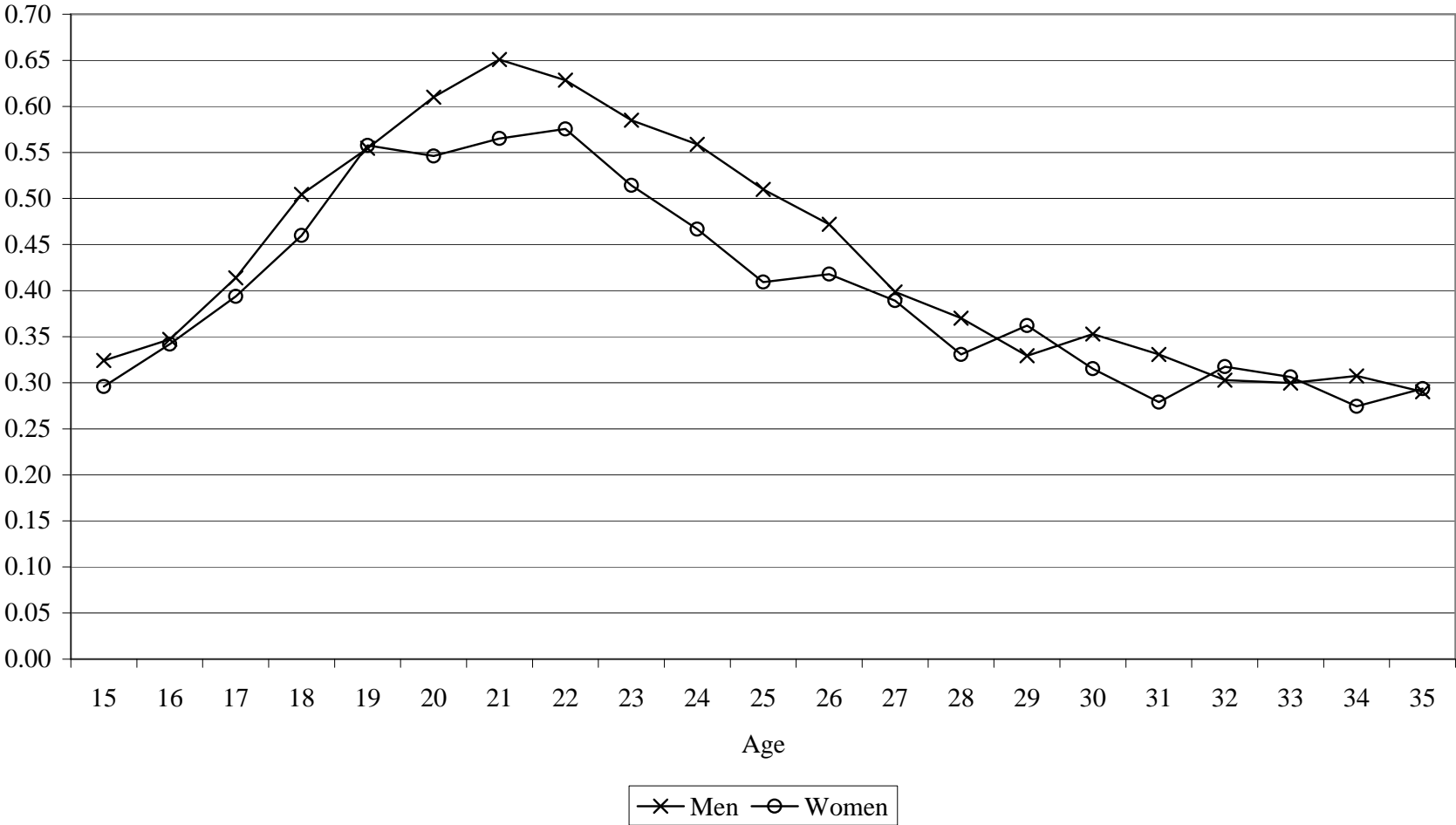


Figure 6  
How does the median remaining length of an uninsured spell change with age?  
SIPP, 1996 and 2001 panels

