UCLA CENTER FOR HEALTH POLICY RESEARCH

Health Policy Brief

December 2019

Persistent Gap: Gender Disparities in Health Insurance and Access to Care in California

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SUMMARY: Historically, men have been more likely than women to be uninsured, as well as less likely than women to enroll in public coverage. This policy brief examines gender differences in health insurance coverage and access to care using data from the 2012-2016 waves of the California Health Interview Survey. By the end of 2016, following three years of full health insurance expansion due to the Patient Protection and Affordable Care Act (which went into effect on January 1, 2014), just over 10% of both men and women had gained coverage, leaving the gender gap in uninsured rates intact. These gains in coverage were predominantly the result of increased enrollment in Medi-Cal. Women remained more likely to be enrolled in public health insurance coverage, while men were more likely to have coverage through an employer. The gains in coverage changed the composition of the uninsured and Medi-Cal populations. The socioeconomic status of Medi-Cal enrollees and of men who remained uninsured improved. Men were less likely than women to have contact with the health care system, but they were also less likely to report experiencing delays in care. Though part of this difference could be due to the greater difficulty Medi-Cal enrollees face in accessing care, these gender disparities are also present by health insurance coverage type, suggesting that they cannot be eliminated solely by expanding health insurance coverage.

Prior to the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, nonelderly adult women (ages 18-64) in California were more likely than similarly aged men to have health insurance coverage. Women were more likely than men to qualify for and enroll in public health insurance programs, such as Medicaid.[1] This gender gap in insurance coverage increased during the first year in which the ACA's coverage expansion was fully implemented, as women were more likely to gain coverage, predominantly through higher enrollment in Medi-Cal, California's Medicaid program.[2]

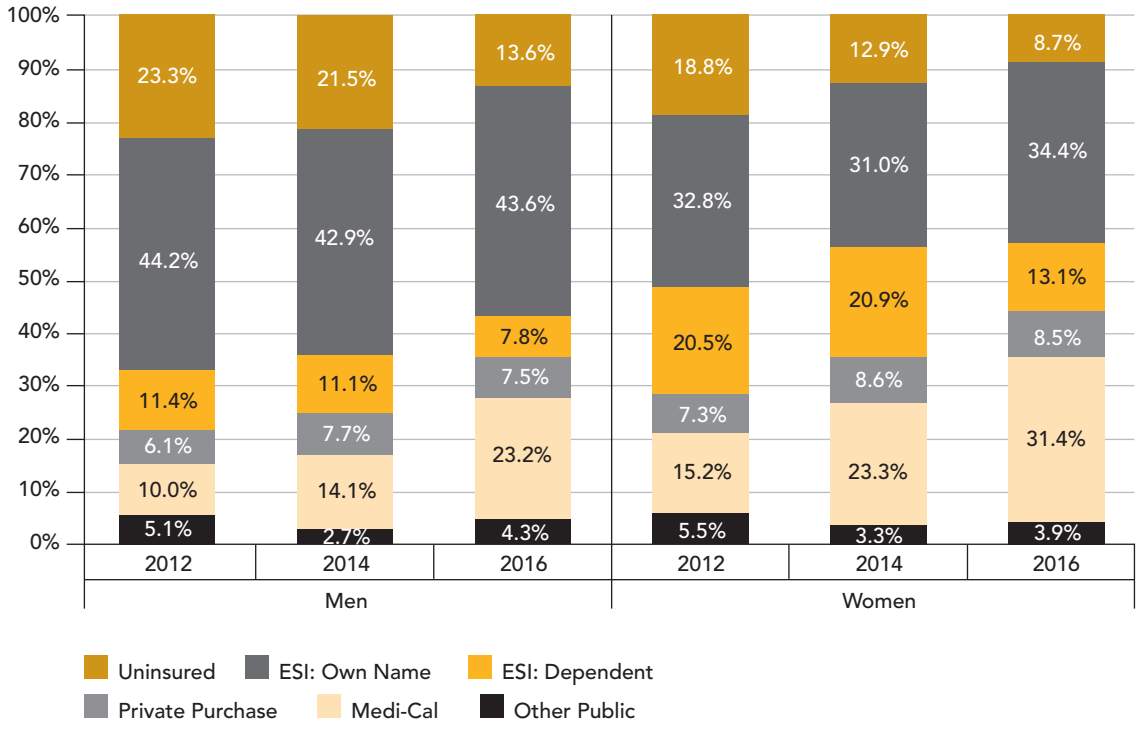
Before the ACA's coverage expansion, adults were eligible for Medi-Cal under a limited number of circumstances: low-income parents of children under age 18, low-income pregnant women, extreme poverty, and disability. Because women face a gender gap in employment and income and are more likely to have custody of young children, they are more likely to meet the eligibility requirements for Medi-Cal. The ACA expanded Medi-Cal coverage to all low-income adults, regardless of parental or disability status, and extended subsidies for purchasing private health insurance coverage to those with incomes below 400% of the federal poverty level (FPL).[3] These changes provided an opportunity to reduce the gender gap in health insurance coverage by removing the child-based and health restrictions for Medi-Cal and making private health insurance more affordable.

