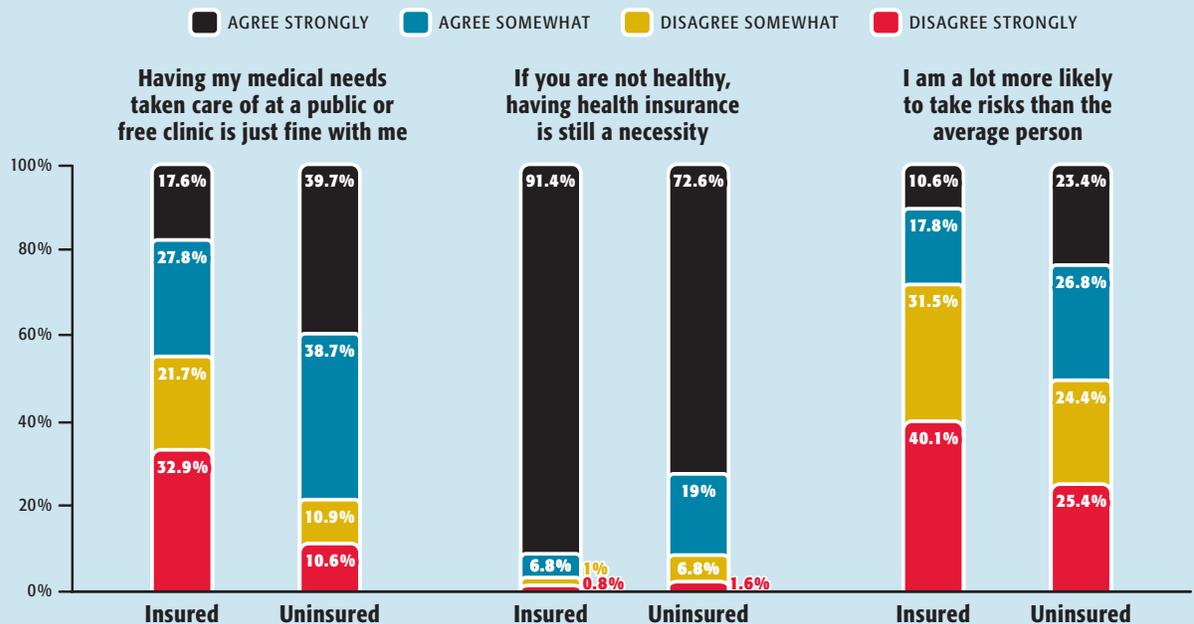


Key findings

- Data on attitudes toward health and health care can be used to predict who will be receptive to outreach efforts and enroll in coverage when new insurance options become available under the Affordable Care Act (ACA) in 2014.
- Among non-elderly adults in New Jersey who responded to the New Jersey Family Health Survey, attitudes toward health and health care account for about an eighth (12.6%) of the variation in who is currently insured and who is not.
- Using these same attitudes, those classified as unlikely to enroll in health insurance are more likely to be male, younger, Hispanic, Asian, or non-citizens. Having dependent children in the household is not related to attitudes toward purchasing insurance.
- Those who are single, separated, or divorced, have less education, or are poorer are also more likely to opt out of coverage, as are those living in the south-east region of New Jersey. Employment status was unrelated to attitudes toward coverage.
- Those with attitudes making them less inclined to enroll in coverage are comprised of both healthy and unhealthy individuals; while they are more likely to rate their general health as poor, there were no differences for mental or dental health.
- Targeted education and outreach by the new health insurance Marketplace (also known as the Exchange), insurers, and others working to implement the ACA to individuals expressing attitudes associated with a lower likelihood of having coverage may help achieve optimal enrollment rates and guard against adverse risk selection in insurance risk pools.

Figure 1 | **Health Attitudes and Insurance Status, Non-Elderly Respondents (N=1951)**



2009 NEW JERSEY FAMILY HEALTH SURVEY

The Affordable Care Act (ACA) mandates that most individuals must purchase health insurance by 2014 or face an annual tax penalty. This annual penalty, although modest in the first year, increases substantially in subsequent years.

