Socioeconomic Status' Effect on Decision-Making for Medical Insurance

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Abstract

This paper examines how socioeconomic status (SES), including income, education, and employment, affects decisions about medical insurance coverage in the United States. Using data from IPUMS USA for 2023 and logistic regression models, the study finds that higher income, higher educational attainment, and stable employment, especially in government sectors, significantly increase the likelihood of insurance coverage. Risk aversion, information asymmetry, and budget constraints offer theoretical explanations for these patterns. The results highlight that financial and informational barriers remain critical determinants of public and private insurance access. Policies aimed at reducing affordability challenges and improving insurance literacy can help bridge existing disparities and promote more equitable access to healthcare.

I. Introduction

Socioeconomic status (SES)—captured here by income, education, and employment—shapes health-insurance decisions made under uncertainty and budget constraints. Financial resources, risk attitudes, and information frictions jointly influence whether individuals obtain any coverage and through which channel. Using U.S. microdata from IPUMS USA (ACS), this study quantifies how SES correlates with (i) any coverage and (ii) coverage type (private vs. public). The contribution is threefold: first, it jointly examines income, education, and employment within survey-weighted logistic models; second, it reports odds ratios and predicted probabilities for representative profiles to gauge magnitudes; third, it assesses robustness to alternative income transformations and outlier trimming. The results inform theories of insurance demand and the design of policies targeting coverage gaps. Section 2 describes data and variables, Section 3 details the empirical strategy, Section 4 presents results, and Section 5 concludes with implications.

Theoretical Frameworks

Economic theory offers several frameworks to explain how individuals make decisions about health insurance. One key concept is risk aversion; people generally seek to avoid large, unexpected medical expenses, making insurance particularly appealing to those who are uncomfortable with financial risk.

According to expected utility theory, a risk-averse individual values insurance because it reduces the uncertainty of large out-of-pocket medical expenses. The theory, developed by von Neumann and Morgenstern (Fishburn, 1989), provides a formal framework for decision-making under risk. It assumes that individuals have consistent preferences over probabilistic outcomes, and that these preferences can be represented by a utility function that is unique up to a positive linear transformation. Empirical evidence shows that risk-averse individuals are significantly more likely—by several percentage points—to enroll in health insurance compared to those who are less risk-averse (Adjei-Mantey and Horioka, 2023). In other words, people with low risk tolerance are more willing to pay insurance premiums to avoid the financial consequences of illness (Adjei-Mantey and Horioka, 2023). This is consistent with the theoretical prediction that greater risk aversion increases demand for insurance.

Information Asymmetry

High-risk people are more likely to buy coverage, which raises insurers' costs and can drive premiums up, potentially pushing low-risk (often lower-cost) people out of the market. In seminal work, Rothschild and Stiglitz (1978) showed that the presence of high-risk individuals imposes a negative externality on low-risk individuals in insurance markets. essentially, when sicker people disproportionately enroll, healthier people face higher prices or reduced coverage options. Conversely, there can be cases of "advantageous selection," where factors like higher education or risk aversion lead healthier (lower-risk) individuals to purchase insurance, improving the risk pool(Adjei-Mantey and Horioka, 2023).

Moral hazard is the other side of information problems, once insured, individuals may consume more healthcare than they would if they bore the full cost, because insurance lowers their out-of-pocket price. Pauly (1968) argued that because people rationally respond to lower costs by using more care, full insurance coverage may be suboptimal. In other words, when medical care is heavily subsidized by insurance, utilization rises, and the cost of this extra use is spread to others in the risk pool (Pauly, 1968).

Budget Constraints

Even if someone is risk-averse and values insurance, their ability to purchase it depends on income and budget limitations. A systematic review of health insurance in low- and middle-income countries found that lack of financial resources and low income levels were consistently associated with lower enrollment in insurance (Adebayo et al., 2015). Budget constraints thus cap the demand for insurance and can result in under-insurance or no insurance, especially in the absence of subsidies or public provision.

These economic frameworks demonstrate that the decision to obtain health insurance is not only about personal attitudes toward risk, but also about informational challenges and financial feasibility. Next, we examine how specific socioeconomic components (income, education, and employment) influence insurance access and choices.