Barriers to accessing health care for those who are uninsured are well documented.[4] Those

The California Endowment

Support for this policy brief was provided by a grant from The California Endowment.

Exhibit 1 **Comparison of Insurance Coverage by Gender, Adults Ages 18-64, California, 2012-2016**



Source: 2012, 2014, and 2016 California Health Interview Survey

Note: ESI refers to employer-sponsored insurance.

enrolled in public health insurance programs, such as Medi-Cal, also face greater difficulty accessing health care than those with private coverage.[5] Because women are more likely than men to be enrolled in public coverage, they may experience greater difficulties accessing care, even though men are less likely to have health insurance coverage. However, the ACA changes in Medi-Cal eligibility requirements could have changed the socioeconomic composition of both the uninsured and those who enrolled in Medi-Cal. This could have led to improvements in access among the Medi-Cal population that are due to changes in the socioeconomic status (SES) of that population rather than to improvements in delivery systems.[6] Similarly, by providing access to health insurance for those with incomes below 400% FPL, the ACA could also have changed the composition of the uninsured population by reducing the percentage of the uninsured who have lower SES.

This policy brief extends previous analyses of gender differences in health insurance coverage among nonelderly adults in California by examining whether women continued to experience larger coverage gains than men after the ACA expansion went into effect. Next, we compare socioeconomic characteristics of men and women by type of health insurance coverage to examine gender differences in composition within insurance type, and to determine whether such compositional differences changed after the ACA's coverage expansion went into effect. Finally, we assess gender differences in access to care and examine whether these differences changed over time.

Men and women experienced similar decreases in uninsured rates under the ACA's coverage expansion.

Though women were more likely to gain health insurance in the first year of the ACA's coverage expansion (2014), two years later, men's gains had caught up (Exhibit 1). In 2012, prior to implementation of the ACA, the uninsured rate was about five percentage points higher among men (23.3%) than among women (18.8%). Between 2012 and 2014, the uninsured rate among men did not change significantly, though it dropped by nearly a third among women,

Socioeconomic Characteristics Within Insurance Type, by Gender, Adults Ages 18-64, California, 2012 and 2016 **Exhibit 2**

