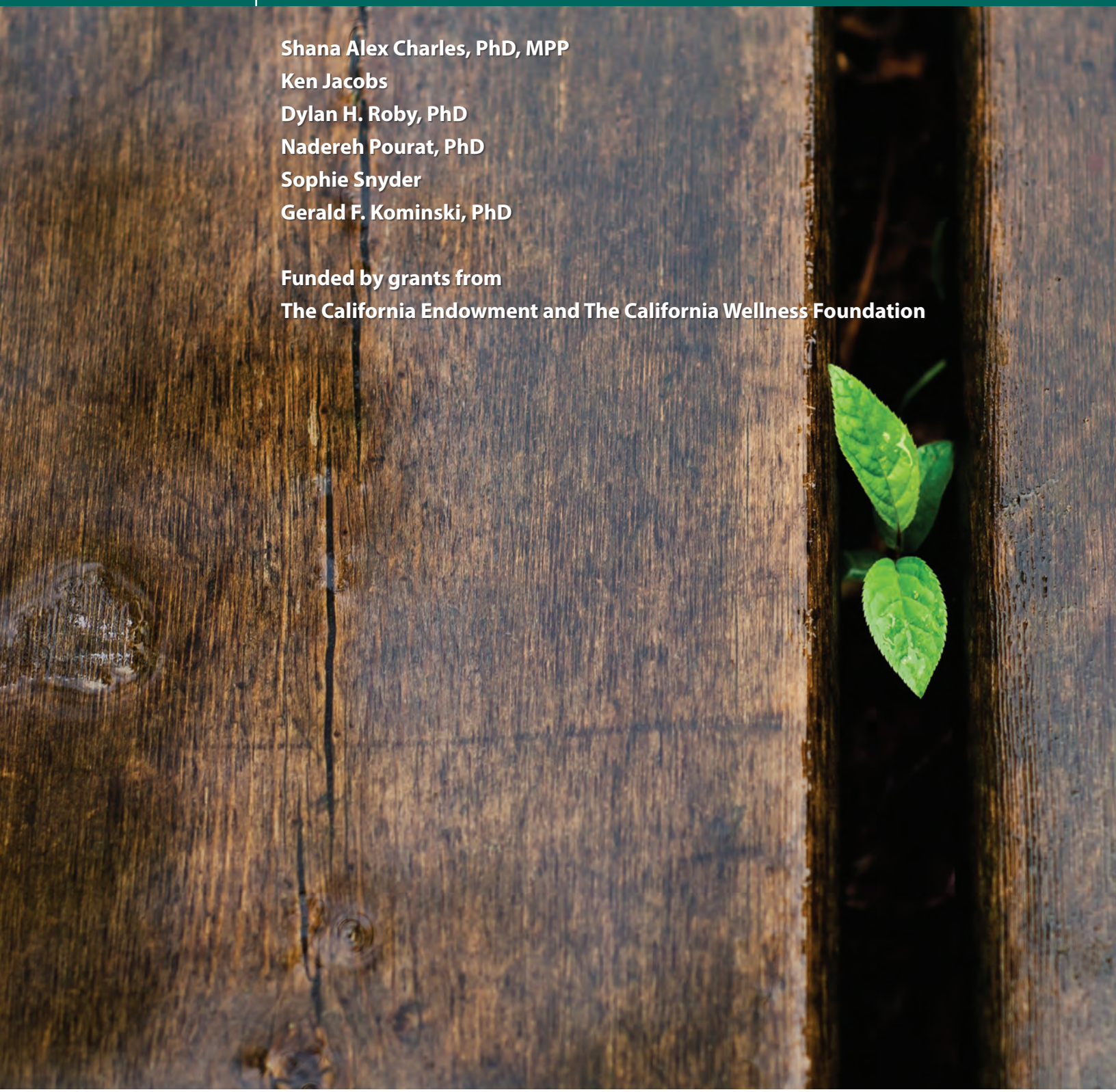
December 2014

The State of Health Insurance in California:

Findings from the 2011/2012 California Health Interview Survey



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Funded by grants from
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www.healthpolicy.ucla.edu

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CHIS california health interview survey

www.chis.ucla.edu

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Foreword

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The implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) signifies a historic period in this country. Social and economic swings have affected coverage trends throughout the years, but the shift that is occurring under the ACA's mandate that all citizens obtain health care coverage is a massive one. The implications of the law will be personal, economic, social, and societal, from our individual health and health care spending, to public health, to funding for government programs, to coverage for those who have previously lacked health insurance.

Since 2001, this biennial report has documented the challenges facing Californians in securing health care insurance for themselves and their families. During the compilation of this year's report, California has been implementing this major shift in health care policy, the many effects of which will play out over years. There will be short-term implications in the number of people able to seek care, but coverage is only one piece of the overall puzzle. Millions of newly insured people need access to health care services, and states must find the workforce to meet this increased demand and facilitate timely access to services.

Both the intended and unintended consequences of the law will unfold over time. Whether the long-term goals of a healthier nation and lower heath care spending are met will take years to track and understand.

In this respect, the *2011-2012 State of Health Insurance in California (SHIC)* report is our most important volume yet. The data from this report will serve as the baseline against which we will measure the change – and ultimately the success or failure – of state policies specifically, and of the ACA in general. New programs have been rolled out across the U.S. as well as here in California, but over several years there may be minor adjustments or major policy changes as new challenges created by the law are identified, along with new ways to meet the ultimate goal of better health and health care for everyone. It is therefore critical that we have a good foundation and a valuable instrument for trending the changes over time at a granular level in order to understand what works and what does not, and which populations may be lagging behind in realizing the benefits of health care coverage.

While the California Health Interview Survey (CHIS) was born of the desire to have better health insurance coverage estimates at the local level and for ethnic subgroups, this rich data source captures critical information not available anywhere else. While institutional data are wonderful for understanding the needs of people who have received treatment or preventive measures, survey data are needed to identify those who are still not receiving medical attention, as well as to illuminate the reasons for delayed or forgone care. Health insurance coverage for all is a major advancement in public health. Nevertheless, it is only when all Americans take advantage of prevention programs, seek medical attention when they first need it, and can afford to utilize ongoing management programs that we can truly improve our global health ranking.

Building on a Foundation

We begin this report, the foundation of our future evaluations of the ACA, with a memorial to our founder, Dr. E. Richard Brown, who passed away suddenly in April 2012. In addition to his sought-after expertise in teaching, research, and policy analysis, his vision for engaging the public and policymakers in health care reform fueled his creation of the UCLA Center for Health Policy Research, the California Health Interview Survey, and this report. He set a high standard for quality data and information to drive evidence-based policy aimed at improving the health of all Californians. The authors of this report are proud to build on his legacy.

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EXECUTIVE SUMMARY

Chapter 1: Health Insurance Prior to the Affordable Care Act Expansions

The health insurance trends in 2011/12 were illustrative of a unique transition period between the Great Recession and the Patient Protection and Affordable Care Act (ACA). During these years, many individuals remained uninsured or dependent on employment-based insurance coverage. Insurance coverage patterns were distinct across age groups and regions in California. Notably, a major health insurance expansion provision of the ACA was enacted early on: the ACA enabled young adults up to age 26 to enroll in a parent's private plan as a dependent. This early enactment gave rise to noticeable changes in coverage within this age group that signify the impact of the ACA.

- Employment-based coverage insured just under half of all nonelderly adults and children (49.1%, or 15.96 million) in 2012. Employment-based insurance among young adults ages 19-26 jumped from 23.2% in 2009 to 27.1% in 2012. This age group also experienced the largest drop in the uninsurance rate, from 28.9% in 2009 to 26% in 2012.
- More than one in five nonelderly Californians were uninsured for all or part of the past year (21.3%, or 6.91 million) in 2012; nearly half of the uninsured were in full-time working families. Latinos remain the group with the highest rate of uninsurance (28.4%) and the lowest rate of job-based coverage (33.9%).
- Medi-Cal, combined with Healthy Families, insured one-fifth of all nonelderly Californians in 2012 (19.7%, or 6.41 million).
- Los Angeles County continues to be home to the highest number of uninsured in the state, with 2.13 million nonelderly residents uninsured for all or part of the year in 2012.

Chapter 2: Employment-Based Coverage and the Individual Market

Employment-based coverage remains the central source of coverage for Californians under the age of 65; however, fewer individuals had coverage through their employer in 2012 than in 2009. The decline in employment-based coverage (both own and dependent coverage) varied by age, race, citizenship status, education, family income, and hourly wage. The rate of job-based coverage also varied by region of the state and firm size.

Several ACA provisions are expected to influence rates of employment-based and non-group insurance coverage. In 2014, low-income families without

an affordable offer of employment-based coverage became eligible for premium subsidies in the individual market. Also, insurance companies could no longer discriminate against individuals based on health status or pre-existing conditions. Finally, small businesses gained the option of purchasing coverage through the SHOP (Small Business Health Options Program) exchange.

- In 2012, 63.6% of full-time workers had employment-based coverage, compared to 66.5% in 2009. Part-time workers also experienced a decline in coverage, from 41.8% in 2009 to 39.6 % in 2012.
- An estimated 16.6% of workers with family incomes below 138% of the Federal poverty level (FPL) had coverage through their own employer, compared to 62.7% of those with family incomes above 400% of the FPL.
- Employer-based dependent coverage rose between 2009 and 2012 for 19-25-year-olds (from 13.6% to 16.7%), but fell for all other age groups.
- Workers in large firms (1,000 or more employees) were more likely to have employment-based coverage than those in firms with 10 to 50 employees (80.2%, compared to 46.1%) in 2012. About 38% of workers in the smallest firms were uninsured for all or part of the year, and 10.0% were enrolled in Medi-Cal or Healthy Families.
- Most Californians who did not take up offers of employment-based coverage had coverage through another source (52.1%).
- Self-employed individuals were the most likely to purchase coverage in the individual market (15%), and they were more likely to be uninsured (40%) than those who worked for an employer.

Chapter 3: Transitions in Medi-Cal, Healthy Families, and Medicare

Public insurance in California changed considerably in 2011 and 2012, facilitated by: 1) partial implementation of the Affordable Care Act (ACA), and 2) movement to Medi-Cal managed care plans for seniors and persons with disabilities in 16 counties. In this section, we focus on the changes in public insurance coverage and characteristics that occurred in 2012, while also looking forward to expected changes related to the ACA and other reforms to the state's health care system.

- In 2012, 34.4% of children were enrolled in Medi-Cal for the entire year, compared to 26.7% in 2009. The percentage of children who were uninsured for all or part of the year fell by 15% between 2009 and 2012, from 9.9% to 8.6%.
- The most rural areas of the state, including the Central Valley, Northern Sierras, and Imperial County, had the highest proportion of nonelderly people in Medi-Cal or Healthy Families, with more than 27% of the nonelderly population enrolled all year. Coastal areas had lower levels of enrollment, with San Luis Obispo and Orange counties and the Bay Area having the lowest rates (less than 15% of the nonelderly population).
- Latinos comprised more than two-thirds of the children enrolled in Medi-Cal, with other non-white minorities representing 18.9% of child beneficiaries. However, the adult Medi-Cal population had a much higher proportion of non-Latino whites (20.7% ages 19-64, and 26.6% ages 65 and over).
- Fully 23.1% of elderly adult Medi-Cal beneficiaries were Asian or Pacific Islander, more than twice the Asian/PI percentage in the nonelderly adult population and three times the percentage in the child population.

- Almost two-thirds of the Medicare beneficiary population ages 65 and over were non-Latino white, with only 15.9% Latino, 10.2% Asian/PI, and 5.8% African-American. As the near-elderly population ages and demographic shifts occur throughout the next decade, it is likely that Latinos will become a larger part of the Medicare population.

Chapter 4: The Role of Insurance in Access to Care

Access to care varies by type of insurance due to variations in benefits and cost-sharing levels. Health insurance is associated not only with higher rates of important preventive services such as flu shots, but also with higher rates of emergency room (ER) use. Preventive services and visits also vary by whether or not an individual has a high-deductible plan. Racial/ethnic disparities in access frequently persist despite having health insurance.

Some of the challenges due to variations in insurance coverage will be addressed by provisions of the ACA. Starting in 2014, all plans in California, including high-deductible plans, must have standard benefits and cover preventive care and some primary care services without applying either a copayment or deductible, in compliance with the ACA.

- Among adults, those who were uninsured all year (52%) were most likely to be without a usual source of care in 2012, and those with employment-based coverage all year (8.6%) were least likely to be without a usual source of care.
- Among adults, the rates of emergency room visits in 2012 were lowest for those uninsured all year (12.1%) and highest for those with Medi-Cal or Healthy Families (32.3%).
- Adults without insurance all year (19.7%) were most likely to report having forgone or delayed needed medical care due to cost or lack of insurance, followed by adults who were uninsured part of the year (23.8%) in 2012.
- Among adults with employment-based coverage, Latino (10.6%) and Asian American/Pacific Islander adults (10.3%) reported no usual source of care more frequently than white adults (7.2%) in 2012.

1 Health Insurance Prior to the Affordable Care Act Expansions

Shana Alex Charles

With the Great Recession ending, California saw two years of strong employment growth in 2011 and 2012. In January 2011, the unemployment rate peaked at 12.5%.[1] By December 2012, the unemployment rate had declined markedly, to 9.8%.[2] Clearly, the job market was enabling more families to go back to work. However, data from the 2011/12 California Health Interview Survey (CHIS) indicate employment-based coverage insured just under half of all nonelderly adults and children (49.1%, or 15.96 million; Exhibit 1), and more than one in five nonelderly Californians were uninsured for all or part of the past year (21.3%, or 6.91 million). This snapshot of health insurance patterns in 2011/12, prior to the Patient Protection and Affordable Care Act (ACA) expansions of 2014, underscores the very real needs that existed under a mainly employment-based coverage system that had reached its limits.

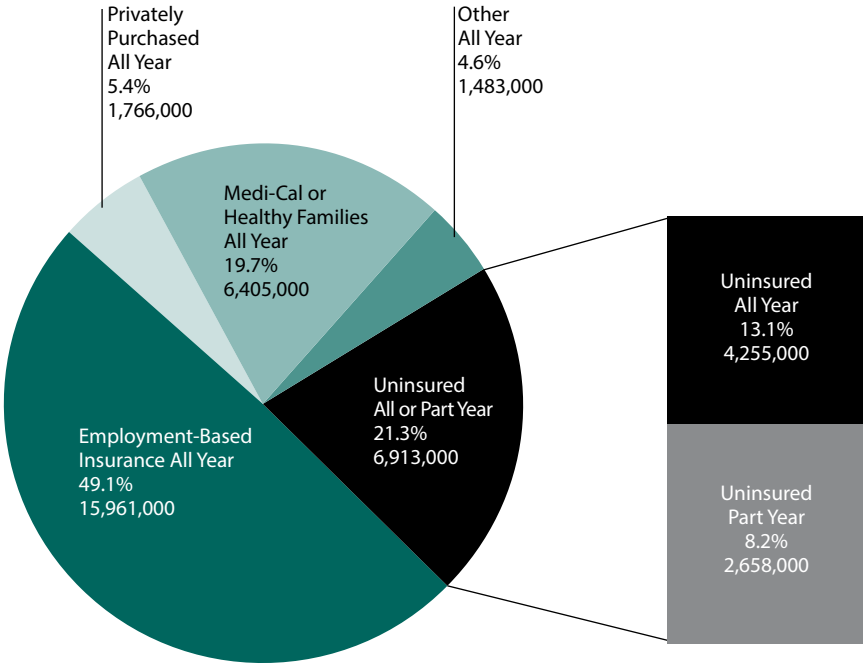
Prior to the expansion of Medi-Cal to include low-income nonelderly adults without children, the program, combined with Healthy Families, already insured one-fifth of all nonelderly Californians in 2012 (19.7%, or 6.41 million; Exhibit 1). Other types of public coverage accounted for 4.6% (1.48 million) of nonelderly adults and children. The individually purchased market languished at only 5.4% (1.77 million) of the total nonelderly population.

Without access to either private or public coverage, 21.3% of nonelderly Californians, or 6.91 million people, were uninsured at some point in 2012 (Exhibit 1). This included the 13.1% (4.26 million) who had no coverage for all of the year, and the additional 8.2% (2.66 million) who had coverage for only part the year.

1 California Employment Development Division (EDD) data. Accessed at *www.edd.ca.gov*, on 3/19/14.

2 California EDD, 2014.

Exhibit 1.
Health Insurance Coverage During Last 12 Months Among Nonelderly Persons, Ages 0-64, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and Medicare, for example) and any combination of insurance types during the past year without a period of uninsurance.

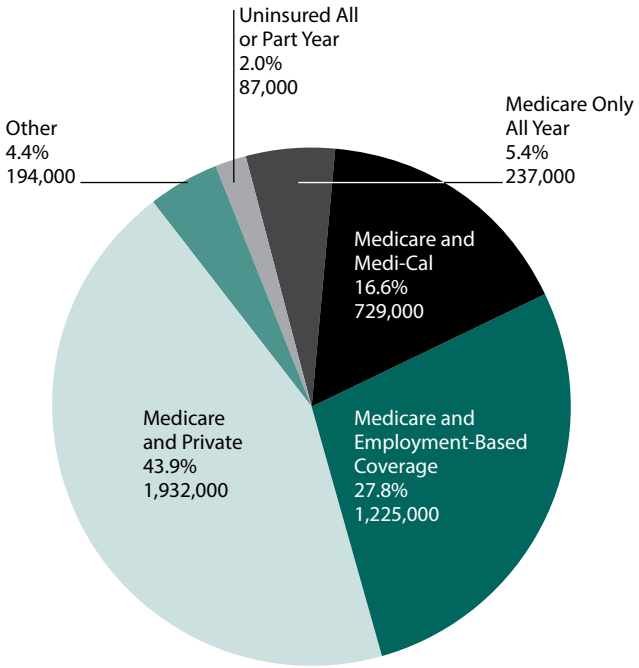
Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

Health insurance patterns among adults ages 65 and older starkly contrast with patterns among their younger counterparts, with only 2% (87,000) of older adults experiencing uninsurance for some part of 2012 (Exhibit 2). Fully 94% of all elderly persons in California had some form of Medicare, ranging from 5% (237,000) with only Medicare coverage to 44% (1.93 million) with both Medicare and private supplemental coverage.

"Medicare and Private" also includes those who were enrolled in a Medicare HMO through Medicare Part C, also called the Medicare Advantage program, along with those who had a private Medicare supplement. About one-sixth of the elderly (17%, or 729,000) were dually enrolled in both Medicare and Medi-Cal due to living in a low-income household, and an additional one-quarter (28%, or 1.23 million) had coverage through both Medicare and their own or a spouse's employment.

Exhibit 2.
Type of Medicare Coverage During Last 12 Months Among Elderly Adults, Ages 65 and Older, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

Young Adults Gained Job-Based Health Insurance from 2009 to 2012

The Affordable Care Act (ACA) enabled young adults up to age 26 to enroll in a parent's private plan as a dependent, regardless of student status or whether they lived in the same household. This key health insurance expansion provision took effect for new policies after September 2010, six months after the ACA was signed into law.

The early effects of allowing dependent enrollment of young adults in their parents' plans could already be seen by 2012. Employment-based insurance among young adults ages 19-26 jumped from 23.2% in 2009 to 27.1% in 2012 (Exhibit 3), corresponding to an increase of 254,000 insured people. In stark contrast, no other age group had any gains in employment-based coverage. In fact, significant drops in employment-based coverage could be seen among those ages 0-11 (44.7% to 40.0%), ages 40-54 (49% to 45.4%), and ages 55-64 (55.2% to 50.4%; Exhibit 3). Young adults ages 19-26 experienced the largest drop in the uninsurance rate, from 28.9% in 2009 to 26% in 2012.

Exhibit 3.
Health Insurance Coverage During Last 12 Months by Age Among Nonelderly Persons, Ages 0-64, California, 2012

		HEALTH INSURANCE STATUS DURING PREVIOUS 12 MONTHS							
Age Group (In Years)	**Year**	**Uninsured All Year**	**Uninsured Part Year**	**Uninsured All or Part Year**	**Employment-Based Coverage All Year**	**Privately Purchased All Year**	**Medi-Cal or Healthy Families All Year**	**Other All Year**	**Total**
0 - 11	**2009**	157,000 2.3%	344,000 5.0%	501,000 7.3%	3,083,000 44.7%	251,000 3.6%	2,261,000 32.8%	302,000 4.4%	6,899,000 100.0%
	2012	130,000 2.0%	308,000 4.8%	438,000 6.8%	2,576,000 40.0%	197,000 3.1%	2,598,000 40.3%	198,000 3.1%	6,445,000 100.0%
12-18	**2009**	221,000 4.7%	322,000 6.8%	543,000 11.4%	2,151,000 45.4%	216,000 4.6%	1,111,000 23.4%	179,000 3.8%	4,743,000 100.0%
	2012	185,000 5.0%	215,000 5.8%	400,000 10.7%	1,712,000 45.8%	224,000 6.0%	1,287,000 34.4%	113,000 3.0%	3,736,000 100.0%
19-26	**2009**	833,000 14.3%	855,000 14.6%	1,688,000 28.9%	1,356,000 23.2%	397,000 6.8%	410,000 7.0%	305,000 5.2%	5,844,000 100.0%
	2012	831,000 14.0%	710,000 12.0%	1,541,000 26.0%	1,610,000 27.1%	380,000 6.4%	576,000 9.7%	285,000 4.8%	5,933,000 100.0%
27-39	**2009**	1,162,000 13.8%	784,000 9.3%	1,947,000 23.1%	3,377,000 40.0%	281,000 3.3%	562,000 6.7%	323,000 3.8%	8,436,000 100.0%
	2012	1,238,000 14.5%	715,000 8.4%	1,953,000 22.9%	3,275,000 38.4%	295,000 3.5%	803,000 9.4%	239,000 2.8%	8,518,000 100.0%
40-54	**2009**	1,254,000 12.8%	541,000 5.5%	1,795,000 18.3%	4,819,000 49.0%	441,000 4.5%	635,000 6.5%	341,000 3.5%	9,826,000 100.0%
	2012	1,311,000 13.9%	505,000 5.4%	1,816,000 19.3%	4,279,000 45.4%	391,000 4.1%	781,000 8.3%	350,000 3.7%	9,433,000 100.0%
55-64	**2009**	436,000 9.4%	162,000 3.5%	598,000 13.0%	2,545,000 55.2%	306,000 6.6%	280,000 6.1%	287,000 6.2%	4,614,000 100.0%
	2012	561,000 11.3%	204,000 4.1%	765,000 15.4%	2,508,000 50.4%	280,000 5.6%	361,000 7.3%	298,000 6.0%	4,977,000 100.0%

Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, in order to increase comparability of the point estimates.