Income Levels: Affordability and Willingness to Pay

Studies across different settings confirm a positive correlation between income and insurance coverage. For example, a study in Kenya found that moving from the poorest to the richest income quintile significantly increased the likelihood of having health insurance (Mugo, 2023).Similarly, a review of community-based insurance schemes in various low-income countries showed that limited income was a major barrier to enrollment(Adebayo et al., 2015). Income not only affects the ability to pay but also the willingness to pay. Wealthier individuals may perceive insurance as a worthwhile investment in financial protection, whereas those with very limited means might prioritize immediate needs (food, housing) over insurance, which provides no immediate tangible benefit.

In the United States, data illustrate a stark income gradient in coverage; Nearly 97% of people in households earning over $150,000 have some form of health insurance, compared to roughly 86% in households with income under $25,000 (Lee et al., 2021). Lower-income Americans either remain uninsured or rely on government programs (like Medicaid), especially if they cannot afford private premiums. Even when low-income individuals are offered insurance, high premium shares or deductibles can lead to low take-up due to affordability issues.

While income constraints generally reduce the likelihood of obtaining health insurance, some studies suggest that poorer individuals may paradoxically be more inclined to seek coverage due to heightened concerns about future financial stability. This aligns with risk aversion theory, which posits that individuals who

perceive greater financial uncertainty may prioritize insurance as a protective mechanism against potential health shocks. Empirical evidence from Tanzania showed that rural communities found that individuals with a higher degree of risk aversion were significantly more likely to enroll in voluntary health insurance schemes (Kagaigai and Grepperud, 2023). The findings suggest that, despite financial limitations, heightened concerns about future uncertainties prompted low-income individuals to seek coverage as a safeguard against catastrophic medical expenses.

Similarly, research conducted in Ghana found that people classified as risk-averse were 3.1 to 3.3 percentage points more likely to enroll in health insurance compared to those who were not risk-averse (Nguyen et al., 2023). This suggests that for some individuals in poverty, the fear of future financial instability outweighs the immediate affordability concerns associated with purchasing insurance.

That said, not all low-income individuals avoid insurance. Some may prioritize it despite budget constraints, which I found interesting in light of the data from Ghana. Instead, they highlight the role of perceived risk and future uncertainty in shaping insurance decisions, particularly among those facing economic hardship.

Education and Health Insurance

Education influences health insurance choices through multiple channels; More educated individuals tend to have better knowledge of insurance concepts, greater ability to navigate complex information, and a longer-term outlook on risk protection. Empirical evidence suggests that education increases both the likelihood of having insurance and the quality of insurance decisions. In a Kenyan analysis, having at least primary or secondary education (versus none) significantly increased the probability of enrolling in health insurance (Mugo, 2023).

In my results, education seems to play a surprising role,not just in increasing the likelihood of being insured, but also possibly influencing how confidently people choose between public and private plans. A recent study from the Netherlands, where everyone is required to have health insurance, found that those with higher education (especially in quantitative fields) made better health insurance choices, capturing more surplus (value) of consumers from their plans (Handel et al., 2024). In contrast, lower-education people may find insurance policies confusing or daunting. In fact, surveys indicate that people with limited education often have a lower level of insurance knowledge and are more likely to find insurance concepts not interesting or difficult(Holst et al., 2023). They may stick to a default plan or no plan because evaluating alternatives is challenging. Moreover, less educated people tend to have a lower willingness to pay for

insurance (Adebayo et al., 2015), possibly due to lower perceived benefits or understanding of how insurance protects against risk. In summary, education is a key SES component that affects both the extensive margin of being insured and the intensive margin of what insurance choices are made. Higher educational attainment generally leads to greater insurance uptake and more informed decision-making, whereas low education can create obstacles to understanding and valuing insurance.

Employment Status

Employment status heavily influences access to medical insurance, particularly in countries where insurance is tied to jobs; Employment often correlates with other SES factors like income and education; for example, a higher-paying job might offer insurance and attract more educated workers. However, even controlling for income, the security of having employer insurance affects decision-making. People with stable jobs that include insurance are spared the decision of whether to buy insurance, their decision is rather how much to utilize the offered plan (or whether to take up an offered plan at all, which some low-wage workers might decline if their share of premium is too high). On the other hand, self-employed or informal workers must actively decide on purchasing private insurance, often facing higher administrative hurdles and costs. In developing countries, formal sector employment often comes with mandatory health insurance contributions (as part of social security), whereas informal workers are left to voluntary schemes. A Kenyan study found that being unemployed or in the informal sector had a significant negative effect on the probability of having health insurance (Mugo, 2023). In short, those outside formal employment are much less likely to be insured, unless there are strong public systems to catch them.