	Uninsured					Medi-Cal					ESI: Any Source				
	2012		2016			2012		2016			2012		2016		
	Men	Women	Men	Women		Men	Women	Men	Women		Men	Women	Men	Women	
Education															
<High School	28.6%	27.5%	30.1%	36.8%		32.5%	35.4%	29.0%	28.0%	a	7.7%	7.7%	9.3%	5.1%*	a
High School	34.3%	24.4%*	30.1%	23.6%		33.2%	30.0%	30.2%	26.4%		22.2%	16.2%*	19.0%	15.7%	
Some College	22.7%	29.0%*	18.4%	18.8%	a	24.2%	27.8%	25.2%	29.3%		22.7%	27.4%*	23.2%	21.6%	a
College Degree	14.4%	19.1%*	21.3%	20.8%	b	10.1%	6.8%	15.6%	16.4%	a	47.4%	48.7%	48.5%	57.7%*	a
Employment Status															
Full-Time (21+ hrs/wk)	60.9%	44.1%*	68.0%	47.0%*		45.8%	29.2%*	57.3%	41.3%*	ab	82.8%	65.5%*	83.9%	69.1%*	
Part-Time/Other	10.5%	13.3%	10.6%	15.7%		8.7%	13.3%	11.3%	13.7%		5.4%	10.4%*	6.0%	10.4%*	
Unemployed	18.2%	15.5%	13.0%	8.2%	a	19.3%	14.9%	10.5%	10.6%	b	4.7%	4.8%	2.9%	2.5%	ab
Not in Labor Force	10.4%	27.2%*	8.3%	29.2%*		26.3%	42.6%*	21.0%	34.4%*	a	7.1%	19.3%*	7.2%	18.0%*	
Income as Percentage of FPL															
Under 100% FPL	30.9%	30.8%	25.9%	31.0%		42.2%	57.2%*	37.9%	47.3%*	a	3.8%	7.0%*	3.6%	3.2%	a
100-199% FPL	32.5%	36.0%	23.4%	29.2%	b	30.2%	28.0%	30.1%	29.9%		11.3%	12.2%	9.6%	9.2%	a
200-299% FPL	16.0%	13.4%	23.1%	12.6%		16.2%	9.2%*	14.0%	9.9%		13.6%	12.4%	12.2%	13.3%	
300-399% FPL	7.3%	8.3%	10.2%	6.6%		5.3%	2.7%	5.7%	6.5%	a	13.5%	12.3%	12.1%	13.0%	
400%+ FPL	13.3%	11.6%	17.4%	20.6%		6.1%	2.8%	12.2%	6.5%*	b	57.9%	56.2%	62.6%	61.3%	a
Owns Home	33.9%	40.4%*	29.9%	43.4%		33.8%	22.8%*	30.8%	29.1%		68.4%	71.5%	62.9%	69.1%*	b

* The difference between men and women is significant at p<0.05.

a For women, the change between 2012 and 2016 is significant at p<0.05.

b For men, the change between 2012 and 2016 is significant at p<0.05.

Note: FPL refers to the federal poverty level, and ESI refers to employer-sponsored insurance.

Source: 2012 and 2016 California Health Interview Survey

from 18.8% to 12.9%. By 2016, however, the uninsured rate had dropped significantly among men, to 13.6% — nearly 10 percentage points lower than it had been in 2012. Among women, the uninsured rate also dropped about 10 percentage points from 2012, to 8.7%. The uninsured rate for men in 2016 remained about 5 percentage points higher than that for women.

Decreases in uninsured rates were driven by higher enrollment in Medi-Cal among both men and women.

Though the ACA provides subsidies to purchase health insurance on the private insurance market, the gains in coverage for both men and women between 2012 and 2016 were driven by increased Medi-Cal coverage. Between 2012 and 2016, the percentage enrolled in Medi-Cal increased by nearly 16 percentage points among women (from 15.2% to 31.4%) and by 13 percentage points among men (from 10.0% to 23.2%). Coverage through an employer decreased over this period, but trends differ by source (own vs. dependent coverage). Coverage received through one's own employer remained steady over the period. The drop in employer-sponsored coverage (ESI) was driven primarily by a decline in dependent coverage. The percentage with ESI dependent coverage decreased from 11.4% to 7.8% among men and from 20.5% to 13.1% among women. This decline in dependent ESI coverage for women was more than compensated for by the increase in coverage through Medi-Cal.