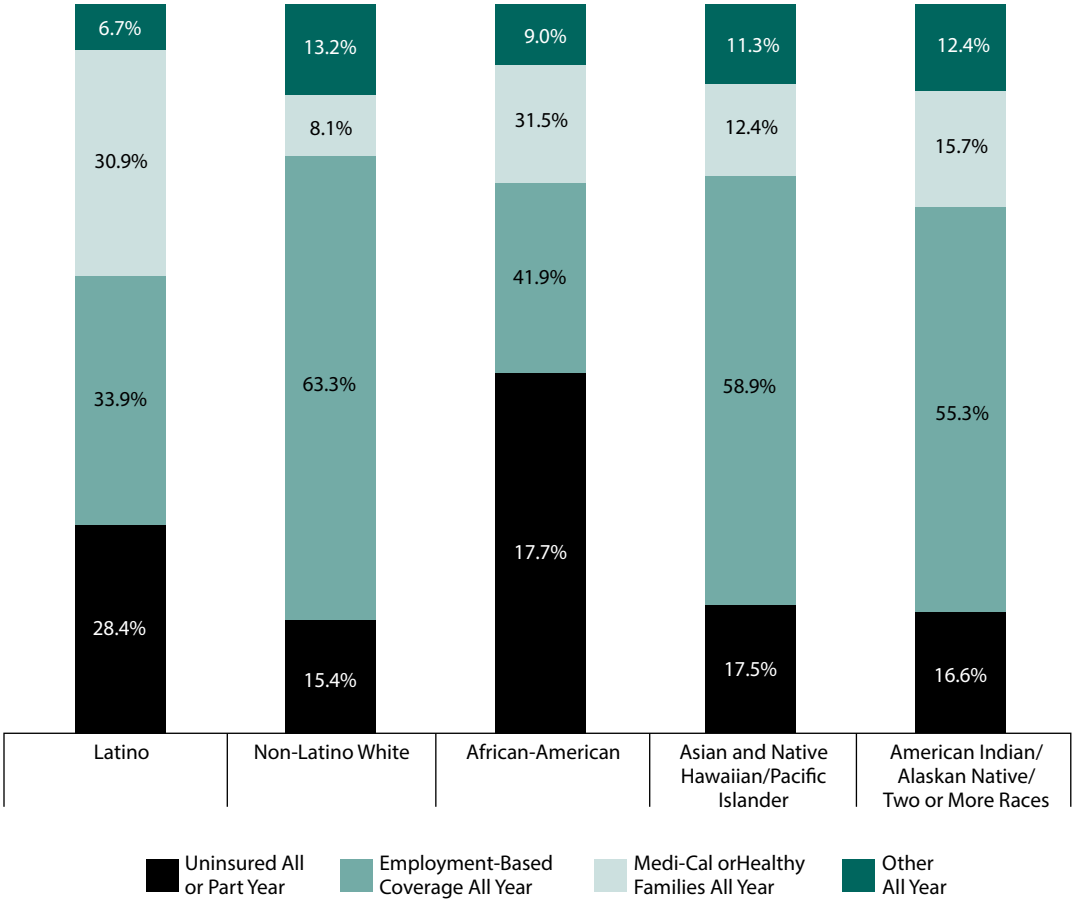
Source: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

More nonelderly Californians qualified for public programs due to ongoing loss of household income, which led to increases in Medi-Cal or Healthy Families coverage in every age group between 2009 and 2012 (Exhibit 3). Young children had the largest increase in public coverage, from 32.8% in 2009 to 40.3% in 2012. These data underscore the fundamental importance of public programs as a safety net in hard economic times, as these gains occurred prior to the expansion of Medi-Cal in 2014 (see Exhibit 8, below) to all households with incomes below 138% of the Federal poverty level (FPL).[3]

When we examine health insurance coverage by racial and ethnic group, Latinos remained the group with the highest rate of uninsurance (28.4%) and the lowest rate of job-based coverage (33.9%; Exhibit 4). Latinos' rate of public coverage (30.9%) was similar to that of African-Americans (31.5%), but nearly four times that of the non-Latino white population (8.1%).

3 In 2014, the federal poverty level was $11,670 for a one-person household, $15,730 for a two-person household, $19,790 for a three-person household, and so forth.

Exhibit 4.
Health Insurance Coverage During Last 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California, 2012



Notes: The category "Other Single or Multiple Race" has been omitted from the exhibit.

Numbers may not add up to 100% because of rounding.

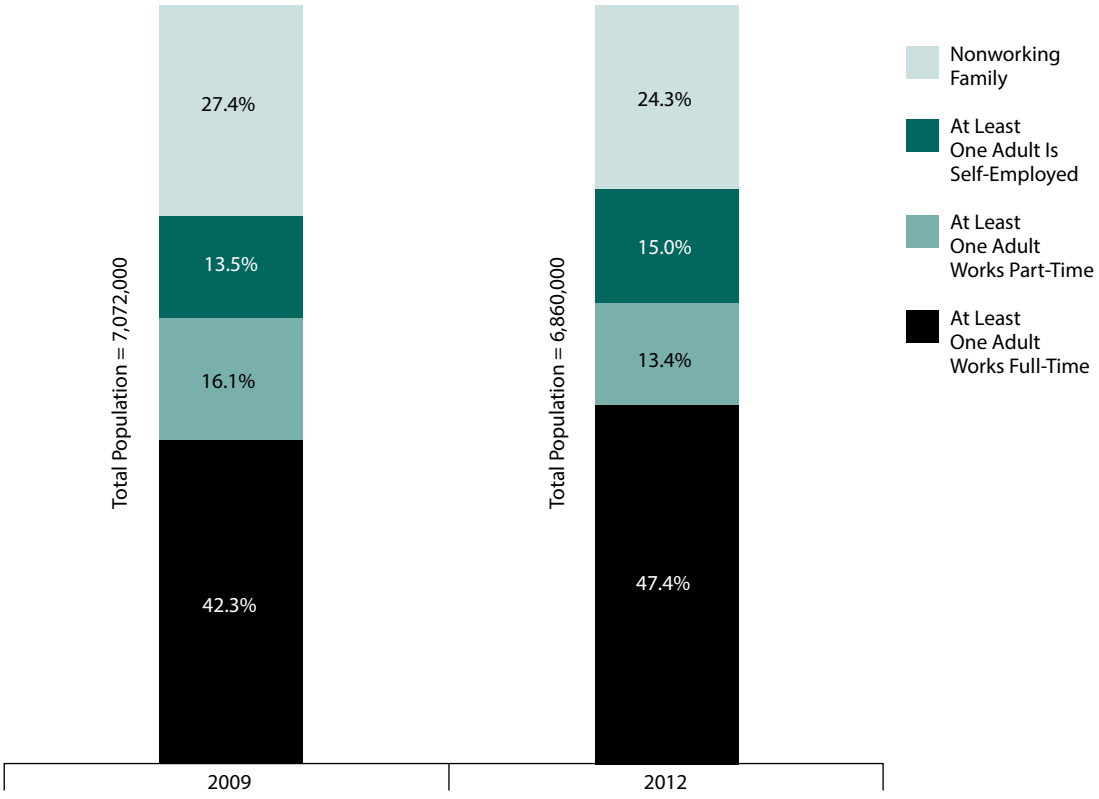
Source: 2011/2012 California Health Interview Survey

Nearly Half of the Uninsured in 2012 Were in Full-Time Working Families

The increase from 2009 to 2012 in employment-based insurance among young adults stands in contrast to the increasing rate of full-time workers among the uninsured. While many people returned to work by the end of 2012,[4] the jobs that returned did not necessarily bring health insurance benefits along with them. In 2009, roughly 4 in 10 nonelderly uninsured (42.3%) were in families that had at least one full-time worker (Exhibit 5). In 2012, nearly half of the uninsured were in full-time working families (47.4%). The percentage of the uninsured in nonworking families dipped to 24.3% in 2012, down from 27.4% in 2009 (Exhibit 5).

4 Unemployment declined to 9.8% by December 2012, according to California Employment Development Division (EDD) data. Accessed at *www.edd.ca.gov* on 3/19/14.

Exhibit 5.
Family Work Status Among Nonelderly Persons Who Were Uninsured During the Past 12 Months, Ages 0-64, California, 2009-2012



Notes: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame in order to increase comparability of the point estimates.

Numbers may not add up to 100% because of rounding.

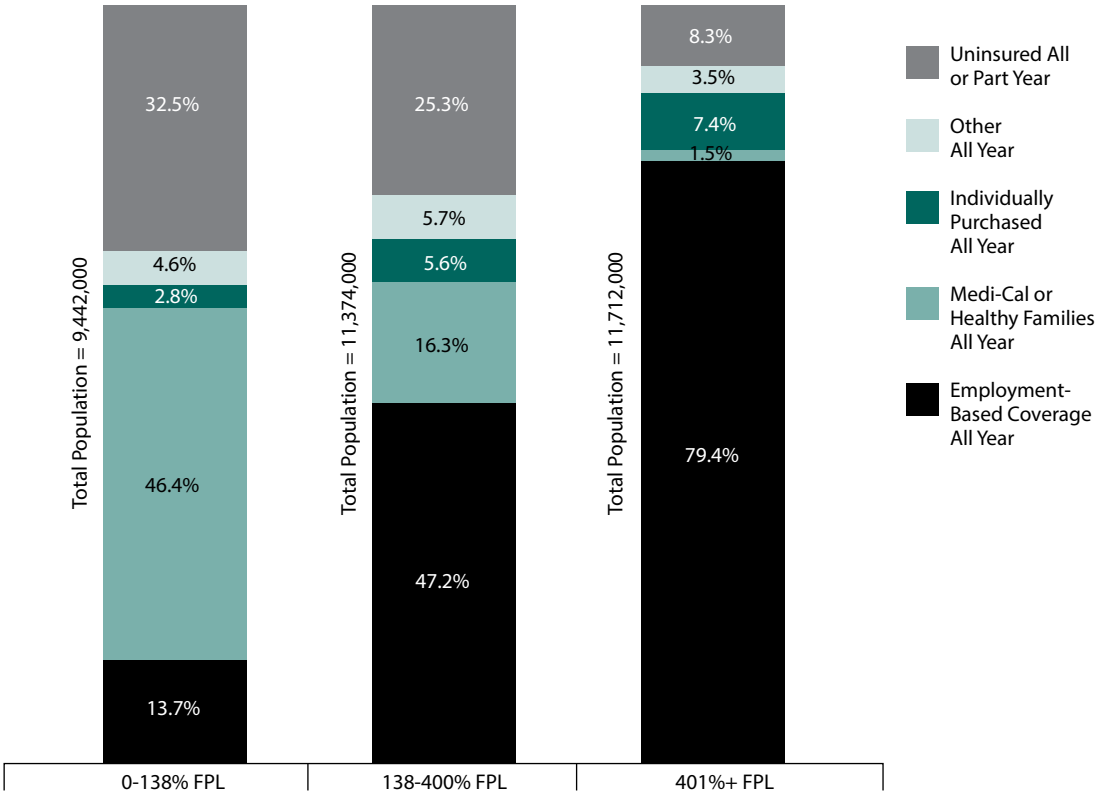
Source: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Nearly 6 Million Low- and Middle-Income Californians Were Uninsured in 2012

The Medi-Cal expansion will help a wide swath of the 9.44 million low-income nonelderly Californians, as one-third remained uninsured in 2012 (32.5%; Exhibit 6). Less than half of California's low-income nonelderly population were eligible for and enrolled in either Medi-Cal or the Healthy Families program (46.4%). Only 13.7% of this group had health insurance through their own, a parent's, or a spouse's employment.

Exhibit 6.

Health Insurance Coverage During Last 12 Months by Federal Poverty Level Among Nonelderly Persons, Ages 0-64, California, 2012



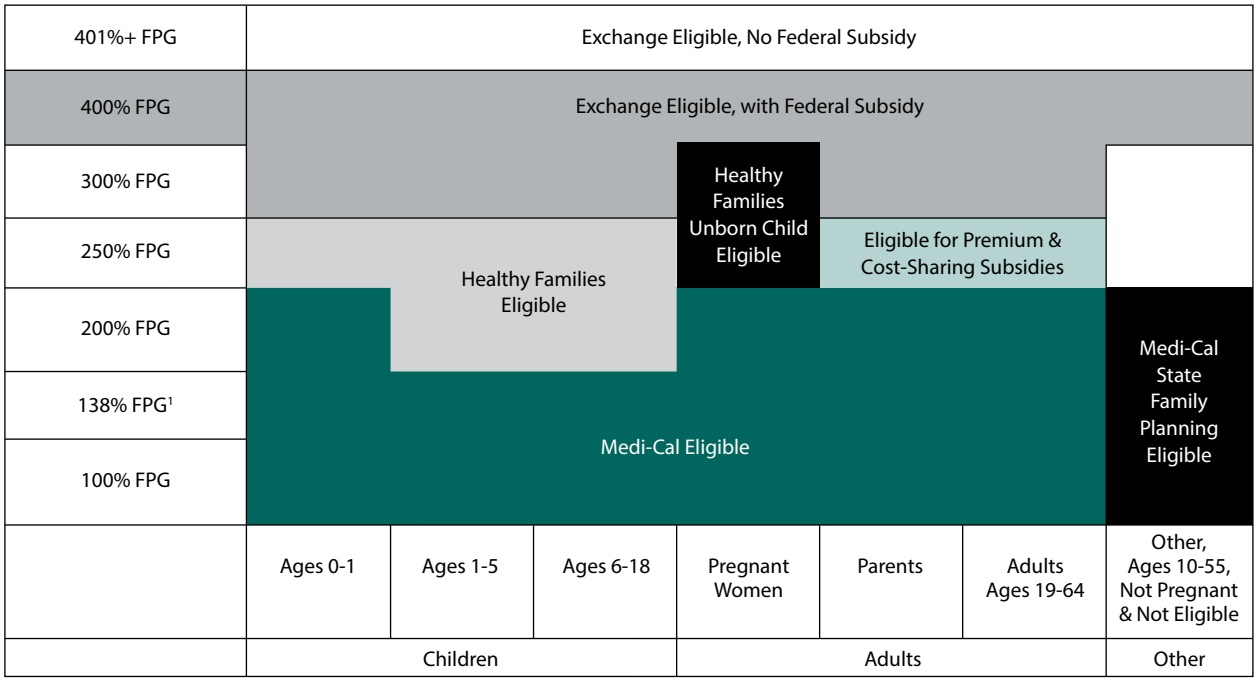
Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

About 11.4 million nonelderly Californians had household incomes at 138-400% FPL in 2012 (Exhibit 6). After the ACA health insurance expansions in 2014, individuals in this income group are potentially able to purchase health insurance through the new marketplace, Covered California, with a federal subsidy to help them buy coverage (Exhibit 7). Of this middle-income group, nearly half (47.2%) had employment-based insurance in 2012. One-quarter (25.3%) of the group had been uninsured for all or part of the past year (Exhibit 6).

Exhibit 7.
Medi-Cal, Healthy Families, and Exchange Eligibility According to the ACA as a Percent of Federal Poverty Guidelines (FPG), California, 2014



Note: FPG = Federal Poverty Guidelines. The poverty guidelines are a simplified version of the federal poverty thresholds used for administrative purposes—for instance, determining financial eligibility for certain federal programs.

1 There is a 5% income disregard, so the effective calculation is 138% FPG. However, 133% is the cutoff specified in the ACA.

Medi-Cal = "full scope" Medi-Cal only, excluding eligibility for the share-of-cost program.

When the health insurance expansions of 2014 are in place, millions of low- and middle-income uninsured Californians will have new options for health insurance coverage. As of April 2014, enrollment data from Covered California indicated that almost 1.4 million people had enrolled in the new private plan options, either with or without federal subsidy assistance. Additionally, nearly 2.0 million had enrolled in the newly expanded Medi-Cal program.[5]

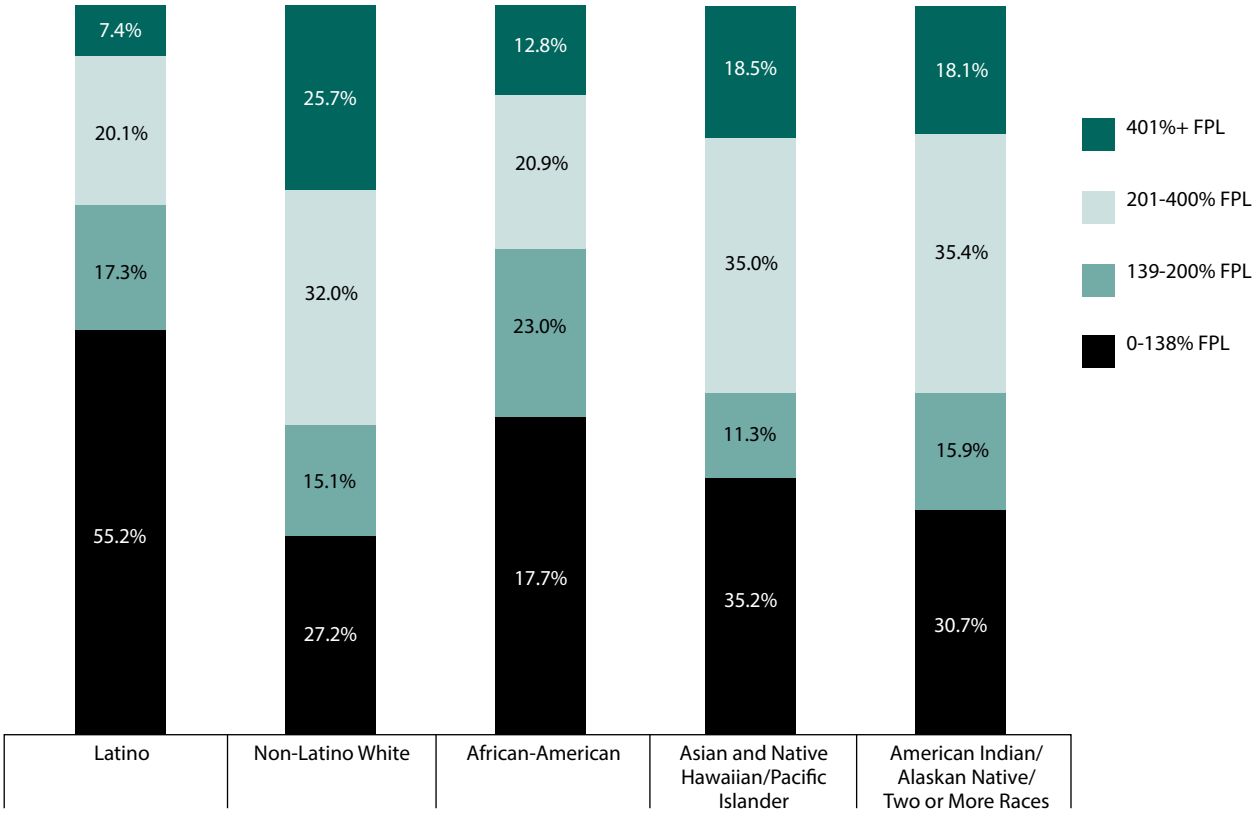
5 Covered California (2014).

Covered California's Historic First Open Enrollment Finishes with Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California. Covered California, Department of Health Care. Posted April 17, 2014, at *http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html*.

The major expansion of public health insurance could potentially impact racial and ethnic group health disparities among the uninsured. Among uninsured Latinos in fair or poor health, 55.2% had household incomes below 138% FPL (Exhibit 8). More than four in ten (43.3%) uninsured African-Americans in fair or poor health also had household incomes that would qualify them for the Medicaid expansion. Health insurance coverage would go far to improve their access to health care and, hopefully, improve their health status over time.

Exhibit 8.

Race and Ethnicity by Poverty Level Among Nonelderly Uninsured All or Part Year and in Fair or Poor Health, Ages 0-64, California, 2012

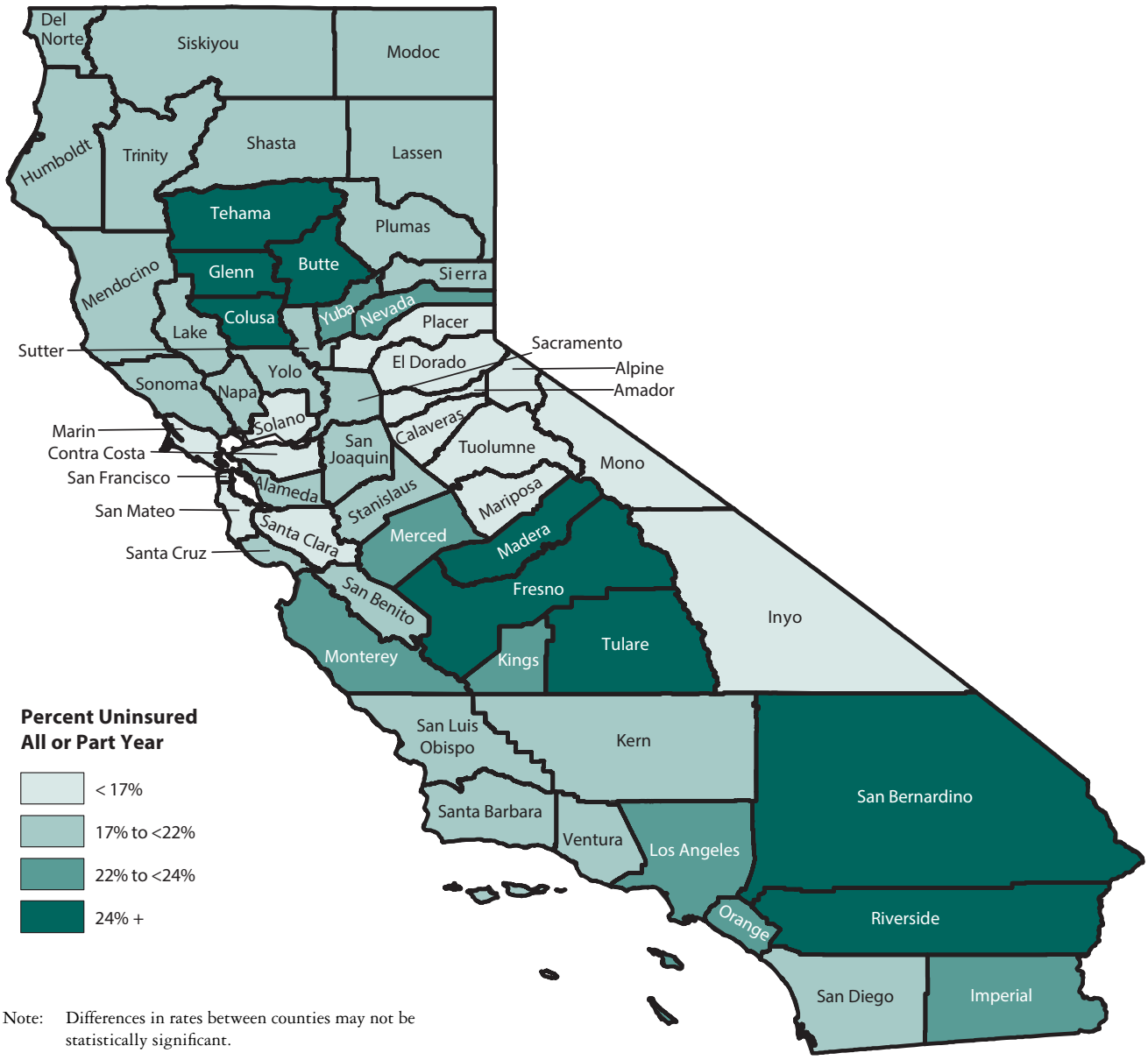


Notes: The category "Other Single or Multiple Race" has been omitted from the exhibit.

Numbers may not add up to 100% because of rounding

Source: 2011/2012 California Health Interview Survey

Exhibit 9.
Percent Uninsured by County Among Nonelderly Persons, Ages 0-64, California, 2012



Note: Differences in rates between counties may not be statistically significant.

