November 2019

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**Funded by a grant from The California Endowment**



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# Foreword

Shana Alex Charles, MPP, PhD

This *State of Health Insurance in California* report is our ninth in-depth examination of health insurance since 2001 using California Health Interview Survey data. In this report, using data from the 2015-2016 survey, we are able to provide estimates for the first time of the full societal impact of the largest national expansion of health insurance since the enactment of Medicare and Medicaid in the 1960s: the program known as "Obamacare." When President Barack Obama signed the Patient Protection and Affordable Care Act (ACA, commonly called Obamacare) into law in March 2010, he fundamentally altered the underlying foundations of our national health insurance system. Instead of having a system focused on private company gain, with public insurance to fill in some (but not all) gaps, the United States would now have a system in which public and private health insurance programs worked together, with the goal of eventually expanding coverage to everyone in the country.

California led the way in implementing ACA reforms, and national data comparisons of all 50 states clearly show we have been one of the most successful states in enrolling eligible people in new coverage from the ACA's full launch in 2014 until today.[1] But California still must contend with and operate under federal rules and guidelines, and when the federal administration changed in 2017 to a president hostile to the ACA, even California felt the pinch and saw uninsured rates begin to creep up again.

This report, which presents 2015-2016 California Health Interview Survey data, is a snapshot in time. Our data are from just before the current administration took power, just before the mantra of a Republican-led Congress was that it was going to "repeal and replace Obamacare" in 2017. That did not happen, and the House became controlled by ACA supporters in the next election. This report shows the peak of the ACA, before federal regulators began to backpedal on expansions.

Additionally, we've added a new focus on Medicare data to this year's report. With the ACA under attack since 2017, much of the policy conversation around expanding health insurance coverage has turned to building instead on the one widely admired public program, Medicare. While proposals can differ on just how to expand Medicare, they all should be based on solid initial data on what Medicare does for its current enrollees and on how the program compares with other public and private coverage. We also cannot forget that while the ACA's impact is now slowly declining, even at its height in 2016, millions of Californians still did not have any health insurance coverage.

## Acknowledgments

The authors would like to thank both the statistical programming and communications teams at the UCLA Center for Health Policy Research, without whom this report would not have been possible. We thank The California Endowment for funding this report, and the funders and survey team of the California Health Interview Survey for providing much-needed public health data. We also wish to thank Michael Cousineau and Lucien Wulsin Jr. for their thoughtful reviews of the report draft.

Finally, the authors thank the legislative and executive branches of the state of California for their continuous commitment to using real-world data to inform both policymaking for and implementation of our vital public health programs.

1 U.S. Census Bureau. 2018. *Health Insurance Coverage in the United States: 2017*. Accessed at: *https://www.census.gov/library/publications/2018/demo/p60-264.html.*

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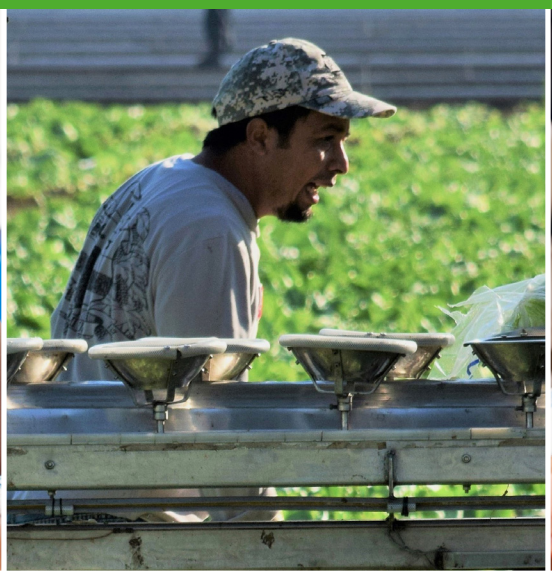
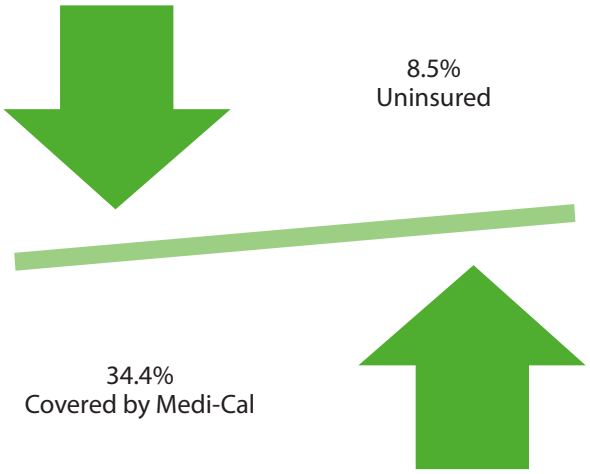
# EXECUTIVE SUMMARY



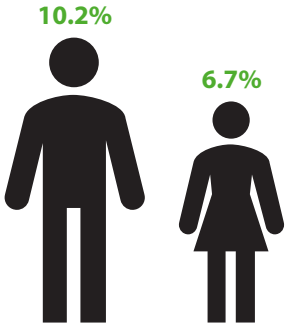


In 2016, California's uninsured rate reached a low of 8.5% among nonelderly people (those ages 0-64), declining by nearly half from a high of 16.3% in 2012. This meant that the number of uninsured nonelderly Californians decreased by more than 2.5 million, reaching a low of 2.8 million in 2016.




The decline in the uninsured rate was driven by increased enrollment in Medi-Cal, which significantly increased from 22.2% to 34.4% between 2012 and 2016, an increase of nearly 4.2 million Californians.

**Uninsured in 2016, Ages 0-64**




The uninsured rate for men was nearly twice that of women.

**Latinos had over twice the uninsured rate of other racial/ethnic groups (12.3%).**

**36.8%** of noncitizens without a green card were uninsured.

Employment-based coverage remained the most common source of coverage for nonelderly adults in California in 2016, with just over half receiving coverage from an employer. Disparities in access to employer-based coverage also continued after implementation of the ACA. Part-time and unemployed workers, as well as the self-employed, were less likely to have employment-based coverage and more likely to be uninsured. Additionally, employment-based coverage was less common among workers in low-wage industries and occupations. These workers were more likely to rely on Medi-Cal or to be uninsured. Medi-Cal coverage increased mainly among adults ages 19-64, with coverage increases spread among all racial/ethnic groups. Among children, coverage increased mostly among U.S.-born children with U.S.-born parents.

**10.5%** of adults (ages 19-64) with Medi-Cal reported having trouble finding a primary care doctor who accepts their insurance.

**19.4%** of adults (ages 19-64) with Medi-Cal reported being treated unfairly by health professionals because of their type of coverage.

The uninsured and those with Medi-Cal and other public insurance reported fair or poor health, risk factors, and chronic conditions at higher rates than those in other insurance groups. Individuals in the former categories of insurance also frequently reported fewer preventive services such as flu shots and mammograms, lower likelihood of doctor visits, and higher likelihood of ED visits and delays in care due to cost or lack of coverage. The combination of poor health and limited access to care poses significant challenges to efforts directed at improving population health and efficiencies in care delivery.

In general, the initial significant impacts of the ACA, documented in our last report, continued through the period covered by this report, resulting in historically low levels of Californians without health insurance. However, since 2017 and the change in administrations in Washington, the ACA has been under continual attack. Although efforts to "repeal and replace" the ACA in 2018 were unsuccessful and the midterm election put such efforts on indefinite hold, as this report goes to press, the courts are about to litigate yet another challenge to the ACA that could result in the entire law being declared unconstitutional. In the face of these efforts to undermine the ACA, California continues to chart a different course.

# 1 A Demographic Look at Health Insurance in California

Tara Becker, PhD


The expansion of health insurance coverage under the Patient Protection and Affordable Care Act of 2010 (ACA) was the single largest extension of coverage since the creation of Medicaid in 1965. Despite this improvement in access to health insurance coverage, the national uninsured rate remained just under 9% in 2017.[2] This fact has prompted proposals at both the state and federal levels to expand upon these gains through legislation that provides universal health care coverage. These proposals have taken many forms. At their most expansive, they create a single-payer public health care system funded through tax dollars that eliminates all forms of cost sharing, including monthly premiums, deductibles, and copayments. More moderate proposals create a public health insurance program modeled on Medicare or Medicaid that individuals or businesses can choose to purchase in lieu of private health insurance coverage. Others gradually expand the age range for eligibility for public health insurance programs — for example, by reducing the age at which individuals become eligible for Medicare.

As proof of what can be achieved through public health insurance programs, many groups proposing these new programs point to the success of the federal Medicare program in providing nearly universal health insurance coverage to the nation's elderly population. The Medicare program has indeed been successful in expanding basic health insurance coverage to all elderly Americans; however, the program relies on extensive cost sharing through premiums, copayments, and deductibles, which can lead to significant out-of-pocket costs for many older Americans. Many Medicare beneficiaries need to enroll in additional coverage to reduce these costs, creating an unequal, multitiered system that provides different levels of access to care for older Americans. This means that while the Medicare program can be seen as both an example of the success of government programs in expanding coverage, it also shows the limitations of an expansion that builds in significant cost sharing, particularly for vulnerable populations.

This chapter will focus on the expansion of coverage among nonelderly Americans that occurred beginning in 2014, and also on the forms of additional health insurance coverage used by older Californians to mitigate the impact of the high levels of cost sharing that are built into the Medicare program. First, the chapter examines enrollment in health insurance coverage by type among all Californians. The subsequent section will examine health insurance coverage type within subgroups of the nonelderly Californian population defined by age, gender, race/ethnicity, family type, education, income, urban/rural status, and citizenship status. Next, the chapter examines coverage type within subgroups of older Californians defined by gender, race/ethnicity, education, income, urban/rural status, and citizenship status. Finally, county and regional differences in health insurance coverage type will be discussed.