Socioeconomic Characteristics of Men and Women by Insurance Type

Most of the change in insurance coverage between 2012 and 2016 was due to changes in the uninsured and enrollment in Medi-Cal and ESI; therefore, in this section our focus is on the SES characteristics of these insurance types (Exhibit 2). Characteristics of those with private purchase coverage, ESI coverage in

their own name, and dependent ESI coverage can be found in the online Appendix (*https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1916*).

Socioeconomic status of uninsured men improved after ACA expansion

In 2012, before the health insurance expansion went into effect, uninsured men generally had a lower SES than uninsured women. Uninsured men were less likely than uninsured women to have attended or graduated from college (37.1% vs. 48.1%) and to own their home (33.9% vs. 40.4%). By 2016, the SES characteristics of uninsured men had improved, while those of women remained mostly unchanged. Uninsured men were as likely as uninsured women to have attended or graduated from college (39.7% vs. 39.6%). The proportion of uninsured men with income below 200% FPL decreased from 63.4% to 49.3%.

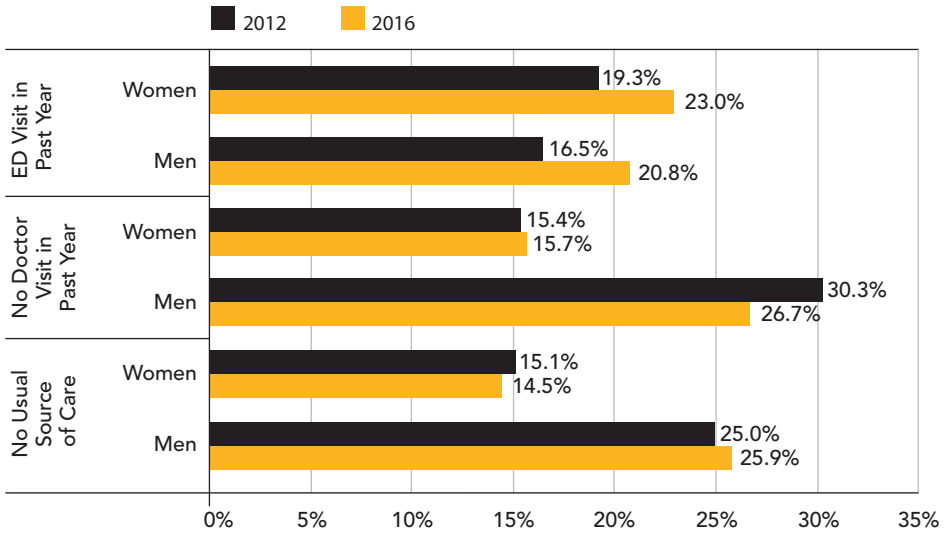
SES higher for both men and women enrolled in Medi-Cal after ACA expansion, but still lower for women than men

Among adults enrolled in Medi-Cal in 2012, women had lower SES than men. Women enrolled in Medi-Cal were more likely than men to be out of the labor force (42.6% vs. 26.3%) and to be living in poverty (57.2% vs. 42.2%). They were less likely to own their own home (22.8% vs. 33.8%). In 2016, after the Medi-Cal expansion, both men and women enrolled in Medi-Cal had higher SES than in 2012; education, employment, and income all increased among both men and women. This increase in socioeconomic status among men and women left the 2012 gender differences within this population intact.