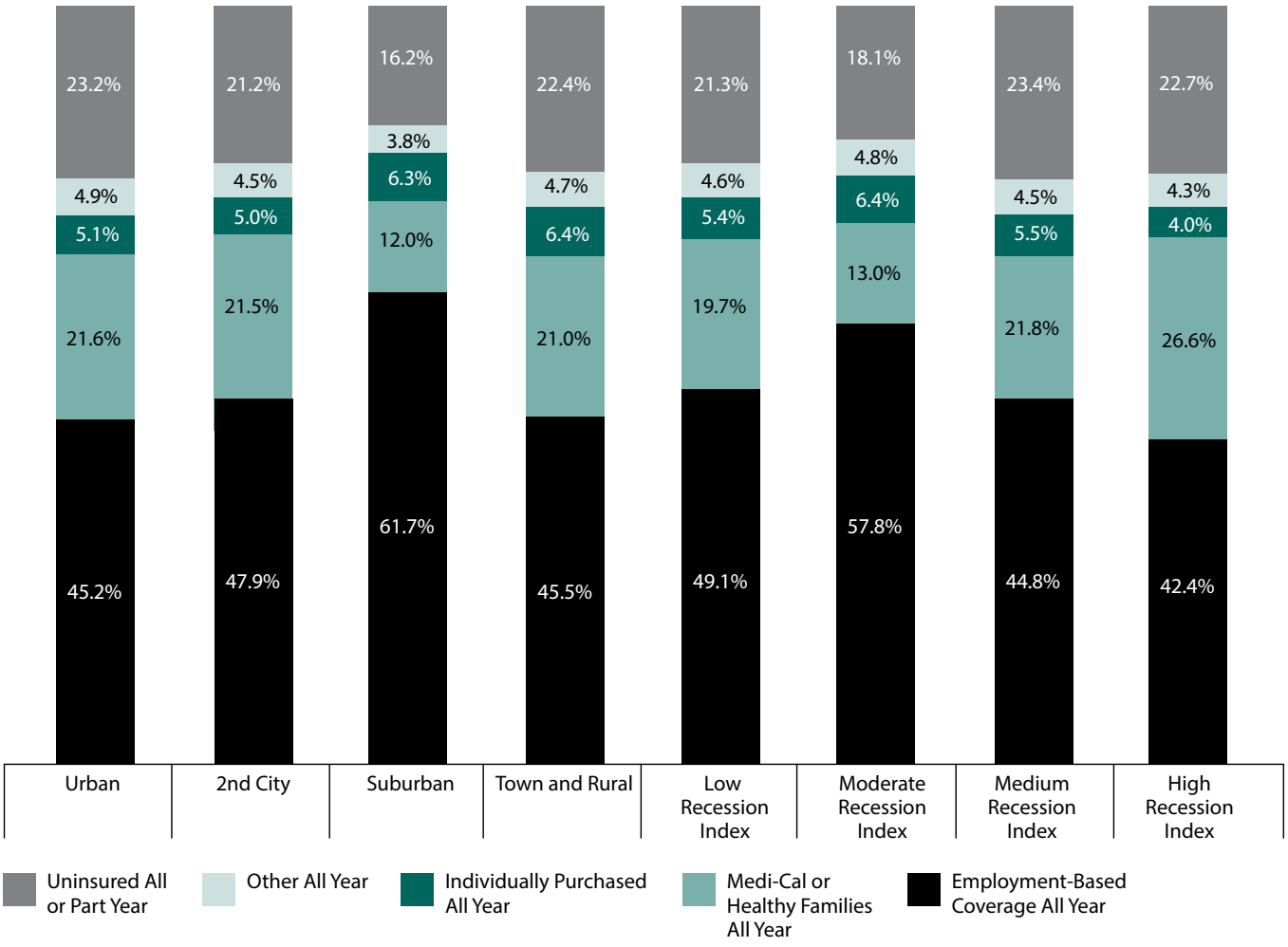
Source: 2011/12 California Health Interview Survey

High Uninsured Rates Were Spread Throughout California

Pockets of high uninsurance rates persisted throughout low-income areas of California, including Riverside and San Bernardino counties in the southern Inland Empire, Fresno and surrounding counties in the Central Valley, and Butte and nearby counties in the Northern and Mountain regions (Exhibit 9). In these counties, the number of uninsured rose to one-quarter of the nonelderly population in 2009 (data not shown) and remained at that level throughout the recession. While the Bay Area retained its status as having the lowest rates of uninsurance, the overall rates there were still higher than they had been prior to the start of the recession. Los Angeles County still had the highest number—although not the highest rate—of uninsured, with 2.13 million nonelderly residents uninsured for all or part of the prior year (data not shown).

Comparing different geographic levels of urbanization in California, suburban areas had a much higher rate of employment-based coverage (61.7%) and a lower rate of uninsurance (16.2%) than any other area (Exhibit 10). Public coverage in suburban areas was also markedly lower (12%) than in other areas, indicating that this type of coverage was not contributing to the overall lower uninsurance rate (unlike trends for the entire population across the state; see Exhibit 3 in this chapter). Health insurance coverage in suburban California stood in sharp contrast to the health insurance patterns in urban, rural, or second-city areas (i.e., an area that is less densely populated than a nearby city but still a city hub).

Exhibit 10.
Health Insurance Coverage During Last 12 Months by Urban/Rural and Recession Index Areas Among Nonelderly Persons, Ages 0-64, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

Conclusions

Although hiring had increased by the end of 2012, the unemployment rate still remained four percentage points higher than the rate prior to the Great Recession. In addition, our data show that the jobs that returned did not necessarily bring health insurance rates back, as the overall employment-based coverage rate languished at below 50% and the percentage of the uninsured in working families increased. Among low-income nonelderly Californians, uninsurance remained at one-third of the population in 2012, regardless of the increases in public coverage as more families fell below the poverty line. California exhibits divisions along geographic lines, with suburban areas having strikingly different health insurance patterns than both the urban and rural areas of the state.

However, the data also show the clear early impact of the ACA. A single provision allowing young adults (through age 25) to either remain on a parent's coverage after graduation or to re-enroll as a dependent enabled hundreds of thousands of Californians to gain or keep health insurance. This group had the largest reduction in uninsurance compared to all other nonelderly age groups, and the change is directly attributable to the ACA.

This early success portends the changes in health insurance that will surely be seen in future CHIS data, following the ACA expansions that began in January 2014. The snapshot of health insurance in California in 2012 provided here shows just how far we have to go before the nonelderly population can reach the 2% level of uninsurance enjoyed by those ages 65 and older because of the nearly universal eligibility for Medicare among seniors.

2 Employment-Based Coverage and the Individual Market

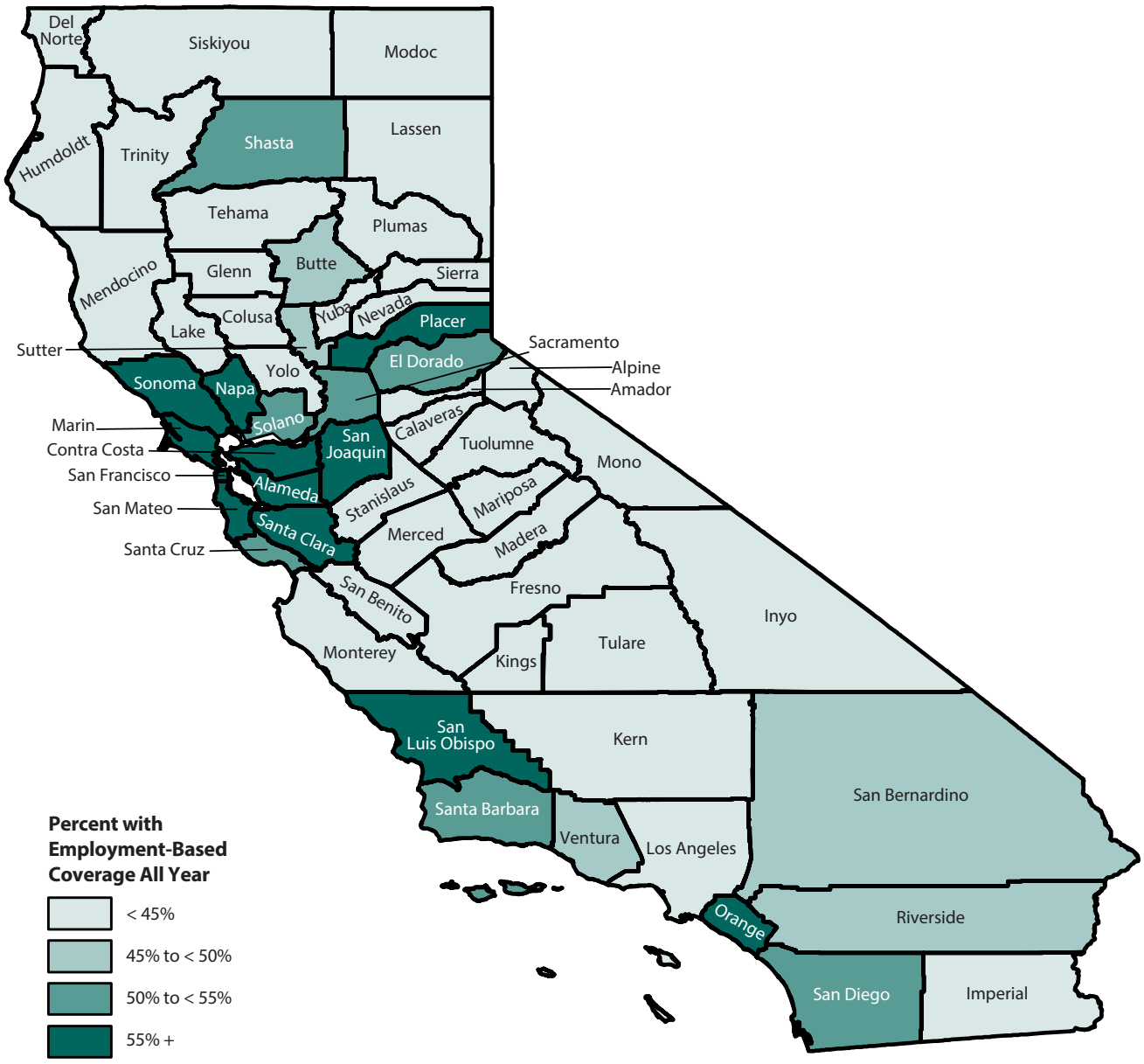
Ken Jacobs

While employment-based coverage has declined over the last decade, it remains the central source of coverage for Americans under the age of 65. As we saw in chapter 1, in 2012, 15.9 million (49.1%) Californians under the ages of 65 were covered through their own or a family member's plan throughout the entire year. This compares to the 1.8 million Californians (5.4%) who were covered by individually purchased plans.

The share of individuals with job-based coverage varied throughout the state (Exhibit 11). Coverage rates were highest in the Greater Bay Area, where more than 55% of individuals had an employment-based plan year-round in all but Solano County. Coverage rates were lowest in rural Northern and Central California counties, Los Angeles County, and the Imperial Valley, all of which had coverage rates below 45%. The county with the highest rate of individuals with year-round employment-based coverage was San Mateo, with 70.7%. The lowest rate was in Lake County, with only 26.9%. Comparing the labor markets of these two counties reveals that Lake has double the unemployment rate of San Mateo, a much smaller labor pool, and an economy that is heavily dependent on the service industry.[6]

6 California Employment Development Department (2014). Labor market statistics found at *http://www.labormarketinfo.edd.ca.gov/*, accessed on August 4, 2014.

Exhibit 11.
Percent with Employment-Based Coverage Among Nonelderly Persons, Ages 0-64, California, 2012



Note: Differences in rates between counties may not be statistically significant.

Source: 2011/2012 California Health Interview Survey

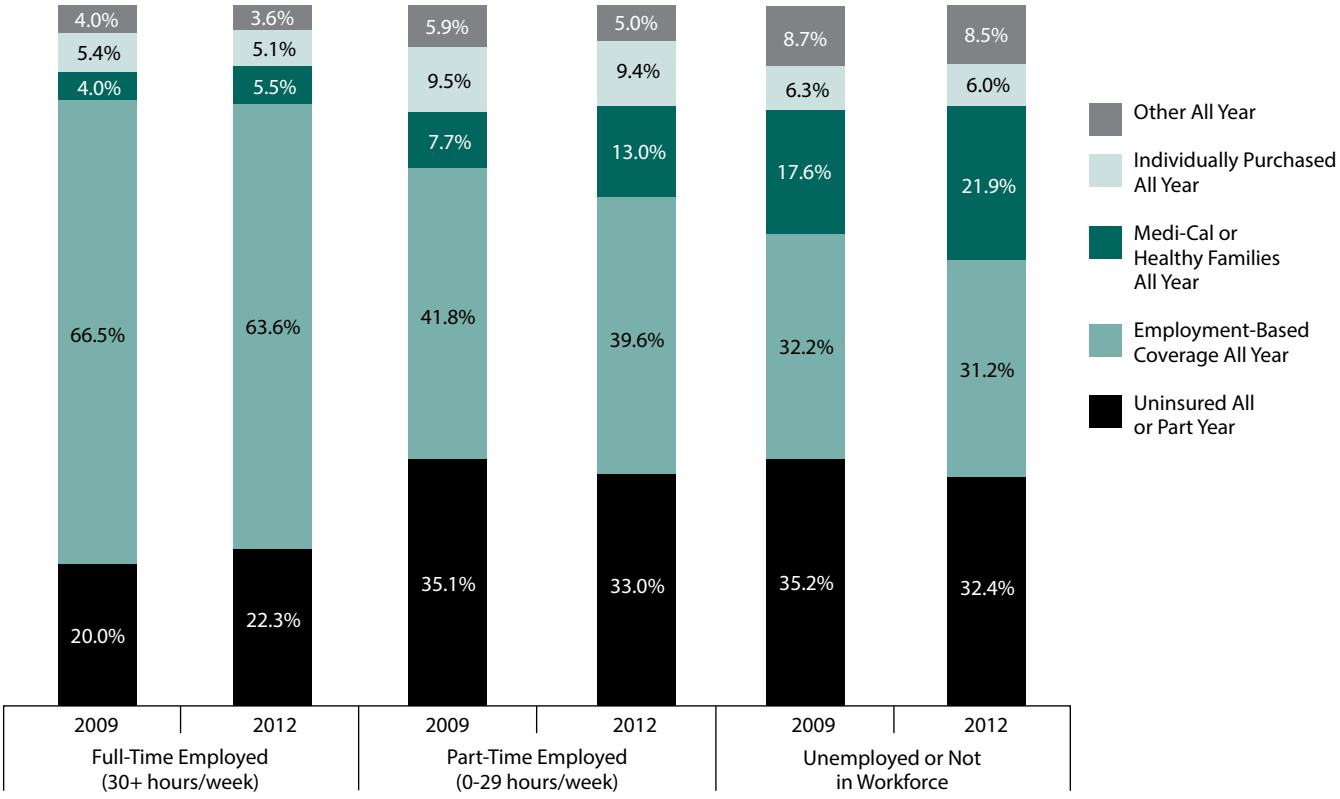
Job-Based Coverage Fell for Both Full- and Part-Time Workers

Even as the economic recovery picked up between 2009 and 2012, the share of workers with employment-based coverage declined (Exhibit 12). The decline was consistent among full-time workers, part-time workers, and the unemployed. In 2012, 63.6% of full-time workers had employment-based coverage, compared to 66.5% three years earlier. Part-time workers experienced a similar decline in coverage, from 41.8% in 2009 to 39.6 % in 2012.

While there is considerable debate on the issue, most analysts anticipate that the ACA will have a modest impact on the overall share of individuals with coverage through an employer. Coverage sources are expected to change most for lower-income workers, who will have access to significant subsidies through the new marketplaces. It will be important to measure any change against this pre-existing trend of declining job-based coverage.

On the eve of implementation of the new health insurance marketplaces under the ACA, the share of workers with individually purchased coverage remained stable, with slightly over 5% for full-time workers and 9.5% for part-timers. Part-time workers were more likely to have individually purchased coverage than adults who were unemployed or not in the workforce. The share of full-time workers uninsured all or part of the year rose from 20% to 22.3%; uninsurance among part-time workers fell from 35.1% to 33%, due mainly to increased enrollment in Medi-Cal.

Exhibit 12.
Employment-Based and Individually Purchased Insurance by Full- and Part-Time Work Status Among Nonelderly Adults, Ages 19-64, California, 2009 and 2012



Notes: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, in order to increase comparability of the point estimates.

Numbers may not add up to 100% because of rounding.

Sources: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Own-Employer Coverage Rates Declined Most for Single Parents, Latinos, and Older Workers

In 2012, 7.53 million working Californians ages 19 to 64 had job-based coverage through their own employer for the full year (46.4%), compared to 7.76 million (48.2%) in 2009 (Exhibit 13). The decline in coverage varied by age, race, citizenship status, education, family income, and hourly wage, which are all strong predictors of a worker's having coverage through his/her own employer (Exhibit 13). However, it must be noted that some of the cells in this table have very small sample sizes, which could contribute to a trend's appearing larger than it actually was due to high variation in the sample.

Own-employer coverage fell among all age groups except those ages 19-25, who were much less likely to have employment-based coverage in the first place. While 56.8 % of workers ages 55-64 had coverage through their own employer in 2012, this was true of only 24.4% of workers ages 19-25.

Latino workers were significantly less likely to have coverage through their own employer (35.4%; Exhibit 13) than white (52.7%), Asian (54.1%) or African-American (55%) workers.[7] Latinos also experienced the largest drop in own-employer coverage of all racial and ethnic groups during this period. A similar story can be seen when looking at immigration status, with the largest declines in coverage between 2009 and 2012 among noncitizens.

Own-employer coverage varied significantly by educational attainment. The coverage gap between workers with a four-year college degree and the rest of the workforce grew larger. While 60.1% of individuals with a college degree had coverage through an employer in 2012, essentially unchanged from three years prior, this was true of only 26.1% of those without a high school diploma, down from 30.9% in 2009 (Exhibit 13). The employment-based health coverage advantage for those with some college compared to those with only a high school diploma disappeared. The advantage for those with a vocational education or associate degree narrowed: while the share of workers with a high school diploma who were covered on the job remained stable at 39.7%, coverage rates fell by 3 and 4 percentage points for the latter two groups, respectively.

7 Own-employer coverage rates among African-Americans have been relatively volatile in CHIS. Both CHIS and the Current Population Survey showed sharply declining coverage rates during the 2000s. Further research is warranted.

Exhibit 13.
Employment-Based Insurance, Own Coverage All Year: Rates by Demographics Among Working Nonelderly Adults, Ages 19-64, California, 2009 and 2012

	2009	2012
All Workers	48.2%	46.4%
Age		
19-25	21.4%	24.4%
26-34	47.7%	45.8%
35-44	51.6%	49.6%
45-54	54.9%	51.1%
55-64	57.6%	56.8%
Race and Ethnicity		
White	53.6%	52.7%
Latino	38.8%	35.4%
African-American	43.6%	55.0%
Asian/Native Hawaiian/Pacific Islander	54.1%	54.1%
American Indian/Alaskan Native/Two or More Races	52.5%	37.4%
Family Composition		
Single Adult	43.5%	40.8%
Single Parent	45.0%	34.0%
Married without Children	55.7%	55.3%
Married with Children	48.4%	49.9%
Citizenship and Immigration Status		
U.S. Citizen	51.6%	50.4%
Non-Citizen with a Green Card	35.2%	33.5%
Non-Citizen without a Green Card	24.8%	19.9%
Highest Level of Education		
Less Than High School	30.9%	26.1%
High School Graduate	39.6%	39.7%
Some College	42.5%	39.5%
Vocational School, AA, AS	47.7%	42.0%
College Graduate or Higher	60.9%	60.1%
Federal Poverty Level		
Less than 138% FPL	17.4%	16.6%
139-200% FPL	33.6%	29.4%
201-400% FPL	49.5%	47.2%
400%+ FPL	61.8%	62.7%
Hourly Wage		
Less than $9.00	22.0%	22.1%
$9.00-$12.99	35.9%	33.4%
$13.00-$14.99	43.9%	35.9%
$15.00-$18.99	47.7%	50.9%
$19.00-$23.99	62.5%	58.0%
$24.00 +	65.0%	65.7%

Notes: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, in order to increase comparability of the point estimates.

Sources: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Family income is the strongest predictor of own-employer coverage. An estimated 16.6% of workers with family incomes below 138% of the federal poverty level (FPL) had coverage through their own employer, while 62.7% of those with family incomes above 400% of the FPL had employer-based insurance (Exhibit 13). Own-employer coverage fell the most between 2009 and 2012 for families with incomes between 138% and 400% of the FPL. As of 2014, families in this income range without an affordable offer of employment-based coverage are eligible for premium subsidies in the individual market through the ACA. Since subsidies are greatest for those with incomes below 200% of the FPL, we would expect any declines in employer-based coverage resulting from the ACA to be concentrated in this group.

Hourly wage is also a strong predictor of own-employer coverage. Only 22.1% of workers earning less than $9 per hour reported having coverage through their own employer in 2012, compared to 65.7% of those with wages above $24 an hour (Exhibit 13). Own-employer coverage rates were stable among the lowest and highest wage groups between 2009 and 2012, while falling for those in between. The biggest decline (8 percentage points) was for workers earning between $13.00 and $14.99 an hour (in 2012 dollars).

Family status was also associated with own-employer coverage. Individuals who were married without children had the highest rates of coverage through their own employer (55.3%; Exhibit 13), while single parents reported the lowest rates of own-employer coverage (34%). Coverage rates for single parents fell considerably between 2009 and 2012, from 45% to 34%.

Employment-Based Dependent Coverage Rose for 19-25-Year-Olds and Fell for All Other Age Groups

Under the ACA, adults under the age of 26 were able to stay on a parent's plan starting in 2010, regardless of whether or not they were attending college or were financially dependent on their parents. In 2009, 13.6% of those between the ages of 19 and 25, or slightly under half a million young adults, had coverage through a parent or spouse. By 2012, this percentage had increased to 16.7%, or 646,000 people (Exhibit 14). During the same time period, dependent coverage declined among all other age groups. As a result, dependent employment-based coverage through a parent or spouse fell for working-age Californians (16-64), from 13.3% to 12.2%.

As with own-employer coverage, dependent coverage varies by age, race, citizenship status, education, and family income. Non-Latino white Californians were nearly three times as likely to have coverage through a parent or spouse (17.7%; Exhibit 14) than African-Americans (6.2%) or Latinos (7.3%). Dependent coverage rates for Asians and Pacific Islanders (14.5%) were twice as high as for Latinos. U.S. citizens were much more likely to be on dependent coverage (13.1%) than non-citizens either with or without a green card (10.8% and 2.3%, respectively).

Those with a college degree or higher were much more likely to have dependent coverage (16.8%; Exhibit 14) than those with less than a high school education (4.6%). Individuals in families with incomes above 400% of the FPL were more than five times as likely to have coverage through a parent or spouse than those with incomes below 138% of the FPL (21.8% compared to 3.8%).

Exhibit 14.
Employment-Based Dependent Coverage All Year: Rates by Demographics Among Nonelderly Persons, Ages 0-64, California, 2009 and 2012

	2009	2012
All Workers	13.3%	12.2%
Age		
19-25	13.6%	16.7%
26-34	11.1%	9.0%
35-44	17.6%	15.5%
45-54	18.0%	16.0%
55-64	17.7%	16.6%
Race and Ethnicity		
White	15.9%	17.7%
Latino	6.8%	7.3%
African-American	6.7%	6.2%
Asian/Native Hawaiian/Pacific Islander	13.1%	14.5%
American Indian/Alaskan Native/Two or More Races	8.1%	6.2%
Family Composition		
Single Adult	7.9%	7.9%
Single Parent	1.2%	1.9%
Married without Children	24.3%	22.8%
Married with Children	11.4%	14.8%
Citizenship and Immigration Status		
U.S. Citizen	11.8%	13.1%
Non-Citizen with a Green Card	13.1%	10.8%
Non-Citizen without a Green Card	2.0%	2.3%
Highest Level of Education		
Less Than High School	5.1%	4.6%
High School Graduate	11.6%	10.3%
Some College	12.5%	13.3%
Vocational School, AA, AS	12.0%	14.3%
College Graduate or Higher	13.3%	16.8%
Federal Poverty Level		
Less than 138% FPL	3.0%	3.8%
139-200% FPL	7.0%	7.5%
201-400% FPL	12.1%	13.0%
400%+ FPL	17.5%	21.2%

Note: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, to increase comparability of the point estimates.