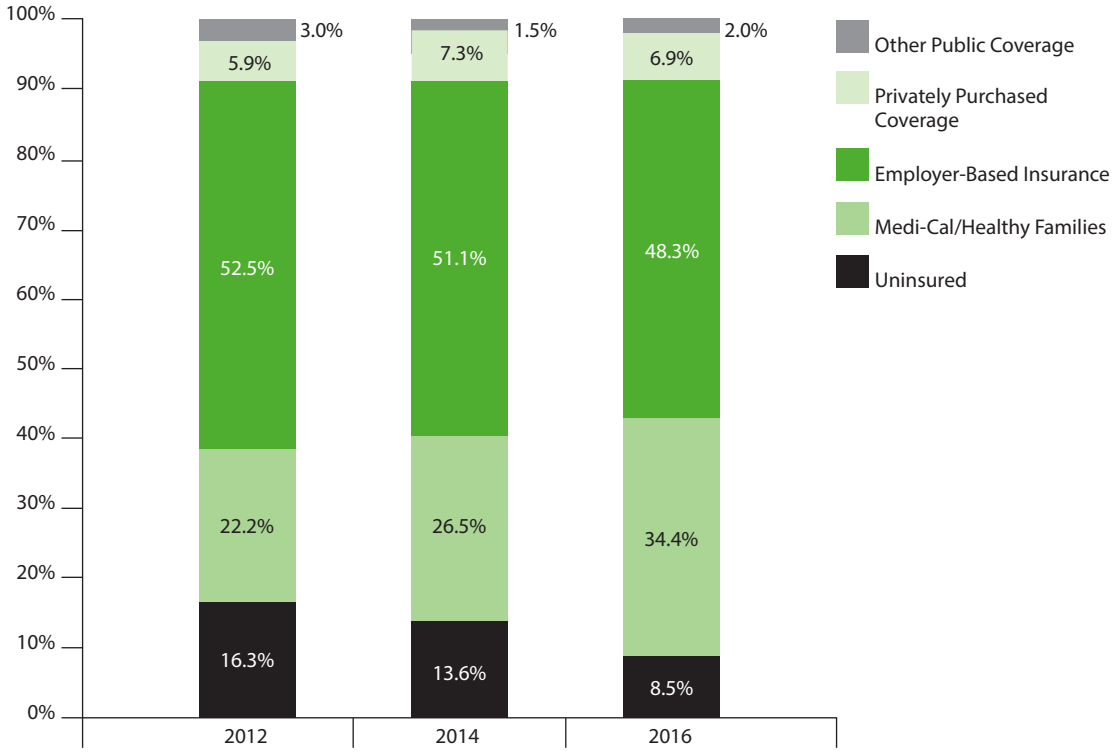
2 Keith K. 2018. Two New Federal Surveys Show Stable Uninsured Rate. Health Affairs blog. September 13, 2018. Available at: *https://www.healthaffairs.org/do/10.1377/hblog20180913.896261/full/* (last accessed 12/5/2018).

## Health Insurance Coverage in California in 2016

In the period since January 1, 2014, when full implementation of the ACA occurred, the uninsured rate for all Californians declined significantly. This was accomplished by requiring individuals to purchase health insurance coverage and by expanding access to coverage. This expansion of access was achieved by widening the eligibility requirements for Medicaid to encompass all low-income U.S. citizens and permanent residents, and by introducing subsidies for the purchase of individual market health insurance coverage through new health insurance exchanges. After these changes went into effect, California's uninsured rate began to decline, dropping from 14.5% in 2012 to 7.4% in 2016 and reducing the state's uninsured population by nearly 2.5 million people (Exhibit 1.1). Most of this decline was due to increased enrollment in the state's Medicaid program, Medi-Cal, with enrollment rising from 19.6% to 29.9% between 2012 and 2016. Enrollment in private purchase coverage increased significantly between 2012 and 2014, from 5.2% to 6.4%, and remained steady at 6.0% in 2016. During this period, coverage through an employer (ESI) declined from 46.6% to 42.2%.

The expansion of coverage under the ACA was directed at and primarily benefited those under age 65. Among nonelderly Californians, the uninsured rate declined by nearly half between 2012 and 2016, decreasing from 16.3% to 8.5% (Exhibit 1.1). This meant that the number of uninsured nonelderly Californians decreased by more than 2.5 million, reaching a low of 2.8 million in 2016. The decline in the uninsured rate was driven by increased enrollment in Medi-Cal, which significantly increased from 22.2% to 34.4% between 2012 and 2016, an increase of nearly 4.2 million Californians. Although subsidies were offered through Covered California for privately purchased insurance, the

**Exhibit 1.1**
Health Insurance Coverage Type, Ages 0-64, California, 2012-2016

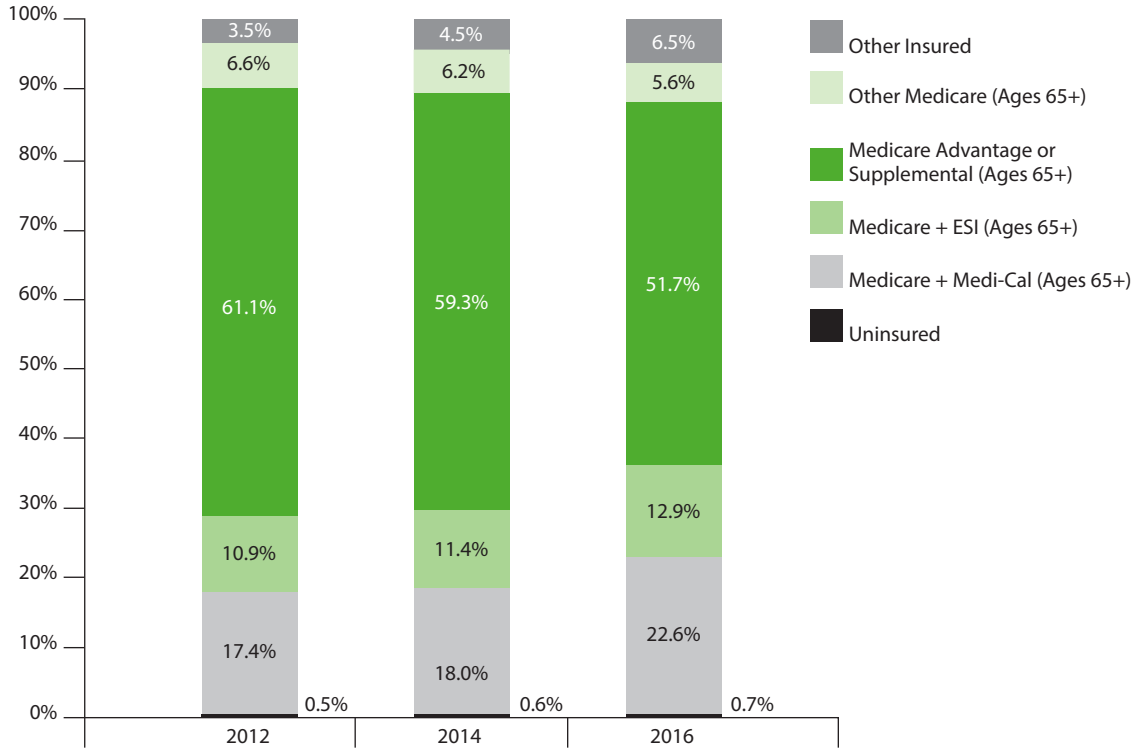



Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: "Privately Purchased" includes Covered California insurance, both with and without subsidies.

**Exhibit 1.2**

Health Insurance Coverage Type, Ages 65 and Over, California, 2012-2016




Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: ESI refers to Employer-Sponsored Insurance, which is also called Employer-Based Insurance.

proportion of this type of coverage remained constant. This increase in Medi-Cal coverage was partially offset by a decline in employer-sponsored health insurance coverage, which decreased from 52.5% to 48.3% over this period.

As the baby-boom generation began to reach age 65, the percentage of older Californians enrolled in Medicare increased from 11.4% to 12.7% between 2012 and 2016, an increase in enrollment of 655,000 individuals. This increase in overall Medicare enrollment was concurrent with an increase in the number of Medicare enrollees who also received health insurance coverage through another source. Between 2012 and 2016, there were significant increases in the numbers enrolled in both Medicare and ESI, with the percentage rising from 1.3% to 1.8%, as well as among those enrolled in both Medicare and Medicaid, with a rise in percentage from 2.1% to 3.1%.

In contrast, the percentages of older Californians enrolled in a Medicare Advantage or supplemental plan and Medicare alone or with another type of insurance remained steady between 2012 and 2016.

The success of the Medicare program in extending health insurance coverage to those ages 65 and over is evident from the fact that almost no older Californians were uninsured during this period (Exhibit 1.2). More than 99% of those ages 65 and over were insured, and more than 90% were enrolled in Medicare in all three years, although the percentage enrolled in Medicare declined from 96% in 2012 to 93% in 2016. The decline in Medicare enrollment is likely due to growing enrollment in the state's CalPERS pension program, as well as growth in California's aging immigrant population, some of whom are ineligible for participation in Medicare.

Though Medicare covers the vast majority of elderly Californians, most Medicare enrollees have additional coverage beyond traditional Medicare through Medi-Cal, a former employer, or a Medicare Advantage or Supplemental plan. The proportion of Medicare enrollees who were dually enrolled in Medi-Cal increased significantly, from 17.4% to 22.6%, between 2012 and 2016, with most of this increase occurring between 2014 and 2016. The increase in dual enrollment can likely be attributed to the Cal Medi-Connect program, California's implementation of the Medicare-Medicaid Financial Alignment Initiative (FAI). Under the ACA, the Center for Medicare and Medicaid Services (CMS) developed the FAI in order to test methods of improving care coordination between Medicare and Medicaid.

