



The Health of Disconnected Low-Income Men

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This brief, part of a series on disconnected low-income men, examines their health insurance coverage and health status using data from the American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) with some additional information provided by the Kaiser Family Foundation. Low-income men are defined as those age 18 to 44 who live in families with incomes below twice the federal poverty level (FPL)¹ and do not have four-year college degrees. Other briefs in the series examine low-income men's demographic profiles, education, employment, and heightened risk of incarceration and disenfranchisement.

We selected the most recent variables available at the state level that captured broad measures of health coverage and access, and general health. We focus primarily on men's connections to health care providers and systems, as opposed to disparities in specific health conditions. We present the national picture and highlight differences across states.

Low-Income Men Are More Likely to Lack Health Insurance Coverage

Less than half (49 percent) of low-income men age 18–44 in the United States have any insurance coverage (figure 1).² The insured rate for low-income men is significantly lower than the rate for all men age 18–44, which is 71 percent. Low-income men are half as likely as all men in that age group to be covered by private insurance only (30 percent versus 62 percent) due to their lower rates of employment and employer-provided coverage.³ Low-income men are also more than twice as likely as all men age 18–44 to have public insurance only: 17 percent versus 7 percent. However, low-income men in this age range have relatively low public insurance coverage compared to other low-income populations, such as children and pregnant women, who qualify for Medicaid. For example, in 2010, 54 percent of children in families with incomes below 200 percent of FPL were covered by Medicaid or CHIP (Holahan and Chen

2011). Nondisabled childless adults have historically not been eligible for Medicaid regardless of their incomes, unless their state uses its own funds or receives a federal waiver (Kaiser Commission 2013).⁴

As a result of these relatively low rates of private and public insurance, 51 percent of low-income men lack any health insurance, significantly higher than the share of all men age 18–44 that are uninsured (29 percent).

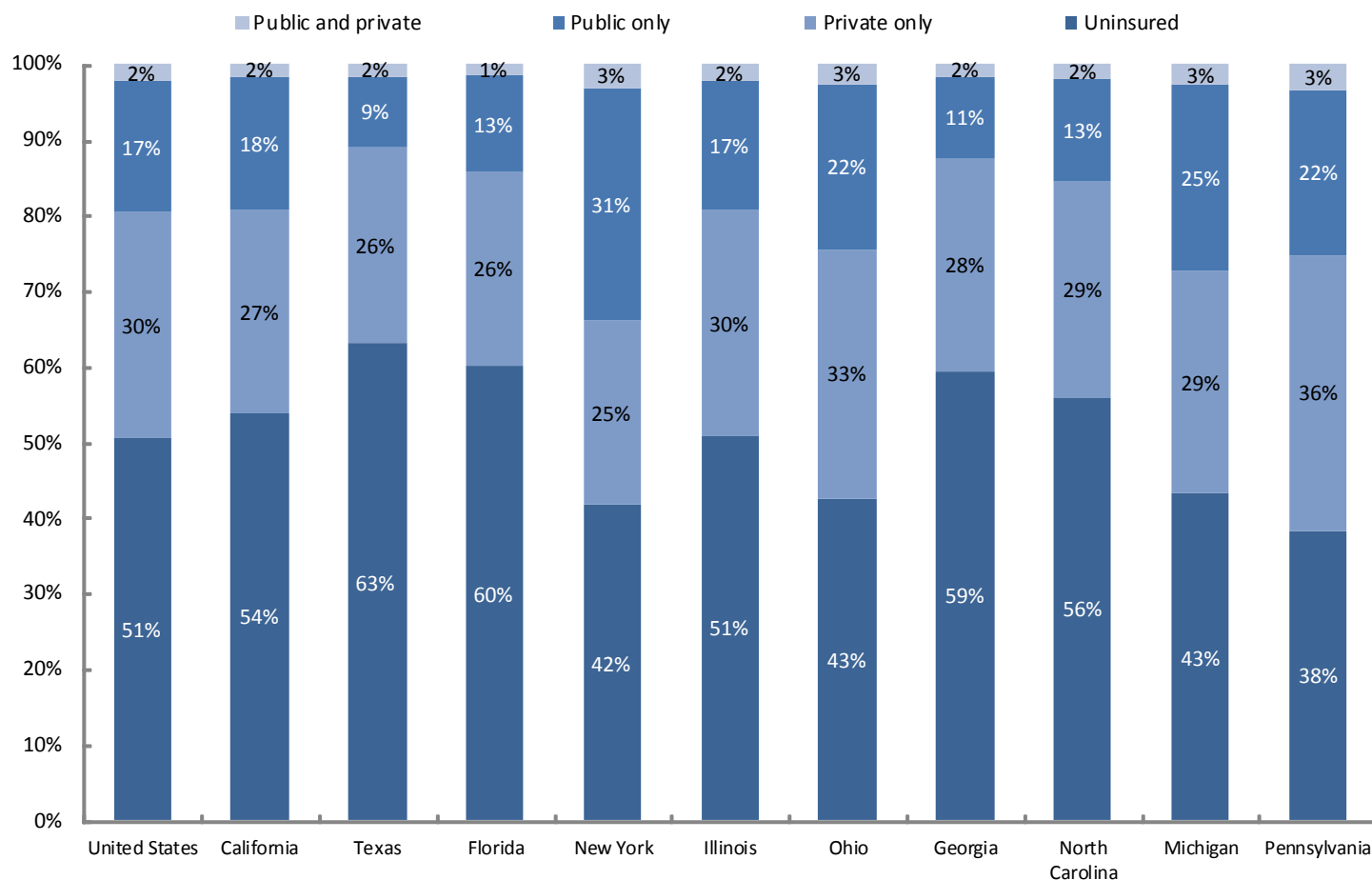
Health Insurance Coverage Varies by State, Citizenship, Ethnicity, and Education