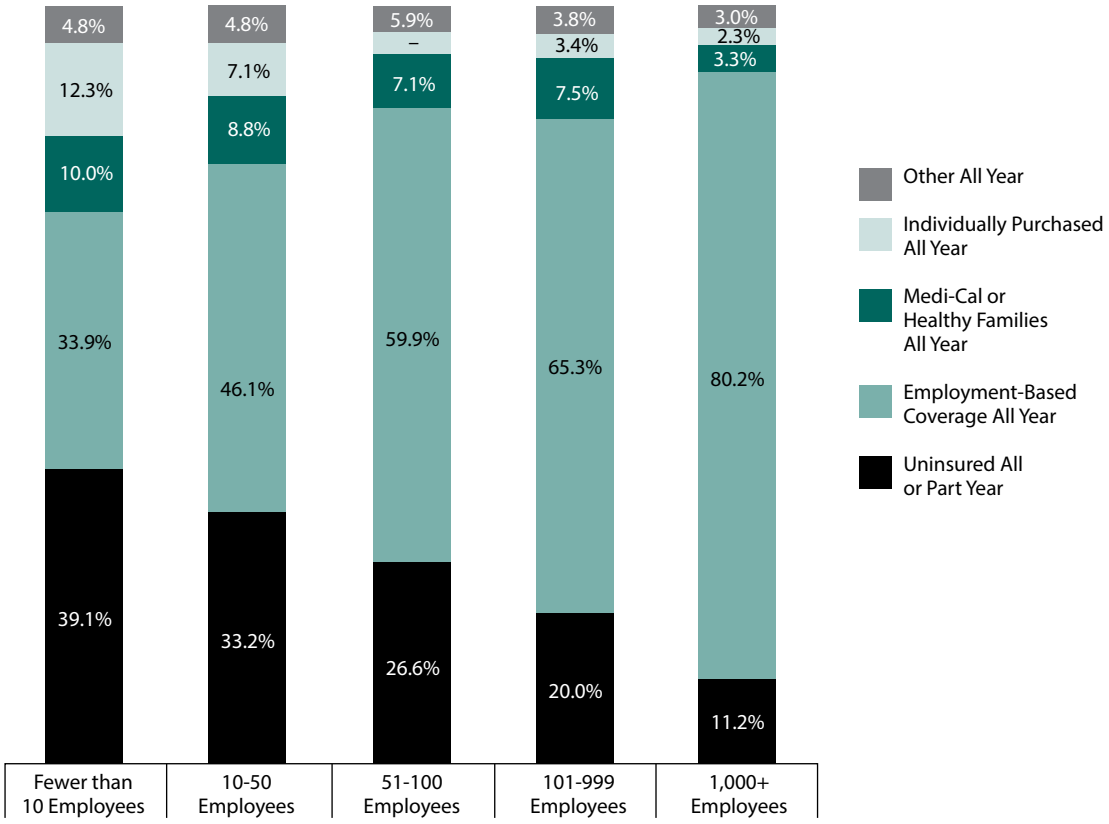
Sources: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Older Workers and Workers in Large Firms Were Much More Likely to Have Employment-Based Coverage

There is a direct and strong correlation between firm size and source of coverage. Individuals who work in the largest firms are much more likely to have coverage through an employer—either their own employer or that of a parent or spouse—than individuals who work in smaller firms. More than 80% of workers in firms of 1,000 or more employees had coverage through an employer, compared to less than half of those in firms with 10 to 50 employees (46.1%; Exhibit 15) and slightly more than a third (33.9%) of those in firms with fewer than 10 employees.

Conversely, those working in smaller firms were much more likely to be uninsured, receive Medi-Cal, or purchase coverage through the individual market. Of the workers in firms of 1,000 or more, only 2.3% purchased coverage in the individual market, 3.3% were enrolled in Medi-Cal or Healthy Families, and 11.2% went without coverage during the year (Exhibit 15). This compares to 39.1% of those in the smallest firms who were uninsured for all or part of the year, 10.0% who were enrolled in Medi-Cal

Exhibit 15.
Health Insurance Coverage During Last 12 Months of Employed Adults by Firm Size, Ages 19-64, California, 2012



– Data are unstable due to coefficient of variation above 30%.

Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

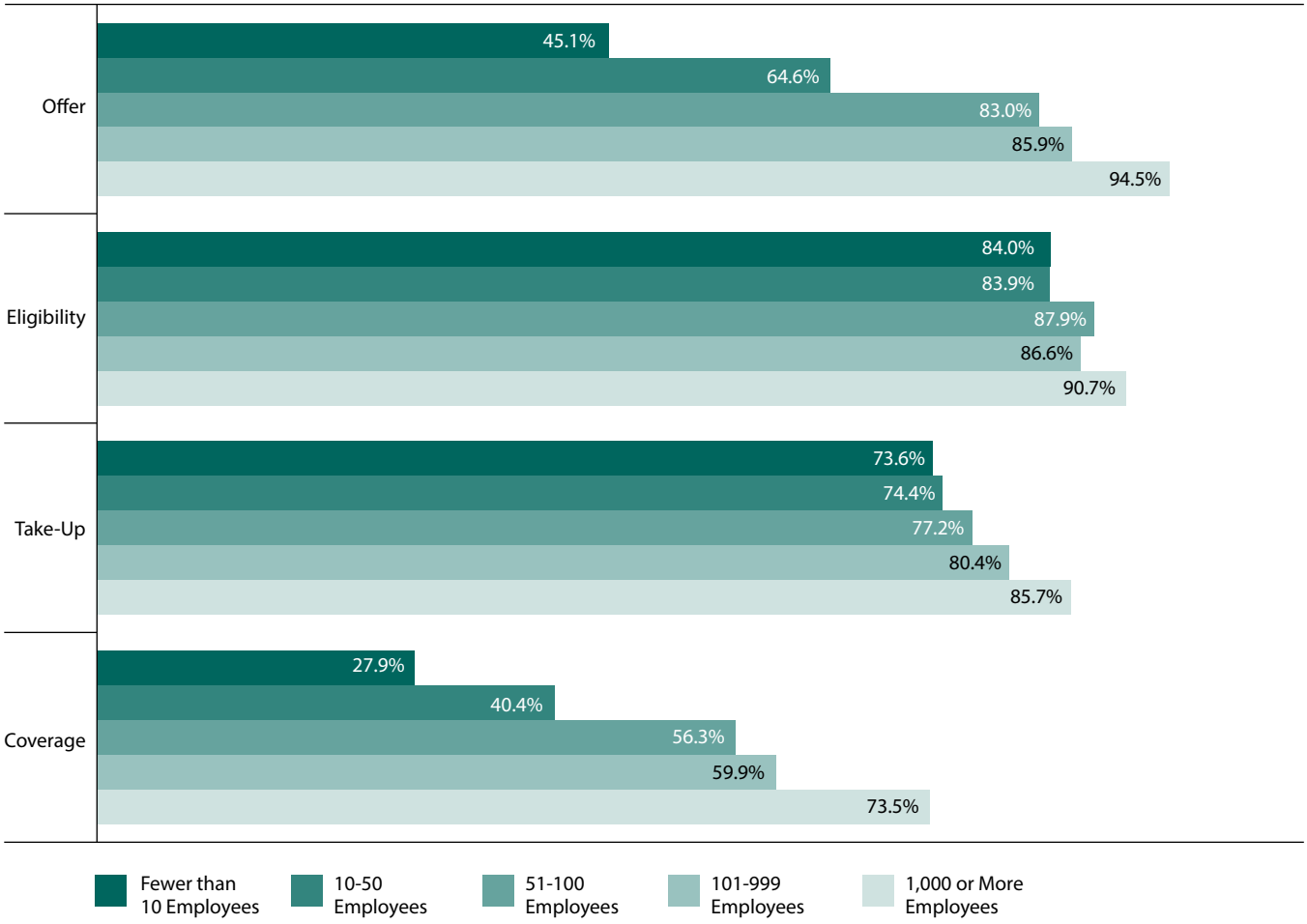
Source: 2011/2012 California Health Interview Survey

or Healthy Families, and 12.3 % who purchased coverage in the individual market.

Coverage rates are a product of the share of workers who are in firms that offer coverage to employees, the share of the employees in offering firms who are eligible for that coverage, and the share of employees who choose to take up the coverage offered to them. Several factors affect eligibility rates in offering firms. Employers are less likely to offer coverage to part-time workers, and they also usually have waiting periods before employees are eligible for coverage. In high-turnover industries, longer waiting periods will result in a lower share of workers who are eligible for coverage at any one time.

The share of workers with coverage through an employer varied significantly by firm size. While nearly three-quarters (73.5%; Exhibit 16) of employees in firms of 1,000 or more had coverage through an employer, the

Exhibit 16.
Rates of Offer, Eligibility, Take-Up, and Coverage of Employment-Based Coverage by Firm Size Among Working Nonelderly Adults, Ages 19-64, California, 2012



Notes: Offer rate = The total number of employees working for employers that offer health insurance, divided by the total number of employees.

Eligibility rate = The total number of employees eligible for their employer's plan, divided by the total number of employees working for employers that offer health insurance.

Take-up rate = The total number of people who accepted insurance, divided by the total number of employees with access to their employer's plan.

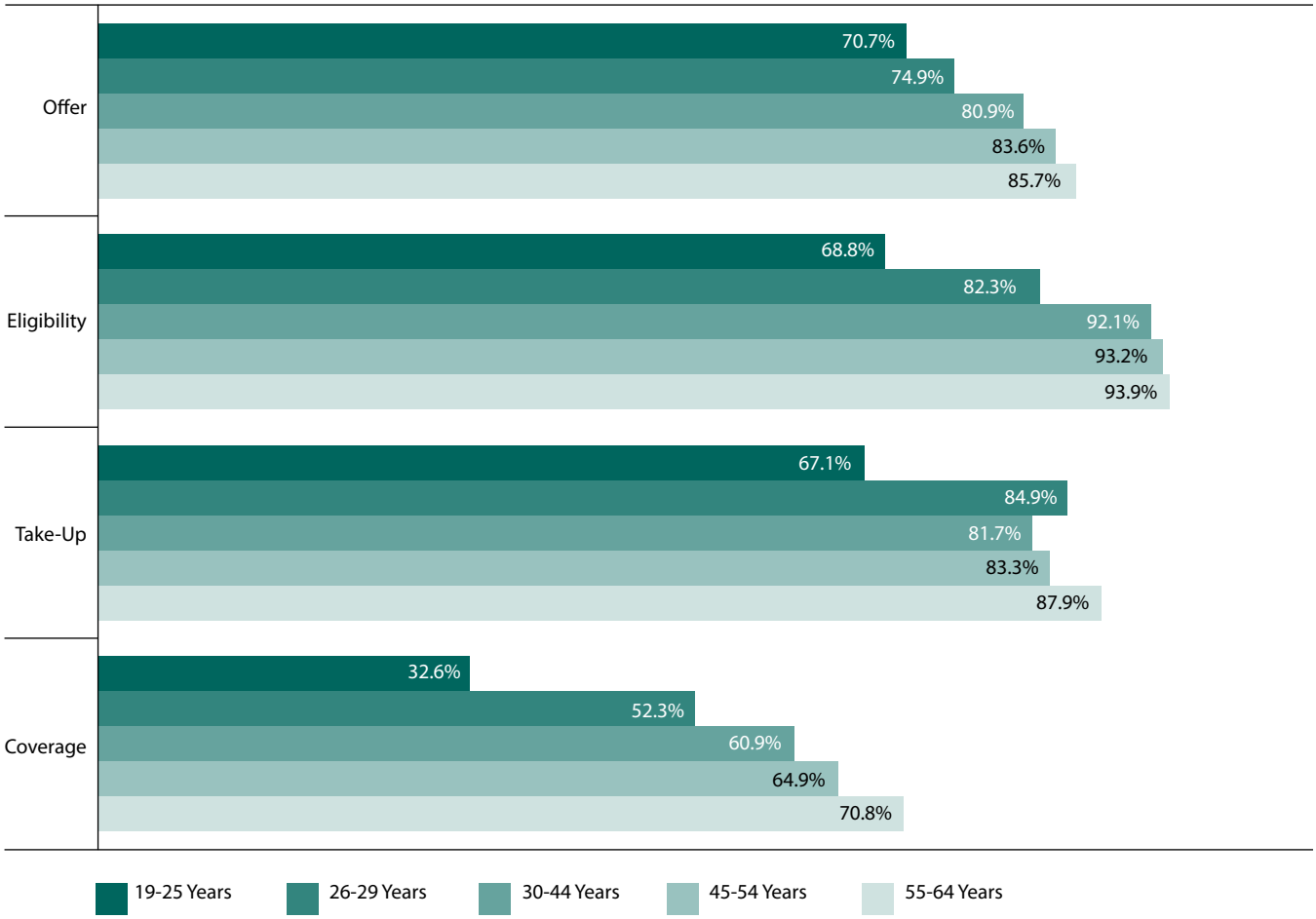
Coverage rate = The product of the offer, eligibility, and take-up rates. The population analyzed excludes self-employed individuals who are in firms with fewer than 10 employees.

Source: 2011/2012 California Health Interview Survey

same was true for only 27.9% of employees in firms with fewer than 10 employees and 40.4% of those in firms with 10 to 50 employees.

In 2012, 94.5% of workers in firms of 1,000 or more worked for an employer who offered coverage, compared to only 45.1% of workers in firms with fewer than 10 employees and 64.6% in firms with 10 to 50 employees (Exhibit 16). Eligibility rates also varied by firm size, but the variation was much less than that of offer rates: 84% of workers in firms with 50 or fewer employees that offered coverage were eligible for that coverage, compared to 90.7% of those who worked for the largest firms. Take-up rates were also higher in large firms, with 85.7% compared to 73.6% among the smallest firms. While there was great variation by industry, workers in larger firms generally both paid lower shares of premium costs and earned higher wages than those in small firms, with both factors possibly contributing to the higher take-up rates.

Exhibit 17.
Rates of Offer, Eligibility, Take-Up, and Coverage of Employment-Based Coverage by Age Among Working Nonelderly Adults, Ages 19-64, California, 2012



Notes: Offer rate = The total number of employees working for employers that offer health insurance, divided by the total number of employees.

Eligibility rate = The total number of employees eligible for their employer's plan, divided by the total number of employees working for employers that offer health insurance.

Take-up rate = The total number of people who accepted insurance, divided by the total number of employees with access to their employer's plan.

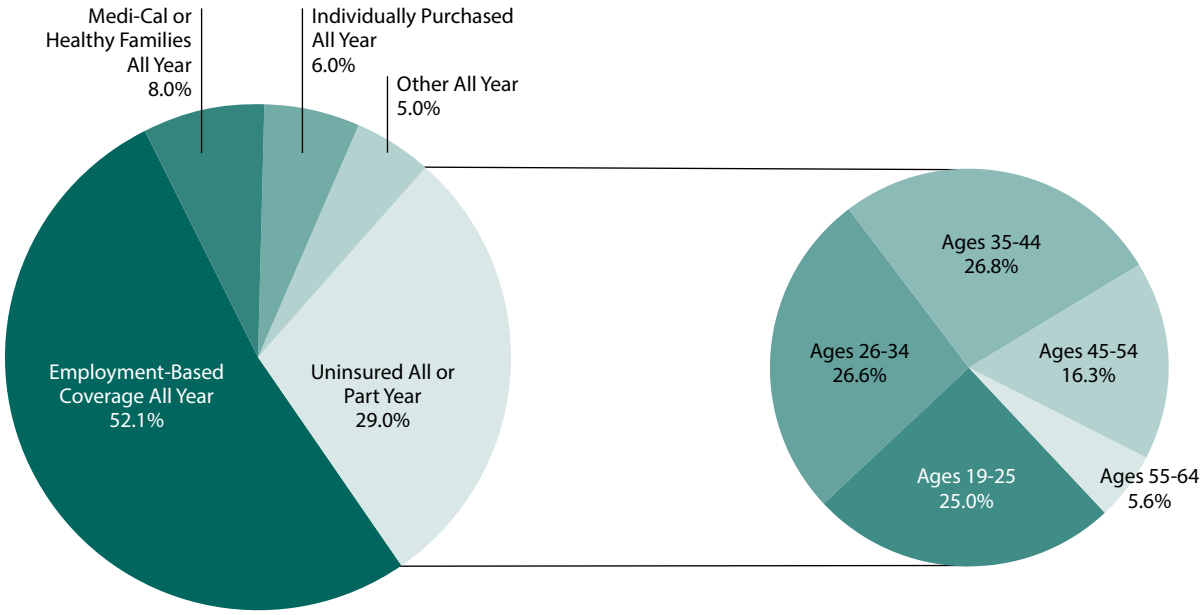
Coverage rate = The product of the offer, eligibility, and take-up rates. The population analyzed excluded self-employed individuals in firms with fewer than 10 employees.

Source: 2011/2012 California Health Interview Survey

Most Californians Who Did Not Take Up Offers of Employment-Based Coverage Had Coverage Through Another Source

Of the 1,783,000 Californians who were offered but did not take up employment-based coverage in 2012, more than half (52.1%; Exhibit 18) had coverage through another employer, either directly or through a spouse's or parent's employer. Smaller shares had coverage through a public source (8.0%) or purchased coverage on the individual market (6.0%). Less than a third (29.0%) were uninsured. As seen in Exhibit 18, the shares of individuals who declined job-based coverage and remained uninsured were spread surprisingly evenly among the age bands under the age of 44. Unsurprisingly, few workers over 55 declined to take up job-based coverage when they did not have another source of coverage.

Exhibit 18.
Type of Health Insurance Coverage Among Working Nonelderly Adults Who Declined Own Employment-Based Coverage, Ages 19-64, California, 2012



Notes: "Employment-Based Coverage All Year" refers to coverage through an employer other than one's own (e.g., a parent's or spouse's employer). "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers [AIM] and the Managed Risk Medical Insurance Program [MRMIP], for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

The Individual (Non-Group) Market Prior to Implementation of the ACA

Overall, in 2012, 1.7 million Californians had year-round coverage through the individual market. Starting in January 2014, insurance companies could no longer discriminate against individuals based on health status or pre-existing conditions. Costs could vary only by age and geography (smoking status has been legally disallowed as a reason for varying the premiums in California). Low- and moderate-income families without an affordable offer of coverage on the job became eligible for premium subsidies.

Nonelderly Californians ages 19-64 with individually purchased coverage were younger than those who were covered in the small- and large-group markets (Exhibit 19). While one out of four (25.1%) of those individually purchasing coverage were between the ages of 19 and 25, that was true of only 14% of those in the small-group market and 9.8% of those in the large-group market. Citizenship and immigration status was relatively stable across the three markets.

Individuals purchasing coverage directly were more likely to report that they were in excellent or very good health (65.1%) than those in the small-group market (60.8%), and less likely to report fair or poor health (9.7%) than those in the small-group market (12.2%). In the large-group market, 64% reported excellent or very good health, and 8.6% reported fair or poor health.

Individuals purchasing coverage directly were significantly less likely to have high blood pressure or to be overweight or obese than those covered through the small- or large-group markets. Smoking rates were similar across the three groups.

A majority (55.9%) of those with individually purchased coverage worked full-time, while an additional 14.2% worked part-time. More than half of those who worked were self-employed (39.9%) or non-self-employed (12.2%) and working in firms of 10 or fewer. Slightly more than one-quarter (25.5%) worked for firms of 50 or more, the cutoff for the employer mandate under the ACA.

Exhibit 19.

Demographics of Individuals with Individually Purchased, Small-Group, or Large-Group Coverage Among Nonelderly Adults, Ages 19-64, California, 2012

	Individually Purchased	Small-Group	Large-Group
All Nonelderly Adults			
Age			
19-25	25.1	14.0	9.8
26-29	11.8	6.3	7.6
30-44	20.0	34.0	37.8
45-54	22.3	25.6	26.6
55-64	20.8	20.2	18.2
Total	100.0%	100.0%	100.0%
Citizenship and Immigration Status			
U.S.-Born or Naturalized Citizen	90.5	87.0	91.4
Non-Citizen with Green Card	6.7	9.4	6.3
Non-Citizen without Green Card	2.9	3.6	2.3
Total	100.0%	100.0%	100.0%
Health Status			
Excellent or Very Good	65.1	60.8	64.0
Good	25.3	27.0	27.4
Fair or Poor	9.7	12.2	8.6
Total	100.0%	100.0%	100.0%
Chronic Conditions			
Currently Has Asthma	8.2	7.6	7.4
Diabetes Prevalence	3.6	4.6	5.0
Heart Disease	2.1	2.8	2.9
High Blood Pressure	13.9	18.0	20.5
Current Smoker	11.6	11.8	11.4
Overweight or Obese	42.7	57.9	60.0
Federal Poverty Level			
Less Than 138% FPL	17.0	10.5	5.9
139%-200% FPL	6.0	8.3	5.7
201%-400% FPL	27.5	26.0	23.9
400%+ FPL	49.4	55.2	64.5
Total	100.0%	100.0%	100.0%
Work Status			
Full-Time	55.9	82.4	93.7
Part-Time	14.2	15.7	5.5
Employed, Not at Work	–	–	–
Unemployed, Looking for Work	7.8	0.9	0.1
Unemployed, Not Looking for Work	21.9	–	0.5
Total	100.0%	100.0%	100.0%
All Working Adults			
Firm Size			
Self-Employed and < 10 Employees	39.9	26.6	–
Not Self-Employed and < 10 Employees	12.7	23.8	–
10-50 Employees	21.9	49.6	–
51-99 Employees	3.0	–	8.1
100-999 Employees	7.4	–	19.7
1,000 or More Employees	15.1	–	72.2
Total	100.0%	100.0%	100.0%

Note: Numbers may not add up to 100% because of rounding. Source: 2011/2012 California Health Interview Survey

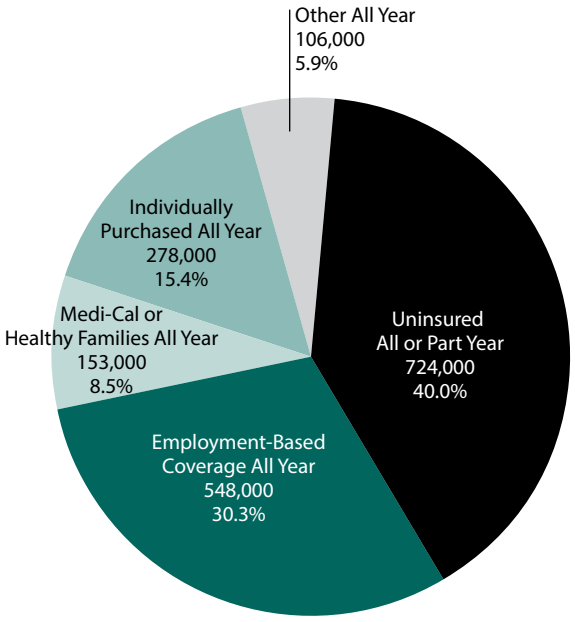
Self-Employed Most Likely to Purchase Coverage in the Individual Market

The United States has one of the lowest rates of self-employment among advanced democracies, and difficulty securing health insurance is an often cited reason.[8]

The self-employed are much more likely to be uninsured than those who work for an employer or own a larger business. In 2012, 1.8 million Californians reported that they were self-employed and worked in a firm with fewer than three employees. Of those, 40% reported that they had been uninsured for all or part of the year, 30% had coverage through an employer, and 15% were covered through the individual market (Exhibit 20). The ACA is likely to impact the number of people who choose to work for themselves or to open small businesses by paying for coverage, affecting the sources of coverage for those groups.