Our last two Facts & Findings in this series examined the health, access, and demographic characteristics of those currently uninsured to help health plans and providers understand the population the ACA was designed to enfranchise. However, it is not clear who will actually take-up insurance and who will instead decide to pay the penalty. If those who decide to enroll in coverage are in poor health while healthy young adults opt to pay the penalty, this adverse risk selection will cause overall health care costs to increase, reducing program sustainability and resulting in further increases in insurance premiums for everyone.

This Facts & Findings examines the health and demographic characteristics of non-elderly adults in New Jersey who, by virtue of their expressed attitudes, may be less receptive to health insurance outreach and enrollment efforts in 2014.¹⁻⁴ This analysis uses the 2009 New Jersey Family Health Survey (NJFHS) which asked respondents a series of health and healthcare-related attitudinal questions. Responses to three of these items that show a strong correlation with being uninsured are used to examine the socio-demographic characteristics of those non-elderly adults who are likely to be hardest to reach and enroll in new health insurance options.

Respondents were asked to rate how much they agree or disagree with the following statements using a four-level response scale (strongly agree, somewhat agree, somewhat disagree, strongly disagree):

- Having my medical needs taken care of at a public or free clinic is just fine with me.
- I am a lot more likely to take risks than the average person.
- If you are healthy, having health insurance is still a necessity.

Figure 1 shows responses to each of these three survey questions by whether a respondent was insured or not. The uninsured were more likely than those who have health insurance to agree that “Having my medical needs taken care of at a public or free clinic is just fine with me” and that “I am a lot more likely to take risks than the average person” but less likely to agree that “If you are healthy, having health insurance is still a necessity”. Using statistical techniques for these attitudinal questions, we created an index indicating how difficult it may be to engage currently uninsured individuals with the outreach and educational efforts aimed at maximizing enrollment in new coverage options that will be available in 2014 under the ACA (see box below). A higher score on the index reflects attitudes that will likely make an individual less receptive to coverage outreach efforts, while a lower score indicates that they are more receptive to coverage outreach efforts.

Who Will Be Less Receptive to Coverage Outreach Efforts?

Those associated with being more likely to opt out of coverage on the attitudinal index (higher score) were significantly more likely to be male, younger, Hispanic, Asian, or non-citizens (see Figure 2). Having dependent children in the household was not related to the attitudinal index. Those who were single, separated, or divorced, had less education, or were poorer were also significantly more likely to opt out of coverage, as were those living in the south-east region of New Jersey; employment status was not related to attitudes toward coverage.