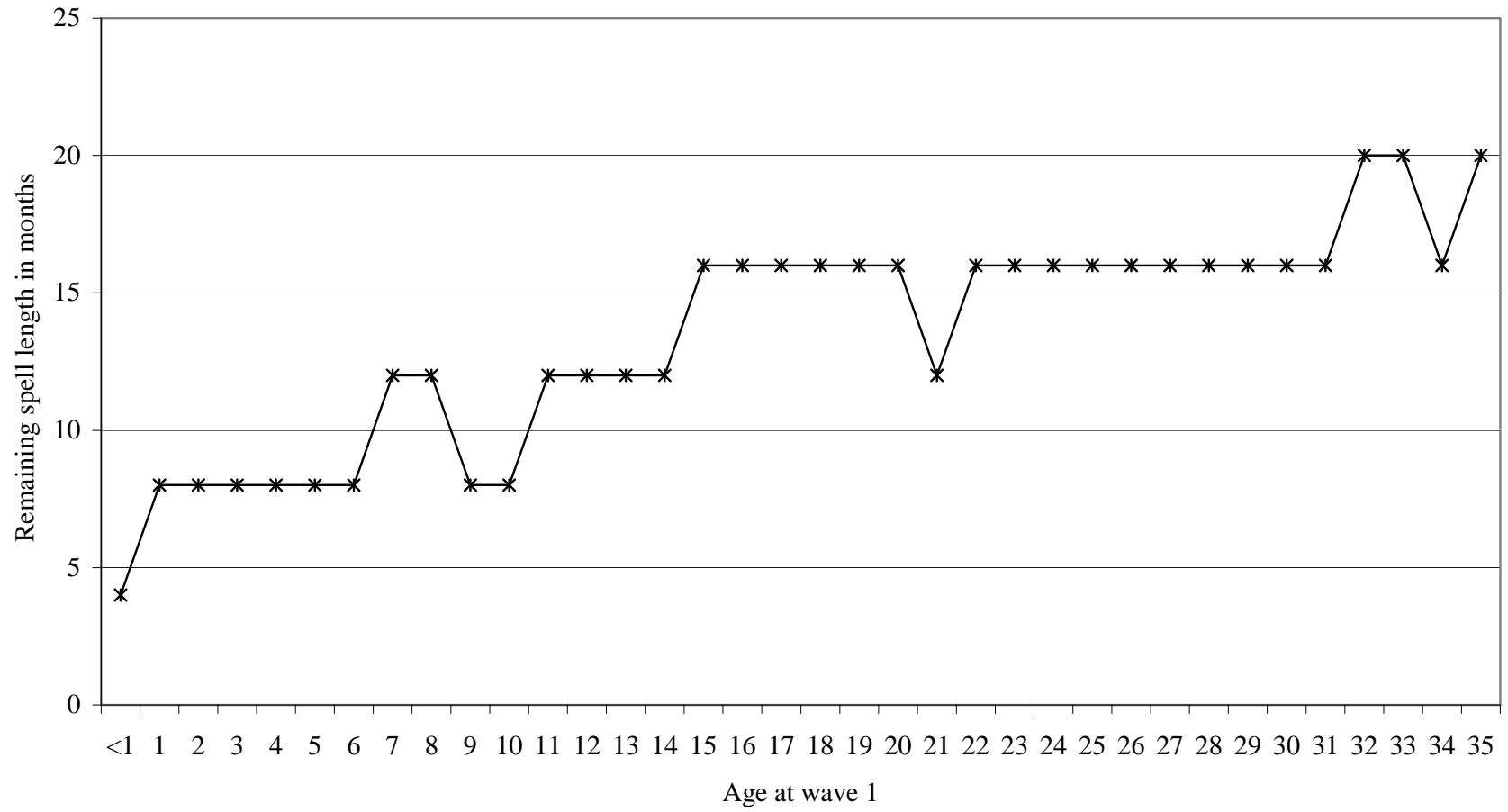


Figure 7  
 Children's health insurance coverage, by parent's education  
 SIPP, 1996 and 2001 panels

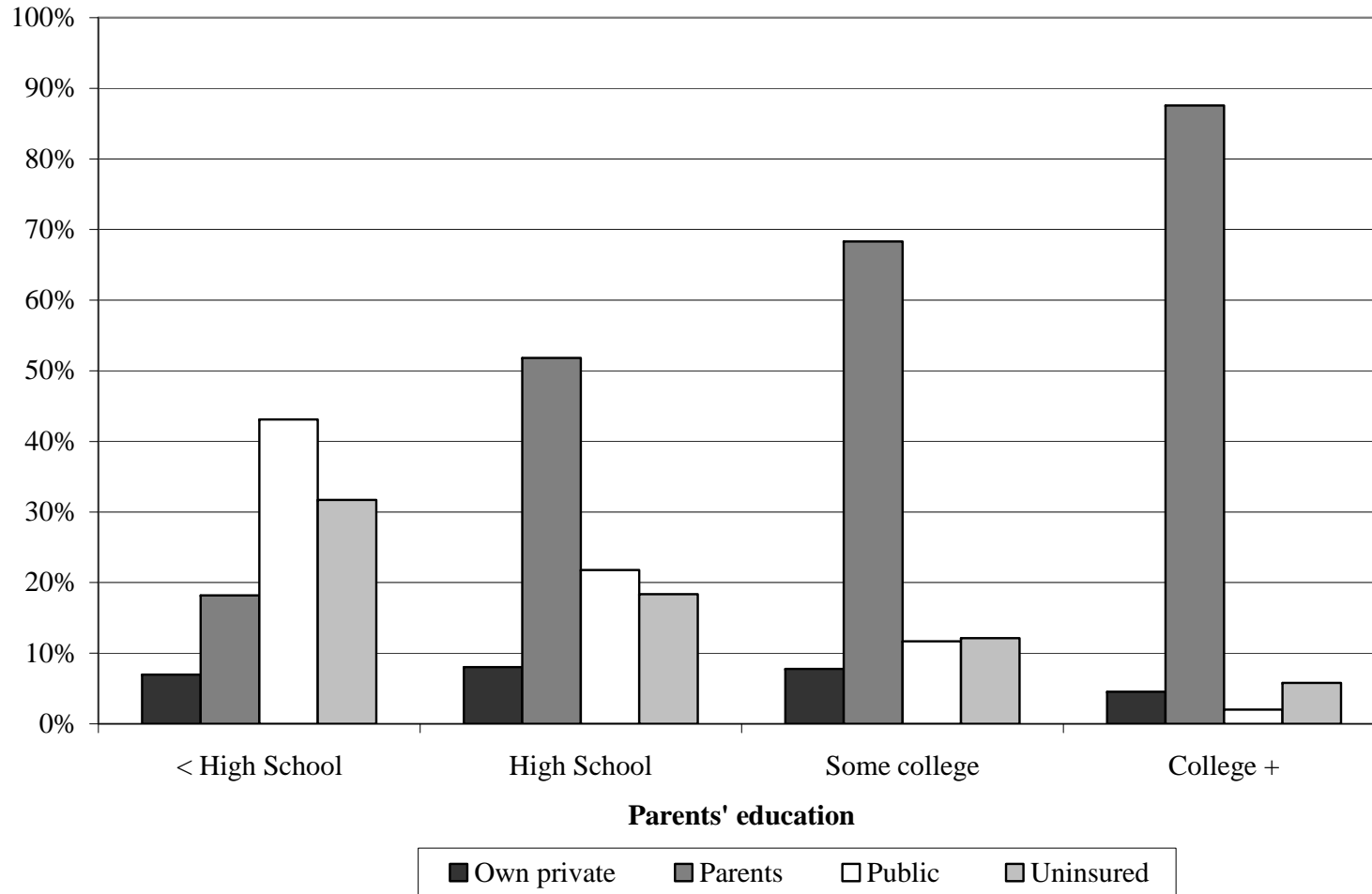


Figure 8  
 Flows into and out of uninsurance by age: Men  
 SIPP, 1996 and 2001 panels