8 John Schmitt and Nathan Lane. *An International Comparison of Small Business Employment*. Center for Economic and Policy Research, 2009. *http://www.cepr.net/documents/publications/small-business-2009-08.pdf*

Exhibit 20.
Health Insurance Coverage During Last 12 Months of Self-Employed Adults in Businesses with Fewer than Three Employees, Ages 19-64, California, 2012



Total Population: 1,809,000

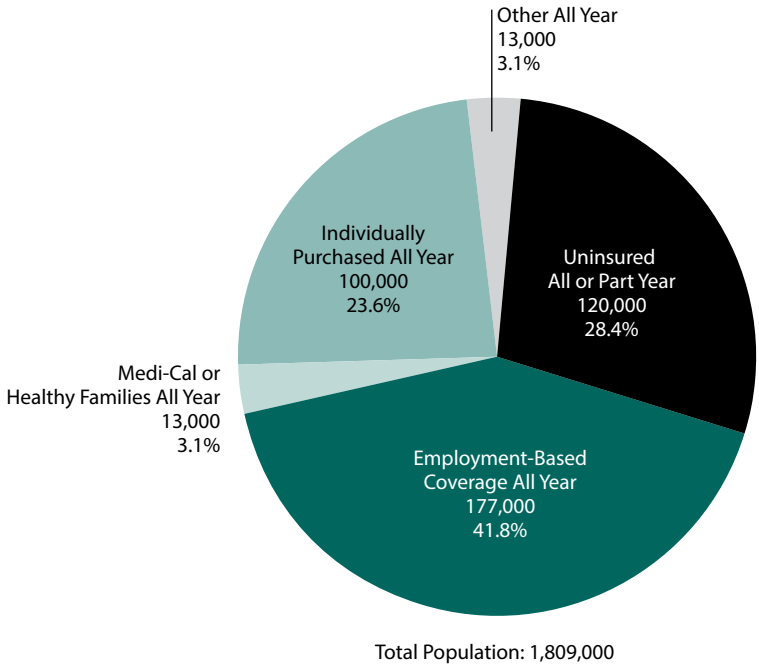
Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

The picture for owners of small businesses with three to nine employees was similar, but with a smaller share going without insurance (28.4%; Exhibit 21) and a larger share purchasing coverage in the individual market (23.6%). Starting in 2014, small businesses have the option of purchasing coverage through the SHOP (Small Business Health Options Program) exchange, while individual workers will be able to purchase coverage through Covered California.

Exhibit 21.
Health Insurance Coverage During Last 12 Months of Self-Employed Adults in Businesses with Three to Nine Employees, Ages 19-64, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Conclusions

There was a marked decline in the share of Californians with employment-based coverage between 2009 and 2012. Coverage rates fell among both full- and part-time workers. The largest declines in own-employer coverage were among Latinos, noncitizens, workers with less than a college education, and workers in families with incomes between 139% and 400% of the FPL. Dependent coverage rose for young adults between the ages of 19 and 25, who can now stay on a parent's plan, but fell for other age groups. The share of Californians under the age of 65 with employer-based coverage varied considerably across the state, with a high of 70.7% in San Mateo County and a low of 26.9% in Lake County.

In 2012, 14.0 million Californians had coverage through an employer. The share of Californians with job-based coverage—either their own or as a dependent—varied significantly by age, race, citizenship status, educational attainment, family income, and firm size. An estimated 35% of Latino workers had coverage through their own employer for a full year in 2012, compared to more than 50% of white, Asian, and African-American workers. Workers who graduated from college were more than twice as likely to have coverage through their work than those without a high school diploma. While 62.7% of workers in families with incomes above 400% of the FPL reported year-round coverage on the job, this was true for only 16.6% of those with incomes below 138% of the FPL.

There is considerable debate over what the eventual impact of the ACA will be on job-based coverage after full implementation. Most analysts anticipate a small net decline in the share of individuals with employment-based coverage as a result of the law.[9] Job-based coverage rates actually rose in Massachusetts following implementation of that state's earlier reforms.[10]

The law affects job-based coverage in several important ways. First, the individual mandate will increase employee demand for coverage. Second, starting in 2015, employers who have 100 or more full-time equivalent workers and who do not make an affordable offer of coverage will face penalties; in 2016, the penalties will apply to firms of 50 or more. The individual and employer mandates could increase take-up rates and result in offers of coverage or expanded eligibility for coverage by firms that would not have done so in the absence of the policy change.

Third, the expansion of Medicaid and the availability of subsidies for low- and middle-income families to purchase coverage through the new marketplaces will create a viable alternative to job-based coverage for a part of the workforce and could lead certain employers to drop coverage. Since the employer penalty only applies to employees working 30 hours or more in larger firms, coverage is most likely to decline for part-time workers and among smaller firms. Some firms may also reduce work hours to avoid the penalty. Finally, new plan standards will raise the cost of coverage for firms that previously offered plans below these standards.

9 Thomas Buchmueller, Colleen Carey, and Helen G. Levy. Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act? *Health Affairs* 32 (9) (2013): 1522-1530.

10 Lisa Dubay, Sharon K. Long, and Emily Lawton. *Will Health Reform Lead to Job Loss? Evidence from Massachusetts Says No*. Urban Institute, 2012.

On the eve of full implementation of the new coverage options in the ACA, the individually purchased market in California remained relatively small, with just 1.7 million individuals under the age of 65 enrolled in nongroup plans. The nongroup market will see the largest changes under the ACA, as the combination of guaranteed issue and community rating along with subsidies to purchase coverage through the new marketplaces is anticipated to significantly expand it.

An estimated 25% of those purchasing coverage in the individual market prior to 2014 were expected to be eligible to receive premium subsidies in California.[11] For those not eligible for subsidies, the impact on price was mixed, depending on age, health status, geography, and the plan in which they had been previously enrolled, among other factors. The demographics of the nongroup market will change as more of the uninsured enroll in coverage. This will in turn affect the risk mix in the pool and the cost of coverage.

The difficulty in obtaining individual coverage is commonly considered to have served as a drag on self-employment and small business creation in the United States. In 2012, 1.8 million workers reported that they were self-employed and worked in firms of fewer than three employees; 15% had purchased coverage through the individual market, while 40% went without coverage. The ACA may influence both the share of workers who are self-employed and whether and how they purchase coverage.

Changes in employer offers and individual decisions of whether, and where, to take up coverage are not likely to take place immediately, but such shifts will occur over time. These changes need to be understood not only in relationship to current rates of employer offer, eligibility, take-up, and coverage, but also as they relate to the existing trend of declining job-based coverage. This chapter provides a baseline from which to measure these changes in the future.

11 *CalSIM Version 1.91 Statewide Data Book 2015-2019*. Available at: *http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/calsimdatabook-may2014.pdf*

3 Transitions in Medi-Cal, Healthy Families, and Medicare

Dylan Roby

The public insurance landscape in California changed considerably in 2011 and 2012, facilitated by the partial implementation of the Affordable Care Act (ACA) and decisions by the state legislature and governor to rely on Medi-Cal managed care plans to administer health care benefits to seniors and persons with disabilities in 16 counties. Further changes were implemented in 2013 with the transition of the Healthy Families population into Medi-Cal, and in 2014 with the implementation of both the ACA's optional Medicaid expansion for childless adults and the Cal Medi-Connect program targeting dually eligible Medicare and Medi-Cal beneficiaries in selected counties. In this section, we focus on the changes in public insurance coverage and characteristics that occurred in 2012, while also looking forward to expected changes related to the ACA and other reforms to the state's health care system.

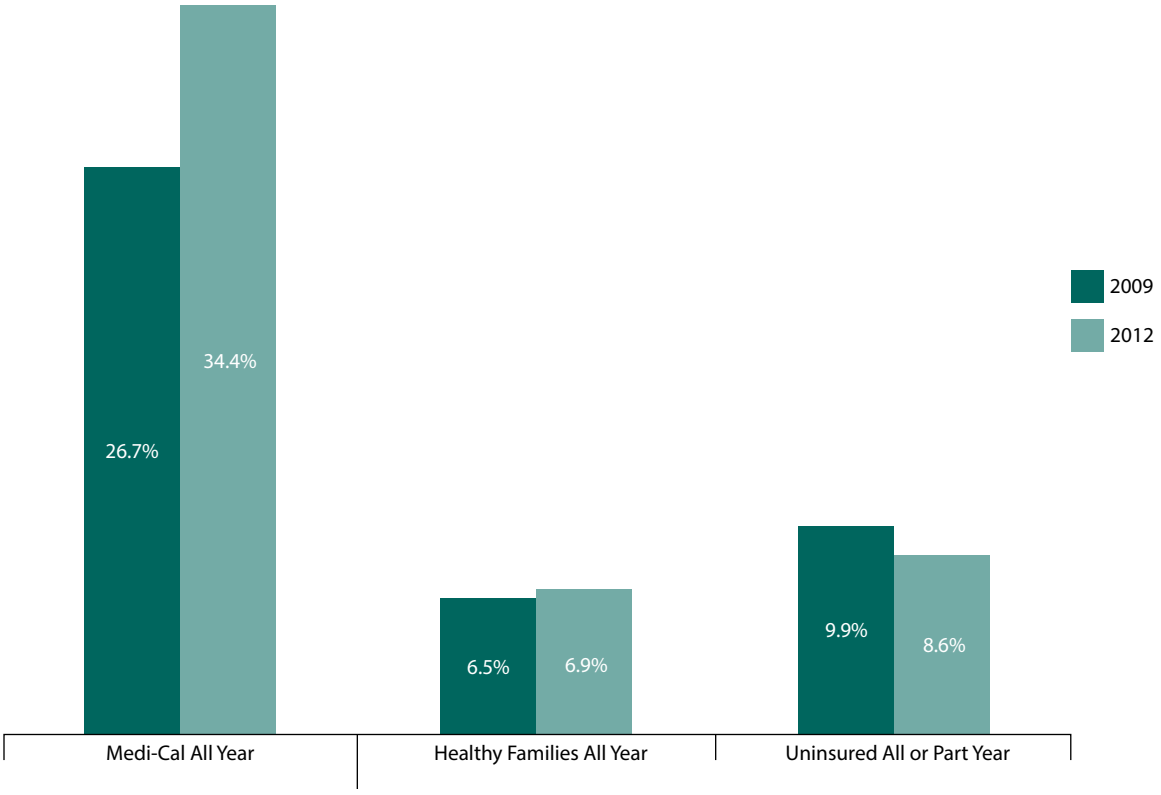
Public insurance coverage is comprised of multiple federal, state, and local programs.[12] In all, these programs insure 12.4 million Californians. Public sources of insurance coverage often have age, citizenship, income, and categorical restrictions on eligibility. For example, Medicare is only available to adults who are 65 or older or to people who are blind or disabled. In 2012, Medi-Cal was a program designed for low-income citizens, lawful permanent-resident children and their caretaker parents, seniors, and persons with disabilities. While these categorical criteria may not act as barriers to Medi-Cal enrollment currently, those policies were in effect in 2012 and influenced whether low-income adults had access to public insurance coverage. While Medi-Cal provides insurance coverage to low-income families and individuals with medical needs or disabilities, Healthy Families is California's Children's Health Insurance Program (CHIP). CHIP programs were implemented to cover children and adolescents ages 0 through 18 whose families earn too much to qualify for Medi-Cal but still cannot afford insurance coverage. People over 18 are not eligible for Healthy Families, regardless of family status. As designed, Healthy Families eligibility covers the gap between Medi-Cal's income threshold for each age group up to 250% of the federal poverty level (FPL). Like Medi-Cal, a portion of the funding for Healthy Families comes from the federal government. The delivery system for Healthy Families is managed-care based, while a significant portion of Medi-Cal during 2012 was delivered in a fee-for-service environment. As with Medi-Cal, there is diversity among the children participating in Healthy Families in terms of race/ethnicity, language, and other characteristics. This is important information for managed care plans that provide services to Healthy Families beneficiaries, and it is also important for understanding the impact of the transition of Healthy Families beneficiaries into Medi-Cal managed care plans in 2013.

12 Other Public Coverage is defined as Medicare Only, Medicare and Medicaid, Medicare and Employer-Based insurance, Medicaid only, CHIP/Healthy Families, VA, TriCare, and Other Public sources of insurance for Californians of all ages.

The Employment Situation Improved, but the Burden on Public Programs Continued

Despite the recent economic recovery in California, the rate of employment-based insurance coverage continued to decline between 2009 and 2012, from 52.1% to 49.1% of the nonelderly population. The fact that unemployment declined during the same period indicates that the majority of Californians could not rely on employers to provide insurance benefits, resulting in a reliance on public programs such as Medi-Cal, Healthy Families, and other government programs to provide coverage and protect individuals and families from unforeseen health care costs. In 2012, the Medi-Cal rules were still based on categorical and income-related eligibility, making children with household incomes up to 250% of the federal poverty level (FPL) likely to qualify for Medi-Cal or Healthy Families. 34.4% of children were enrolled in Medi-Cal for the entire year, compared to 26.7% in 2009 (Exhibit 22). The percentage of children who were uninsured for all or part of the year fell by 15% between 2009 and 2012, from 9.9% to 8.6%. Given the high income eligibility limit for children in Medi-Cal and Healthy Families, it is still troubling that almost 9% of children remained uninsured in California in 2012. The reasons for this could include lack of information, churning in and out of coverage due to income changes or paperwork barriers, or immigration status.

Exhibit 22.
Percent of Children in Medi-Cal or Healthy Families or Who Were Uninsured All or Part Year, Ages 0-18, California, 2009 and 2012



Notes: "Medi-Cal" is comprised of Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other, and Medi-Cal and Healthy Families All Year.

Differences are not significant at the 95% confidence level.

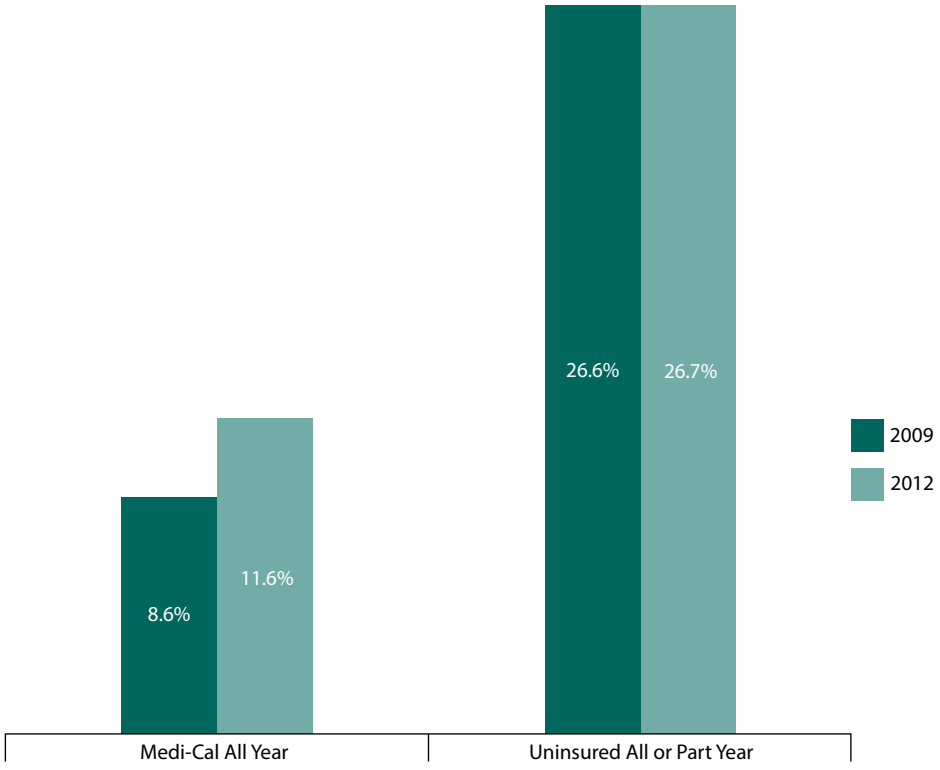
Sources: 2009 and 2011/2012 California Health Interview Surveys

Medi-Cal and Healthy Families continued to grow in importance for children, offsetting the decline in employer-based insurance. While adult parents and childless adults do not qualify for Healthy Families, Medi-Cal eligibility in 2012 allowed for enrollment of low-income parents (earning up to 106% FPL). The percentage of Medi-Cal enrolled adults increased in 2012 (Exhibit 23). However, the rate of adults who were uninsured all or part year had not changed since 2009, with adults being three times more likely than children to be uninsured all or part of the year.

Medi-Cal Coverage Is Concentrated in Certain Areas of the State

Medi-Cal and Healthy Families enrollment prior to 2014 was multifaceted due to the categorical, income, and age-based eligibility rules. The most rural areas of the state, including the Central Valley, Northern Sierras, and Imperial County, had the highest proportions of nonelderly people in Medi-Cal or Healthy Families, with more than 27% of the nonelderly population enrolled all year (Exhibit 24). Coastal areas had lower levels of enrollment, with San Luis Obispo and Orange counties and the Bay Area having the lowest rates (less than 15% of the nonelderly population). Due to the categorical nature of Medi-Cal and Healthy Families eligibility, the areas with proportionately higher enrollment in the state are likely to have more children and low-income parents. In addition, counties with significant levels of undocumented immigrants may have lower Medi-Cal and Healthy Families participation because legal residence is required for children and parents to fully enroll in the two programs.

Exhibit 23.
Percent of Adults with Medi-Cal Coverage All Year or Uninsured All or Part Year, Ages 19-64, California, 2009 and 2012

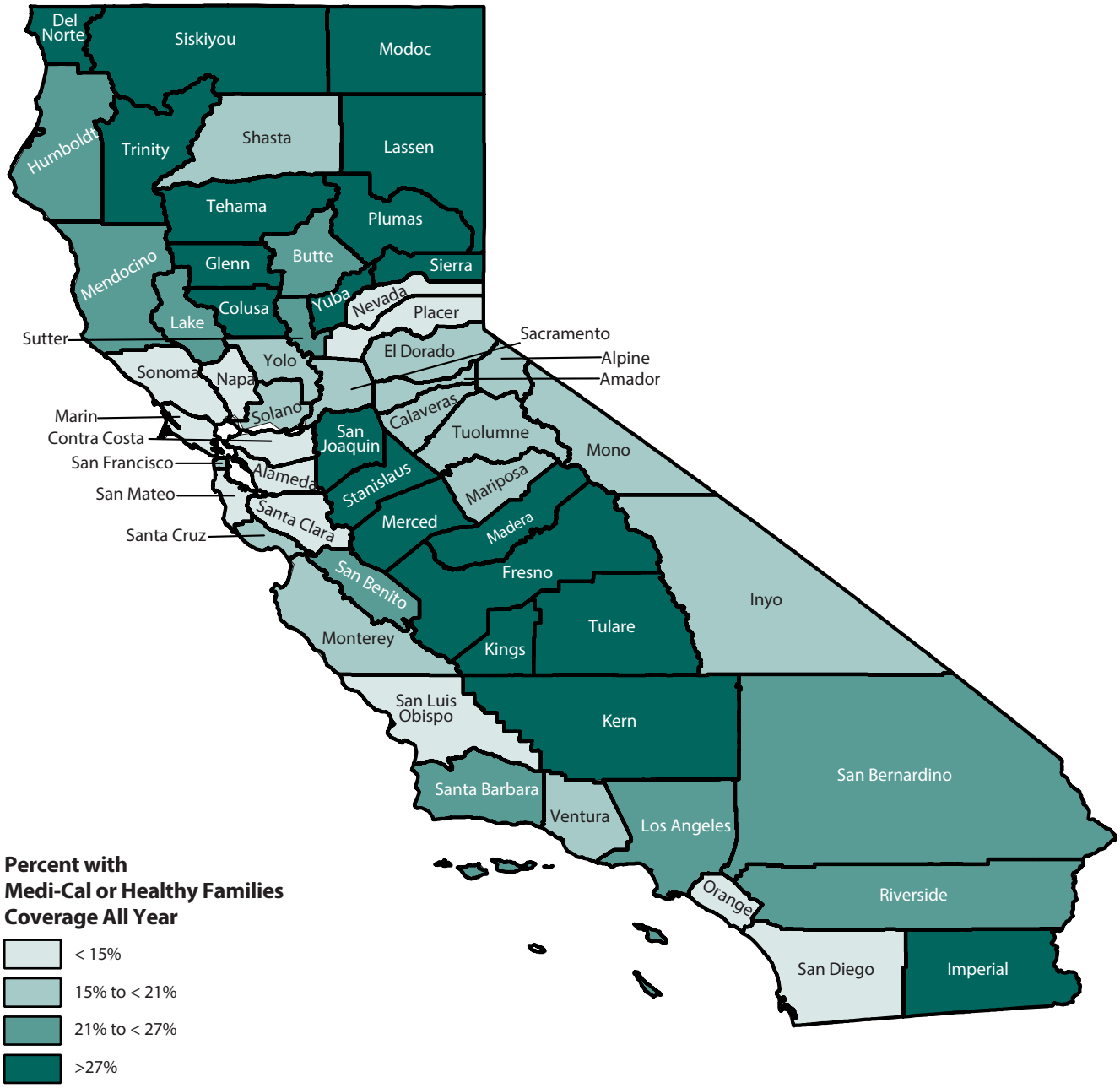


Notes: "Medi-Cal" is comprised of Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other, and Medi-Cal and Healthy Families All Year.

Differences are not significant at the 95% confidence level.

Sources: 2009 and 2011/2012 California Health Interview Surveys

Exhibit 24.
Percent of Adults with Medi-Cal Coverage All Year or Uninsured All or Part Year, Ages 19-64, California, 2009 and 2012



Note: Differences in rates between counties may not be statistically significant.

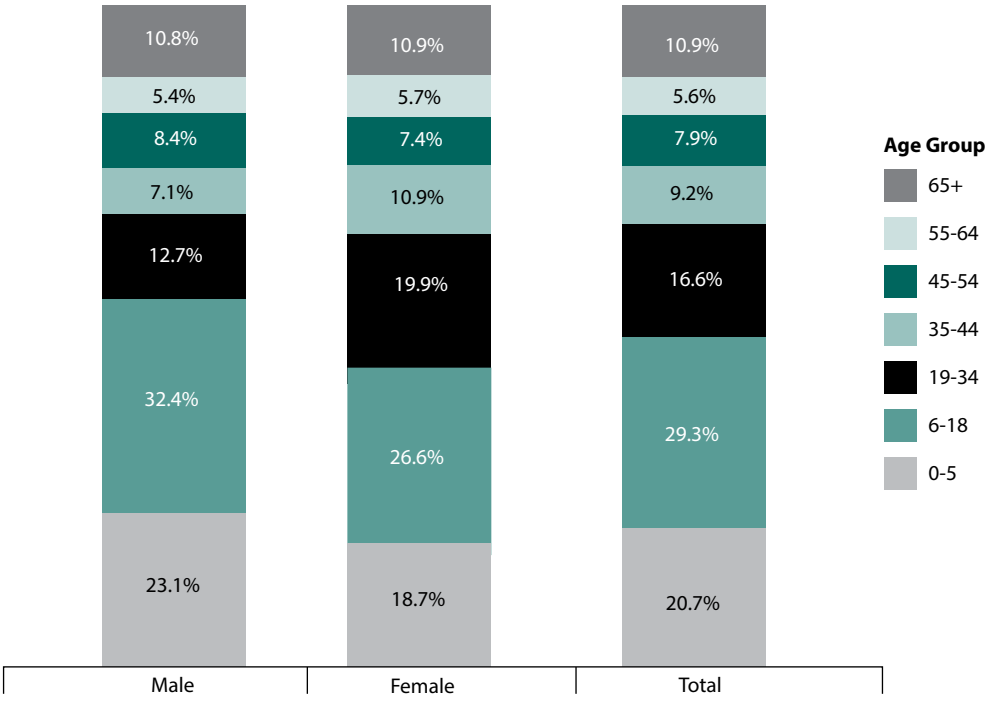
Source: 2011/2012 California Health Interview Survey

Characteristics of Medi-Cal Beneficiaries

Children ages 0-18 represented half of all Medi-Cal beneficiaries across the state, which is likely to change in future years. In 2013, the Healthy Families transition to Medi-Cal resulted in more children entering the program. However, in 2014, a substantial number of adults entered via the Medi-Cal expansion funded by the ACA. The 19-64 population represented more than 60% of Californians, but only 39.3% of the Medi-Cal beneficiary population (Exhibit 25). In addition, because people over the age of 65 are very likely to have either Medicare or Medi-Cal or to be dually enrolled in both, it is apparent that those in the childless adult population between the ages of 35 and 64 are not only most at risk of being uninsured, but they are also the least likely group to qualify for Medi-Cal coverage. This is expected to change in 2014, as mentioned in chapter 1, due to California's expansion of Medi-Cal to individuals earning up to 138% of FPL.