Among the 10 states with the largest number of low-income men ("the top 10 states"), rates of private and public insurance coverage vary widely (figure 1). Low-income men in Pennsylvania (36 percent), Ohio (33 percent), and Illinois (30 percent) have the highest rates of private insurance only. Private insurance rates are lowest in New York (25 percent).

Among the top 10 states, low-income men in Texas (11 percent), Georgia (13 percent), and Florida (14 percent) have the lowest rates of public insurance (public only or both public and private insurance). Low-income men in New York and Michigan have the highest rates of public insurance coverage (34 and 28 percent, respectively). New York, California, and Michigan are among the small number of states that provide Medicaid coverage to income-eligible men without children using a federal waiver or state-only funding, while Illinois in November 2012 made adults in Cook County with incomes up to 133 percent of FPL eligible for Medicaid.⁵

Figure 1 also shows that low-income men in states with the *lowest* public insurance coverage have the *highest* uninsured rates: Texas (63 percent), Florida (60 percent), and Georgia (59 percent). Low-income men in states with the highest rates of public insurance (New York and Michigan) are the least likely to lack any health insurance coverage (42 and 43 percent, respectively).

Figure 1. Health Insurance Coverage by Type for Low-Income Men Nationwide and in the Top 10 States, 2008–10



Source: ASPE tabulations of the American Community Survey (2008–10).

Notes: Low-income men are ages 18–44, live in families with incomes below 200 percent of the federal poverty level, and do not have four-year college degrees. “Top 10 states” are states with the largest populations of low-income men.

As shown in figure 2, the states with the highest uninsured rates for low-income men (above 50 percent) are located primarily in the southeast (Arkansas, Florida, Louisiana, Mississippi, North Carolina, South Carolina, and Georgia), the southwest (Texas, Oklahoma, New Mexico, and Colorado), and the west (California and Nevada). Northern areas of the country tend to have lower rates of uninsured men. The District of Columbia (23 percent) and Massachusetts (21 percent), Hawaii (26 percent), and

Vermont (28 percent) have the lowest uninsured rates (data not shown). Massachusetts and Vermont have state health care systems designed to expand coverage to low-income populations, as does the District of Columbia.

Public insurance coverage across the states appears to follow a similar pattern to that of uninsured rates. Low-income men have the lowest rates of public insurance coverage in the south and midwest (Georgia, Nebraska, Utah, Kansas, Wyoming, Idaho, Texas, and Nevada) at 12

percent or below. Northeastern states (New York, Maine, Massachusetts, and Vermont) have the highest public insurance rates for low-income men: at or above 34 percent. Low-income men in the District of Columbia have the highest public insurance rate (48 percent).