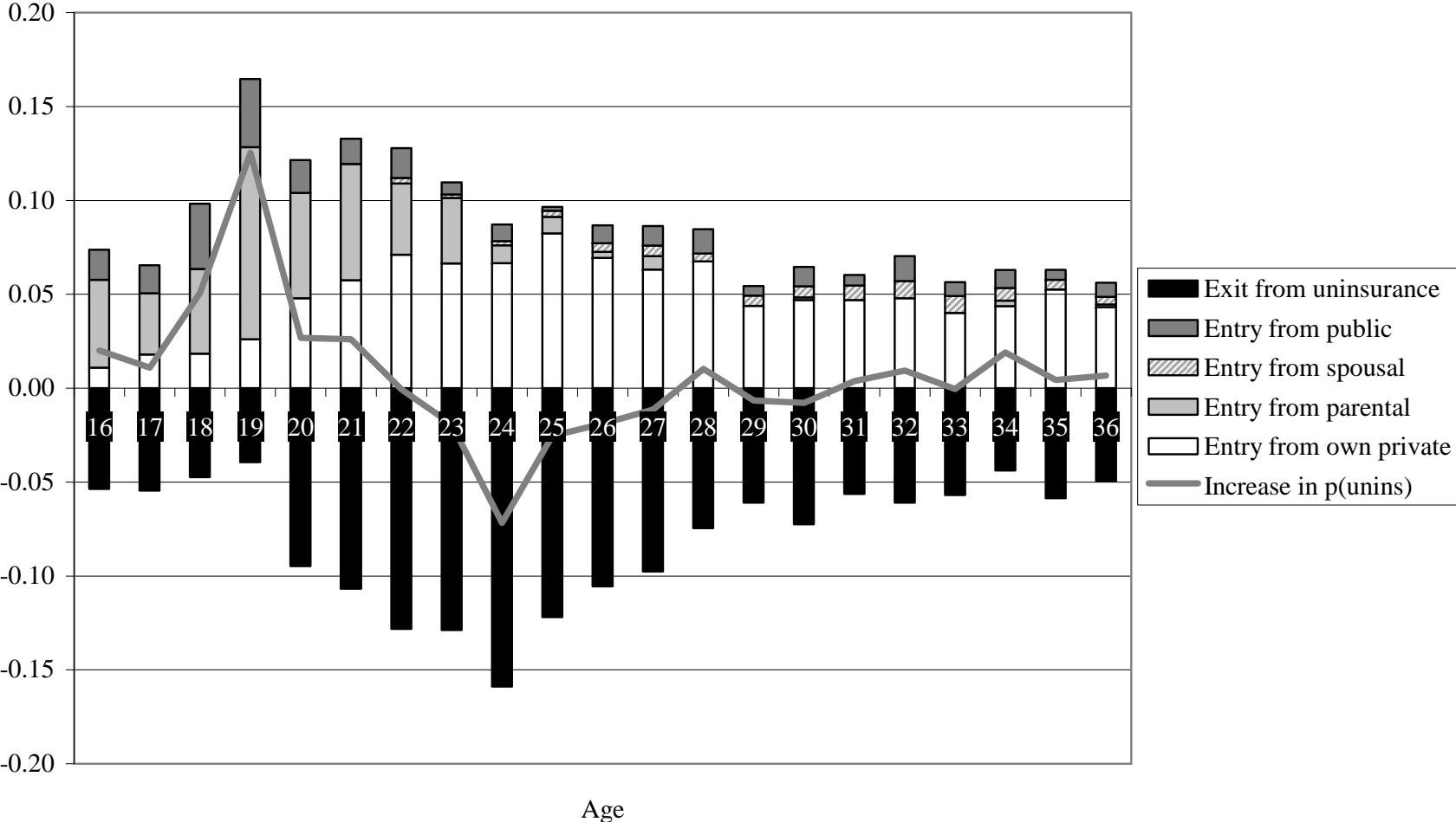


Figure 9  
 Flows into and out of uninsurance by age: Women  
 SIPP, 1996 and 2001 panels