The majority of Medi-Cal beneficiaries in 2012 were female (54.8%). Several differences appear when gender is compared to age for Medi-Cal beneficiaries. While male children ages 0 to 5 (23.1%) and 6 to 18 (32.4%) made up a larger portion of the overall male Medi-Cal enrolled population than their female counterparts (18.7% ages 0 to 5, and 26.6% ages 6 to 18), females made up a larger share of Medi-Cal enrollment than males when comparing adult age groups. For example, among those ages 19 to 34, the number of female Medi-Cal enrollees was 57% higher than the number of male enrollees in the same age group, due mainly to the requirement of being a custodial parent in order to be eligible for coverage.

Exhibit 25.
Medi-Cal Beneficiaries During Last 12 Months by Gender and Age, All Ages, California, 2012



Notes: "Medi-Cal Beneficiaries" are individuals who have Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other All Year, Medi-Cal and Healthy Families All Year, Medicare + Medi-Cal + Employer-Paid All Year and Medicare + Medi-Cal All Year.

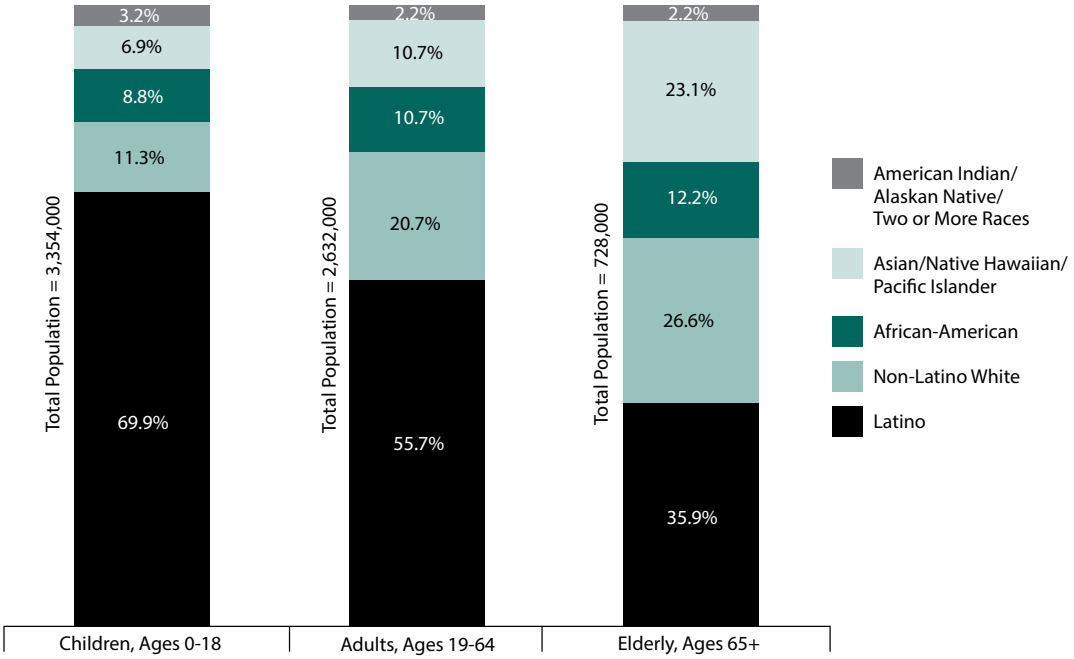
Numbers may not add to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

The population of Medi-Cal beneficiaries in California is quite diverse, with Latinos making up more than two-thirds of the children enrolled in the program in 2012, and other non-white minorities representing 18.9% of beneficiaries (Exhibit 26). However, the adult population had a much higher proportion of non-Latino whites (20.7% ages 19-64 and 26.6% ages 65 and over). Showing the demographic shift occurring in California, Latinos made up more than half of all nonelderly Medi-Cal beneficiaries, but 35.9% of the elderly Medi-Cal beneficiary population. Interestingly, 23.1% of elderly adult Medi-Cal beneficiaries were Asian or Pacific Islander —more than twice the percentage of Asian/PI in the nonelderly adult population, and three times the percentage in the child population.

Language diversity is a well-known characteristic of California's population as a whole, and this is no different in the Medi-Cal program. Due to the high Latino enrollment in Medi-Cal, a substantial percentage of the beneficiary population spoke Spanish (59% of children and 47.3% of nonelderly adults). The majority of Spanish speakers reported a lack of English proficiency, but the vast majority (64.1%) of Medi-Cal beneficiaries spoke English (Exhibit 26). The highest rate of English proficiency was in the elderly population enrolled in Medi-Cal.

Exhibit 26.
Medi-Cal Beneficiaries by Race/Ethnicity, All Ages, California, 2012



Notes: "Medi-Cal Beneficiaries" are individuals who have Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other All Year, Medi-Cal and Healthy Families All Year, Medicare + Medi-Cal + Employer-Paid All Year, and Medicare + Medi-Cal All Year.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Exhibit 27.

Languages Spoken Among Medi-Cal Beneficiaries, All Ages, California, 2012

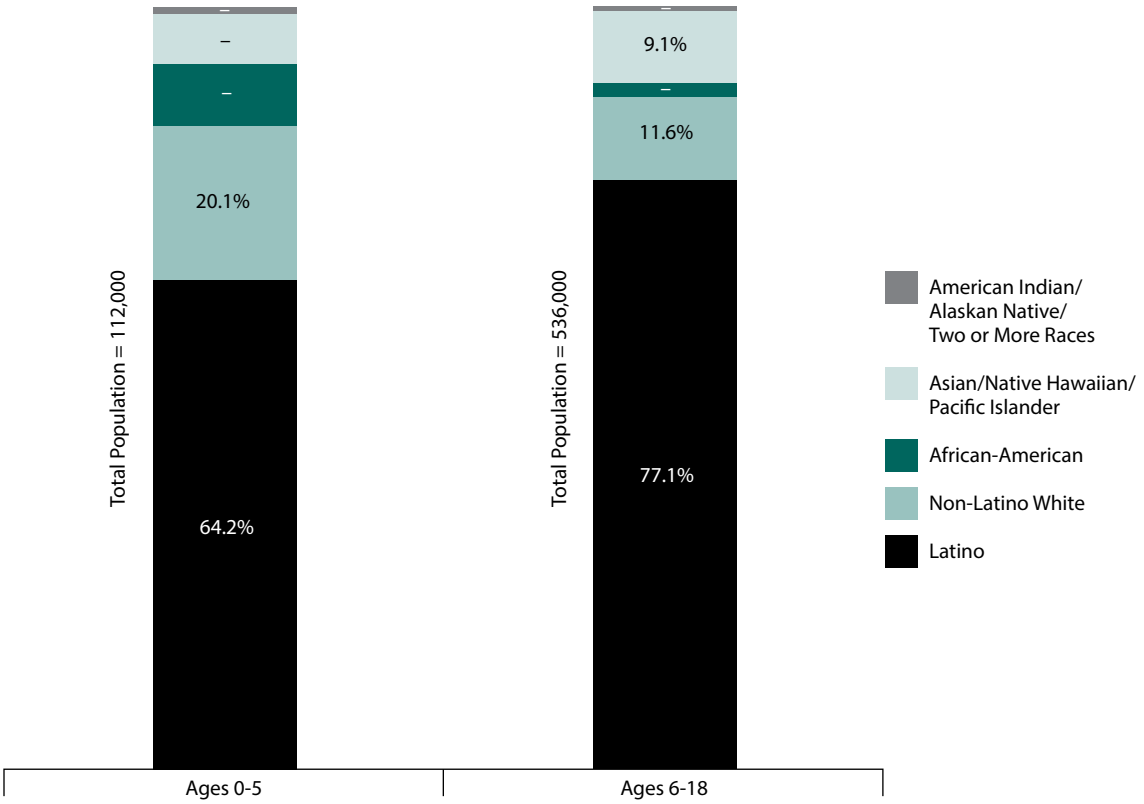
	Children 0-18	Adults 19-64	Elders 65+	Total Population
English Speaking	32.2%	39.6%	41.2%	2,418,000
Spanish Speaking - English Proficient	23.2%	21.9%	10.9%	1,431,000
Spanish Speaking - Not English Proficient	35.8%	25.4%	21.6%	2,023,000
Asian Language - English Proficient	3.0%	4.1%	3.7%	236,000
Asian Language - Not English Proficient	2.6%	4.0%	16.3%	309,000
Other Language - English Proficient	2.7%	3.5%	3.6%	210,000
Other Language - Not English Proficient	0.5%	1.5%	2.7%	74,000
Total Percent	**100.0%**	**100.0%**	**100.0%**	**-**
Total Population	**3,340,000**	**2,632,000**	**729,000**	**6,701,000**

Note: "Medi-Cal" coverage for children and adults is comprised of Medi-Cal only, Medi-Cal and Employment-Based Insurance, Medi-Cal and Other, and Medi-Cal and Healthy Families. "Medi-Cal" coverage for the elderly is comprised of Medicare and Medi-Cal and Employer-Paid All Year, and Medicare and Medi-Cal All Year. "Spanish Speaking" includes: Spanish Only, and English and Spanish. "Asian Language" includes: Chinese, Vietnamese, Korean, Other Asian Language, English and Chinese, and English and Another Asian Language. "Other Language" includes: Other Non-Asian Language, English and European Language, English and One Other Language, and Other Languages. Children's type of language is identified by the parent (ages 0-11); teens report for themselves (ages 12-17).

Source: 2011/2012 California Health Interview Survey

Exhibit 28.

Children with Healthy Families by Race/Ethnicity, Ages 0-18, California, 2012



Notes: "Healthy Families" is comprised of Healthy Families Only All Year, Healthy Families and Employment-Based Insurance All Year, and Healthy Families and Other All Year.

Numbers may not add up to 100% because of rounding.

– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2011/2012 California Health Interview Survey

Characteristics of Healthy Families Beneficiaries

Similar to the Medi-Cal enrollees ages 0-18, Healthy Families enrollees in 2012 were also largely Latino—64.2% between the ages of 0 and 5, and 77.1% ages 6 to 18 (Exhibit 28). Non-Latino whites were the next largest group, representing less than one-fifth of Healthy Families enrollees. Among the largely Latino Healthy Families enrollees ages 6 to 18, the rate of English proficiency was also fairly low. Only 54.7% of Healthy Families enrollees ages 6 to 18 were English proficient, in contrast with 73.2% of children ages 0 to 5 from English-only households (Exhibit 29).

Exhibit 29.
Languages Spoken Among Healthy Families Children, Ages 0-18, California, 2012

	Ages 0-5	Ages 6-18	Total Population
English Only	32.9%	18.7%	136,000
Spanish Speaking - English Proficient	29.7%	27.9%	181,000
Spanish Speaking - Not English Proficient	22.7%	41.3%	245,000
Asian Language - English Proficient	2.1%	5.2%	30,000
Asian Language - Not English Proficient	4.2%	3.5%	24,000
Other Language - English Proficient	8.5%	2.9%	25,000
Other Language - Not English Proficient	-	0.3%	2,000
Total Percent	100.0%	100.0%	–
Total Population	163,000	471,000	643,000

Notes: "Healthy Families" is comprised of Healthy Families Only All Year, Healthy Families and Employment-Based Insurance All Year, and Healthy Families and Other All Year.

Numbers may not add up to 100% because of rounding.

– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2011/2012 California Health Interview Survey

The Remaining Uninsured Prior to the ACA: Why Didn't People Enroll?

Despite the passage of the Affordable Care Act in 2010, the Medi-Cal expansion and creation of Covered California (the state Health Benefit Exchange) had not yet occurred in 2012. Restricted eligibility criteria for Medi-Cal and Healthy Families can certainly serve as a barrier for childless adults or higher-income parents who cannot qualify for either program. However, it is important to understand the reasons why those eligible for Medi-Cal or Healthy Families in 2012 did not enroll. Among those adults and children who were eligible for Medi-Cal, more than one-quarter reported that they did not know about the program. Almost 11% reported being ineligible due to citizenship status; 5.4% already had existing insurance coverage; and 10.3% did not want to sign up despite their eligibility, not wanting the coverage due to perception (Exhibit 30). The reasons were substantially different among those children who did not enroll in Healthy Families, despite being eligible. Only 11.2% of children had parents that did not know about the program, while 11.5% reported ineligibility due to citizenship status, and 14.2% already had other coverage. In 2014, the clearer eligibility guidelines and "no-wrong-door" eligibility called for by the ACA is expected to have removed some of the barriers around income, knowledge of the program, and paperwork. It appears that response to the Medi-Cal expansion has been high during the first open enrollment period for Covered California. However, there are still problems to be dealt with both in the state and nationally with regard to redeterminations of eligibility, data systems, and knowledge of the program. It is still likely that a portion of Medi-Cal eligibles will continue to be uninsured, despite the individual mandate, Medi-Cal expansion, and the creation of Covered California.

Exhibit 30.
Reasons for Not Having Medi-Cal or Healthy Families Among Those Who Were Eligible, Ages 0-64, California, 2012

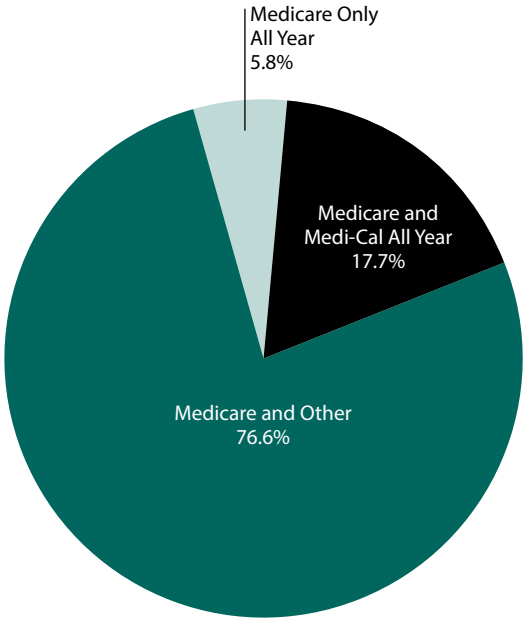
	Medi-Cal All Year	Healthy Families All Year
Didn't Know If Eligible/It Existed	25.8%	11.2%
Other, Not Eligible	20.5%	20.8%
Ineligible Due to Income	15.2%	21.6%
Ineligible Due to Citizenship/Immigration Status	10.6%	11.5%
Do Not Believe In or Didn't Like or Want Welfare	10.3%	4.2%
Has Not Applied/Doesn't Know How to Apply	7.1%	5.7%
Already Has Insurance/Thought Was Insured	5.4%	14.2%
Paperwork Too Difficult	2.9%	5.6%
Too Expensive	2.2%	5.0%

Source: 2011/2012 California Health Interview Survey

Medicare's Contribution to Insuring Californians

In addition to Medi-Cal and Healthy Families, the other major public program that provides coverage to Californians is Medicare. Medicare is designed for the elderly (ages 65 and over), but it also covers individuals with federally recognized disabilities. As described in the previous section, low-income Medicare beneficiaries may also qualify and enroll in Medi-Cal so that they are covered by both programs ("dual-eligible"). Similarly, retirees and current members of the workforce may also carry dual coverage with Medicare and their existing employment-based policy. Except in certain circumstances, Medicare acts as the primary payer in using and paying for health services when an individual has both Medicare and another source of coverage. More than 4 million elderly Californians had some Medicare coverage in 2012 (94.7%), often combined with supplemental coverage offered by private insurers, employers, or Medi-Cal. Almost 6% of Medicare beneficiaries did not have additional coverage and instead relied on Medicare for all of their health care needs, making them more financially vulnerable to out-of-pocket costs. 17.7% were dually eligible and were enrolled in both Medicare and Medi-Cal. More than three-quarters were covered by both Medicare and another private source of coverage (Exhibit 31).

Exhibit 31.
Medicare Coverage During Last 12 Months and Additional Insurance Coverage Among Elderly Adults, Ages 65 and Older, California, 2012



Notes: "Medicare and Medi-Cal All Year" is comprised of Medicare + Medi-Cal + Employer-Paid All Year and Medicare + Medi-Cal All Year. "Medicare and Other" is comprised of Medicare + Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

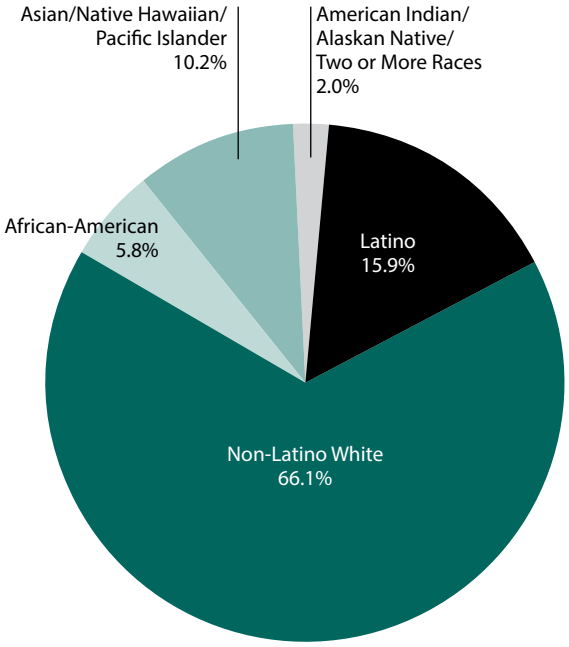
Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Characteristics of Medicare Beneficiaries

Unlike the situation with Medi-Cal, the elderly demographic and the nature of Medicare as a social insurance, non-means-tested program indicate that the majority of beneficiaries were non-Latino whites. Almost two-thirds of the Medicare beneficiary population ages 65 and over were non-Latino white, with only 15.9% Latino, 10.2% Asian/PI, and 5.8% African-American (Exhibit 32). As the near-elderly population ages and demographic shifts occur throughout the next decade, it is likely that Latinos will become a larger part of the Medicare population. However, it is unlikely that Latino enrollment in Medicare will mirror the enrollment in Medi-Cal. Data showed the Medicare beneficiary population to be less diverse than the Medi-Cal population—73.4% of Medicare beneficiaries spoke English only, and only 6.7% spoke Spanish and reported not being English proficient (Exhibit 33).

Exhibit 32.
Race and Ethnicity of Medicare Beneficiaries, Ages 65 and Older, California, 2012



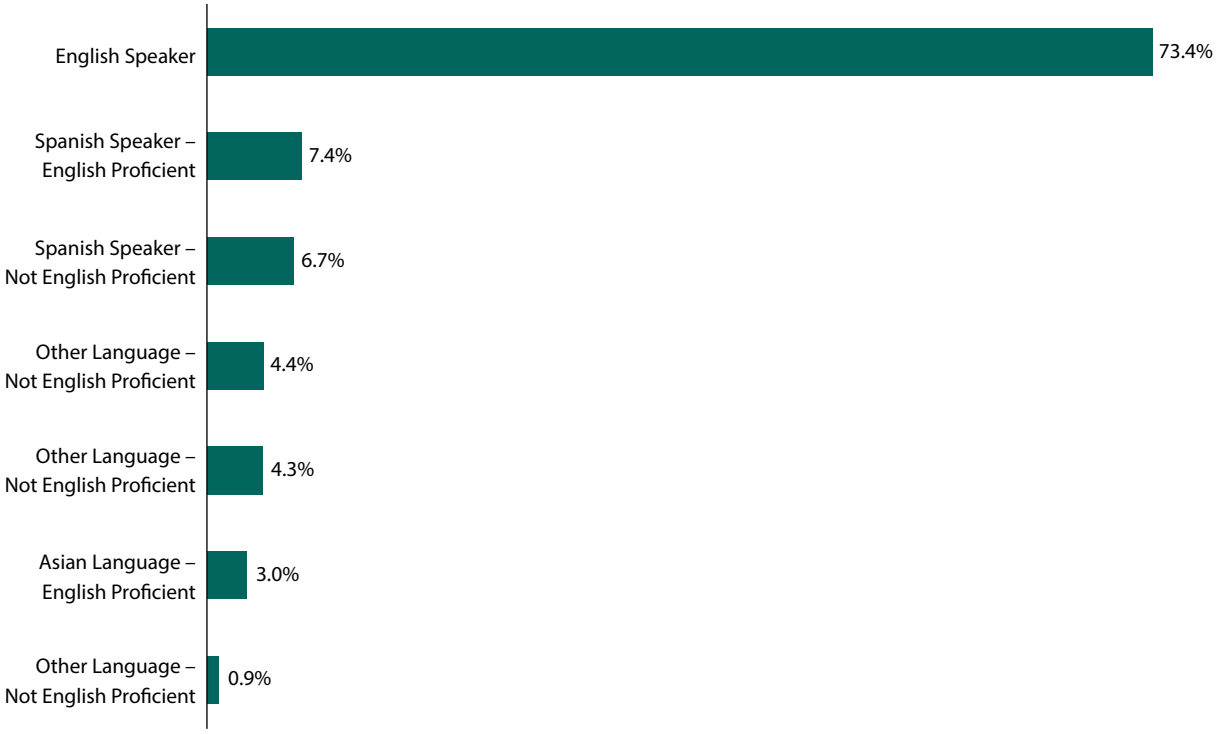
Notes: Medicare is comprised of Medicare Only All Year, Medicare and Medi-Cal and Employer-Paid All Year, Medicare and Medi-Cal All Year, and Medicare and Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

Numbers may not add to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

Exhibit 33.

Languages Spoken and English Proficiency of Medicare Beneficiaries, Ages 65 and Older, California, 2012



Notes: Medicare is comprised of Medicare Only All Year, Medicare and Medi-Cal and Employer-Paid All Year, Medicare and Medi-Cal All Year, and Medicare and Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

"Spanish Speaking" includes: Spanish Only, and English and Spanish. "Asian Language" includes: Chinese, Vietnamese, Korean, Other Asian Language, English and Chinese, and English and Another Asian Language. "Other Language" includes: Other Non-Asian Language, English and European Language, English and One Other Language, and Other Languages.

Numbers may not add to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

Health Needs and Characteristics of the Medicare Beneficiary Population

There are far fewer elderly individuals in California who remain uninsured when compared to the non-elderly population, because Medicare acts as primary coverage for millions of people in the state. However, those in the elderly population who are covered by Medicare are also more likely to report being in fair or poor health status or having a chronic illness. In addition, differences exist in health status, chronic illness, usual source of care, delays, and ER use among the elderly, even among those who are enrolled in Medicare. More than half (50.3%) of dually eligible Medicare/Medi-Cal beneficiaries reported fair or poor health status, in contrast to the 22.1% with Medicare and other private insurance or the 23.4% who had Medicare only (Exhibit 34). Although the rate of diabetes was 7 to 10 percentage points higher among the dually eligible population, the rate of chronic illness for Medicare beneficiaries was comparable across all three groups. It seems that the self-reported fair and poor health status for the dual-eligible population was not necessarily linked to the overall chronic illness burden in the population, but generally to poor health and disability, coupled with lower incomes.