Global Disparities

High and low income countries present very different landscapes of decision-making for health insurance , largely due to differences in healthcare systems. In most high-income nations, some form of universal health coverage (UHC) is in place, which greatly reduces the impact of SES on basic insurance coverage. Virtually all high-income countries ensure that the vast majority of their population has health insurance, either via tax-funded national health services or mandated/social insurance models (Ortiz-Ospina and Roser, 2017). For example, countries in Western Europe, Canada, Japan, South Korea, Australia, and others all boast insurance coverage rates near 100%, effectively removing the choice of "whether to have insurance" from the individual decision; everyone is

covered by default. The notable exception is the United States, where health insurance is not universal; as of recent years about 8% of the U.S. population remains uninsured(Gunja et al., 2024). In those high-income countries with universal-coverage, SES factors like income or education have limited influence on the existence of coverage (since even the poor are covered), though they can influence how the system is navigated. For instance, higher-income or better educated individuals in these countries might be more likely to purchase supplementary private insurance (for faster access or services not covered by the public system) or to use their knowledge to select optimal plans if there is a choice. But fundamentally, the gap in having insurance between rich and poor in high-income countries (other than the U.S.) is minimal because of the policy design(Ortiz-Ospina and Roser, 2017).

In low- and lower-middle-income countries, by contrast, large portions of the population lack health insurance, and SES-driven differences are pronounced. In many such countries, health financing is still dominated by out-of-pocket spending, and insurance coverage is partial or fragmented. Over half of the world's population is not covered by essential health services (Organization et al., 2024), and this uninsured population is heavily concentrated in low-income nations. When insurance is voluntary or only available to certain sectors, wealthier and formally-employed people are far more likely to be insured. Poor households often must decide between paying for insurance versus other immediate needs, leading many to remain uninsured. The result indicate, those least able to afford healthcare are also the least likely to have financial protection, making them highly vulnerable to health shocks. Empirical patterns show stark disparities. For example, many sub-Saharan African and South Asian countries have insurance coverage rates below 20-30%, meaning the majority (often the rural poor) have no coverage (Ortiz-Ospina and Roser, 2017).

In summary, high-income countries generally manage to neutralize SES differences in basic insurance coverage through universal systems (though disparities may appear in plan choice or supplemental coverage), whereas low and middle income countries still exhibit strong SES gradients in who is insured. Bridging this gap is a major policy challenge. The literature indicates that improving public insurance availability, subsidizing coverage for the poor, and investing in education and outreach can help reduce SES-driven inequities in health insurance coverage across different country contexts.

Policy Implications and Discussion

Socioeconomic status significantly shapes decision-making around medical insurance, through both economic incentives and practical access considerations. Theoretical economic frameworks explain why risk-averse individuals value insurance, how information asymmetries can distort insurance markets, and why

budget constraints may prevent low-income people from obtaining coverage. Empirical evidence is consistent with the theories that higher income and education consistently promote insurance uptake and better choices, while poverty and low education correspond to lower coverage and understanding. Employment emerges as a critical link to insurance in many systems, advantaging those in formal jobs and leaving others reliant on weaker alternatives. Across the globe, the influence of SES is evident, though its expression varies from subtle differences in plan selection in countries where everyone is insured, to dramatic gaps in coverage in countries where many lack any insurance.

From an economics perspective, these findings highlight the importance of reducing financial and informational barriers to insurance. Policies that subsidize premiums, mandate coverage, or provide default public insurance can reduce the role of ability-to-pay in insurance decisions. Likewise, improving health insurance literacy and simplifying choice can empower lower-SES individuals to make informed decisions and gain protection against health risks. Ultimately, narrowing SES disparities in health insurance is seen as a pathway to more equitable health outcomes. When more people, regardless of income or education, are covered by insurance, access to healthcare becomes more uniform and financial shocks from illness are lessened. The literature suggests that a combination of theoretical insight and empirical lessons can guide interventions to ensure that the decision to have health insurance is less dependent on socioeconomic status and more on healthcare needs. Achieving this will require sustained policy effort, particularly in low-income settings, but offers substantial social benefits by promoting inclusive health security.