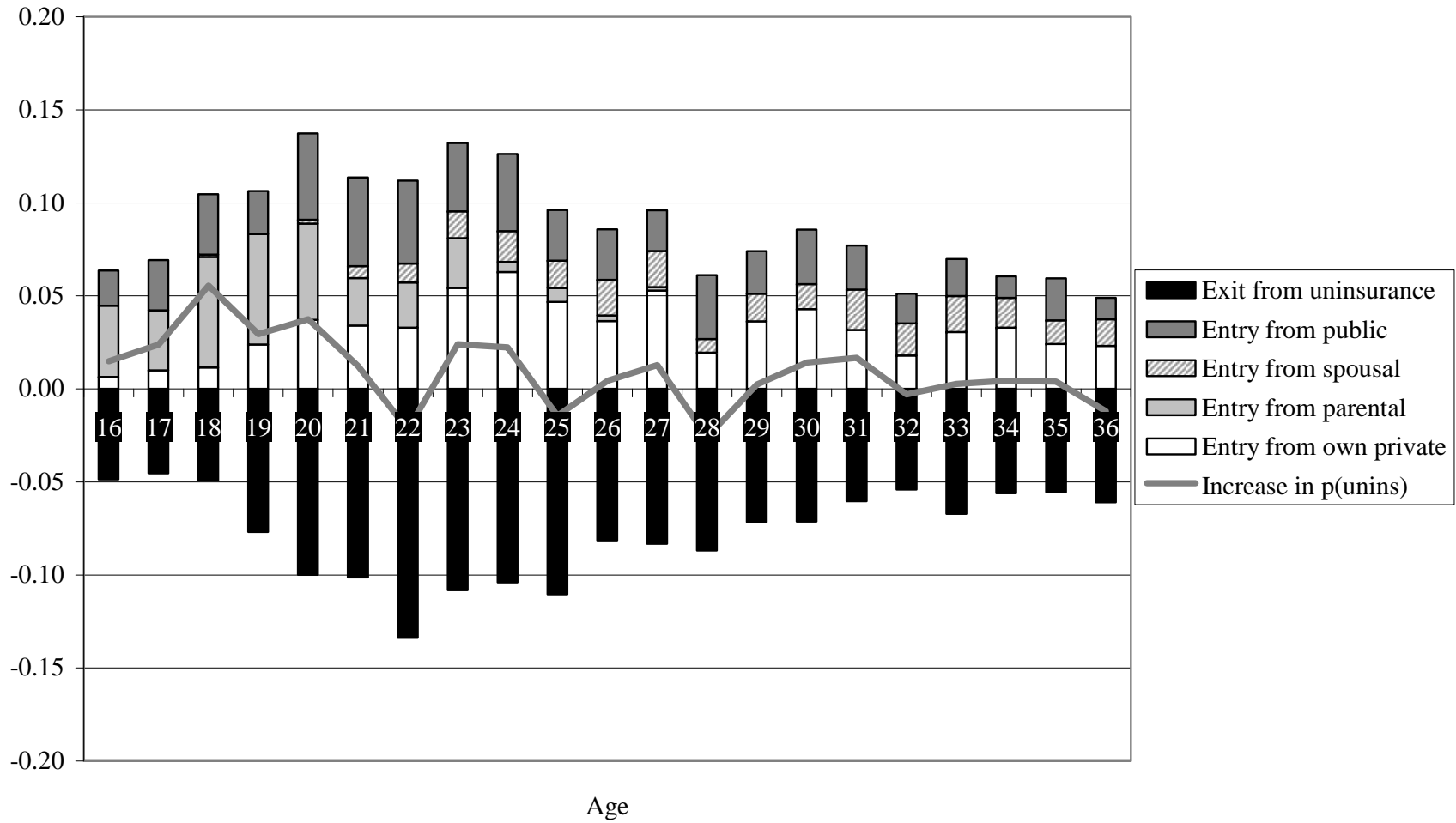


Figure 10  
Can observable characteristics explain the spike in uninsurance for men?  
SIPP, 1996 and 2001 panels

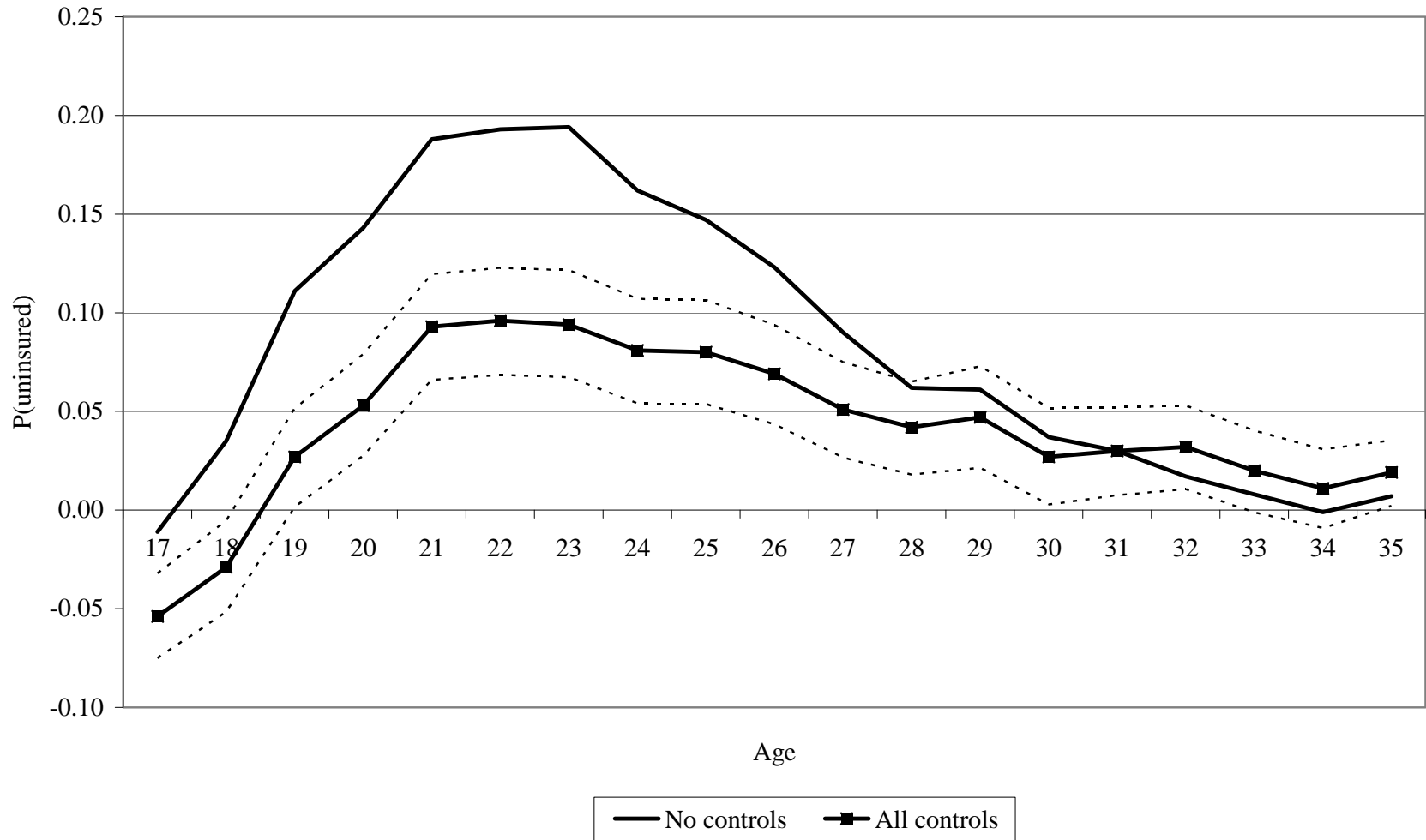


Figure 11  
Can observable characteristics explain the spike in uninsurance for women?  
SIPP, 1996 and 2001 panels