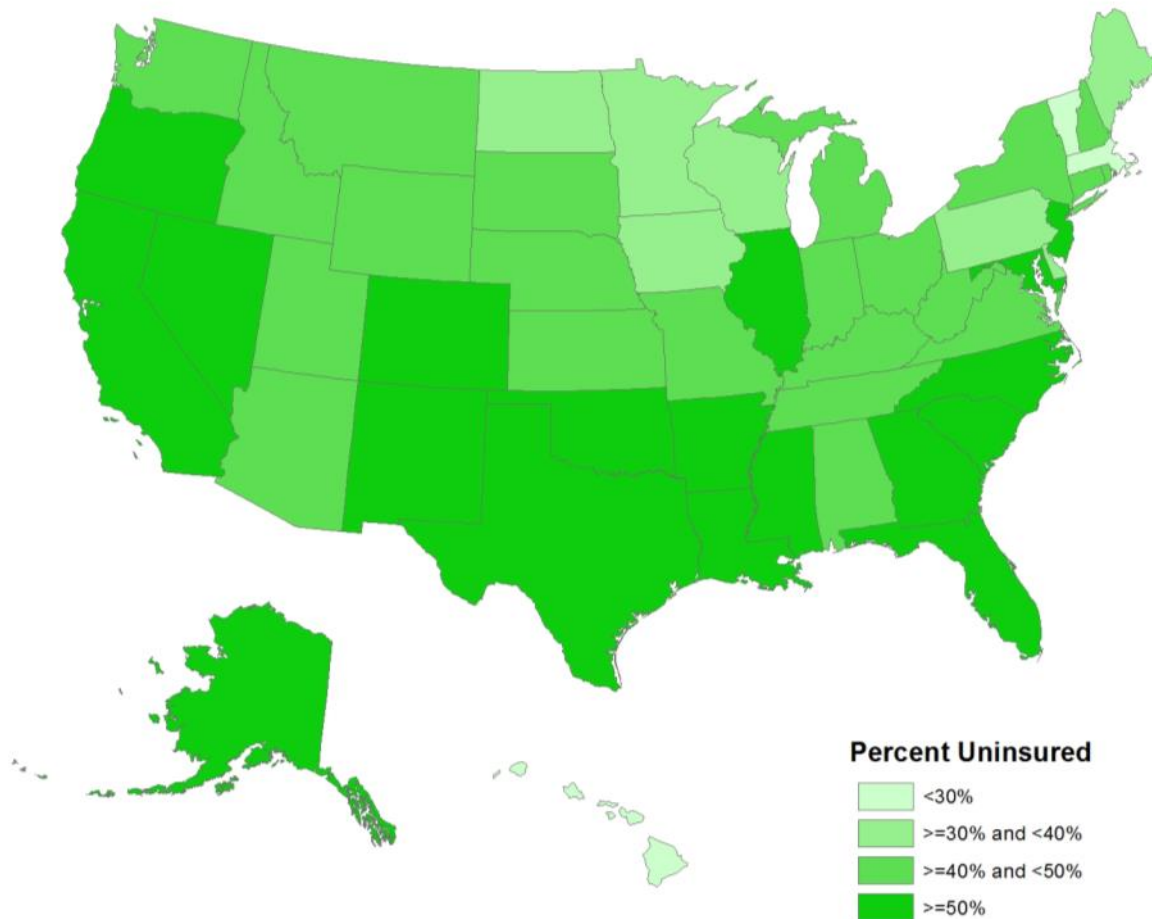
Among low-income men nationally, Hispanics are the most likely to lack health insurance coverage (66 percent), followed by African American men (48 percent).⁶ White men have the lowest uninsured rate (41 percent).⁷ Many Hispanic men are foreign born and may not qualify for public health insurance coverage depending on their citizenship

and immigration status (Kenney and Huntress 2012; Motel and Patten 2012).

Uninsurance rates do vary by citizenship status. Low-income men who are noncitizens, a group that includes both lawfully present immigrants and undocumented immigrants, have the highest uninsured rate (74 percent). The uninsured rate for foreign-born men who are naturalized US citizens is the same as the uninsured rate for native-born men (45 versus 44 percent).