As part of this program, Cal Medi-Connect began passively enrolling dually eligible Californians in the program beginning in April 2014 and continued to do so through 2016. The proportion of Medicare enrollees who also held insurance through a current or former employer increased only slightly, from 10.9% in 2012 to 12.9% in 2016. More than half of older Californians purchased a Medicare Advantage plan or a Medicare supplemental plan during this period, though the percentage declined over time as the percentage enrolled in Medi-Cal increased.[3] In 2012, 61.1% of older Californians were enrolled in one of these types of plans, but by 2016 the percentage had declined to 51.7%.

3 Medicare Advantage plans — which include managed care plans — and supplemental private plans are combined in a single question on the CHIS survey and cannot be reported separately.

## Exhibit 1.3

Health Insurance Coverage Type by Gender, Ages 0-64, California, 2012-2016

| | Men | | | Women | | |
|---|---|---|---|---|---|---|
| | 2012 | 2014 | 2016 | 2012 | 2014 | 2016 |
| **Uninsured** | 17.8%<br>2,896,000 | 16.7%<br>2,734,000 | 10.2%<br>1,700,000 | 14.9%<br>2,420,000 | 10.6%<br>1,724,000 | 6.7%<br>1,112,000 |
| **Medi-Cal/Healthy Families** | 20.5%<br>3,349,000 | 23.4%<br>3,839,000 | 31.6%<br>5,253,000 | 23.9%<br>3,878,000 | 29.6%<br>4,828,000 | 37.1%<br>6,125,000 |
| **Employer-Based Insurance** | 53.4%<br>8,707,000 | 51.8%<br>8,501,000 | 49.6%<br>8,237,000 | 51.7%<br>8,385,000 | 50.3%<br>8,219,000 | 46.9%<br>7,754,000 |
| **Privately Purchased Insurance** | 5.4%<br>885,000 | 6.9%<br>1,126,000 | 6.6%<br>1,090,000 | 6.3%<br>1,023,000 | 7.8%<br>1,272,000 | 7.2%<br>1,181,000 |
| **Other Public (Including Medicare <65)** | 2.9%<br>479,000 | 1.4%<br>221,000 | 1.9%<br>323,000 | 3.1%<br>507,000 | 1.7%<br>283,000 | 2.1%<br>348,000 |

Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: "Privately Purchased" includes Covered California insurance, both with and without subsidies. Percentages may not add to 100% due to rounding.

# Demographic Disparities in Health Insurance Coverage

## Gender

Female Californians were less likely to be uninsured and more likely to have Medi-Cal coverage than male Californians throughout the period (Exhibit 1.3). However, both groups experienced improvements in coverage and were less likely to be uninsured in 2016 than in 2012. Among male Californians under age 65, the uninsured rate decreased from 17.8% to 10.2%, while among female Californians, it decreased from 14.9% to 6.7%. Though they began the period with lower uninsured rates, women were early adopters of the ACA's expansion of coverage. They experienced a steady decline in their uninsured rate over the period, with significant decreases in both two-year periods. In contrast, nearly all of the decline in the uninsured rate among men occurred between 2014 and 2016. Women were more likely than men to enroll in Medi-Cal during this period, widening the gender gap in Medi-Cal coverage: Men's enrollment in Medi-Cal increased from 20.5% to 31.6% between 2012 and 2016, while women's enrollment increased from 23.9% to 37.1%. Both men and women experienced a decline in coverage through an employer.

Unlike the situation for those under age 65, there were few gender differences in coverage within the 65-and-older California population (Exhibit 1.4).

## Exhibit 1.4

Health Insurance Coverage Type by Gender, Ages 65 and Over, California, 2012-2016

| | | Men | | | Women | | |
|---|---|---|---|---|---|---|---|
| | | 2012 | 2014 | 2016 | 2012 | 2014 | 2016 |
| **Medicare (Ages 65+)** | **And Medi-Cal** | 19.0%<br>363,000 | 16.3%<br>345,000 | 22.9%<br>537,000 | 16.2%<br>404,000 | 19.3%<br>523,000 | 22.4%<br>650,000 |
| | **And ESI** | 11.6%<br>222,000 | 14.6%<br>310,000 | 14.6%<br>344,000 | 10.3%<br>256,000 | 8.8%<br>239,000 | 11.5%<br>334,000 |
| | **Advantage/Supplemental** | 58.5%<br>1,119,000 | 58.2%<br>239,000 | 47.7%<br>1,121,000 | 63.0%<br>1,569,000 | 60.3%<br>1,634,000 | 55.0%<br>1,594,000 |
| | **Other Medicare** | 6.7%<br>128,000 | 5.9%<br>1,634,000 | 7.0%<br>164,000 | 6.4%<br>160,000 | 6.3%<br>172,000 | 4.5%<br>132,000 |
| | **Other Insured†** | 3.5%<br>67,000 | 4.8%<br>101,000 | 7.3%<br>170,000 | 3.5%<br>88,000 | 4.4%<br>118,000 | 5.8%<br>168,000 |

† Includes those enrolled in Medi-Cal or ESI only, private purchase, or other public insurance coverage

Note: ESI refers to Employer-Sponsored Insurance, which is also called Employer-Based Insurance.

Note: Data on the uninsured are not shown, so percentages will not total to 100%.

Sources: 2012, 2014, and 2016 California Health Interview Surveys

The largest gender difference was in the percentage covered through Medicare Advantage or a Medicare supplemental plan. More women than men are covered by this type of plan each year (though this difference was not significant in 2014); for example, in 2016, 55.0% of women had a Medicare Advantage or supplemental plan, compared to only 47.7% of men. Women were less likely to be jointly enrolled in Medicare and an employer plan. Though both men and women experienced increased enrollment in both Medicare and Medi-Cal, only the increase among women was significant, extending the gender difference in Medi-Cal coverage into older ages.

## Racial and Ethnic Group

Two of the most important effects of the ACA's coverage expansion have been the near-elimination of race-based differences in coverage rates among nonelderly non-Latino Californians, and a significant reduction in the gap between Latino and non-Latino Californians (Exhibit 1.5). In 2012, 10.3% of non-Latino white Californians were uninsured, compared to 11.9% of non-Latino African Americans, 14.1% of non-Latino Asians and Pacific Islanders, and 11.1% of non-Latinos who were multiracial or another race. After the expansion in coverage, all of these groups experienced significant gains in coverage, so that by 2016, only 5.8% of non-Latino whites, 5.8% of non-Latino African Americans, 5.6% of non-Latino

**Exhibit 1.5**

Health Insurance Coverage Type by Race/Ethnicity, Ages 0-64, California, 2012-2016

| | | Uninsured | Medi-Cal/ Healthy Families | Employment-Based Insurance | Privately Purchased Insurance | Other Public† |
|---|---|---|---|---|---|---|
| **Latino** | **2012** | 23.3%<br>3,152,000 | 34.4%<br>4,651,000 | 35.9%<br>4,857,000 | 3.3%<br>451,000 | 3.1%<br>420,000 |
| | **2014** | 20.1%<br>2,766,000 | 39.6%<br>5,440,000 | 34.7%<br>4,770,000 | 4.3%<br>589,000 | 1.4%<br>187,000 |
| | **2016** | 12.3%<br>1,728,000 | 47.8%<br>6,692,000 | 33.7%<br>4,719,000 | 4.0%<br>558,000 | 2.1%<br>295,000 |
| **Non-Latino White** | **2012** | 10.3%<br>1,204,000 | 9.5%<br>1,113,000 | 69.3%<br>8,119,000 | 8.2%<br>962,000 | 2.7%<br>311,000 |
| | **2014** | 7.6%<br>885,000 | 13.0%<br>1,510,000 | 67.7%<br>7,838,000 | 9.8%<br>1,139,000 | 1.8%<br>211,000 |
| | **2016** | 5.8%<br>663,000 | 20.3%<br>2,326,000 | 61.6%<br>7,055,000 | 10.4%<br>1,187,000 | 2.0%<br>229,000 |
| **Non-Latino African American** | **2012** | 11.9%<br>220,000 | 37.2%<br>688,000 | 42.3%<br>781,000 | ***<br>54,000 | 5.7%<br>104,000 |
| | **2014** | 8.2%<br>149,000 | 33.3%<br>607,000 | 52.8%<br>963,000 | ***<br>63,000 | ***<br>40,000 |
| | **2016** | 5.8%<br>107,000 | 48.5%<br>898,000 | 39.9%<br>739,000 | ***<br>57,000 | ***<br>53,000 |
| **Non-Latino Asian and Pacific Islander** | **2012** | 14.1%<br>627,000 | 13.4%<br>592,000 | 61.3%<br>2,714,000 | 8.3%<br>368,000 | 2.9%<br>129,000 |
| | **2014** | 12.4%<br>558,000 | 19.1%<br>858,000 | 55.9%<br>2,516,000 | 11.3%<br>509,000 | ***<br>57,000 |
| | **2016** | 5.6%<br>259,000 | 23.0%<br>1,073,000 | 62.5%<br>2,915,000 | 7.7%<br>358,000 | ***<br>61,000 |
| **Non-Latino Other Race or Multiple Races** | **2012** | 11.1%<br>112,000 | 18.1%<br>183,000 | 61.4%<br>620,000 | ***<br>73,000 | ***<br>22,000 |
| | **2014** | 9.2%<br>101,000 | 23.1%<br>252,000 | 58.0%<br>634,000 | ***<br>98,000 | ***<br>9,000 |
| | **2016** | 4.8%<br>55,000 | 33.9%<br>389,000 | 49.0%<br>563,000 | ***<br>109,000 | ***<br>33,000 |

† Includes Californians ages 18-64 who are enrolled in Medicare

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: "Privately Purchased" includes Covered California insurance, both with and without subsidies. Percentages may not add to 100% due to rounding.