Data and Method

This study uses individual-level data extracted from the IPUMS USA database, focusing specifically on the sample year of 2023. The data set provides comprehensive demographic, socioeconomic, and health insurance information for a nationally representative sample of the US population.

We restrict the analysis to adults (age 18+) so results reflect adult coverage patterns. To improve data quality, we exclude observations with missing values in key income and insurance variables and keep only valid responses for any coverage, private coverage, and public coverage (mapped to IPUMS variables: FTOTINC, INCTOT, INCWAGE; HCOVANY, HCOVPRIV, HCOVPUB). Insurance measures are coded as binary indicators (1 = covered, 0 = otherwise). Employment status is harmonized to three categories (employed, unemployed, and not in the labor force) for consistency across models. To limit undue influence of outliers, we retain observations with total personal income in a reasonable range.

Because income is highly skewed, we apply a monotone log transformation that preserves zero values. Specifically, income measures enter models as $\log(1 + x)$ (where x denotes the original income amount); results are robust to alternative top-codes and trims. Survey person-weights are used in all estimations.

Occupational classifications were based on the detailed class of worker variable (CLASSWKRD). Individuals were categorized into employment types such as private wage/salary workers, government employees at the federal, state, and local levels, nonprofit employees, self-employed individuals (both incorporated and unincorporated) and unpaid family workers. In all regression analyses, the "Works for wages" category serves as the reference group.

Given the binary nature of the dependent variables, logistic regression models were used to estimate the associations between employment type, socioeconomic characteristics, and insurance coverage outcomes. All models control for age, sex, and logarithmic transformed income variables to address potential confounders.

Model

We estimate logistic regression models to relate employment type and other socioeconomic characteristics to binary insurance outcomes. Three specifications are fit, corresponding to (i) any coverage, (ii) public coverage, and (iii) private coverage; each uses an identical set of regressors for comparability. Educational attainment and class of worker enter as sets of indicator variables with the private wage/salary category as the reference group. Age and sex are included as basic demographic controls. To address the right-skew of income, an increasing log transformation is applied (e.g., $\log(1 + x)$), and income is summarized parsimoniously to avoid multicollinearity (alternative income constructs are examined in robustness checks).

The general form of the logistic regression model estimated is:

$$\begin{aligned}\operatorname{logit}\left(P(Y_i = 1)\right) &= \beta_0 + \beta_1 \text{CLASSWKRD}_i + \beta_2 \text{EDUC}_i + \beta_3 \text{EMPSTAT}_i \\ &+ \beta_4 \text{SEX}_i + \beta_5 \text{AGE}_i + \beta_6 \log(\text{INCTOT}_i) + \beta_7 \log(\text{FTOTINC}_i) + \beta_8 \log(\text{INCWAGE}_i) + \epsilon_i\end{aligned}$$

where Y_i represents the binary insurance coverage outcome for individual i, and ϵ_i is the error term.

All models are estimated by maximum likelihood with robust inference and survey weights. Statistical significance is assessed at conventional 1%, 5%, and 10% levels. Estimates are reported as coefficients with accompanying odds

ratios and, where helpful, average marginal effects to aid interpretation across outcomes.

Summary Statistics

Table 1 reports descriptive statistics for the main variables used in the analysis. The sample consists of 1,168,956 individuals after applying the filtering criteria described earlier. Educational attainment (EDUC) ranges from no schooling to advanced degrees, with an average level corresponding approximately to 7th or 8th grade. Employment status (EMPSTAT) shows that a majority of the sample are employed, with some representation from unemployed individuals and those not in the labor force.

Descriptive statistics indicate a middle-aged sample (mean age 46; range 18–96). Log-transformed income measures show substantial dispersion, with earnings-based income exhibiting the greatest variability. On insurance status, about 91% report having any coverage, roughly 74% hold private coverage, and about 28.5% report public coverage. Because private and public programs can overlap (e.g., dual coverage), the private and public shares need not sum to the "any coverage" rate. These patterns provide context for interpreting the regression estimates that follow.