In relation to educational attainment, low-income men without high school degrees or GEDs have the highest

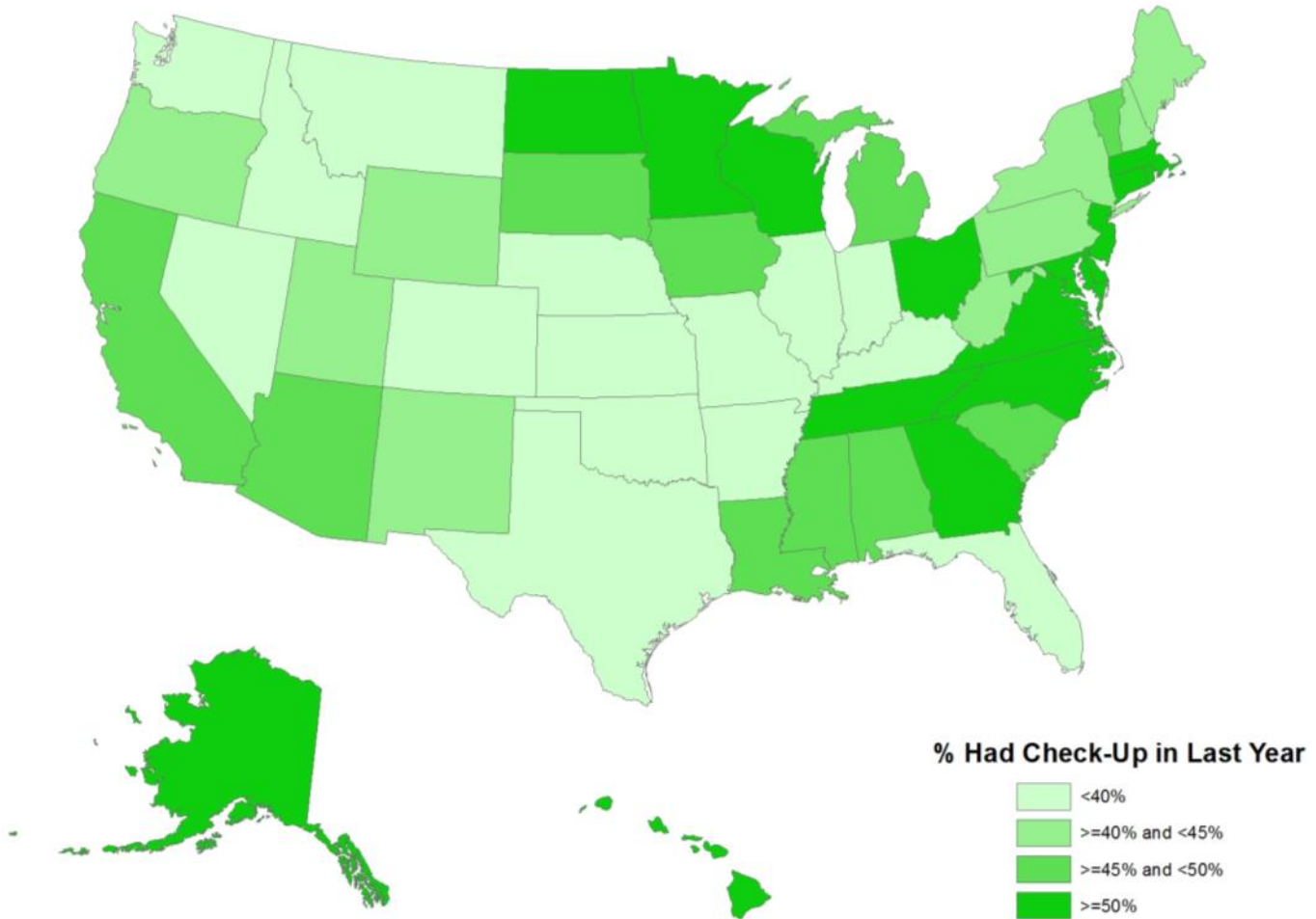
Figure 2. Uninsurance Rates for Low-Income Men by State, 2008–10



Source: ASPE tabulations of the American Community Survey (2008–10).

Note: Low-income men are age 18–44, live in families with incomes below 200 percent of the federal poverty level, and do not have four-year college degrees.