Asians and Pacific Islanders, and 4.8% of non-Latinos who were multiracial or another race were uninsured. In contrast to non-Latinos, Californian Latinos experienced much higher uninsured rates throughout the period, even though Latinos experienced the largest percentage point drop in their uninsured rate. In 2012, 23.3% of nonelderly Latinos were uninsured; by 2016, their uninsured rate had declined to 12.3%.

Every racial/ethnic group accomplished this increase in coverage primarily through significant increases in enrollment in Medi-Cal among the nonelderly. Between 2012 and 2016, Medi-Cal enrollment increased from 9.5% to 20.3% among non-Latino whites, 34.4% to 47.8% among Latinos, 37.2% to 48.5% among non-Latino African Americans, 13.4% to 23.0% among non-Latino Asians and Pacific Islanders, and 18.1% to 33.9% among non-Latinos who were multiracial or another race. Declines in ESI partially offset these gains in coverage among non-Latino whites and non-Latinos who were multiracial or another race, though only the change for non-Latino whites reached statistical significance. The percentage of non-Latino whites who were covered through an employer decreased from 69.3% in 2012 to 61.6% in 2016; among non-Latinos who were multiracial or another race, the decline was from 61.4% to 49.0%.

There were significant racial/ethnic differences in the type of coverage among Californians who were ages 65 and over (Exhibit 1.6). In 2012, before the Medi-Connect program went into effect, non-Latino white and multiracial or other race Californians were significantly more likely to be enrolled in a Medicare

## Exhibit 1.6

Health Insurance Coverage Type by Race/Ethnicity, Ages 65 and Over, California, 2012-2016

| | | Medicare (Ages 65+) | | | |
|---|---|---|---|---|---|
| | | And Medi-Cal | And ESI | Advantage or Supplemental | Any Other |
| Latino | 2012 | 39.5%<br>270,000 | 5.8%<br>40,000 | 42.0%<br>287,000 | 7.3%<br>50,000 |
| | 2014 | 38.2%<br>325,000 | 8.2%<br>70,000 | 38.7%<br>329,000 | 4.0%<br>34,000 |
| | 2016 | 44.5%<br>466,000 | ***<br>56,000 | 31.7%<br>333,000 | ***<br>68,000 |
| Non-Latino White | 2012 | 7.3%<br>209,000 | 12.7%<br>367,000 | 70.0%<br>2,016,000 | 6.5%<br>188,000 |
| | 2014 | 6.2%<br>186,000 | 13.1%<br>393,000 | 70.2%<br>2,106,000 | 6.8%<br>204,000 |
| | 2016 | 10.5%<br>335,000 | 15.2%<br>485,000 | 63.5%<br>2,030,000 | 5.5%<br>177,000 |
| Non-Latino African American | 2012 | 30.3%<br>67,000 | 9.0%<br>20,000 | 49.0%<br>108,000 | ***<br>13,000 |
| | 2014 | 28.5%<br>74,000 | ***<br>39,000 | 47.0%<br>122,000 | ***<br>10,000 |
| | 2016 | 35.0%<br>91,000 | ***<br>44,000 | 38.3%<br>100,000 | ***<br>12,000 |
| Non-Latino Asian and Pacific Islander | 2012 | 39.6%<br>207,000 | 8.5%<br>44,000 | 41.5%<br>217,000 | 5.3%<br>28,000 |
| | 2014 | 41.3%<br>254,000 | 6.1%<br>37,000 | 41.4%<br>254,000 | ***<br>45,000 |
| | 2016 | 43.0%<br>267,000 | 9.3%<br>57,000 | 32.3%<br>200,000 | ***<br>32,000 |

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: ESI refers to Employer-Sponsored Insurance, which is also called Employer-Based Insurance.

Note: Categories with too many unstable estimates have been excluded, including the uninsured, older persons with only non-Medicare coverage, and persons of other single or multiple races.

Advantage or Medicare supplemental plan and less likely to be enrolled in Medicare and Medi-Cal than other older Californians. In 2012, 70.0% of non-Latino white Californians were enrolled in a Medicare Advantage or supplemental plan, compared to only 42.0% of Latinos, 49.0% of non-Latino African Americans, and 41.5% of non-Latino Asian or Pacific Islanders. Enrolled in both Medicare and Medi-Cal were 39.5% of Latinos, 30.3% of non-Latino African Americans, and 39.6% of non-Latino Asians and Pacific Islanders.

These differences in coverage are likely due to racial/ethnic disparities in socioeconomic status. After the implementation of the Medi-Connect program, enrollment in Medi-Cal increased significantly; however, this increase was smallest among non-Latino whites and largest among non-Latino multiracial Californians and Californians of another race, increasing the differences between non-Latino whites and other Californians. In 2016, 63.5% of non-Latino white Californians over age 65 were enrolled in a Medicare Advantage or a supplemental plan, compared to only 31.7% of Latinos, 38.3% of non-Latino African Americans, and 32.3% of non-Latino Asian or Pacific Islanders. In contrast, only 10.5% of non-Latino whites were enrolled in both Medicare and Medi-Cal, a percentage significantly lower than the 44.5% of Latinos, 35.0% of non-Latino African Americans, and 43.0% of non-Latino Asians and Pacific Islanders.

## Exhibit 1.7

Health Insurance Coverage Type by Income as a Percentage of the Federal Poverty Level (FPL), Ages 0-64 Years, California, 2012-2016

| | | Uninsured | Medi-Cal/ Healthy Families | Employment-Based Insurance | Privately Purchased Coverage | Other Public Coverage† |
|---|---|---|---|---|---|---|
| **Below 139% FPL** | **2012** | 26.2%<br>2,562,000 | 49.7%<br>4,861,000 | 16.3%<br>1,591,000 | 3.4%<br>336,000 | 4.4%<br>431,000 |
| | **2014** | 20.5%<br>2,046,000 | 58.6%<br>5,856,000 | 14.7%<br>1,471,000 | 4.4%<br>443,000 | 1.8%<br>178,000 |
| | **2016** | 11.6%<br>1,153,000 | 73.1%<br>7,248,000 | 10.2%<br>1,011,000 | 2.8%<br>281,000 | 2.3%<br>226,000 |
| **139-249% FPL** | **2012** | 23.0%<br>1,343,000 | 28.1%<br>1,638,000 | 39.9%<br>2,328,000 | 4.9%<br>283,000 | 4.2%<br>247,000 |
| | **2014** | 22.0%<br>1,312,000 | 29.5%<br>1,759,000 | 39.7%<br>2,366,000 | 6.6%<br>391,000 | 2.2%<br>134,000 |
| | **2016** | 11.8%<br>654,000 | 42.0%<br>2,317,000 | 36.9%<br>2,037,000 | 7.0%<br>387,000 | ***<br>129,000 |
| **250-399% FPL** | **2012** | 14.2%<br>774,000 | 9.4%<br>514,000 | 64.7%<br>3,522,000 | 8.5%<br>461,000 | 3.1%<br>170,000 |
| | **2014** | 10.5%<br>576,000 | 12.3%<br>675,000 | 66.8%<br>3,679,000 | 9.1%<br>503,000 | 1.3%<br>71,000 |
| | **2016** | 8.9%<br>469,000 | 18.5%<br>982,000 | 58.8%<br>3,117,000 | 10.8%<br>573,000 | ***<br>161,000 |
| **400% FPL or Above** | **2012** | 5.6%<br>637,000 | 1.9%<br>214,000 | 84.2%<br>9,650,000 | 7.2%<br>828,000 | 1.2%<br>138,000 |
| | **2014** | 4.6%<br>524,000 | 3.3%<br>377,000 | 81.5%<br>9,204,000 | 9.4%<br>1,062,000 | 1.1%<br>121,000 |
| | **2016** | 4.3%<br>536,000 | 6.7%<br>831,000 | 79.4%<br>9,825,000 | 8.3%<br>1,030,000 | 1.2%<br>154,000 |

† Includes Californians ages 18-64 who are enrolled in Medicare

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014 and 2016 California Health Interview Surveys

Note: "Privately Purchased" includes Covered California insurance, both with and without subsidies.

### Household Income

The ACA's coverage expansion predominantly expanded access to those with incomes below 400% of the federal poverty level (FPL) through the Medicaid eligibility expansion and provision of subsidies to purchase coverage through Covered California. The success of these provisions can be seen in the fact that these were the Californians who experienced the largest improvements in their coverage rates (Exhibit 1.7). The uninsured rate decreased significantly for those with household incomes below 139% FPL (from 26.2% to 11.6%), those with incomes between 139% FPL and 249% FPL (from 23.0% to 11.8%), and those with household incomes between 250% FPL and 399% FPL (from 14.2% to 8.9%). Only households with incomes of 400% FPL or more did not experience a significant drop in the percentage of uninsured, though the uninsured rate for this group reached a low of 4.3% in 2016. From these results, it's clear that the ACA was successful in substantially reducing income-based disparities in health insurance coverage.

Under the ACA's Medicaid eligibility rules, adults with household incomes below 139% FPL and children in households with incomes below 266% FPL became eligible for coverage through Medicaid. Many of these children were already enrolled in the California Healthy Families Program (HFP) — the state's implementation of the federal Children's Health Insurance Program (CHIP) — and were automatically enrolled in Medi-Cal as of January

2014. Consistent with these changes, the largest increases in Medi-Cal coverage between 2012 and 2016 occurred among those with household incomes below 139% (from 49.7% to 73.1%). Nonelderly Californians with incomes between 139% FPL and 249% FPL also experienced a significant increase in Medi-Cal enrollment (from 28.1% to 42.0%). Even those with household incomes above the Medi-Cal eligibility threshold experienced smaller, but still significant, increases in Medi-Cal enrollment. Medi-Cal enrollment increased from 9.4% in 2012 to 18.5% in 2016 among those with household incomes between 250% FPL and 399% FPL, and from 1.9% to 6.7% among those with household incomes of 400% FPL or more. Health insurance coverage through an employer declined among all four income groups, but only the declines among those with incomes below 139% FPL or above 399% FPL were significant.[4]

4 This discrepancy between household income and Medi-Cal eligibility has several sources. First, Medi-Cal eligibility is based on income earned in the past month, whereas this analysis is based on household income in the previous calendar year. Some households that had higher income in the previous year could have experienced a change in income that now made them eligible for Medi-Cal. Second, this analysis is based on total household income from all sources; however, certain types of income, such as child support or worker's compensation, are disregarded when calculating Medi-Cal eligibility. This means that total household income may exceed the total family income that is used to establish eligibility. Finally, it is possible that a household that previously qualified for Medi-Cal has since experienced an increase in income that leaves the household no longer eligible. Because Medi-Cal income redeterminations occur once per year, household members may have retained their Medi-Cal coverage after they were no longer eligible.