Decline in ESI coverage post-ACA accompanied by increased SES among women with ESI

In 2012, nonelderly adult men and women with insurance coverage through their employer had similar SES levels. Among those with ESI, the proportions of men and women who had a college degree, whose income was above 400% FPL, and who owned their homes were similar. However, men with ESI were more likely than women to be employed for 20 or more hours per week (82.8% vs. 65.5%), and women were more likely to have household incomes below the poverty line. After the ACA's health insurance expansion went into effect, ESI declined due to a reduction in dependent coverage, particularly among women. Consistent with this, we saw significant increases in SES between 2012 and 2016 among women with ESI coverage. In 2016, among those with ESI, women were more likely than men to have a college degree (57.7% vs. 48.5%) and to own their own home (69.1% vs. 62.9%). By 2016, household income had increased among women with ESI coverage, erasing the gender gap that had been present in 2012. Taken together, the increases in socioeconomic status among those with ESI are consistent with the hypothesis that the decline in ESI coverage was driven by the increase in available alternatives to dependent coverage for those with incomes below 400% FPL after the ACA was fully implemented.

Gender Differences in Access to Care, Adults Ages 18-64, California, 2012 and 2016 **Exhibit 3**



Source: 2012 and 2016 California Health Interview Survey

Gender Differences in Access to Care

The growth in health insurance coverage did not always lead to improvements in access to care, nor to decreases in gender disparities in access (Exhibit 3). Men reported weaker ties and fewer contacts with the medical system than women, both overall and within health insurance coverage type. This was true in both 2012 and in 2016, after the health insurance expansion had taken hold.

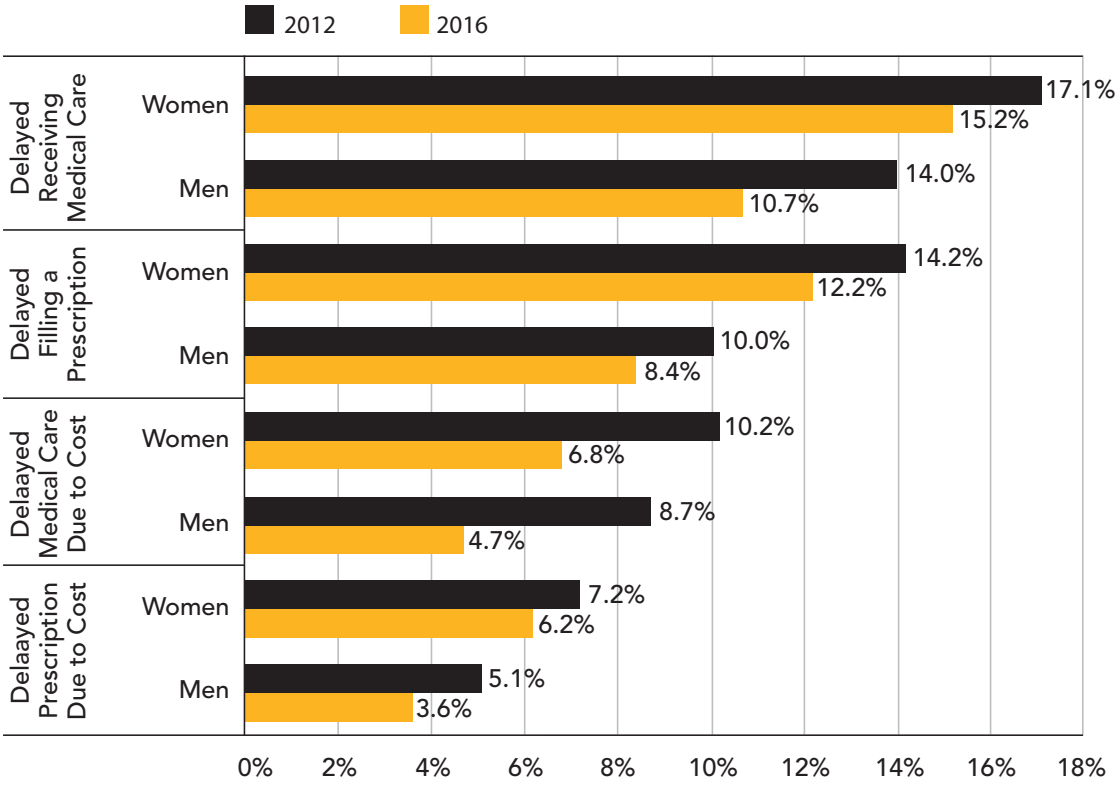
Men More Likely Than Women to Have No Usual Source of Care