Figure 3. Share of Low-Income Men Reporting a Routine Checkup in the Past 12 Months by State, 2010



Source: Urban Institute tabulations of the 2010 Behavioral Risk Factor Surveillance System.

Note: Low-income men are age 18–44, live in families with incomes below \$35,000, and do not have four-year college degrees.

uninsured rate (61 percent), more than one and a half times higher than the uninsured rate for men with associate’s degrees (38 percent). The uninsured rate for low-income men with a high school degree or GED, but not a college degree, falls in the middle (52 percent).

Low-Income Men Have Less Access to Health Care and Poorer Health

Less than half (45 percent) of low-income men nationwide report a routine health checkup in the past year.⁸ By

comparison, 56 percent of higher-income men age 18–44 report a routine checkup in the past year.⁹

Rates of routine checkup in the past year vary across the states (figure 3). Among the 10 states with the largest number of low-income men, Florida’s (35 percent) and Texas’s (36 percent) rates of routine checkups for low-income men are below the national average (45 percent). As shown previously, both states have a high percentage of uninsured low-income men; this may explain the relatively low rates of a routine checkup.

The nation's capital and states along the East Coast tend to have the highest rates of low-income men who report a routine checkup in the past year, ranging from 54 percent in Georgia to 74 percent in Massachusetts and the District of Columbia. Other states with relatively high rates of routine checkups for low-income men include Minnesota and Wisconsin (55 percent each). Given the variation in insurance coverage among these states, it would seem that something other than insurance drives or invites men to seek regular health care.

In most states, low-income men age 18–44 are less likely than men in families with incomes above \$35,000 (or “higher-income men”) in that age group to report a routine checkup in the past year. The largest differences are in Kansas (25.7 percentage points), followed by Alabama, Florida, Kentucky, New York, and Oklahoma (all greater than 18 percentage points). Some states, however, have higher rates of routine checkups among low-income men than among higher-income men. The District of Columbia and North Dakota, Hawaii, Wisconsin, and Alaska all have higher checkup rates for low-income men age 18–44 than for higher-income men (7 percentage points or more).

Nationally, a greater percentage of low-income African American men reports a routine checkup in past year (61 percent) than low-income white men (44 percent) and Hispanic men (40 percent) do. However, the checkup rates for men are generally lower than those for women at similar income levels. For example, the rate for African American women with incomes below \$35,000 is above 80 percent.

Low-income men are four times as likely as higher-income men to report fair or poor health. Almost one in five (19 percent) low-income men report being in fair or poor health versus one in 20 (4.9 percent) higher-income men age 18–44. Low-income men are also less likely than higher-income men in this age group to report that they are in either very good or excellent health (41 versus 70 percent).

Among low-income men, Hispanics are more likely to report fair or poor health (23 percent) than whites (17 percent) and African Americans (18 percent). Low-income Hispanic men are also the least likely to report excellent or very good health (34 percent) while African American men are the most likely (50 percent). The share for low-income white men is 45 percent.

Reports of health status across the states generally appear to follow trends in health insurance coverage. Nevada, which has the fourth-largest uninsured rate among

low-income men, has the second-largest share of men reporting fair or poor health (31 percent). Similarly, Texas, New Mexico, and North Carolina have above-average uninsured rates and an above-average share of low-income men reporting fair or poor health. The District of Columbia, with the second-lowest uninsurance rate, has the highest share of low-income men reporting excellent or very good health (58 percent).