Similar differences in coverage type are seen when older Californians are compared by income (Exhibit 1.8). Higher-income older Californians were more likely than those with lower incomes to be enrolled in a Medicare Advantage or supplemental plan and less likely to be dually enrolled in Medicare and Medi-Cal. Although most Medicare enrollees have coverage beyond traditional Medicare — through either a Medicare Advantage plan or another type of plan — initially, those with incomes above 400% FPL were significantly more likely than other older Californians to have this additional coverage. High-income California residents were less likely than those with less income to fall in the "any other" Medicare group, which is predominantly those who are insured through Medicare alone and do not have a secondary source of coverage. Among those with incomes above 400% FPL, 4.5% fall into this group, compared to 7.8% of those with incomes below 139% FPL, 8.8% of those with incomes between 139% FPL and 250% FPL, and 7.1% of those with incomes between 250% FPL and 400% FPL. If not for the availability of Medi-Cal to those with lower income, the difference would have been larger. About half of those with incomes below 139% FPL were enrolled in both Medicare and Medi-Cal in 2012, compared to only 3.3% of those with incomes over 400% FPL. In contrast, just over one-third of those in the lowest-income group were enrolled in a Medicare Advantage or supplemental plan, while 71.7% of those with incomes above 400% FPL had this type of plan.

A significant increase in dual-coverage Medi-Cal between 2012 and 2016 occurred exclusively among older people with incomes below 250% FPL. Among those with incomes below 139% FPL, the percentage

## Exhibit 1.8

Health Insurance Coverage Type by Income as a Percentage of the Federal Poverty Level (FPL), Ages 65 and Over, California, 2012-2016

| | | Medicare (Ages 65+) | | | | Other Insured† |
|---|---|---|---|---|---|---|
| | | And Medi-Cal | And ESI | Advantage or Supplemental | Any Other | |
| **Below 139% FPL** | **2012** | 49.2%<br>456,000 | 4.5%<br>42,000 | 35.0%<br>325,000 | 7.8%<br>72,000 | 1.6%<br>15,000 |
| | **2014** | 52.3%<br>475,000 | ***<br>27,000 | 29.1%<br>265,000 | ***<br>86,000 | 5.2%<br>47,000 |
| | **2016** | 60.2%<br>725,000 | 2.8%<br>33,000 | 22.2%<br>267,000 | ***<br>69,000 | 7.3%<br>88,000 |
| **139-249% FPL** | **2012** | 18.9%<br>163,000 | 7.6%<br>65,000 | 61.5%<br>528,000 | 8.8%<br>76,000 | 2.4%<br>21,000 |
| | **2014** | 23.2%<br>252,000 | 9.9%<br>108,000 | 54.9%<br>596,000 | 8.0%<br>87,000 | 3.2%<br>34,000 |
| | **2016** | 26.2%<br>265,000 | 8.2%<br>83,000 | 49.3%<br>499,000 | 11.5%<br>116,000 | 4.3%<br>43,000 |
| **250-399% FPL** | **2012** | 10.3%<br>91,000 | 11.2%<br>99,000 | 67.2%<br>596,000 | 7.1%<br>63,000 | ***<br>*** |
| | **2014** | 9.0%<br>89,000 | 10.9%<br>107,000 | 68.6%<br>672,000 | 6.6%<br>65,000 | ***<br>*** |
| | **2016** | 11.6%<br>95,000 | 17.7%<br>144,000 | 60.9%<br>498,000 | ***<br>31,000 | 5.8%<br>47,000 |
| **400% FPL or Above** | **2012** | 3.3%<br>57,000 | 15.7%<br>272,000 | 71.7%<br>1,240,000 | 4.5%<br>77,000 | 4.7%<br>81,000 |
| | **2014** | 2.9%<br>53,000 | 16.5%<br>307,000 | 71.9%<br>1,336,000 | 3.2%<br>60,000 | 5.5%<br>102,000 |
| | **2016** | 4.6%<br>103,000 | 18.8%<br>417,000 | 65.5%<br>1,452,000 | 3.6%<br>79,000 | 7.2%<br>160,000 |

† Includes those enrolled in Medi-Cal or ESI only, private purchase, or other public insurance coverage

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: Categories with too many unstable estimates have been excluded, including the uninsured.

with Medicare and Medi-Cal increased by 11 percentage points, while it increased by 7.3 percentage points among those with incomes between 139% and 249% FPL. Among those with incomes of 250% FPL and above, the percentage with Medi-Cal was unchanged. This increase in coverage in Medi-Cal among lower-income older Californians was offset by a decline in enrollment in Medicare Advantage or supplemental plans, with enrollment falling by more than 12 percentage points in the two lowest income groups. Among those with incomes between 139% and 249% FPL, the decline in Medicare Advantage exceeded the increase in dual enrollment in Medi-Cal, resulting in a significantly higher percentage of Medicare enrollees who were enrolled in traditional Medicare alone, without another form of coverage. Enrollment in Medicare Advantage and supplemental plans also decreased among those with incomes of 250% FPL and above, though by a smaller amount. This decrease was driven in part by increases in coverage through Medicare and ESI and in other non-Medicare coverage among these higher-income groups, though these increases were not statistically significant.

## Urban vs. Rural Residence

The gains in health insurance coverage were widespread across California, reaching through urban and rural areas alike (Exhibit 1.9). The uninsured rate decreased from 17.8% to 10.1% in primary urban areas, from 15.3% to 6.8% in second cities (usually around 1 million people, limited to regional impact), from 12.9% to 6.0% in suburban areas, and from 16.9% to 7.8% in rural areas and small towns. All of these areas experienced dramatic increases in Medi-Cal enrollment, though enrollment was lower in suburban areas than in other areas. In suburban areas of the state, Medi-Cal enrollment increased from 14.6% to 23.3%, while in urban areas it increased from 24.4% to 36.4%, in second cities from 21.7% to 36.5%, and in rural areas and small towns from 25.2% to 37.7%.

### Exhibit 1.9

Health Insurance Coverage Type by Urban-Rural Status, Ages 0-64 Years, California, 2012-2016

| | | Uninsured | Medi-Cal/ Healthy Families | Employment-Based Insurance | Privately Purchased Coverage | Other Public Coverage† |
|---|---|---|---|---|---|---|
| **Urban** | **2012** | 17.8%<br>2,989,000 | 24.4%<br>4,097,000 | 49.1%<br>8,250,000 | 5.4%<br>907,000 | 3.3%<br>549,000 |
| | **2014** | 14.2%<br>2,483,000 | 28.5%<br>4,986,000 | 49.2%<br>8,616,000 | 6.9%<br>1,207,000 | 1.2%<br>217,000 |
| | **2016** | 10.1%<br>1,744,000 | 36.4%<br>6,277,000 | 45.4%<br>7,822,000 | 6.0%<br>1,038,000 | 2.0%<br>343,000 |
| **Second City** | **2012** | 15.3%<br>1,082,000 | 21.7%<br>1,528,000 | 54.1%<br>3,818,000 | 5.9%<br>415,000 | 2.9%<br>208,000 |
| | **2014** | 14.0%<br>988,000 | 27.0%<br>1,911,000 | 51.2%<br>3,620,000 | 6.0%<br>425,000 | 1.8%<br>128,000 |
| | **2016** | 6.8%<br>495,000 | 36.5%<br>2,656,000 | 48.6%<br>3,539,000 | 6.2%<br>449,000 | 1.9%<br>139,000 |
| **Suburban** | **2012** | 12.9%<br>714,000 | 14.6%<br>809,000 | 63.0%<br>3,491,000 | 7.2%<br>399,000 | 2.4%<br>131,000 |
| | **2014** | 11.0%<br>559,000 | 17.5%<br>892,000 | 59.4%<br>3,029,000 | 11.0%<br>561,000 | ***<br>54,000 |
| | **2016** | 6.0%<br>335,000 | 23.3%<br>1,297,000 | 60.9%<br>3,394,000 | 8.4%<br>468,000 | ***<br>76,000 |
| **Rural/Town** | **2012** | 16.9%<br>531,000 | 25.2%<br>793,000 | 48.8%<br>1,532,000 | 5.9%<br>186,000 | 3.1%<br>99,000 |
| | **2014** | 13.9%<br>428,000 | 28.5%<br>877,000 | 47.4%<br>1,455,000 | 6.7%<br>205,000 | 3.5%<br>106,000 |
| | **2016** | 7.8%<br>238,000 | 37.7%<br>1,148,000 | 40.5%<br>1,236,000 | 10.3%<br>315,000 | ***<br>113,000 |

† Includes Californians ages 18-64 who are enrolled in Medicare

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: "Privately Purchased" includes Covered California insurance, both with and without subsidies.