Men were less likely than women to have a usual source of care, and this did not change between 2012 and 2016. About one-fourth of the men (approximately 25%) reported they did not have a usual source of care at both time points, compared to roughly 15% of women. The gender gap was largest among the uninsured, who were the least likely to have a usual source of care at both time points, and smallest among those with ESI, who were the most likely to have a usual care source at both time points (data by insurance type are not shown but are available in the online Appendix: *https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1916*). The percentage of men with ESI who had no usual source of care increased significantly between 2012 and 2016. However, there was no change among men overall, because many uninsured men gained coverage through Medi-Cal during this period, and the percentage of Medi-Cal enrollees who lacked a usual source of care was lower than the percentage of uninsured men who lacked a usual source of care.

Men More Likely Than Women to Report No Doctor Visit in the Past Year

Men were more likely than women to report that they hadn't visited a doctor in the past year. The gender gap narrowed slightly between 2012 and 2016, from 14.9 percentage points to 11.0 percentage points, because the percentage of men with no doctor visits in the past year significantly decreased — from 30.3% to 26.7% — while the percentage of women remained at about 15.5%. A gender gap was apparent within each insurance type in both years, but the largest gender gap occurred among the uninsured, who also were the least likely to have visited a doctor in the past year. The overall decline among men was due in part to declines in the uninsured rate, which shifted more uninsured men into Medi-Cal, where they were more likely to have had at least one doctor visit in the past year.

Exhibit 4 **Gender Differences in Delays in Care, Adults Ages 18-64, California, 2012 and 2016**



Source: 2012 and 2016 California Health Interview Survey

ED Visits Higher in 2016 Than 2012 Among Both Men and Women

Overall, both men and women were more likely to have visited the ED in 2016 than in 2012. Among men, the percentage who visited the ED in the past year increased from 16.5% to 20.8%; among women, the percentage increased from 19.3% to 23.0%. Women were more likely than men to report visiting the ED in 2012, but not in 2016. Men and women who were enrolled in Medi-Cal were more likely to have visited the ED in the past year than those who were either uninsured or had ESI throughout the period. The overall increase between 2012 and 2016 was most likely due to the increased enrollment in Medi-Cal in 2016.

Gender Differences in Delays in Care

Though men have fewer ties to the health care system and are less likely to be insured, women are more likely to report experiencing delays in care (Exhibit 4). This was true in both 2012 and 2016. Although delays in care declined somewhat among both women and men, men generally experienced slightly greater improvements.

Women More Likely to Report Delaying Care, Despite Declines in Delays of Care Between 2012 and 2016

Women were significantly more likely than men to report that they had delayed needed medical care in the past year (15.2% vs. 10.7% in 2016). The gender gap remained relatively stable between 2012 and 2016. Both men and women experienced a decline over this period, but only the decline among men was statistically significant. The uninsured were less likely to report delaying medical care in 2016 than they were in 2012, regardless of gender (data by insurance type are not shown but are available in the online Appendix: *https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1916*). Because of this, by

2016, Medi-Cal enrollees had become the most likely group to have delayed medical care.

Women More Likely to Report Delays in Filling a Prescription

Women were significantly more likely than men to report that they had delayed filling a prescription in the past year at both time points. The proportion of women who delayed filling a prescription was approximately 4 percentage points higher than the proportion of men in both 2012 and 2016. Among those with either Medi-Cal or ESI, women were significantly more likely to have delayed filling a prescription in 2012.