Table 1: Summary Statistics of Variables

Variable	Min	Median	Mean	SD	Max	N
EDUC	0	6	7.26	2.32	11	1168956
EMPSTAT	1	1	1.38	0.764	3	1168956
CLASSWKR	1	2	1.89	0.313	2	1168956
SEX	1	1	1.48	0.500	2	1168956
AGE	18	46	46.4	16.5	96	1168956
log_INCTOT	0	10.6	10.1	2.36	12.6	1168956
log_FTOTINC	0	11.5	11.3	1.29	14.7	1168888
log_INCWAGE	0	10.4	8.48	4.23	12.6	1168956
HCOVANY	0	1	0.914	0.281	1	1168956
HCOVPUB	0	0	0.285	0.452	1	1168956
HCOVPRIV	0	1	0.739	0.439	1	1168956

Tables

Table 2 presents the results of the logistic regression model estimating the likelihood of having any form of health insurance (HCOVANY). The coefficients indicate that, compared to the reference group, individuals classified as self-employed, private sector employees, nonprofit workers, and all categories of government employees are significantly more likely to have health insurance coverage. Notably, state and federal government employees exhibit the highest positive associations with insurance coverage. In addition, higher age, being male, and higher levels of personal and family income are all positively associated with insurance coverage, while higher wage income appears slightly negatively associated.

Table 2: Logistic Regression Results for Any Insurance Coverage (HCOVANY)

Variable	Coefficient	p-value	95% CI
(Intercept)	-4.550	0	(-4.620, -4.480)
EDUC	0.220	0	(0.216, 0.223)
EMPSTAT	0.135	1.71e-85	(0.122, 0.149)
CLASSWKR	0.694	0	(0.670, 0.717)
SEX	0.314	0	(0.300, 0.328)
AGE	0.0291	0	(0.0287, 0.0296)
log_INCTOT	0.0876	0	(0.0839, 0.0913)
log_FTOTINC	0.137	0	(0.133, 0.141)
log_INCWAGE	-0.0138	4.44e-21	(-0.0167, -0.0109)

Table 3 shows the logistic regression results for the probability of having public health insurance (HCOVPUB). The results suggest that employment in the private, nonprofit, and self-employed sectors is strongly associated with a higher likelihood of holding public insurance relative to wage workers. Unpaid family workers also show a strong positive association. Higher age and income are associated with greater likelihood of public coverage, but higher family income (`log_FTOTINC`) is negatively associated with public insurance, consistent with eligibility criteria for public programs.

Table 3: Logistic Regression Results for Public Insurance Coverage (HCOVPUB)

Variable	Coefficient	p-value	95% CI
(Intercept)	-0.498	5.72e-62	(-0.556, -0.439)
EDUC	-0.0922	0	(-0.0943, -0.0901)
EMPSTAT	0.466	0	(0.457, 0.474)
CLASSWKR	0.230	4.37e-156	(0.213, 0.247)
SEX	0.0926	3.50e-82	(0.0832, 0.102)
AGE	0.0416	0	(0.0413, 0.0419)
log_INCTOT	0.111	0	(0.109, 0.114)
log_FTOTINC	-0.289	0	(-0.294, -0.285)
log_INCWAGE	-0.111	0	(-0.112, -0.109)

Finally, Table 4 presents results for the likelihood of having private health insurance coverage (HCOVPRIV). In contrast to public coverage, government employees at all levels are positively associated with private insurance coverage relative to the reference group. However, being self-employed or an unpaid family worker is associated with a lower probability of having private coverage. Additionally, higher family income (`log_FTOTINC`) shows a strong positive relationship with private insurance, highlighting the income dependency of private coverage access.