In 2014, when Covered California first opened for business, the percentage of Californians covered through private purchase insurance increased significantly from 2012 rates in urban areas (from 5.4% to 6.9%) and suburban areas (from 7.2% to 11.0%). However, after 2014, rates of coverage through this type of insurance fell in these areas and were no longer significantly different from 2012. The only areas in which coverage through private purchase insurance increased between 2014 and 2016 were rural areas and small towns. In these areas, the percentage covered grew from 5.9% in 2012 to 10.3% in 2016. The declines in private purchase insurance coverage between 2014 and 2016 in urban and suburban areas could reflect increases in premiums during this period; however, premiums were generally higher in rural areas and small towns, where coverage increased. The change in coverage in rural areas and small towns could be a result of the concurrent decline in ESI coverage that occurred in these areas between 2014 and 2016, although urban areas also experienced a significant decline in ESI coverage, but not an increase in private purchase coverage.

Before the Medi-Connect program was implemented, urban areas experienced different patterns of health insurance coverage than less populated areas of the state (Exhibit 1.10). Urban Californians were less likely to be enrolled in a Medicare Advantage or supplemental plan (57.4% vs. 63.4% or more in other areas) or to have ESI coverage in addition to Medicare coverage (8.3% vs. 11.3% or more in other areas), and more likely to have Medicare and Medi-Cal coverage (23.3% vs. 14.1% or less in other areas). The increased enrollment in Medicare and Medi-Cal and the decline in enrollment in Medicare Advantage or supplemental plans occurred throughout the state. The one exception was in suburban areas, where there was no change in coverage between 2012 and 2016.

## Exhibit 1.10

Health Insurance Coverage Type by Urban-Rural Status, Ages 65 and Over, California, 2012-2016

| | | Medicare (Ages 65+) | | | | Other Insured† |
|---|---|---|---|---|---|---|
| | | And Medi-Cal | And ESI | Advantage or Supplemental | (Any Other) | |
| **Urban** | **2012** | 23.3%<br>481,000 | 8.3%<br>172,000 | 57.4%<br>1,184,000 | 5.9%<br>121,000 | 4.1%<br>85,000 |
| | **2014** | 24.0%<br>558,000 | 9.5%<br>221,000 | 54.5%<br>1,269,000 | 5.6%<br>131,000 | 5.3%<br>123,000 |
| | **2016** | 30.1%<br>750,000 | 10.7%<br>266,000 | 46.5%<br>1,159,000 | 4.5%<br>113,000 | 7.7%<br>191,000 |
| **Second City** | **2012** | 11.7%<br>100,000 | 13.1%<br>112,000 | 63.4%<br>543,000 | 6.7%<br>57,000 | 4.3%<br>37,000 |
| | **2014** | 12.5%<br>117,000 | 14.9%<br>141,000 | 59.2%<br>558,000 | 7.8%<br>74,000 | 5.1%<br>48,000 |
| | **2016** | 19.6%<br>212,000 | 14.6%<br>158,000 | 51.4%<br>557,000 | 7.3%<br>80,000 | 5.9%<br>64,000 |
| **Suburban** | **2012** | 14.1%<br>131,000 | 11.3%<br>105,000 | 65.6%<br>609,000 | 6.6%<br>61,000 | ***<br>*** |
| | **2014** | 11.7%<br>108,000 | 9.6%<br>88,000 | 69.9%<br>645,000 | ***<br>46,000 | 3.8%<br>35,000 |
| | **2016** | 12.0%<br>118,000 | 14.3%<br>141,000 | 64.9%<br>639,000 | ***<br>38,000 | ***<br>*** |
| **Rural/Town** | **2012** | 9.7%<br>54,000 | 16.0%<br>89,000 | 63.4%<br>353,000 | 8.8%<br>49,000 | ***<br>*** |
| | **2014** | 13.2%<br>85,000 | 15.4%<br>99,000 | 61.8%<br>397,000 | 7.3%<br>47,000 | 2.1%<br>14,000 |
| | **2016** | 15.5%<br>107,000 | 16.3%<br>113,000 | 52.0%<br>360,000 | 9.3%<br>65,000 | 5.3%<br>37,000 |

† Includes those enrolled in Medi-Cal or ESI only, private purchase, or other public insurance coverage

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014 and 2016 California Health Interview Surveys

Note: Categories with too many unstable estimates have been excluded, including the uninsured.

## Citizenship Status

California has historically experienced a higher uninsured rate than other states due to its large population of noncitizens, who lack access to many public health programs. Because of this lack of access, uninsured rates are strongly related to citizenship status (Exhibit 1.11). In 2012, while only 11.1% of U.S.-born citizens were uninsured, 20.3% of naturalized citizens, 31.1% of noncitizens with a green card (permanent residents), and 47.2% of noncitizens without a green card were uninsured. This final category includes immigrants with authorized status, as well as those whose presence in the U.S. is unauthorized by the federal government.

After implementation of the ACA's coverage expansion, the uninsured rate decreased significantly between 2012 and 2016 among U.S. citizens and permanent residents, and the gap in coverage between U.S.-born and naturalized citizens narrowed substantially. By 2016, the uninsured rate among U.S.-born citizens was reduced to 5.6%, while the uninsured rate among naturalized citizens was reduced to 7.4%. The uninsured rate among permanent residents dropped to 11.1%, a significant improvement but still a significantly higher rate than that of U.S.-born citizens. The ACA restricted its benefits to citizens and lawful permanent residents of the U.S., excluding unauthorized residents from enrolling in Medi-Cal or purchasing health insurance coverage through Covered California.[5] For this reason, although uninsured rates decreased significantly among all other citizenship groups between 2012 and 2014, uninsured rates did not change among noncitizens who did not have a green card, leading to a growing coverage gap. To begin to address this, the state of California expanded

5 Limited-scope, emergency Medi-Cal is still available to all regardless of citizenship status, as is prenatal care for pregnant women. This analysis excludes these types of coverage, since they are not comprehensive medical insurance.

### Exhibit 1.11

Health Insurance Coverage Type by Citizenship Status, Ages 0-64, California, 2012-2016

| | | Uninsured | Medi-Cal/ Healthy Families | Employment-Based Insurance | Privately Purchased Coverage | Other Public Coverage† |
|---|---|---|---|---|---|---|
| U.S.-Born Citizen | 2012 | 11.1%<br>2,614,000 | 23.6%<br>5,541,000 | 56.5%<br>13,277,000 | 6.1%<br>1,433,000 | 2.6%<br>616,000 |
| | 2014 | 9.2%<br>2,162,000 | 26.7%<br>6,244,000 | 55.9%<br>13,096,000 | 6.5%<br>1,533,000 | 1.6%<br>385,000 |
| | 2016 | 5.6%<br>1,355,000 | 34.1%<br>8,210,000 | 51.0%<br>12,273,000 | 6.9%<br>1,673,000 | 2.3%<br>563,000 |
| Naturalized Citizen | 2012 | 20.3%<br>868,000 | 12.6%<br>539,000 | 56.2%<br>2,405,000 | 6.8%<br>293,000 | 4.0%<br>172,000 |
| | 2014 | 12.9%<br>546,000 | 21.4%<br>908,000 | 55.1%<br>2,334,000 | 9.5%<br>403,000 | ***<br>46,000 |
| | 2016 | 7.4%<br>310,000 | 28.8%<br>1,207,000 | 54.5%<br>2,287,000 | 7.8%<br>327,000 | ***<br>63,000 |
| Noncitizen With Green Card | 2012 | 31.1%<br>804,000 | 23.4%<br>605,000 | 36.7%<br>948,000 | 4.2%<br>109,000 | 4.7%<br>122,000 |
| | 2014 | 24.6%<br>743,000 | 31.6%<br>956,000 | 32.0%<br>968,000 | 11.5%<br>349,000 | ***<br>8,000 |
| | 2016 | 11.1%<br>278,000 | 39.0%<br>973,000 | 40.0%<br>996,000 | ***<br>234,000 | ***<br>12,000 |
| Noncitizen Without Green Card | 2012 | 47.2%<br>1,029,000 | 24.9%<br>543,000 | 21.1%<br>461,000 | ***<br>73,000 | ***<br>76,000 |
| | 2014 | 48.8%<br>1,008,000 | 27.0%<br>558,000 | 15.6%<br>322,000 | 5.5%<br>113,000 | ***<br>66,000 |
| | 2016 | 36.8%<br>869,000 | 41.8%<br>988,000 | 18.4%<br>435,000 | ***<br>37,000 | ***<br>33,000 |

† Includes Californians ages 18-64 who are enrolled in Medicare

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014, and 2016 California Health Interview Surveys

Note: "Privately Purchased" includes Covered California insurance, both with and without subsidies.

Medi-Cal coverage to unauthorized children in 2016, which subsequently led to a significant decline in the uninsured rate among noncitizens without a green card. However, in 2016 the uninsured rate for this group remained at 36.8%, more than at least three times higher than the uninsured rate of any other citizenship group.

Here, too, gains in health insurance coverage for all groups were driven by increases in Medi-Cal coverage. The percentage of Californians covered through Medi-Cal increased from 23.6% to 34.1% among U.S.-born citizens, from 12.6% to 28.8% among naturalized citizens, from 23.4% to 39.0% among noncitizens with a green card, and from 24.9% to 41.8% among noncitizens without a green card.[6] These gains in Medi-Cal coverage were partially offset by a decrease in ESI coverage from 56.5% to 51.0% among U.S.-born citizens. Although the percentage of naturalized citizens and permanent residents covered through private purchase insurance increased significantly between 2012 and 2014, coverage through this type of insurance subsequently declined, leaving 2016 rates not significantly different from 2012.

The type of health insurance coverage older Californians have is related to citizenship status (Exhibit 1.12). This is due both to eligibility requirements and to the relative affluence of older U.S.-born citizens compared to naturalized citizens

6 Noncitizens without a green card may have been eligible for Medi-Cal through other legal categorical eligibility requirements, including having a visa or refugee status. It is possible that the coverage rates among this group increased due to a spillover from other family members enrolling and then learning about options for noncitizen family members, but this speculation needs more investigation that cannot be addressed with CHIS data.