The highest rates of having no usual source of care (9.2%), facing delays in obtaining prescription drugs (9.7%), and needing to use the ER (29.1%) in the past 12 months were found in the dual-eligible population, which makes sense, given their perceived health status and chronic illness burden. However, the fact that people with Medicare Only (who did not have secondary employer-based or Medigap coverage) faced significant delays in getting medications (9.1%), needed to use the ER (25.7%), and lacked a usual source of care (7.5%) may be indicative of problems with access and affordability in Medicare, given the high costs of deductibles, coinsurance, and lack of out-of-pocket spending caps.

Exhibit 34.

Health Care Needs and Status of All Publicly Insured Elderly Adults, Ages 65 and Older, California, 2012

	Medicare	Medicare and Medi-Cal	Medicare and Other
Health Status			
Excellent or Very Good	39.8%	23.2%	47.5%
Good	36.8%	26.5%	30.4%
Fair or Poor	23.4%	50.3%	22.1%
Total	100.0%	100.0%	100.0%
Chronic Conditions			
Asthma	5.4%	9.5%	8.4%
Heart Disease	22.1%	20.8%	21.7%
High Blood Pressure	67.0%	66.8%	60.3%
Diabetes	20.2%	27.7%	17.3%
Usual Source of Care			
Doctor's Office/HMO/Kaiser	70.3%	71.8%	86.8%
Community or Hospital Clinic	20.7%	18.4%	9.7%
Emergency Room/Urgent Care	-	-	-
Other Place/No One Place	-	-	0.5%
No Usual Source of Care	7.5%	9.2%	2.8%
Delays in Health Care			
Had Delay in Getting Any Care	6.0%	6.2%	6.0%
Had Delay in Getting Medicine	9.1%	9.7%	7.9%
Emergency Room Visits			
At Least One ER Visit in the Past 12 Months	25.7%	29.1%	23.4%

Notes: "Medicare and Medi-Cal All Year" is comprised of Medicare + Medi-Cal + Employer-Paid All Year and Medicare + Medi-Cal All Year. "Medicare and Other" is comprised of Medicare + Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

Numbers may not add to 100% due to rounding.

– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2011/2012 California Health Interview Survey

Conclusions

As the reliance on public programs grows, those same programs face barriers in providing care to their beneficiaries due to payment reductions, higher out-of-pocket costs, and the greater cost of health care in general.

Many changes nationally and statewide will alter the landscape in public coverage, to be noted in the next SHIC report. Starting in January of 2013, the Healthy Families program was transitioned to Medi-Cal, so that children ages 0-18 with family incomes up to 250% FPL were moved into Medi-Cal managed care products or fee-for-service in rural counties. Then, in January of 2014, Medi-Cal expanded to the childless adult population earning up to 138% FPL (and parents earning 106% to 138% FPL), and all full-scope Medi-Cal beneficiaries were concurrently transitioned into managed care in all counties. The number of enrollees in Medi-Cal will surge due to both changes, and the impact of Medi-Cal provider networks, reimbursement, and benefits will be important to monitor.

Public coverage from Medi-Cal, Healthy Families, and Medicare covers a large proportion of Californians, with more than 12 million relying on these state and federal programs to care for their health needs. It is evident that the populations enrolled in Medicare, Medi-Cal, and Healthy Families are some of the more vulnerable groups within the state: children and mothers from low-income families, the elderly and disabled, and children whose parents cannot afford coverage on their own.

The burden on public programs, especially Medi-Cal and Healthy Families, initially increased due to the recession of 2008 and the stagnant employment market that has decreased the number of full-time, commercially insured workers. However, even as the unemployment rate has declined, it still appears that job-based health coverage for dependents and parents has not improved as hoped. The state received additional funding to operate these programs via federal stimulus dollars, but that money is no longer available to support the program as the economy recovers. The ACA's Medicaid expansion will pay for the full cost of the Medi-Cal expansion from 2014 to 2016, and it will continue to contribute at least 90% in 2020 and beyond. However, the existing Medi-Cal enrollee population will continue to receive only a partial match from the federal government.

These programs will be bolstered by new investment in 2014 and beyond, with the ACA extending the life of Medicare through payroll tax increases for higher-income workers and providing more support for states to operate both Medicaid and their Children's Health Insurance Programs. As Medi-Cal becomes a larger source of public coverage, there are opportunities and risks. The strengthening of Medi-Cal via additional matching funds, the addition of newly insured individuals in 2014, and coordination through private managed care plans should alleviate pressure from other parts of the safety net, including public hospitals and community health centers that provide the bulk of care for the uninsured and low-income populations. However, there are risks related to provider reimbursement, capacity, and sustainability in the face of federal budget pressures that could undermine this investment in public programs by the ACA.

4 The Role of Insurance in Access to Care

Nadereh Pourat

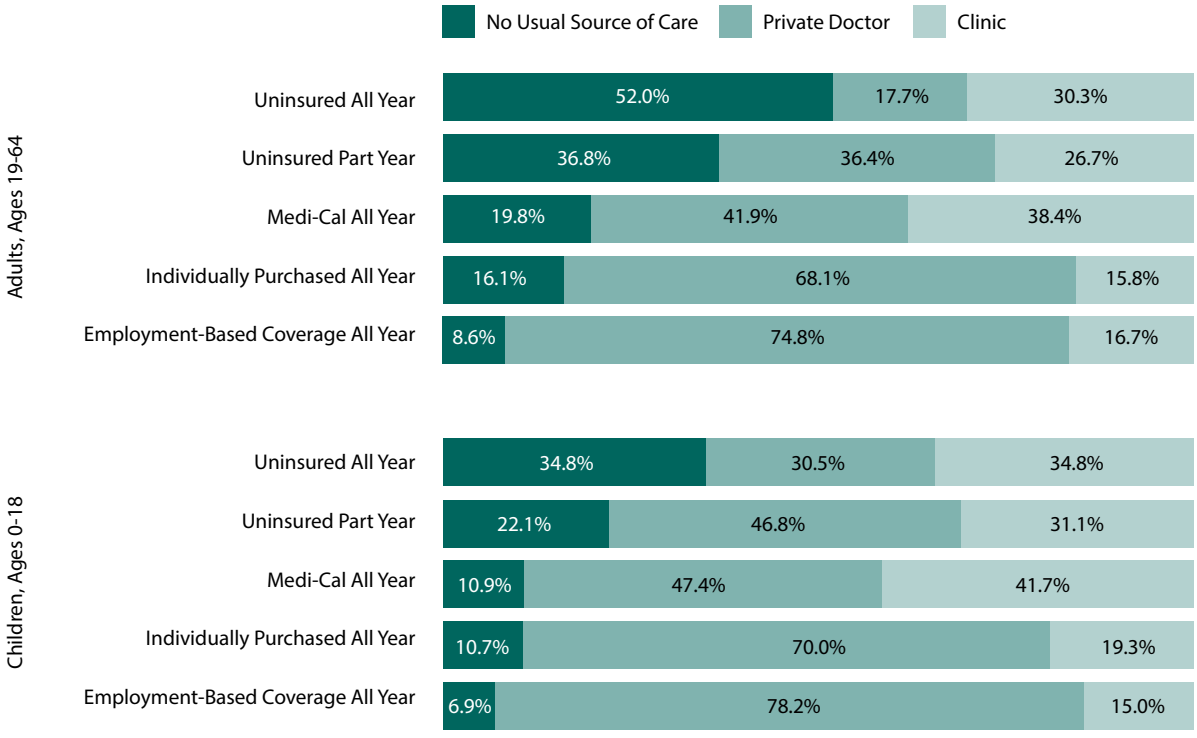
Health insurance is a significant determinant of access to care because it reduces financial barriers to the use of essential health care services, including primary care and emergency services. Individuals with health insurance coverage have better access to primary care providers who serve as the first point of contact with the health care system, manage the patient's preventive and chronic health care needs, and coordinate patient care with specialists and other providers. Individuals with health insurance coverage are also empowered to use health care as needed, and they have more options in their choice of providers. Access to care varies by type of insurance due to variations in benefits and cost-sharing levels, although some of the challenges resulting from these variations will be addressed by provisions of the Patient Protection and Affordable Care Act (ACA) that took effect in January 2014.

Health Insurance Improves Access to Primary Care Providers

Insurance allows individuals to establish relationships with primary care providers who are the first point of contact when care is needed and who improve continuity of care. According to data from the 2011-2012 California Health Interview Survey (CHIS), insurance type continues to be associated with having a usual source of care and with the setting in which the usual provider operates. Among adults, those who were uninsured all year (52%) were most likely to be without a usual source of care, and those with employment-based coverage all year (8.6%) were least likely to be without a usual source of care (Exhibit 35). Individuals with employment-based coverage more frequently reported using office-based private doctors for their usual source of care (74.8%) than did those with individually purchased all-year coverage (68.1%).

In contrast, adults with Medi-Cal all year most frequently reported a clinic as their usual source of care (38.4%; Exhibit 35). In addition, many individuals who were uninsured all or part of the year also reported using clinics as their main usual source of care (30.3% and 26.7%, respectively). The role of insurance coverage in having a usual source of care and the setting of the providers was similar among children and adults, with one notable difference: among those who were uninsured all year, a smaller proportion of children than adults reported no usual source of care (34.8% and 52%, respectively; Exhibit 35).

Exhibit 35.
Health Insurance Coverage During Last 12 Months by Usual Source of Care Among Nonelderly Adults and Children, Ages 0-64, California, 2012



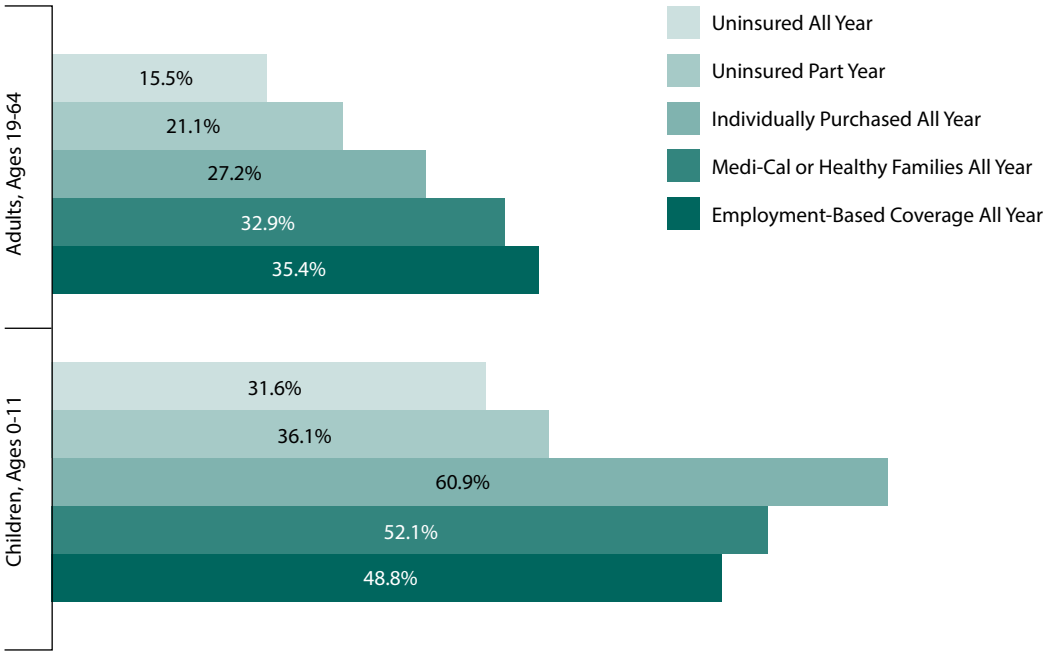
Note: Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Health Insurance Improves Receipt of Preventive, Primary, and Urgent Care

Health insurance is associated with important preventive services, such as flu shots. The rates of flu shots were generally higher among children ages 0-11 than adults (Exhibit 36). Among children, those with employment-based coverage all year (48.8%), individually purchased coverage all year (60.9%), and Medi-Cal all year (52.1%) had the highest rates of flu shots, while those uninsured all year (31.6%) or part year (36.1%) had the lowest rates. A similar pattern was observed among adults: the insured were more likely to receive flu shots than the uninsured. However, adults with individually purchased insurance all year (27.2%) were less likely than adults with employment-based coverage all year (35.4%) or Medi-Cal all year (32.9%) to have received a flu shot.

Exhibit 36.
Flu Shot Rates by Health Insurance Coverage During Last 12 Months Among Nonelderly Adults, Ages 19-64, and Children, Ages 0-11, California, 2012

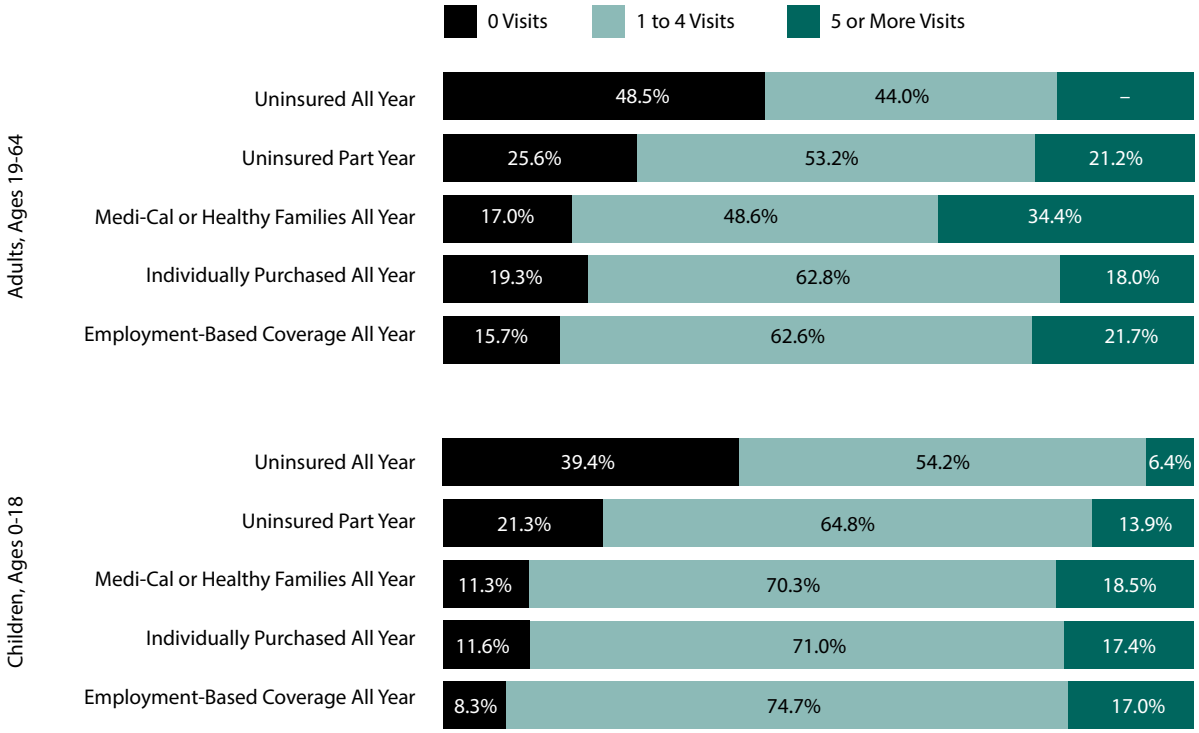


Note: Data for ages 12-17 were not available in CHIS 2011/2012.

Source: 2011/2012 California Health Interview Survey

Health insurance is also associated with a higher likelihood of outpatient visits. Among adults, those uninsured all year (48.5%) were most likely to have had no doctor visits, while adults with employment-based coverage were least likely to have had no doctor visits (15.7%; Exhibit 37). Among adults with any doctor visits, those with employment-based and individually purchased coverage (62.8%) were most likely to have had between one and four visits. The patterns of visits given the type of insurance coverage were similar among children and adults, although the overall proportions without any doctor visits were lower among children than adults.

Exhibit 37.
Health Insurance Coverage During Last 12 Months by Number of Doctor Visits Among Nonelderly Persons, Ages 0-64, California, 2012



-Unstable estimate due to coefficient of variation greater than 30%.

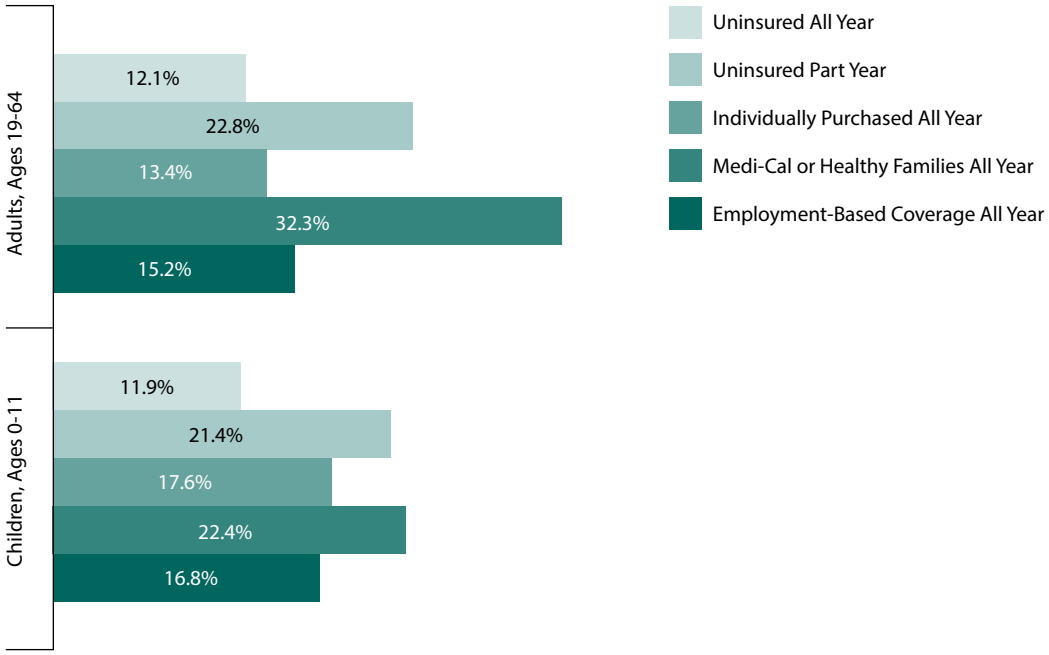
Numbers may not add up to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

Insurance coverage is associated with higher rates of emergency room (ER) use in the past year. Among adults, the rates of emergency room visits were lowest for those uninsured all year (12.1%), and highest for those with Medi-Cal or Healthy Families (32.3%; Exhibit 38), suggesting difficulty in accessing a doctor's office for regular care. ER visit rates were similar among adults with employment-based insurance (15.2%) and individually purchased insurance (13.4%). Adults who were uninsured for part of the year (22.8%) had even higher rates than those with employment-based insurance or individually purchased insurance. It is not clear why those who were uninsured part of the year had the highest rate of ER visits, but the reasons might include loss of coverage due to illness or poor health status.

The patterns of ER visits were similar for adults and children. Among children, ER visit rates were lowest among those uninsured all year (11.9%; Exhibit 38), higher for those with employment-based and individually purchased coverage (16.8% and 17.6%, respectively), and highest for those who had Medi-Cal and Healthy Families coverage (22.4%) or who had been uninsured part of the year (21.4%).

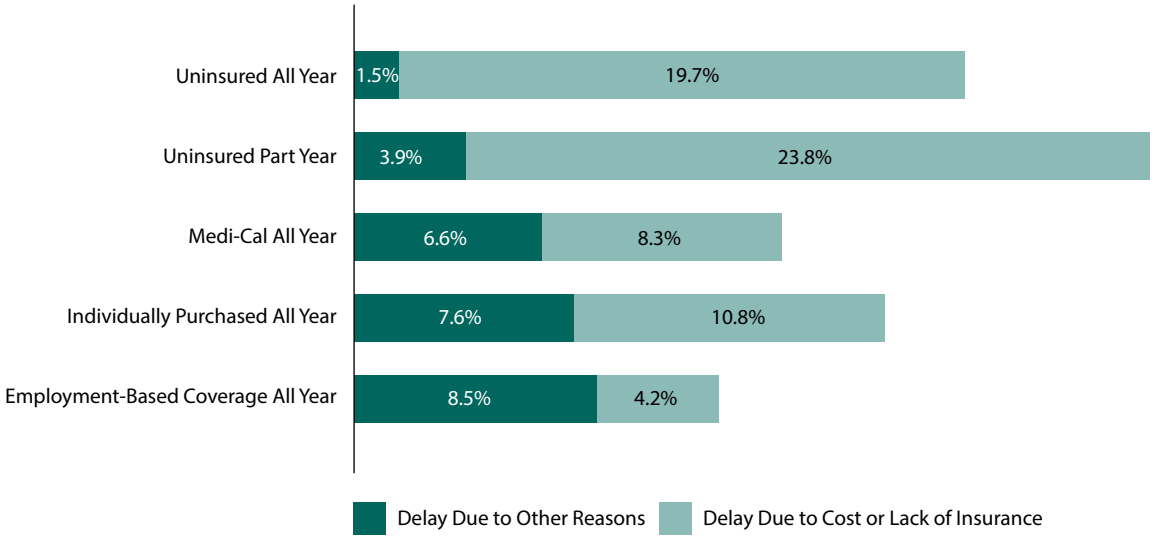
Exhibit 38.
At Least One Emergency Room Visit in the Last 12 Months by Health Insurance Coverage During Last 12 Months Among Nonelderly Persons, Ages 0-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Forgone or delayed care due to cost or lack of insurance is an indicator that financial barriers limit access due to higher levels of out-of-pocket costs. Adults without insurance all year (19.7%) were most likely to report having forgone or delayed needed medical care due to cost or lack of insurance, followed by adults who were uninsured part of the year (23.8%; Exhibit 39). Reporting of forgone or delayed care due to costs was least common among adults with employment-based coverage (4.2%), followed by the other two insured groups.

Exhibit 39.
Reasons for Forgone or Delayed Needed Medical Care by Health Insurance Coverage During Last 12 Months Among Nonelderly Adults, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Access to Care Under High-Deductible Plans

High-deductible plans are designed to reduce the use of non-urgent and discretionary services through greater cost sharing. These plans can be combined with a voluntary savings account to pay for services subject to the deductible. Starting in 2014, all plans in California, including high-deductible plans, must have standard benefits and cover preventive care and some primary care services without applying either a copayment or deductible, in compliance with the ACA.[13, 14] Prior to implementation of the ACA, many of these plans either did not provide comprehensive benefits or varied in cost-sharing levels, and they may thus have negatively impacted access to care.