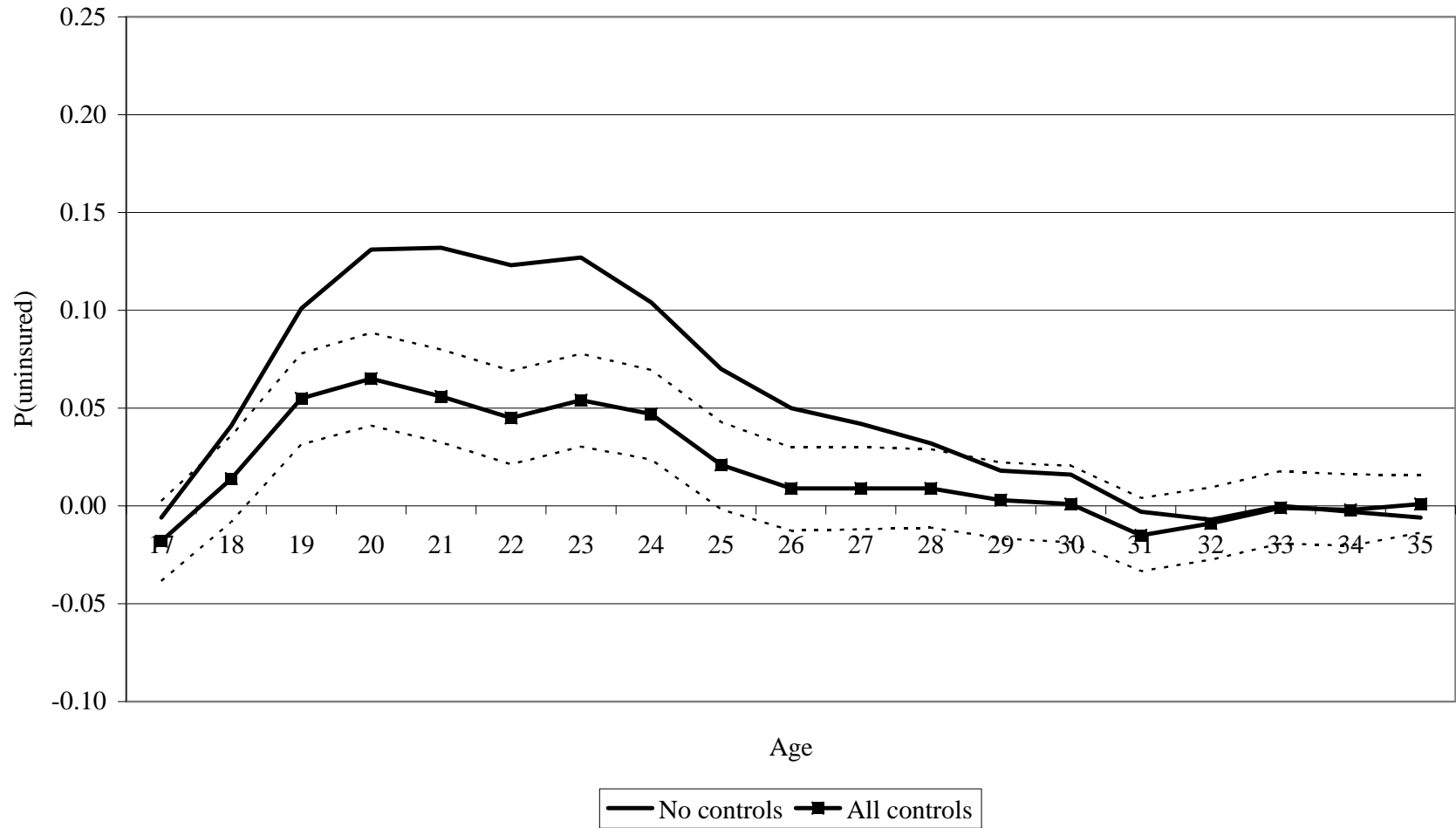


Figure 12  
Probability of no health insurance, by age and birth cohort  
March CPS, 1989 - 2006