Both Women and Men Experienced Declines in Delaying Medical Care Due to Cost

There was no difference between men and women in the percentage who delayed medical care due to cost. Between 2012 and 2016, both men and women experienced a significant decrease in cost-based delays in medical care, with a decline from 8.7% to 4.7% for men and 10.2% to 6.8% for women. The percentage of the uninsured who delayed medical care due to cost decreased by 11.1 percentage points among both men and women. The percentage of Medi-Cal enrollees who experienced a cost-based delay in medical care declined by 6.0 percentage points.

Women Were More Likely to Experience a Delay in Filling Prescriptions Due to Cost in Both 2012 and 2016

Women were more likely than men to experience delays in filling a prescription due to cost at both time points. The percentage of men who experienced a delay in filling a prescription due to cost in the past year significantly decreased, while there was no change among women overall. Among women enrolled in Medi-Cal, the percentage reporting they had delayed filling a prescription due to cost significantly decreased from 7.2% in 2012 to 6.2% in 2016.

Discussion

When fully implemented in 2014, the Affordable Care Act opened new health insurance options to many Californians. As a result, millions of uninsured Californians signed up for Medi-Cal or private purchase health insurance coverage through California's private health insurance exchange, Covered California. Many Californians who had previously received employer-sponsored dependent coverage through a parent or spouse shifted to less expensive coverage through Medi-Cal or the private purchase market. Both men and women benefited from these coverage expansions in similar ways. Because of this, the gender gap in coverage observed prior to implementation of the ACA remained in 2016. Men continued to be more likely to be uninsured, and women continued to be more likely to enroll in public health insurance coverage programs, such as Medi-Cal. Among Californians who remained uninsured in 2016, men were less likely to meet eligibility requirements for Medi-Cal,[7] suggesting that further efforts to increase enrollment in that program under current eligibility rules will not eliminate the gender gap in coverage. Instead, it appears that reducing the gender gap will require expanding access to affordable coverage either through the private market or through the expansion of eligibility requirements for public programs.

The increases in health insurance coverage did not substantially alter gender differences in most measures of health care access and utilization. Both before and after the coverage expansion, women were more likely than men to have a usual source of care and to have visited the doctor in the past year. However, the gender gap for visiting a doctor in the past year became narrower: A decline in the percentage of men who were uninsured led to a decrease in the percentage of men who had not visited a doctor in the past year. The largest gains in access came from decreases over time in delays seeking care, particularly delays due to cost or lack of insurance. Though both men and women experienced fewer delays in general and fewer

delays due to cost or lack of insurance, men tended to see slightly greater improvements, so gender differences in access to care remained stable or grew over the period.

The stability of the gender gap in access to health care could reflect the fact that the ACA's coverage expansion led to similar declines in the uninsured rates of both men and women in California. Moreover, there were few gender differences in the type of coverage gained: Both men and women primarily gained coverage through the expansion of Medicaid, minimizing the impact that this expansion had on gender disparities in access to care. Though these disparities in access are long-standing[8] — due in part to a lack of medical providers who accept the lower reimbursement rates paid by Medi-Cal compared to private health insurance — the rapid growth in enrollment in Medi-Cal after the ACA's expansion of eligibility may have exacerbated these issues.

The expansion of eligibility also affected the socioeconomic composition of the uninsured, Medi-Cal, and ESI populations, which could have contributed to changes over time within these insurance types. However, many of the gender disparities within insurance type did not change in ways that were consistent with these compositional changes. For example, uninsured women experienced reductions similar to those of uninsured men in delays in receiving medical care due to cost, though only uninsured men had higher SES in 2016 than 2012. Therefore, it seems less likely that these compositional changes explain the changes in access by insurance type over time. Though gender disparities might be reduced by expanding coverage, they will not be totally eliminated even if disparities in access to health insurance coverage are diminished. Instead, these disparities might reflect gender-based differences in overall health, health care utilization, and socioeconomic status — differences that are more entrenched and resistant to change.