Table 4: Logistic Regression Results for Private Insurance Coverage (HCOVPRIV)

Variable	Coefficient	p-value	95% CI
(Intercept)	-6.010	0	(-6.080, -5.950)
EDUC	0.189	0	(0.187, 0.192)
EMPSTAT	-0.253	0	(-0.261, -0.245)
CLASSWKR	0.336	0	(0.320, 0.351)
SEX	0.00416	0.369	(-0.00492, 0.0132)
AGE	0.00356	2.63e-122	(0.00326, 0.00386)
log_INCTOT	0.00607	3.79e-7	(0.00373, 0.00842)
log_FTOTINC	0.427	0	(0.423, 0.432)
log_INCWAGE	0.0579	0	(0.0562, 0.0597)

The results presented in Tables 5,6, and 7 provide insight into the relationship between employment type and the probability of having any health insurance coverage (HCOVANY), public health insurance coverage (HCOVPUB),

and private health insurance coverage (HCOVPRIV), respectively. Unlike the previous models, these regressions focus specifically on employment characteristics and basic demographic and income controls, excluding education level (EDUC) and employment status (EMPSTAT) to allow a cleaner interpretation of occupational effects. Across all models, employment type significantly influences insurance outcomes, with strong statistical significance at the 1% level.

In the HCOVANY model (Table 5), individuals employed in government sectors (federal, state, and local) exhibit the largest positive coefficients, suggesting a notably higher likelihood of having any form of health insurance compared to the reference group (those working for wages). Private wage/salary workers, nonprofit employees, and self-employed individuals also show positive associations, although to varying degrees. Demographic controls, such as age and sex, are positively and significantly related to insurance coverage, with older individuals and males being more likely to be insured.

For public insurance coverage (Table 6), the patterns are somewhat different. Self-employed individuals, unpaid family workers, and workers in private, nonprofit, and government sectors all have positive coefficients, indicating a greater probability of being covered under public programs relative to the baseline. However, the magnitudes differ: unpaid family workers and self-employed individuals have particularly strong associations with public insurance coverage. As expected, age shows a large and highly significant positive effect on public insurance, consistent with increased eligibility through programs like Medicare.

In contrast, the model for private insurance coverage (Table 7) reveals an inverse relationship for some employment types. Self-employed individuals and unpaid family workers are significantly less likely to have private insurance, reflected in negative coefficients. Workers in the federal, state, and local governments display strong positive associations with private insurance, suggesting better access to employer-sponsored plans in these sectors. Age again remains positively associated with private coverage, although the effect size is relatively smaller compared to public insurance.

Overall, these results highlight the critical role that employment characteristics play in shaping health insurance outcomes. Government employment is strongly protective across all types of insurance, while being self-employed or working in unpaid family roles is associated with significant disadvantages, especially in private insurance access. The findings emphasize the importance of employment-linked benefits and economic status in determining individuals' insurance coverage types.

Table 5: Logistic Regression Results for HCOVANY

Variable	Coefficient	Std. Error	z-value	p-value	95% CI
(Intercept)	-2.6700	0.0287	-93.10	<0.001	(-2.7300, -2.6200)
CLASSWKRDSelf-employed	0.6370	0.0221	28.80	<0.001	(0.5930, 0.6800)
CLASSWKRDPrivate wage/salary	0.9260	0.0162	57.30	<0.001	(0.8950, 0.9580)
CLASSWKRDNon-profit wage/salary	1.4700	0.0216	68.20	<0.001	(1.4300, 1.5100)
CLASSWKRDFederal govt employee	1.8700	0.0314	59.40	<0.001	(1.8100, 1.9300)
CLASSWKRDState govt employee	2.0000	0.0312	64.10	<0.001	(1.9400, 2.0600)
CLASSWKRDLocal govt employee	1.8000	0.0238	75.70	<0.001	(1.7500, 1.8500)
CLASSWKRDUnpaid family worker	0.3870	0.0464	8.33	<0.001	(0.2960, 0.4790)
SEX	0.3470	0.00701	49.60	<0.001	(0.3340, 0.3610)
AGE	0.0286	0.000233	123.00	<0.001	(0.0281, 0.0290)