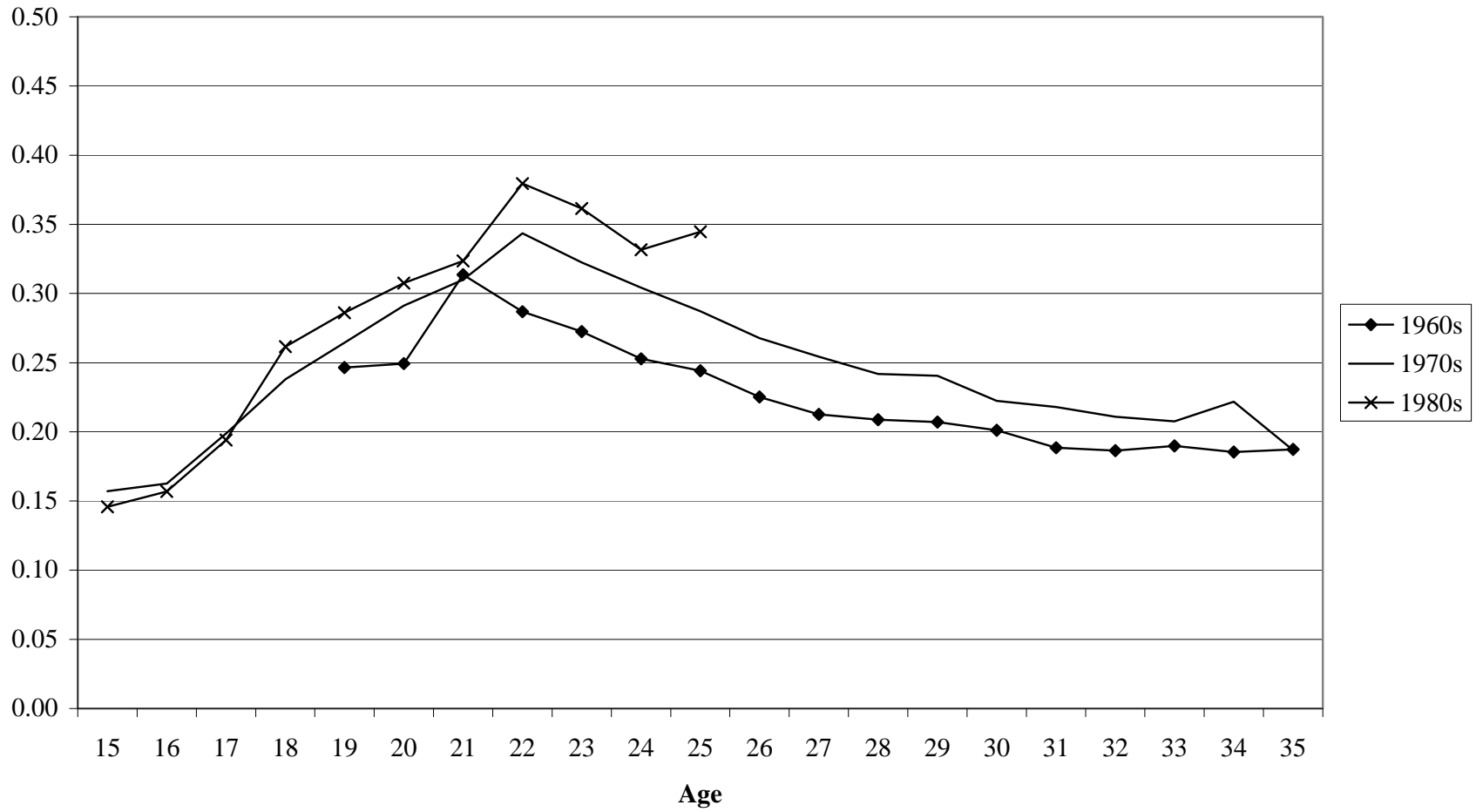


Figure 13  
Probability of parental health insurance coverage, by age and birth cohort  
March CPS, 1989 - 2006

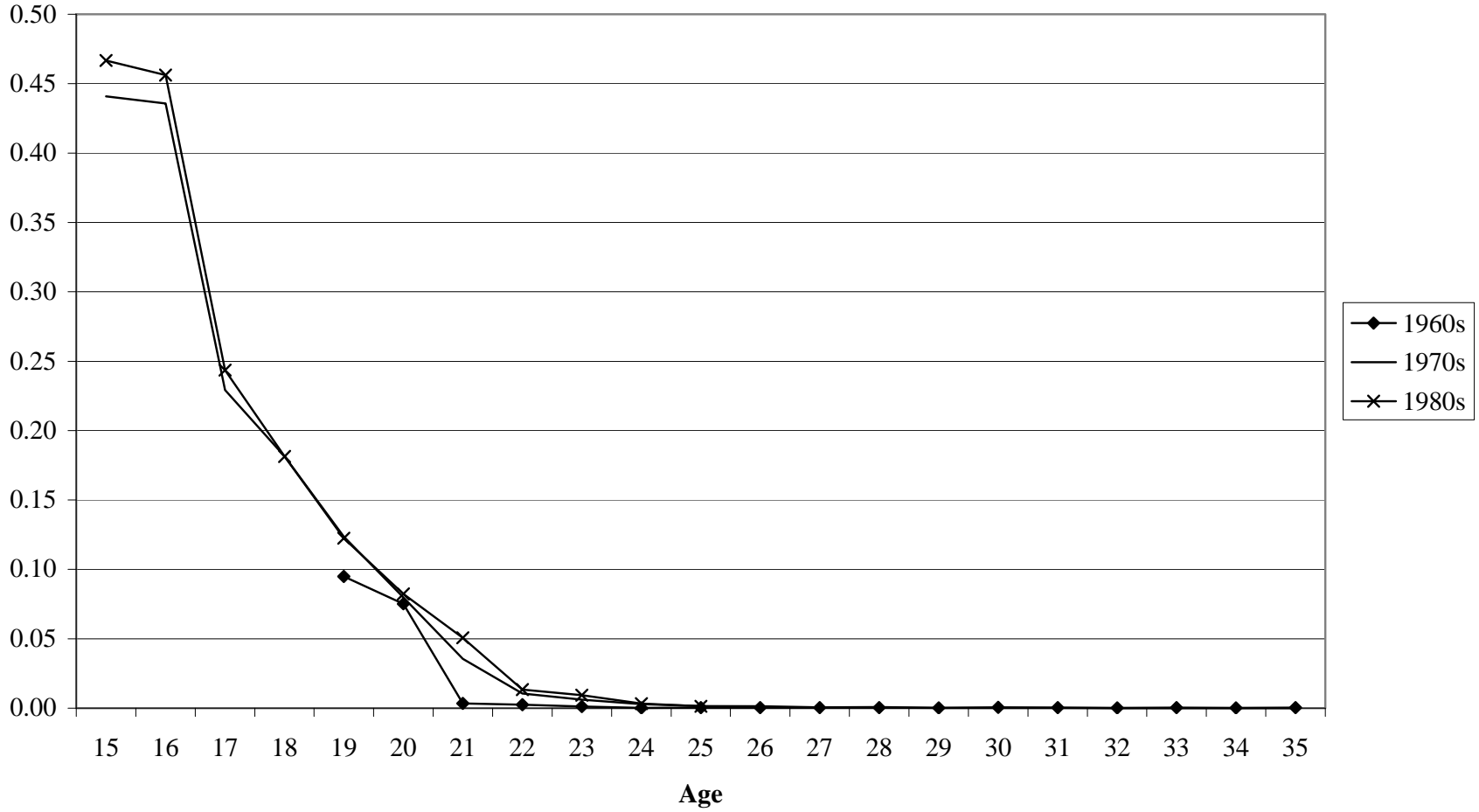
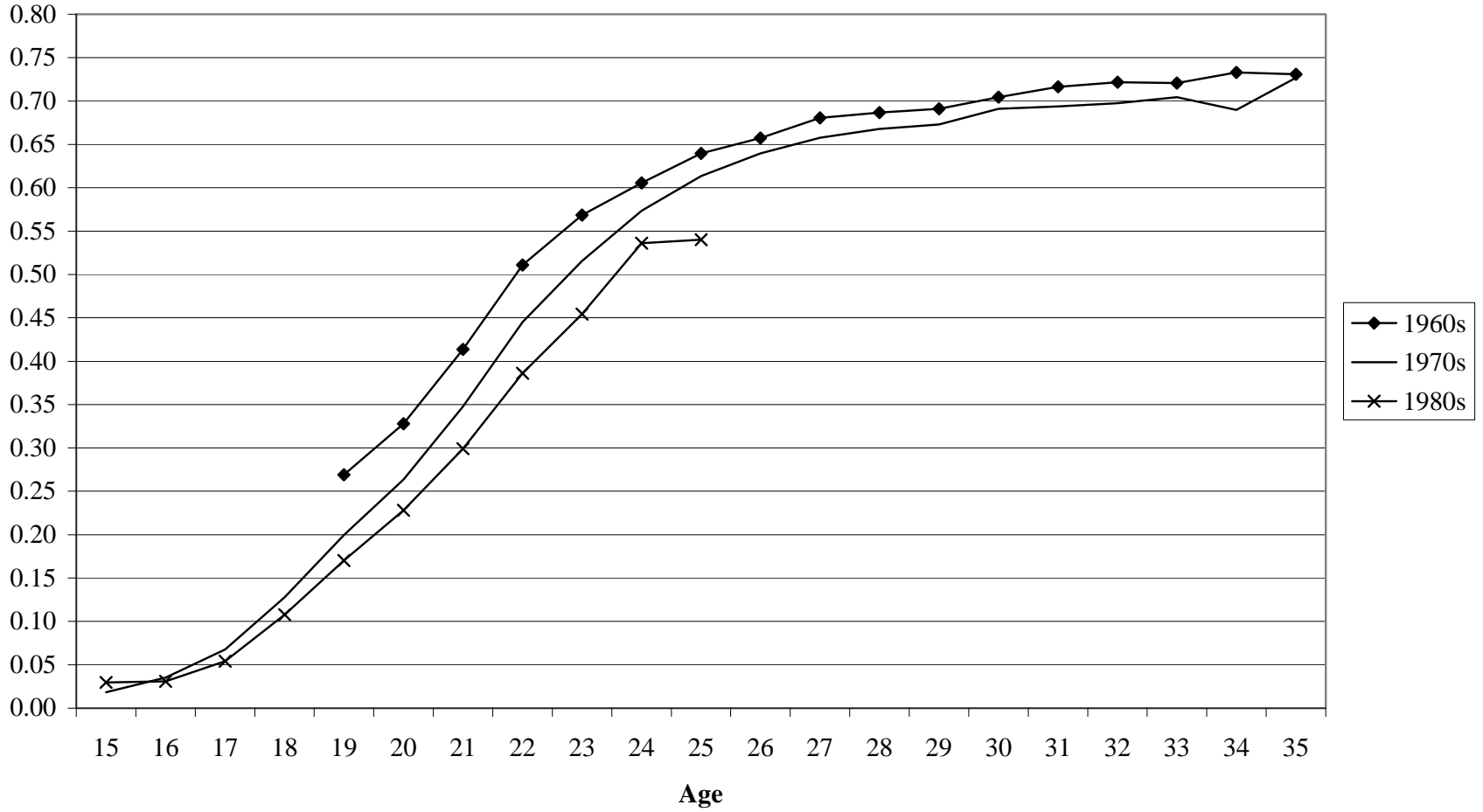