## Exhibit 1.12

Health Insurance Coverage Type by Citizenship Status, Ages 65 and Over, California, 2012-2016

| | | Medicare (Ages 65+) | | | | Other Insured† |
|---|---|---|---|---|---|---|
| | | And Medi-Cal | And ESI | Advantage or Supplemental | (Any Other) | |
| U.S.-Born Citizen | 2012 | 10.9%<br>357,000 | 12.2%<br>399,000 | 67.1%<br>2,188,000 | 6.1%<br>200,000 | 3.3%<br>109,000 |
| | 2014 | 10.4%<br>356,000 | 13.5%<br>463,000 | 66.2%<br>2,278,000 | 5.7%<br>195,000 | 4.3%<br>147,000 |
| | 2016 | 14.5%<br>544,000 | 15.5%<br>583,000 | 59.2%<br>2,230,000 | 5.3%<br>200,000 | 5.4%<br>202,000 |
| Naturalized Citizen | 2012 | 34.1%<br>319,000 | 7.2%<br>67,000 | 47.4%<br>442,000 | 7.9%<br>73,000 | 3.3%<br>31,000 |
| | 2014 | 36.8%<br>449,000 | 6.7%<br>82,000 | 44.3%<br>541,000 | ***<br>78,000 | 4.2%<br>52,000 |
| | 2016 | 44.3%<br>523,000 | 7.7%<br>91,000 | 36.1%<br>427,000 | ***<br>81,000 | 4.5%<br>53,000 |
| Noncitizen (Includes Permanent Residents) | 2012 | 43.7%<br>92,000 | ***<br>12,000 | 28.1%<br>59,000 | ***<br>15,000 | 3.3%<br>14,000 |
| | 2014 | 36.8%<br>63,000 | ***<br>4,000 | 29.0%<br>49,000 | ***<br>25,000 | 11.9%<br>20,000 |
| | 2016 | 39.5%<br>120,000 | ***<br>4,000 | ***<br>59,000 | ***<br>15,000 | 27.4%<br>83,000 |

† Includes those enrolled in Medi-Cal or ESI only, private purchase, or other public insurance coverage

*** Unstable estimate (coefficient of variation > 0.3)

Sources: 2012, 2014 and 2016 California Health Interview Surveys

and noncitizens. Due to the small number of respondents over age 65 who are noncitizens and not permanent residents, the two noncitizen groups were combined for this age group. In 2012, U.S.-born citizens were more likely to be enrolled in a Medicare Advantage or supplemental plan (67.1%) than naturalized citizens (47.4%) or noncitizens (28.1%). They were also more likely to have both Medicare and ESI coverage (12.2%) than naturalized citizens (7.2%). However, U.S.-born citizens were less likely to be covered through Medicare and Medi-Cal (10.9%) than either naturalized citizens (34.1%) or noncitizens (43.7%). The high Medicaid enrollment occurred despite the fact that this category contains both permanent residents and nonpermanent residents, with only permanent residents eligible for Medicaid.

Naturalized citizens experienced the largest increase in dual Medicare and Medi-Cal coverage and, subsequently, the largest decrease in coverage through Medicare Advantage. By 2016, the percentage of naturalized citizens enrolled in a Medicare Advantage or supplemental plan had decreased by 11.3 percentage points, to 36.1%, while the percentage enrolled in Medicare and Medicaid had increased by 10.2 percentage points, to 44.3%. U.S.-born citizens experienced a smaller decline in enrollment in Medicare Advantage and supplemental plans (7.9 percentage points) and a smaller increase in Medi-Cal enrollment (3.5 percentage points). U.S.-born citizens were the only group that experienced a significant increase in joint coverage through Medicare and an employer (3.3 percentage points). In contrast to citizens, noncitizens became less likely to be enrolled in Medicare over time, although this change was not statistically significant.

# 2 Private Health Insurance Markets in California

Ian Eve Perry, MPP, and Ken Jacobs

Many of the major provisions of the Affordable Care Act (ACA) that affected individually purchased coverage and Medi-Cal were implemented in 2014. By 2015-2016, employment-based coverage remained the most common source of health insurance for nonelderly adult Californians. In 2015-2016, 50.4% of Californians between the ages of 19 and 64 (or 11.8 million people) had employment-based coverage.[7] Eighty percent (9.5 million people) of the 11.8 million nonelderly adult Californians with employment-based coverage received their coverage from their own employer, and the remaining 20% (2.3 million people) received their coverage through a family member.

The prevalence of employment-based coverage varies significantly depending on individuals' employment situation, region, and demographics.

Nearly 2 million nonelderly adult Californians (8.1%) purchased coverage in the individual market in 2015-2016. In 2014, the ACA brought a number of reforms to the individual market, introducing premium and out-of-pocket subsidies for low- to moderate-income Californians, banning denial of insurance or the setting of premiums based on preexisting health conditions, and limiting how much more insurers could charge older enrollees relative to younger enrollees.

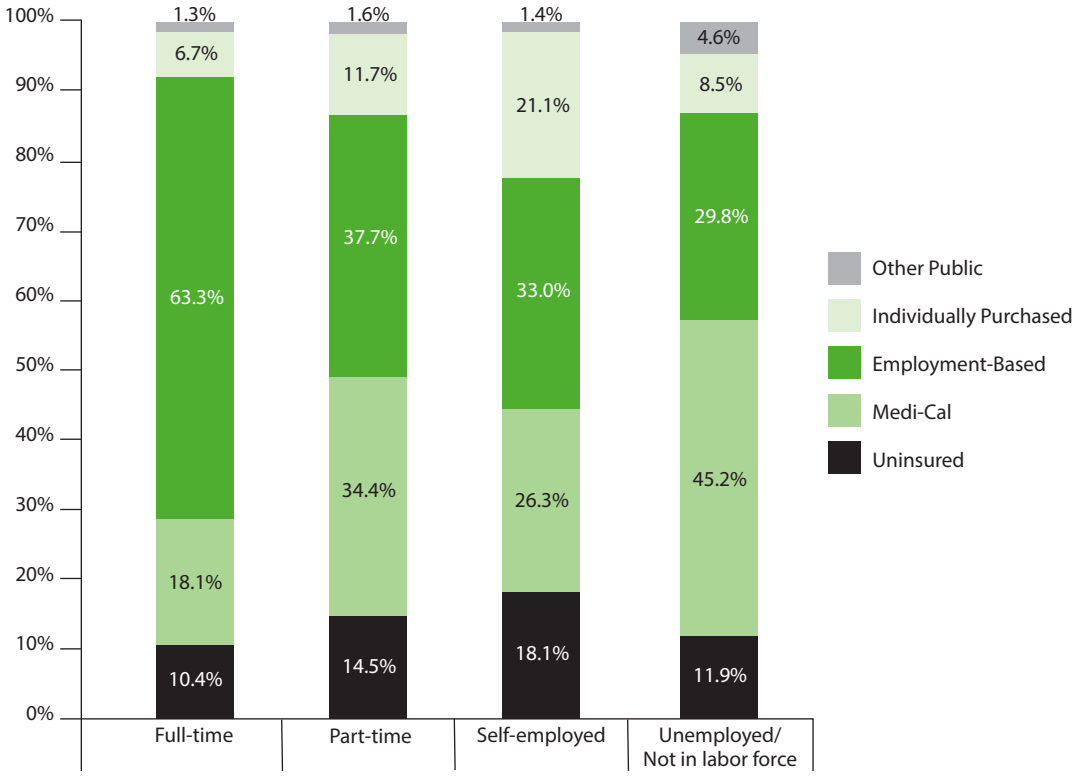
7 Some Californians have multiple sources of health coverage. This chapter uses the following hierarchy to determine a mutually exclusive source of health insurance: Medi-Cal, employment-based coverage, individually purchased coverage, other public insurance, and, finally, being uninsured.

## Full-Time Workers More Likely to Have Employment-Based Coverage Than Part-Time Workers, the Self-Employed, and the Unemployed

In 2015-2016, 11.5% of all working-age Californians (19-64) were uninsured. Half (50.4%) of all working-age Californians were covered through an employment-based plan, but the insurance coverage varied greatly by work status (Exhibit 2.1). Full-time workers were the most likely to receive coverage through an employer (63.3 percent) and the least likely to be uninsured (10.4%) or enrolled in Medi-Cal (18.1%). By contrast, approximately one in three self-employed and part-time workers received employment-based coverage (33% for self-employed Californians and 37.7% for part-time workers), and a similar share of workers in each group were uninsured (18.1% for self-employed Californians and 14.5% for part-time workers). The largest difference between the self-employed and part-time workers was in individually purchased and Medi-Cal coverage. Self-employed Californians were much more likely to be covered through individually purchased plans (21.1% compared to 11.7% for part-time workers), and part-time workers were more likely to have Medi-Cal coverage (34.4%, compared to 26.3% for the self-employed).