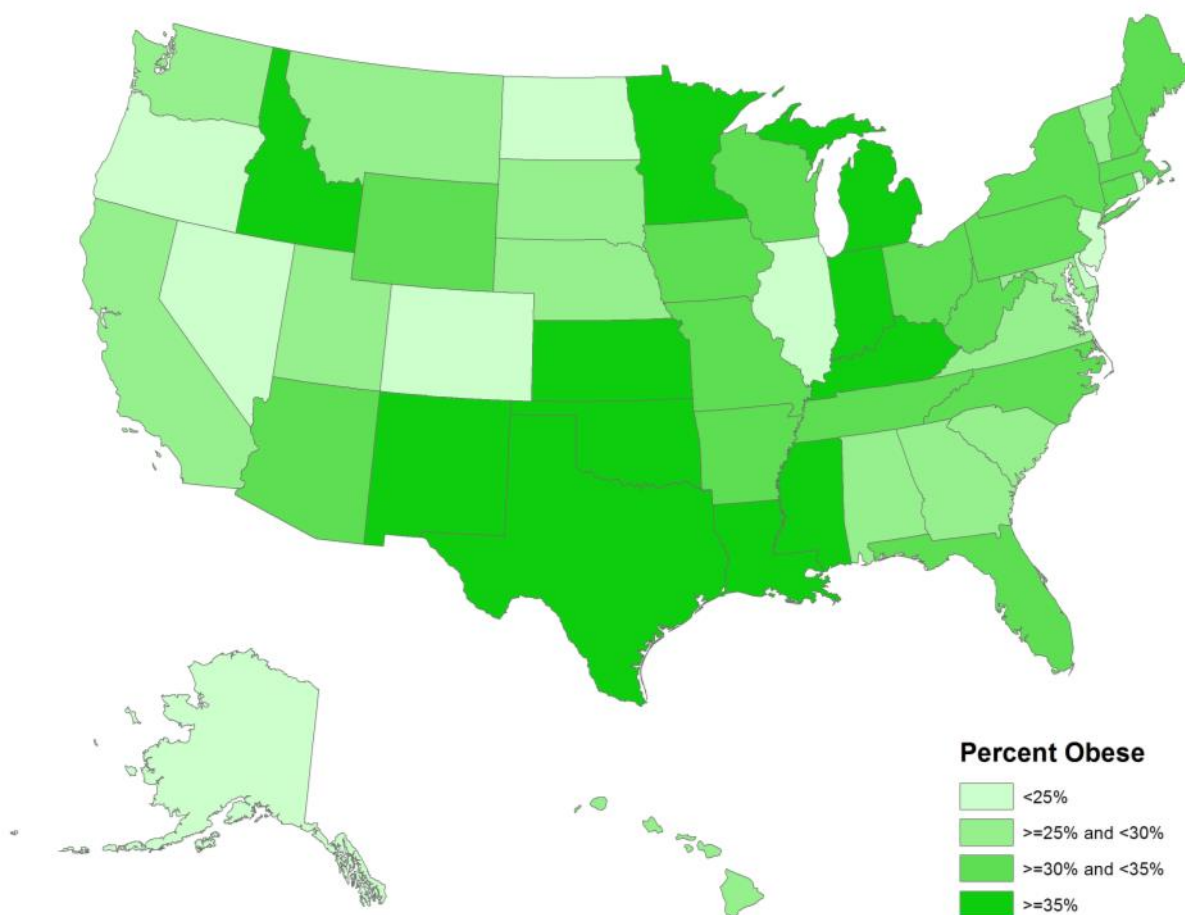
There are exceptions. Georgia, which has the third-highest uninsured rate, has the third-lowest rate of low-income men reporting poor health (9 percent). Massachusetts has the highest share of low-income men reporting fair or poor health (31 percent), despite having the lowest percentage of low-income men who lack insurance coverage. Mississippi, which has a high share of uninsured low-income men, has the second-highest rate of low-income men reporting excellent or very good health (57 percent). Massachusetts has the largest disparity in reported fair or poor health between low-income men and higher-income men (27.3 percentage points). The disparity is greater than 10 percentage points in 37 other states.

Looking at another measure of health, obesity, nearly one in three (30.8 percent) low-income men in the United States is obese; this is somewhat higher than the rate for non-low-income men age 18–44 (26.3 percent). Among the top 10 states, Texas and Michigan have the highest obesity rates for low-income men at 37 and 35 percent, respectively (figure 4). The obesity rate for low-income men is also above the national average for higher-income men age 18–44 (26.3 percent) in Florida, North Carolina, and Pennsylvania. Illinois, another top 10 state, has the fourth-lowest obesity rate of all states (22 percent).

In the nation as a whole, Oklahoma, Minnesota, Indiana, Kansas, Idaho, and New Mexico have the highest obesity rates for low-income men at 38 percent or higher. The states with the largest differences in obesity rates for low-income men relative to higher-income men are Idaho, New Mexico, and Minnesota (14 percentage points), Oklahoma (13.1 percentage points), and the District of Columbia (12.7 percentage points). In a few states, such as Alaska, Oregon, and West Virginia, low-income men are less likely than higher-income men to be obese.