Data Source and Methods

This policy brief presents data from the 2012, 2014, and 2016 years of the California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research (CHPR). Health insurance coverage was measured at a point in time (at the time of responding to the survey). As a result, estimates presented here may differ from other sources that report coverage over the past year. CHIS is a telephone survey that uses a dual-frame, random-digit-dial (RDD) technique. Through the use of traditional landline RDD and cell-phone RDD sampling frames, the survey is representative of the state's population. Survey items for the adult modules are self-reported, with data collected by trained interviewers.

CHIS data are collected continuously throughout the year, and each full cycle is comprised of two years. Each year, CHIS completes interviews with adults, adolescents, and parents of children in more than 20,000 households, drawn from every county in the state. Interviews are conducted in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Tagalog, and Korean. Interviews cover a diverse array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. CHIS employs a complex survey design that requires analysts to use complex survey weights to provide accurate variance estimates and statistical testing. All analyses presented in this policy brief incorporate replicate weights to provide corrected confidence interval estimates and statistical tests.

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PB2019-9

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Acknowledgments

The authors would like to thank Venetia Lai, Elaiza Torralba, and Celeste Maglan Peralta for their assistance. The authors are grateful to the following reviewers for their helpful feedback:

Claire Brindis, DrPH, who holds the following positions at the University of California, San Francisco: Caldwell B. Esselstyn Chair in Health Policy; director, Philip R. Lee Institute for Health Policy Studies; distinguished professor of pediatrics in the Division of Adolescent and Young Adult Health and Department of Obstetrics, Gynecology, and Reproductive Health Sciences; and founding director and senior scholar, Bixby Center for Global Reproductive Health

Usha Ranji, MS, associate director, Women's Health Policy, Kaiser Family Foundation

Joelle Wolstein, PhD, MPP, research scientist, UCLA Center for Health Policy Research

Roberta Wyn, PhD, associate, Pacific Institute for Women's Health and UCLA Center for Health Policy Research

Suggested Citation

Becker T, Babey SH. 2019. *Persistent Gap: Gender Disparities in Health Insurance and Access to Care in California*. Los Angeles, Calif.: UCLA Center for Health Policy Research.

Endnotes

1 Source: 2009 California Health Interview Survey, accessed using *Ask*CHIS at *Ask.CHIS.ucla.edu*.

2 Charles SA, Becker T, Jacobs K, Pourat N, Ebrahim R, Kominski GF. 2017. *The State of Health Insurance in California: Findings from the 2014 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research. Available at: *http://healthpolicy.ucla.edu/publications/Documents/PDF/2017/shicreport-jan2017.pdf*

3 The federal poverty level, used to establish eligibility for public programs, is published annually by the U.S. Department of Health and Human Services as the federal poverty guidelines. These guidelines vary by family size. In 2016, 400% FPL for a family of four was $97,200.

4 For example, see: Garfield R, Orgera K, Damico A. 2019. *The Uninsured and the ACA: A Primer*. Kaiser Family Foundation Report #7451-14.

5 Becker T, Charles SA, Scheitler AJ, Ponce N. 2015. *Medi-Cal Versus Employer-Based Coverage: Comparing Access to Care*. Report for the California Health Care Foundation. Available at: *https://www.chcf.org/wp-content/uploads/2017/12/PDF-MediCalAccessComparedUCLA.pdf*

6 For example, see: Adler NE, Newman K. 2002. *Health Affairs* 21 (2): 60-76.

7 Author calculation using estimates from *Ask*CHIS (*ask.chis.ucla.edu*) that compare Medi-Cal eligibility among the uninsured by gender, ages 18-64, in 2016.

8 Becker T, Charles SA, Scheitler AJ, and Ponce N. 2015. *Medi-Cal Versus Employer-Based Coverage: Comparing Access to Care*. Report prepared for the California Health Care Foundation (July 2015). Available for download at: *http://garnerhealth.com/wp-content/uploads/2014/02/PDF-MediCalAccessComparedUCLA.pdf*