Figure 14  
Probability of own or spouse's health insurance, by age and birth cohort  
March CPS, 1989 - 2006



## **Data Appendix**

### *The Survey of Income and Program Participation (SIPP)*

The data for the main analysis come from the 1996 and 2001 panels of the Survey of Income and Program Participation (SIPP). The 1996 SIPP panel first interviewed 36,730 households containing 95,315 individuals in March, April, May or June of 1996 and then attempted to re-interview each household every four months for the next four years. The 2001 SIPP panel began with 35,106 households containing 90,408 individuals who were followed for up to three years. The SIPP collects four months' worth of retrospective monthly information at each interview. Because of the well-documented problem of "seam bias" I use data for the fourth reference month only (the month in which the interview actually occurred). "Seam bias" refers to respondents' tendency to report any changes as occurring in the month that a reference period began. That is, the respondent's status may have changed in month two of a four-month reference period, but respondents tend to report that they had the same status for the entire period. Thus transitions in health insurance, employment, etc. are more likely at the "seams" of the survey. I restrict my sample for analysis to individuals who provide at least two years of data beginning with wave 1, and further restrict the sample to data from the first two years for which these individuals are observed. The first restriction reduces the sample of individuals by about one-third, to 185,723 in all (counting both the 1996 and 2001 panels). The second restriction means I am throwing away additional information on these individuals – up to two years' worth, depending on the panel.<sup>10</sup> The resulting sample consists of 122,776 individuals in 42,212 households. By construction, I have exactly six observations on each individual. My analysis focuses on children and young adults through age 35; Data Appendix Table 1 shows the distribution of the sample by age at wave 1, sex, and panel.

The SIPP asks about public and private health insurance coverage, whether private insurance is in the respondent's own name, and if it is not who the policyholder is. This enables me to construct a variable reflecting whether the respondent has his/her own private coverage, coverage from a parent, or coverage from a spouse. Individuals with both public and private coverage are counted as having private coverage. The SIPP asks about paid employment during the reference period and whether it was part-time or full-time, as well as whether the respondent was enrolled in school part-time or full-time during the reference period. My analysis of health insurance coverage by parental education uses the highest education ever reported by either parent of a child in any wave of the survey.

All estimates from the SIPP are weighted using the wave 1 sampling weights.

### *The Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)*

For an analysis of changes in health insurance coverage across cohorts, I use data from the Annual Social and Economic Supplements to the Current Population Survey for 1989 through 2006 (the "March supplements"). These supplements contain information on health insurance in the calendar year prior to the survey. Unlike the SIPP, which asks about coverage at a point in time, the CPS questions ask about coverage at any point during the prior year. In spite of the differences between the surveys, a comparison of Figure 4 and Figure 12 reveals remarkable similarity in the age profile of the probability of being uninsured across the two surveys. One complication of using the CPS is that a considerable fraction of children and young adults (about 30 percent of respondents ages 15 to 19 and about 10 percent of those in their 20s) have "other private" coverage the source of which (own employer, parent, spouse)

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<sup>10</sup> Preliminary analyses using the additional observations suggests that the same substantive story emerges if I look at a longer time period.

cannot be determined. The patterns of change across cohorts in Figures 13 and 14 are robust to re-categorizing these individuals as covered by parental insurance or covered by their own private insurance.