Nationally, Hispanics have the highest obesity rate among low-income men (33 percent), followed by whites (30 percent) and African Americans (28 percent). Ohio has the highest obesity rate among low-income Hispanics (58 percent); the rates for white and African American men in

Figure 4. Obesity Rate for Low-Income Men by State, 2010



Source: Urban Institute tabulations of the 2010 Behavioral Risk Factor Surveillance System data.

Note: Low-income men are age 18–44, live in families with incomes below \$35,000, and do not have four-year college degrees.

the state are significantly lower (32 and 28 percent, respectively). Florida and Pennsylvania have the highest obesity rates among low-income African Americans (42 and 40 percent), while North Carolina has the highest obesity rate among white men (38 percent).

Conclusion

Compared with higher-income men age 18–44, low-income men are more likely to lack health insurance coverage, have lower access to routine health care, and have worse health

outcomes as measured by self-reported health and obesity. The health insurance coverage and health status of low-income men depend on where they live. Low-income men in Texas, Florida, and North Carolina, among the 10 states with the largest low-income male populations, have high uninsured rates, low rates of a routine checkup in the past year, and relatively high rates of self-reported poor/fair health and obesity.

Notes

1. In 2010, the year for the data estimates, the federal poverty threshold was \$11,344 for a single adult and \$17,552 for a family of three with one child. Twice the poverty level was \$22,688 for a single adult and \$35,104 for a family of three (<http://www.census.gov/hhes/www/poverty/data/threshld/>).
2. Data on health insurance coverage are for 2008–10 and are based on data from the ACS (2008–10).
3. The rate of employer-provided coverage for low-income adults age 19–64 is 24 percent compared with 71 percent for nonelderly adults with incomes between 250 and 400 percent of FPL and 85 percent for those with incomes above 400 percent of FPL (Kaiser State Health Facts, <http://www.statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1>). Also see Margaret Simms, Karina Fortuny, Marla McDaniel, and William Monson, “Education and Employment of Disconnected Low-Income Men” (Washington, DC: The Urban Institute, 2013), Race, Place, and Poverty Symposium Issue Brief 2.
4. “Medicaid by Population,” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/By-Population.html>. Nondisabled adults without dependent children are not eligible for Medicaid regardless of their income. States can cover them using state-only funding or by obtaining a federal waiver (Kaiser Commission on Medicaid and the Uninsured 2013).
5. “Adult Income Eligibility Limits at Application as a Percent of the Federal Poverty Level (FPL), January 2013,” Kaiser State Health Facts, <http://kff.org/medicaid/state-indicator/income-eligibility-low-income-adults/>.
6. African American refers to non-Hispanic African American or black, and includes those who identified themselves in the decennial census as black or African American only. White refers to non-Hispanic white, and includes those who identified themselves in the census as white only. People of Hispanic origin may be of any race. Respondents who identified as other or two or more races are grouped under “other non-Hispanic.”
7. Authors’ tabulations of the ACS 2008–10.
8. Data on health outcomes for 2010 are based on Urban Institute tabulations of the 2010 BRFSS. Family income of less than \$35,000 is used for a proxy of low-income status. For additional indicators on health care access and

methodology, see Kenney et al. (2012). The BRFSS is accessible at <http://www.cdc.gov/brfss/>.

9. The BRFSS asks whether the respondent has seen a doctor for a routine checkup less than 12 months ago. A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

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About the Series

A large number of US men of prime working age are neither gainfully employed nor pursuing education or other training, suggesting a potentially significant disconnection from mainstream economic and social life. The Urban Institute, funded by the Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services, convened the Race, Place, and Poverty symposium to better understand the experiences of men who were disengaged or at high risk of disengagement from mainstream economic and social systems. The symposium explored the state of knowledge on disconnected low-income men and discussed effective strategies for improving their well-being.

The five briefs in this series on disconnected low-income men summarize the symposium, provide a geographic and demographic snapshot of low-income men, and examine their education, employment, health, and heightened risk of incarceration and disenfranchisement. A related background paper prepared for the symposium features key themes from ethnographic and other qualitative research.

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