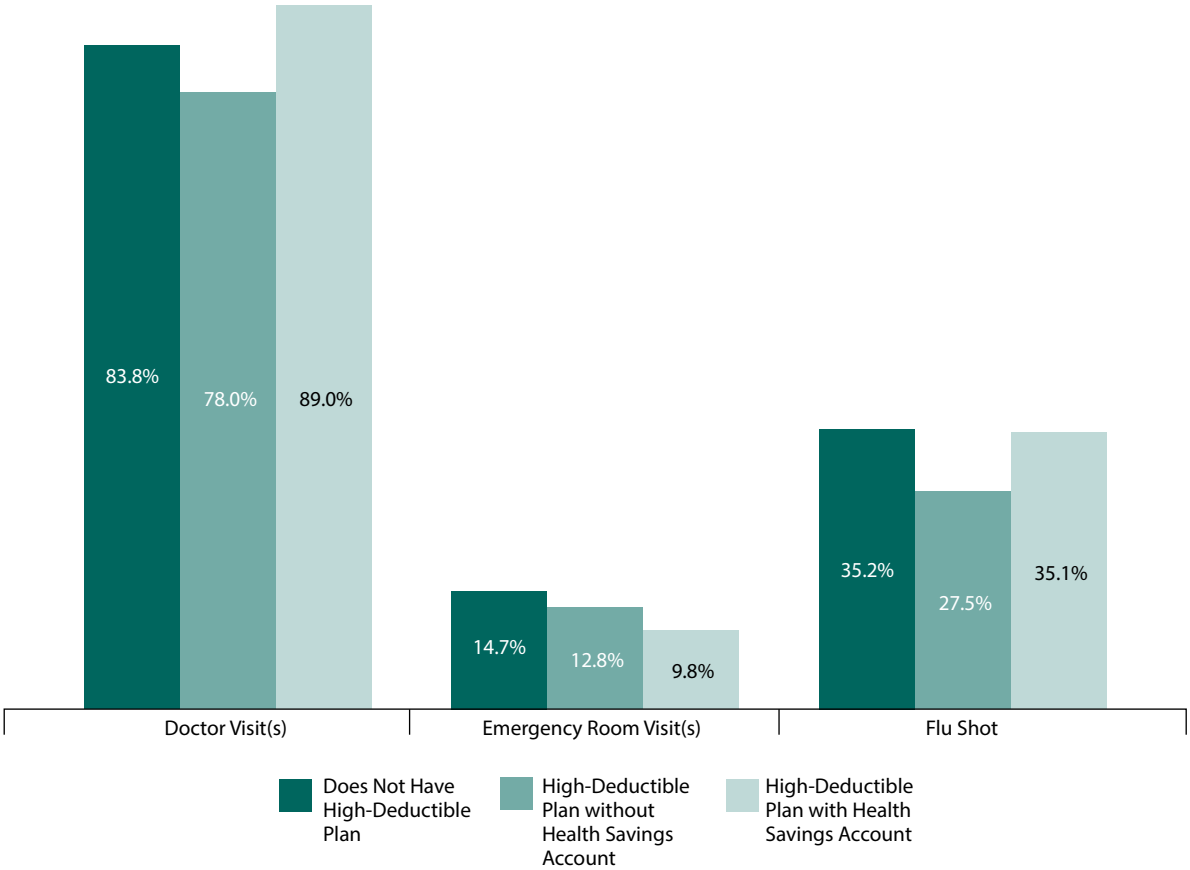
An estimated 15% of employment-based and 18% of individually purchased plans in California were high-deductible plans, and the great majority of these (15% and 13%, respectively) were not associated with health savings accounts (HSAs; data not shown). Measures of access under high-deductible plans, including doctor visits and ER visits in the past year,

13 Pourat N, Kominski G. Private Health Insurance. In Kominski G, ed. *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management* (4th ed). San Francisco: Jossey-Bass, 2013.

14 Kominski G. The Patient Protection and Affordable Care Act of 2010. In Kominski G, ed. *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management* (4th ed.). San Francisco: Jossey-Bass, 2013.

Exhibit 40.

Nonelderly Adults with Doctor Visits, Emergency Room Visits, and Flu Shots During Last 12 Months by High-Deductible Coverage and Health Savings Accounts, Ages 19-64, California, 2012



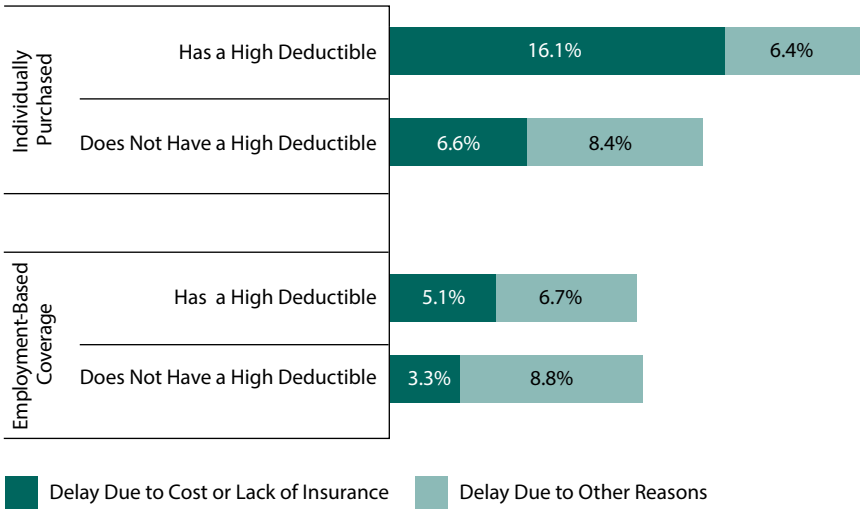
Source: 2011/2012 California Health Interview Survey

showed significant differences based on availability of an HSA (Exhibit 40). Specifically, enrollees with HSAs were more likely to have had at least one doctor visit in the past year (89%) compared to those without an HSA (78%). Enrollees with high-deductible coverage and an HSA were less likely to have visited the emergency room in the past year (9.8%) than those without an HSA (12.8%) or without a high-deductible plan (14.7%).

The rate of flu vaccinations also varied by whether people had high-deductible coverage. Among adults with employment-based coverage, those without high-deductible coverage and those with high-deductible coverage and an HSA were equally likely to receive a flu shot (35.2% vs. 35.1%, respectively), while those with high-deductible coverage without an HSA had a lower rate (27.5%; Exhibit 40).

Forgoing or delaying needed medical care due to cost or lack of insurance was reported more frequently among those covered by individually purchased high-deductible plans (16.1%) compared to those without high-deductible plans (6.6%; Exhibit 41).

Exhibit 41.
Forgone or Delayed Needed Medical Care by High-Deductible Insurance Coverage Among Nonelderly Adults, Ages 19-64, California, 2012

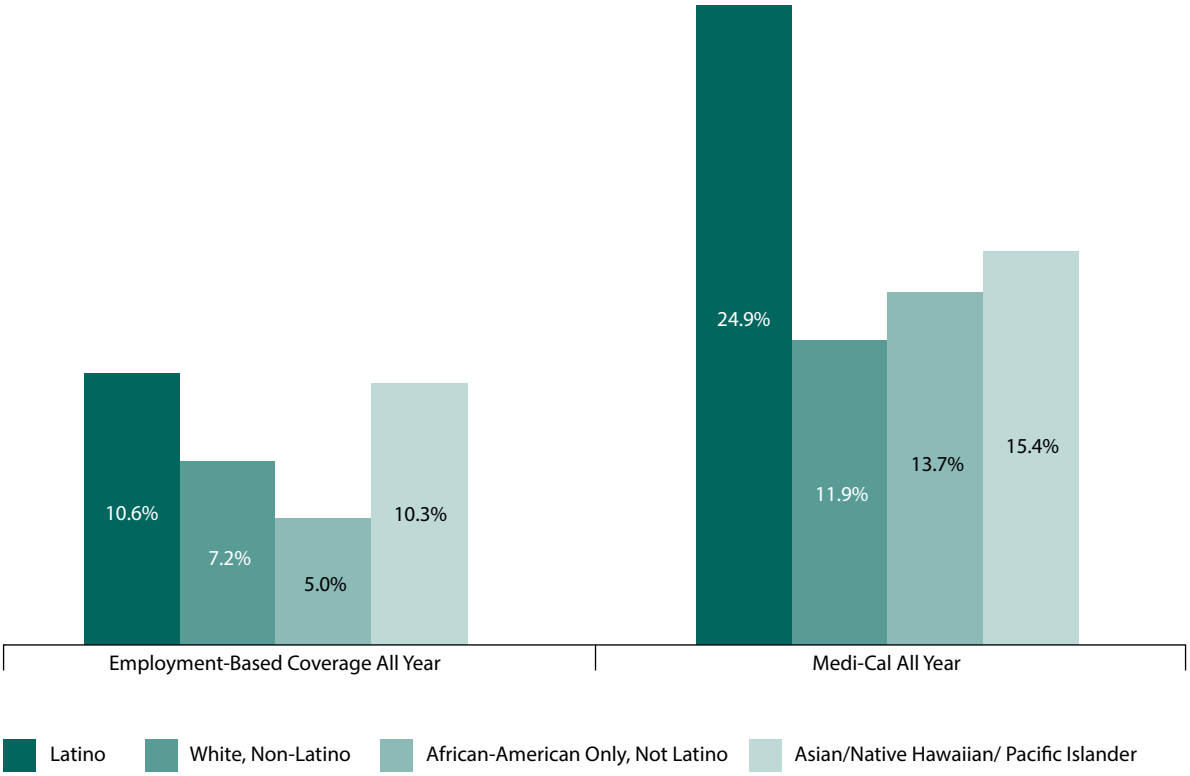


Source: 2011/2012 California Health Interview Survey

Racial/Ethnic Disparities in Access Persist

Insurance coverage increases the likelihood of access significantly for everyone. However, racial/ethnic disparities in access frequently persist despite having health insurance. For example, among adults with employment-based coverage, Latino (10.6%) and Asian American/Pacific Islander adults (10.3%) more frequently reported no usual source of care than white adults (7.2%; Exhibit 42). In contrast, whites more frequently reported no usual source of care than African-American adults (5%). Among Medi-Cal beneficiaries, Latino adults were most likely to report no usual source of care, at 24.9%—substantially higher than all other groups, which reported statistically similar rates.

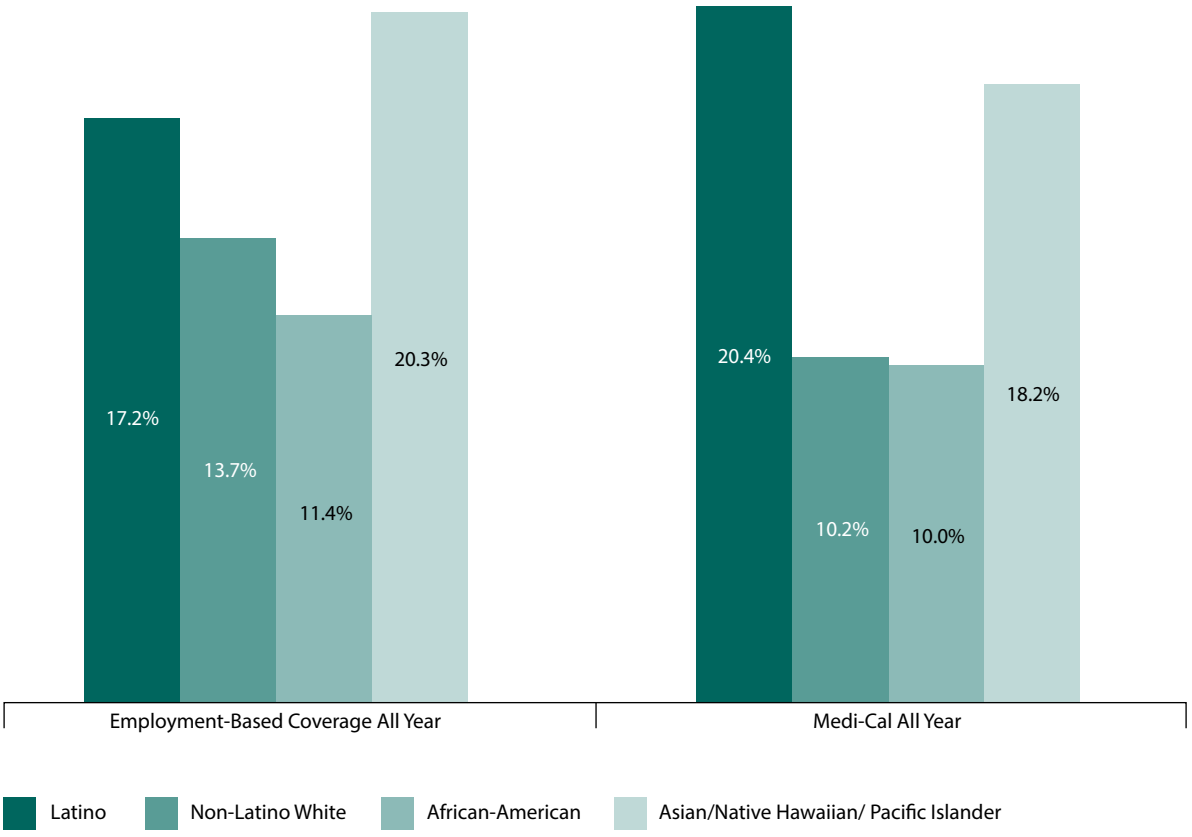
Exhibit 42.
Rates of Not Having a Usual Source of Care by Racial and Ethnic Group Among Nonelderly Adults with Employment-Based Coverage or Medi-Cal All Year, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Disparities in usual source of care coincided with disparities in doctor visits. Among those with employment-based coverage, Asian Americans/Pacific Islanders (20.3%) were most likely to have had no visits to the doctor, and African-Americans (11.4%) were least likely to report this (Exhibit 43). Among those with Medi-Cal coverage, whites (10.2%) and African-Americans (10.0%) were least likely to report having had no doctor visits.

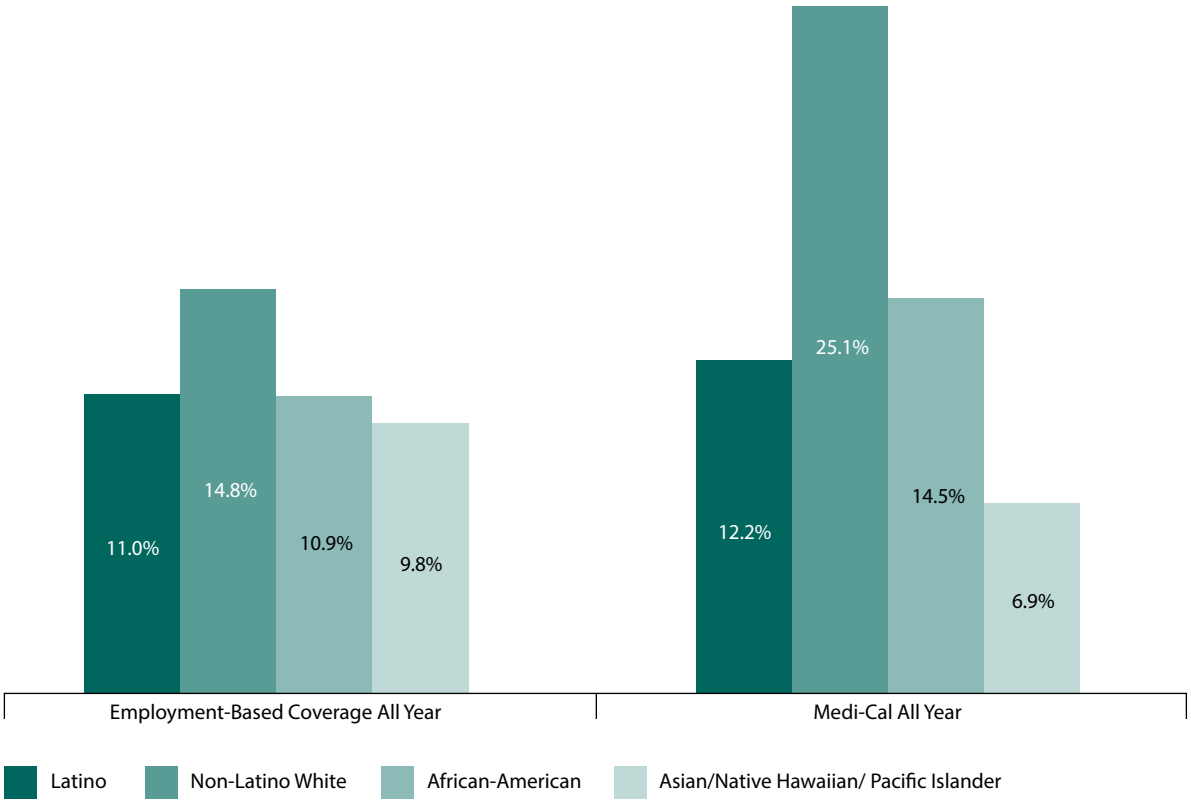
Exhibit 43.
Rates of No Doctor Visits During Last 12 Months by Racial and Ethnic Group Among Nonelderly Adults with Employment-Based Coverage or Medi-Cal All Year, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Despite these disparities in usual source of care and doctor visits, non-whites less frequently reported having delayed or forgone medical care in the past year. Among those with employment-based coverage, whites (14.8%) were more likely to report delays than all other groups (Exhibit 44). The same pattern was also observed among those with Medi-Cal coverage. However, Asian Americans/Pacific Islanders (6.9%) were least likely to report such delays. Underreporting of delays or forgone care is possible, since some non-white populations have been found to underreport health problems.

Exhibit 44.
Rates of Delays in Medical Care During Last 12 Months by Racial and Ethnic Group Among Nonelderly Adults with Employment-Based Coverage or Medi-Cal All Year, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Conclusions

The findings in this chapter confirm that health insurance plays a central role in access to health care. Health insurance is essential to having a usual source of care, which can provide continuity, improve receipt of preventive care services, and reduce use of urgent and emergency services for insured and uninsured alike. Health insurance improves the likelihood of receipt of preventive services such as flu shots, improves rates of doctor visits, and reduces the likelihood of delaying or forgoing needed medical care.

Variations in health care use, particularly among those with public coverage or high-deductible plans, highlight the need for policy interventions to reduce such differences. For example, the higher rates of ER visits for those with Medi-Cal coverage are most likely a reflection of barriers in access to primary care providers who accept Medi-Cal or of an insufficiency of resources to provide better care for Medi-Cal enrollees. Medi-Cal has been transitioning several eligibility categories to managed care; the trend in high rates of ER use will be important to monitor in future reports. Similarly, the variations in service use among enrollees with high-deductible plans highlight the importance of cost-sharing protections for these individuals.

Racial/ethnic disparities in access to care despite insurance coverage are a significant and persistent problem that highlight the need for policy solutions addressing cultural, linguistic, and systemic barriers to access. Policy solutions include, but are not limited to, tailoring care delivery to target populations and improving the cultural and linguistic competency of providers.

The successful enrollment of previously uninsured individuals in Covered California and Medi-Cal following the implementation of the ACA bodes well for access to preventive and other needed health care by newly insured Californians. However, the data provided in this chapter indicate that while health insurance alleviates barriers in access to care, other barriers—such as the capacity of the system to provide care to the newly insured population—should remain a central policy focus.

5 The Affordable Care Act and Its Impact on California's Uninsured

Gerald F. Kominski

The Affordable Care Act (ACA) of 2010 is expected to substantially reduce the high rate of uninsurance in California and the nation. The major provisions of ACA did not go into effect until the beginning of 2014, with the availability of federal subsidies to buy insurance through Covered California and the state's Medi-Cal expansion. Therefore, this report provides an essential baseline for the health insurance status of Californians in the period just prior to the implementation of ACA provisions that are expected to yield a significant reduction in the number of uninsured Californians. As of May 2014, Covered California reported that almost 1.4 million Californians had purchased insurance through the exchange, including 1.2 with subsidies, and roughly 2.0 million more had enrolled in Medi-Cal, with another 800,000 applications still being processed. Although not all of these individuals were previously uninsured, we expect that these overwhelming numbers will produce significant reductions in the number of uninsured Californians that will be documented in the next edition of this report.

The ACA is the most significant piece of health care legislation since the enactment of Medicare and Medicaid in 1965, and it promises to substantially reduce the high rate of uninsurance in California and the nation. Because the major provisions of ACA did not go into effect until 2014, Californians continued to experience high rates of uninsurance in 2011/12, the time period covered by this report. Although the state had experienced significant economic recovery since the Great Recession that began in late 2008, 4.26 million nonelderly Californians reported being uninsured all year in 2012, and another 2.66 million reported being uninsured part of the year. The overall rate of uninsurance was lower in 2012 compared to our last report using 2009 data for those ages 0-39, but the rate was slightly higher for those ages 40-64.

California was the first state to establish a state-based marketplace – or health benefit exchange – under the ACA, known as Covered California. In October 2013, Covered California opened for business. Despite some relatively minor glitches, it avoided the major problems experienced by the 36 states that defaulted to the federally facilitated marketplaces operated as part of the healthcare.gov website. California's commitment to broadly expanding coverage under the ACA produced tremendous success in enrollment both in exchange-based policies and in the Medi-Cal program. In addition, about 1.9 million Californians were newly enrolled in Medi-Cal, including almost 650,000 who were previously enrolled in the state's Low-Income Health Program (LIHP) Medicaid 1115 waiver demonstration project. LIHP allowed counties to leverage their expenditures for eligible enrollees—uninsured adults who are citizens or legal residents with at least five years of residency and with incomes below 200% of the federal poverty level—to qualify for federal matching funds for health care services provided to LIHP enrollees. LIHP therefore

served as a "Bridge to Reform" by providing health care coverage for 650,000 Californians who would otherwise have remained uninsured until 2014. LIHP enrollees were automatically transitioned into Medi-Cal on January 1, 2014, without the need to enroll individually. In total, Covered California enrolled more than 2.5 million Californians in either private insurance offered through the exchange or in Medi-Cal. To place this accomplishment in context, Covered California enrolled more than twice the number of individuals covered by CalPERS, and it enrolled more Californians than all but two of the largest private insurers in the state.

Of course, not all the individuals enrolled by Covered California were previously uninsured. We expect that many of the 1.4 million Californians who purchased insurance through Covered California both with and without subsidies were previously insured. These individuals took advantage of either federal subsidies or more affordable premiums offered through the exchange to purchase more affordable insurance. These efforts to make insurance more affordable provide important financial benefits to low- and middle-income Californians, but they won't reduce the rate of uninsurance. Previous research by Center researchers, in collaboration with UC Berkeley and

using the California Simulation of Insurance Markets (CalSIM) model, suggested that 57 percent of those enrolling in Covered California with subsidies and 75 percent of those newly eligible for Medi-Cal were previously uninsured.[15] If these estimates prove accurate, more than 1.5 million Californians were newly insured in 2014 due to the ACA. This total is in addition to the 650,000 LIHP enrollees who were "pre-enrolled" in Medi-Cal, plus the more than 500,000 young adults ages 19-26 who were newly insured through their parents' insurance policies after 2010 as a result of the ACA.[16] Therefore, in our next report, we have good reason to expect that between 2.6 and 2.7 million Californians will have been newly insured by the end of 2014 as a result of the ACA.

In this report, we've already observed some of the early impacts of the ACA, including a reduction in the rate of uninsured young adults ages 19-26. Given the substantial first-year success of Covered California in meeting and exceeding its enrollment targets, we believe that significant reductions in the number of uninsured Californians have already occurred in California. We expect these reductions to show up in the 2013/14 CHIS survey. While the recovery from the Great Recession has produced improvements in the unemployment rate, the state budget, and the overall economic conditions of California, those improvements have not produced substantial improvements in the health insurance status of Californians, at least in terms of stemming the erosion in employment-based insurance. As a result, the ACA may be even more important to securing the health insurance status of millions of Californians in the future who otherwise might have been uninsured despite the growth of the state's economy and its ongoing recovery from the Great Recession.

15 CalSIM version 1.8 Statewide Data Book, 2014–2019. Available at *http://healthpolicy.ucla.edu/programs/health-economics/projects/CalSIM/Documents/CalSIM_Statewide.pdf*.

16 Families USA. *The New Health Care Law: Fact Sheet*, March 2011. Available at *http://familiesusa.org/sites/default/files/product_documents/Benefits-of-Health-Care-Law.pdf*.

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