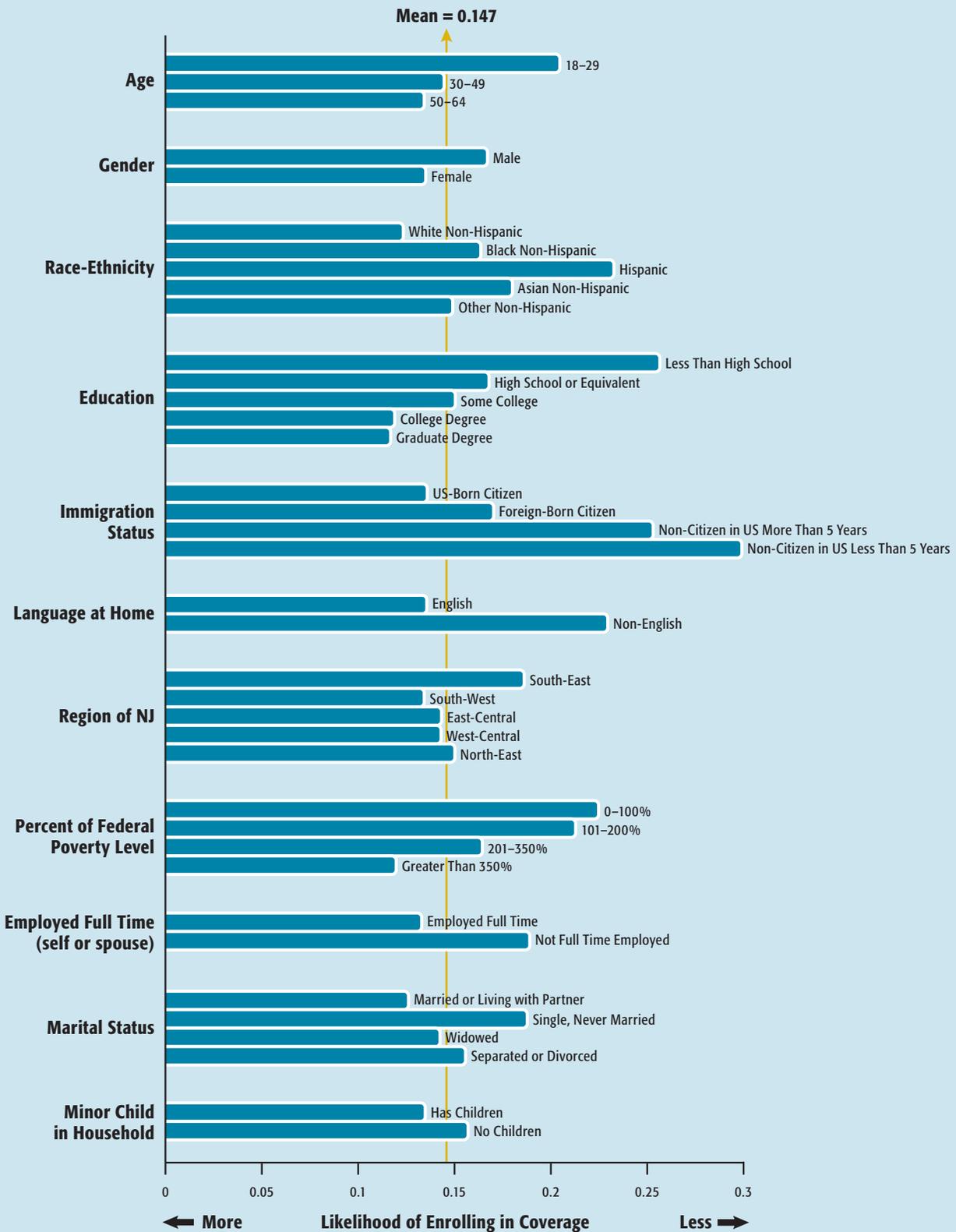
Those less likely to enroll in coverage were comprised of both healthy and unhealthy individuals: they were significantly more likely to rate their general health as poor, but diagnosis of any chronic disease and self-assessments of dental and mental health were unrelated to attitudes toward coverage.

Creating an Index of Likelihood of Enrolling in Coverage

Statistical analysis was conducted in two phases. First, using regression analysis, the three attitudinal variables were entered in categorical form into a linear probability model predicting whether or not an individual had health coverage of any kind at the time of their interview. This analysis shows that about one-eighth (12.6%) of the variation in being uninsured among non-elderly New Jersey adults can be explained by responses to just these three attitude items. The resulting predicted value is equivalent to the attitude-related likelihood of being uninsured. A higher value indicates

having attitudes predicting a greater likelihood of being uninsured. A second linear multiple regression was then conducted using these predicted values as the dependent measure to examine the characteristics of those who are more likely to opt out of health insurance coverage. Almost a quarter (23.7%) of the variation in attitudes toward purchasing coverage was explained by these characteristics. The results of this second analysis are used to identify groups that may be less receptive to coverage outreach and educational efforts and decide to opt out of coverage.

Figure 2 | **Attitude Index: Likelihood of Enrolling in Coverage, Non-Elderly Respondents (N=1951)**
(higher scores mean less likely to enroll)



2009 NEW JERSEY FAMILY HEALTH SURVEY

Other Family Members

The survey asked only one household respondent the health-related attitude questions, but for other items the respondent provided data for both him or herself and all other related members of the household. This includes the socio-demographic and health status measures that were related to the attitudinal predicted values discussed above. However, the adult “most knowledgeable about the health and health care needs of the family” was selected as the survey respondent, so it is likely that this adult may influence many of the health care decisions for other family members. We conducted additional analyses to evaluate whether the findings described above also hold for non-elderly family members other than

the household respondent by applying the respondent’s attitudinal index to other non-elderly family members. This analysis revealed that most of the findings described above also hold for family members other than the household respondent, with a few exceptions: non-Hispanic blacks and those living in the south-west and east-central regions of New Jersey were also characterized as more likely to opt out of coverage. Also, those likely to opt out of coverage were less likely to have been diagnosed with any chronic condition, although they still rated their general health as poorer; however, they rated their dental health as better and there were no differences for self-assessed mental health.