Table 6: Logistic Regression Results for HCOVPUB

Variable	Coefficient	Std. Error	z-value	p-value	95% CI
(Intercept)	-0.2090	0.0278	-7.54	<0.001	(-0.2640, -0.1550)
CLASSWKRDSelf-employed	1.3800	0.0153	90.50	<0.001	(1.3500, 1.4100)
CLASSWKRDPrivate wage/salary	1.2400	0.0110	113.00	<0.001	(1.2200, 1.2600)
CLASSWKRDNon-profit wage/salary	1.2000	0.0133	90.60	<0.001	(1.1800, 1.2300)
CLASSWKRDFederal govt employee	1.2000	0.0169	70.90	<0.001	(1.1600, 1.2300)
CLASSWKRDState govt employee	0.7960	0.0160	49.70	<0.001	(0.7650, 0.8280)
CLASSWKRDLocal govt employee	0.8150	0.0134	60.70	<0.001	(0.7880, 0.8410)
CLASSWKRDUnpaid family worker	1.4100	0.0384	36.80	<0.001	(1.3400, 1.4900)
SEX	0.0733	0.00483	15.20	<0.001	(0.0639, 0.0828)
AGE	0.0427	0.000163	261.00	<0.001	(0.0423, 0.0430)

Table 7: Logistic Regression Results for HCOVPRIV

Variable	Coefficient	Std. Error	z-value	p-value	95% CI
(Intercept)	-5.4500	0.0306	-178.00	<0.001	(-5.5100, -5.3900)
CLASSWKRDSelf-employed	-0.5260	0.0141	-37.30	<0.001	(-0.5530, -0.4980)
CLASSWKRDPrivate wage/salary	-0.2350	0.00970	-24.20	<0.001	(-0.2540, -0.2160)
CLASSWKRDNon-profit wage/salary	0.0837	0.0123	6.78	<0.001	(0.0595, 0.1080)
CLASSWKRDFederal govt employee	0.7440	0.0185	40.30	<0.001	(0.7080, 0.7800)
CLASSWKRDState govt employee	0.7260	0.0168	43.30	<0.001	(0.6930, 0.7590)
CLASSWKRDLocal govt employee	0.5040	0.0130	38.70	<0.001	(0.4780, 0.5290)
CLASSWKRDUnpaid family worker	-0.5760	0.0348	-16.60	<0.001	(-0.6450, -0.5080)
SEX	0.0359	0.00462	7.76	<0.001	(0.0268, 0.0449)
AGE	0.00224	0.000151	14.90	<0.001	(0.00195, 0.00254)

Conclusion

This study highlights the profound impact of socioeconomic status on decision-making regarding medical insurance coverage in the United States. Building on theoretical insights from economic models of risk aversion, information asymmetry, and budget constraints, the empirical results provide strong evidence that employment type, income, and education levels play critical roles in shaping insurance outcomes.

Logistic regression models reveal consistent and statistically significant relationships between employment characteristics and types of insurance coverage. Individuals employed in government sectors federal, state, and local exhibit substantially higher probabilities of having any health insurance, public insurance, and private insurance relative to wage workers. In contrast, self-employed individuals and unpaid family workers are significantly disadvantaged, particularly with regard to access to private health insurance. These disparities emphasize the importance of employer-provided insurance benefits in securing financial protection against medical costs.

Income effects further reinforce the role of affordability: higher levels of personal and family income are associated with greater likelihoods of both public and private insurance coverage, although the relationship differs by insurance type. Higher family income is negatively associated with public insurance uptake, consistent with income-based eligibility thresholds, but positively associated with private insurance enrollment, highlighting how private coverage remains closely tied to financial capacity.

Demographic factors such as age and sex also significantly influence insurance decisions. Older individuals consistently show a greater likelihood of holding both public and private insurance, reflecting the life-cycle dynamics of healthcare needs and insurance eligibility. Males display slightly higher probabilities of having any insurance, although the magnitude of this effect is modest.

Overall, the findings illustrate that while risk preferences and informational factors shape insurance behavior, structural socioeconomic constraints remain decisive in determining who gains insurance coverage and through which channels. Policies aiming to expand insurance access must therefore address not only informational barriers but also the employment-based inequalities and income-related affordability challenges that persist. Strengthening public insurance options, providing affordable private alternatives, and extending employment-based benefits to more precarious workers are potential strategies to mitigate SES-driven disparities in health coverage.

By combining theoretical foundations with robust empirical analysis, this paper underscores the continuing importance of socioeconomic status in explaining gaps in medical insurance coverage and, by extension, access to healthcare it-

self. Future research could further explore how policy innovations affect these dynamics, particularly in light of ongoing healthcare reforms and labor market shifts.

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