All estimates from the CPS are weighted using the March supplement sampling weights.

Data Appendix Table 1  
Sample size by age and SIPP panel

Age at wave 1	1996 Panel: Men	1996 Panel: Women	2001 Panel: Men	2001 Panel: Women	Total
<1	438	462	382	342	1,624
1	515	491	406	447	1,859
2	530	500	466	414	1,910
3	591	563	445	391	1,990
4	604	584	424	421	2,033
5	589	558	427	415	1,989
6	561	596	397	409	1,963
7	598	578	421	436	2,033
8	582	564	415	461	2,022
9	536	552	439	427	1,954
10	600	546	466	482	2,094
11	560	506	468	446	1,980
12	552	554	423	433	1,962
13	552	495	455	417	1,919
14	506	556	459	384	1,905
15	578	550	423	387	1,938
16	507	482	458	384	1,831
17	424	428	385	348	1,585
18	403	410	347	341	1,501
19	404	373	313	319	1,409
20	324	368	283	326	1,301
21	338	351	263	304	1,256
22	309	349	258	295	1,211
23	308	419	292	334	1,353
24	329	425	257	317	1,328
25	410	516	255	301	1,482
26	424	442	299	310	1,475
27	407	435	291	367	1,500
28	420	509	325	361	1,615
29	420	465	348	377	1,610
30	422	555	334	384	1,695
31	483	585	317	419	1,804
32	530	537	387	369	1,823
33	516	580	349	385	1,830
34	542	604	388	411	1,945
35	547	617	360	427	1,951
Total ages 15-35	9,045	10,000	6,932	7,466	33,443
Total ages 0-35	17,359	18,105	13,425	13,791	62,680

Appendix Table 1  
 Regression results: effect of covariates on age profile of uninsurance for men  
 Linear probability model with dependent variable = 1 if uninsured

	No covariates model		All covariates model	
	Coefficient	Standard error	Coefficient	Standard error
Independent variables:				
Age = 17	-0.011	0.010	<b>-0.052**</b>	0.011
Age = 18	<b>0.035**</b>	0.012	<b>-0.027*</b>	0.012
Age = 19	<b>0.111**</b>	0.013	<b>0.027*</b>	0.013
Age = 20	<b>0.143**</b>	0.014	<b>0.054**</b>	0.013
Age = 21	<b>0.188**</b>	0.014	<b>0.093**</b>	0.014
Age = 22	<b>0.193**</b>	0.015	<b>0.095**</b>	0.014
Age = 23	<b>0.194**</b>	0.015	<b>0.093**</b>	0.014
Age = 24	<b>0.162**</b>	0.015	<b>0.079**</b>	0.013
Age = 25	<b>0.147**</b>	0.015	<b>0.078**</b>	0.013
Age = 26	<b>0.123**</b>	0.014	<b>0.067**</b>	0.013
Age = 27	<b>0.090**</b>	0.014	<b>0.048**</b>	0.012
Age = 28	<b>0.062**</b>	0.013	<b>0.038**</b>	0.012
Age = 29	<b>0.061**</b>	0.017	<b>0.045**</b>	0.013
Age = 30	<b>0.037*</b>	0.015	<b>0.026*</b>	0.012
Age = 31	<b>0.030*</b>	0.013	<b>0.027*</b>	0.011
Age = 32	0.017	0.012	<b>0.028**</b>	0.011
Age = 33	0.008	0.012	0.014	0.010
Age = 34	-0.001	0.011	0.006	0.010
Age = 35	0.007	0.009	<b>0.017*</b>	0.008
Omitted: Age = 16				
Family income relative to poverty threshold:				
50 - 100%			<b>-0.030**</b>	0.014
100 - 150%			<b>-0.065**</b>	0.014
150 - 200%			<b>-0.122**</b>	0.013
200 - 250%			<b>-0.197**</b>	0.013
250 - 300%			<b>-0.240**</b>	0.013
300 - 350%			<b>-0.286**</b>	0.013
350 - 400%			<b>-0.297**</b>	0.013
>400%			<b>-0.340**</b>	0.013
Omitted: <50% FPL				

Table continues on next page.

Appendix Table 1 (continued)

	No covariates model		All covariates model	
	Coefficient	Standard error	Coefficient	Standard error
Independent variables:				
Lives with own children			<b>-0.021**</b>	0.008
Single parent			0.020	0.015
Spouse does not work			<b>-0.067**</b>	0.012
Spouse in school FT			<b>-0.075**</b>	0.020
Spouse working FT			<b>-0.084**</b>	0.009
Spouse working PT			<b>-0.093**</b>	0.010
Establishment size				
Unknown			<b>0.229**</b>	0.020
<25 workers			<b>0.082**</b>	0.013
25 – 99 workers			-0.013	0.013
100+ workers			<b>-0.066**</b>	0.013
Omitted: Nonworker				
Homeowner			<b>-0.050**</b>	0.006
Lives with parents			<b>0.071**</b>	0.014
Lives with parents and is full-time student			<b>-0.086**</b>	0.019
In school full-time			<b>-0.069**</b>	0.020
Works part-time			<b>0.035**</b>	0.012
Has more than one job			<b>0.066**</b>	0.008
Job tenure if full-time worker			<b>0.000**</b>	0.000
Full-time worker, tenure>1 year			<b>-0.084**</b>	0.007
Hispanic			<b>0.145**</b>	0.010
Black			<b>0.033**</b>	0.009
Other nonwhite race			0.019	0.012
Intercept	<b>0.178**</b>	0.009	<b>0.517**</b>	0.017
<hr/>				
Number of observations	89,855		89,855	
Number of individuals	14,999		14,999	
R <sup>2</sup>	0.0252		0.2012	

**Notes:** \*Significantly different from zero with  $p < 0.05$

\*\*Significantly different from zero with  $p < 0.01$