These findings indicate that some people may opt out of mandated health insurance under the ACA and decide to pay the tax penalty. The evidence is mixed as to whether these people will be healthier or not; but if those who opt out are healthier, then adverse selection will occur, potentially raising premiums for those who do purchase coverage as well as the costs of government subsidies. To help reduce the risk of uneven enrollment and adverse selection, outreach should be targeted to those less inclined to buying insurance and should be sensitive to their socio-demographic characteristics. Premium affordability will also be a key component to reducing adverse selection as individuals weigh the utility of cost versus being insured.

This Facts & Findings highlights the importance of tailoring educational messages to consumers who perceive themselves as not needing coverage, willing to bear risk, satisfied with available safety net services, or unfamiliar with health insurance as a mechanism for managing their health care. For example, messages for these consumers might emphasize that being covered will give individuals more health care access points compared with those who remain uninsured, or that coverage will help them obtain no-cost preventive care. Consequently, it may be effective to make staying healthy a salient point in educational outreach efforts delivered through avenues unrelated to the health care system. Additional survey and focus group work may be needed to refine such messages, but it is clear that carefully crafted consumer education will be needed to ensure robust enrollment and broad risk pools in 2014.

Coverage Eligibility Rules under the ACA

Under the ACA, individuals with incomes up to 138% of the federal poverty level (FPL) are eligible for coverage in expanded state Medicaid programs. Those with incomes between 139-400% FPL are eligible for subsidies to purchase health insurance through an Exchange, and individuals with incomes above 400% FPL, while still subject to the coverage mandate, are not eligible for federal subsidies to offset the cost of purchasing health insurance. Notable exceptions to these income-eligibility rules exist for certain immigrant

groups. The ACA maintains the current prohibition on using federal Medicaid funds to cover low-income immigrant adults residing in the country less than five years. Instead, the ACA authorizes legally resident low-income recent immigrant adults to purchase subsidized coverage through the Exchange. Undocumented immigrants are excluded entirely from the provisions in the ACA. They will continue to be ineligible for Medicaid and will not be permitted to enter exchanges nor obtain subsidies to purchase health insurance.

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Other NJFHS Reports

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Methods

The 2009 New Jersey Family Health Survey (NJFHS) was designed to provide population-based estimates of health care coverage, access, use, and other health topics important for New Jersey policy formulation and evaluation in the coming years. It was funded by the Robert Wood Johnson Foundation and designed and analyzed by the Rutgers Center for State Health Policy (CSHP). The fieldwork was conducted by Abt SRBI between November 2008 and November 2009. It was a random-digit-dialed telephone survey of 2,100 families with landlines and 400 families with cell phones residing in New Jersey. It collected information about a total of 7,336 individuals and had an overall response rate of 45.4% (52.6% for landlines and 26.0% for cell phones). The adult who was most knowledgeable about the health and health care needs of the family was interviewed.

Further information on the 2009 NJFHS, including a comprehensive methods report and the full text of the survey questionnaire, can be found on the Center's web site:

- [The 2009 New Jersey Family Health Survey Methods Report](#)
- [The 2009 New Jersey Family Health Survey Questionnaire](#)

All findings reported in this Facts & Findings were significant at the $p < .05$ level unless otherwise noted. All data was weighted to accurately reflect the New Jersey household population. The counties assigned to each region of the state for this analysis are as follows:

- South-East: Cape May, Cumberland, Salem, and Atlantic counties
- South-West: Gloucester, Camden, and Burlington counties
- Central-East: Ocean, Monmouth, and Middlesex counties
- North-Central West: Mercer, Somerset, Morris, Hunterdon, Warren, and Sussex counties
- North-East: Passaic, Bergen, Union, Essex, and Hudson counties

CSHP's Facts & Findings

Facts & Findings from Rutgers Center for State Health Policy highlight findings from major research initiatives at the Center, including the New Jersey Family Health Survey. Previous Facts & Findings, along with other publications, are available at www.cshp.rutgers.edu.

RUTGERS

Center for State Health Policy

112 Paterson Street, 5th Floor
New Brunswick, NJ 08901

www.cshp.rutgers.edu

For more information email CSHP_Info@ifh.rutgers.edu

Contributing to this issue:

Susan Brownlee, PhD

Joel C. Cantor, ScD

Kristen Lloyd, MPH