**Exhibit 2.1**

Source of Coverage by Work Status, California, Ages 19-64

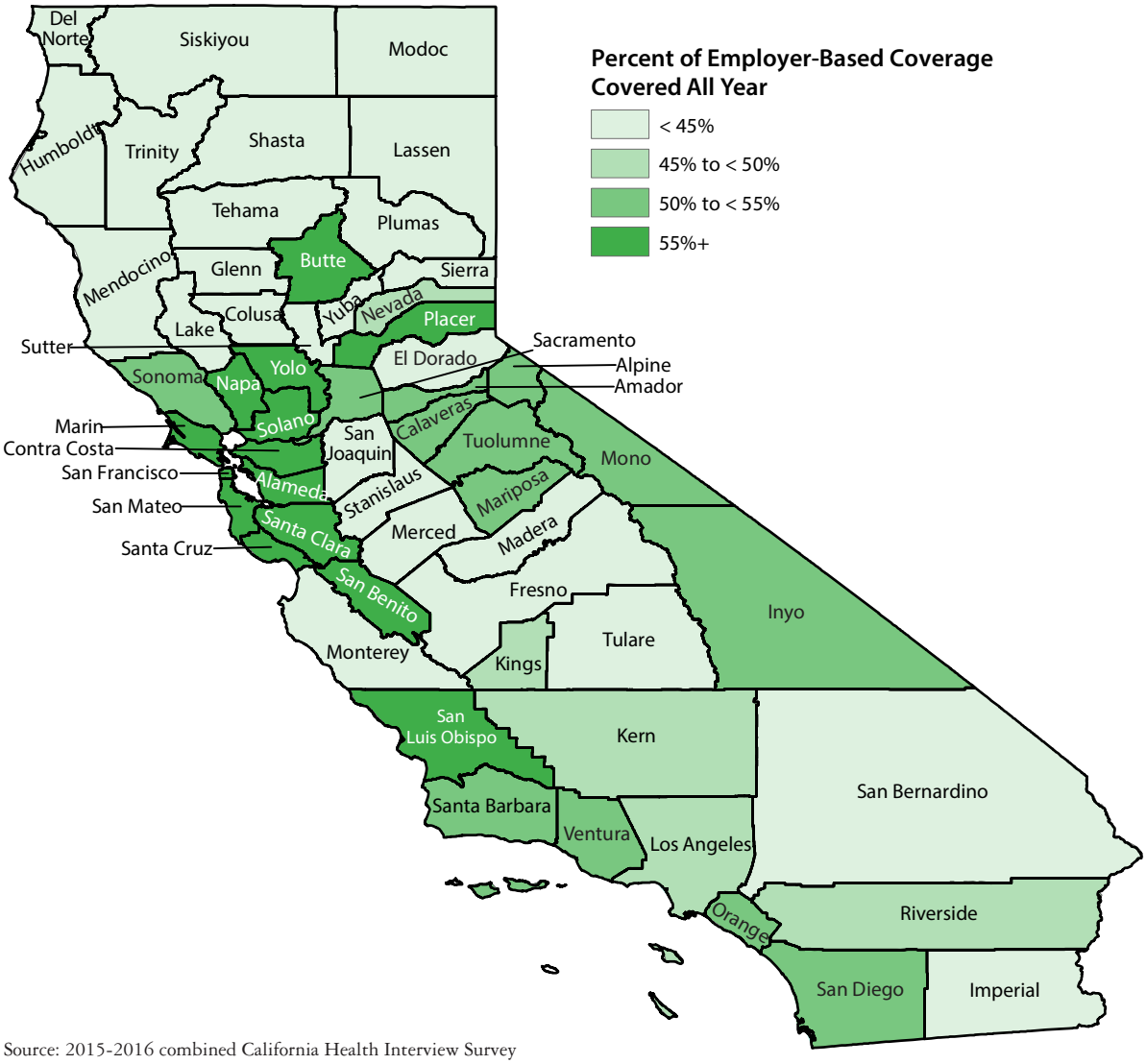



Sources: 2015-2016 combined California Health Interview Survey

Note: Self-employed Californians are also included in the data for full-time and part-time workers.

**Exhibit 2.2**

Employment-Based Coverage Rates by County, Ages 19-64, California, 2015-2016




Source: 2015-2016 combined California Health Interview Survey

## Employment-Based Coverage Was More Common in the Bay Area, Less Common In the Central Valley and Northern California

The prevalence of employment-based coverage varied greatly across California (Exhibit 2.2). While the overall employment-based coverage rate for working-age adult Californians was 50.4%, different areas of the state showed much higher and lower levels of employment-based coverage. The Greater Bay Area had the highest levels of employment-based coverage, with every county except for Sonoma showing coverage rates above 55%. Napa County had the highest share of adults covered through an employment-based plan (71%).

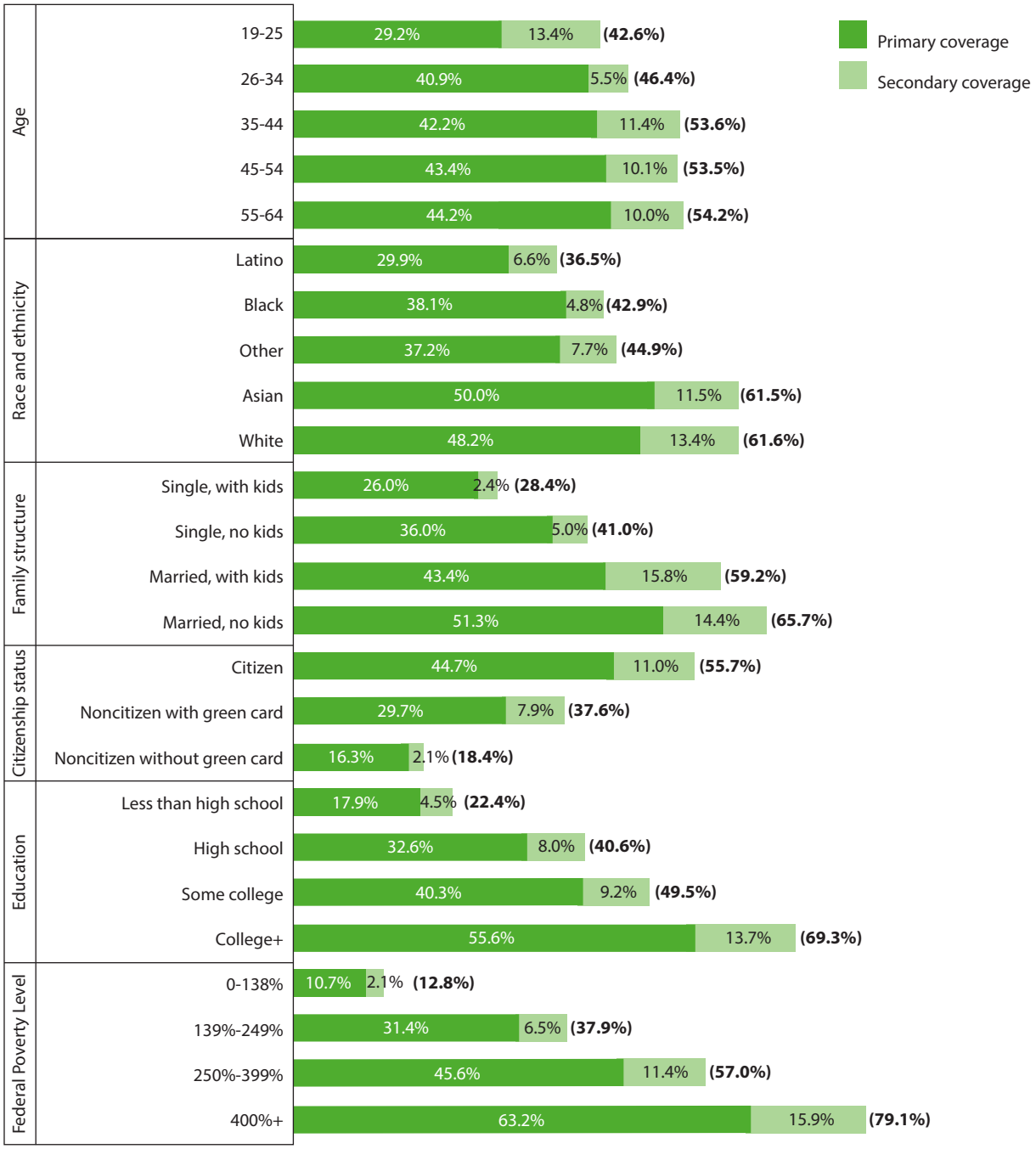
Employment-based coverage was less common in the Central Valley, in Northern California, and in San Bernardino and Imperial counties. In these regions, less than 45% of adults had employment-based coverage. Mendocino County had the lowest rate of employment-based coverage (30%). In Los Angeles County, the largest county by population, less than half of the working-age residents (45%) had employment-based coverage.

## Employment-Based Coverage Was Rarer Among Members of Vulnerable Communities

Having employment-based coverage was correlated with many demographic characteristics and was rarer for more vulnerable groups (Exhibit 2.3). White and Asian nonelderly adult Californians had the highest rates of employment-based coverage (nearly 62% for both groups). Less than half of Latino (36.5%), black (42.9%), and multiracial Californians, as well as Californians from other racial/ethnic groups (44.9%), had employment-based coverage.

**Exhibit 2.3**

Employment-Based Coverage Rates by Demographic Group, Ages 19-64, California, 2015-2016




Source: 2015-2016 combined California Health Interview Survey

Education was another strong predictor of employment-based coverage. Only 22.4% of adult Californians without a high school diploma had employment-based coverage, and fewer than half (40.6%) of Californians with only a high school diploma had employment-based coverage. Employment-based coverage rates were higher for those with at least some college experience. Among Californians with some college experience, 49.5% had employment-based coverage, and 69.3% of Californians with a college or advanced degree were covered through an employment-based plan.

Employment-based coverage was also highly associated with income. Only 12.8% of nonelderly adult Californians in families with income below 139% of the federal poverty level (FPL) had employment-based coverage,[8] but 79.1% of Californians with a family income at or above 400% FPL were covered through an employment-based plan.

8 The low rate of employment-based coverage below 139% FPL may be partially due to the method for determining a mutually exclusive coverage type. Individuals may report having had both employment-based coverage and Medi-Cal coverage during the past year. Since Medi-Cal coverage is higher in the mutually exclusive coverage hierarchy used in this chapter, those individuals would only be counted as receiving coverage through Medi-Cal. This would be most common for adults with incomes at or below 138% FPL because of the ACA's Medicaid expansion.

Age and family structure were also correlated with employment-based coverage. Just 42.6% of Californians between ages 19 and 25 were covered through an employment-based plan, compared to 54.2% of those ages 55 to 64. Adults in married families were more likely than unmarried nonelderly adults to have employment-based coverage.

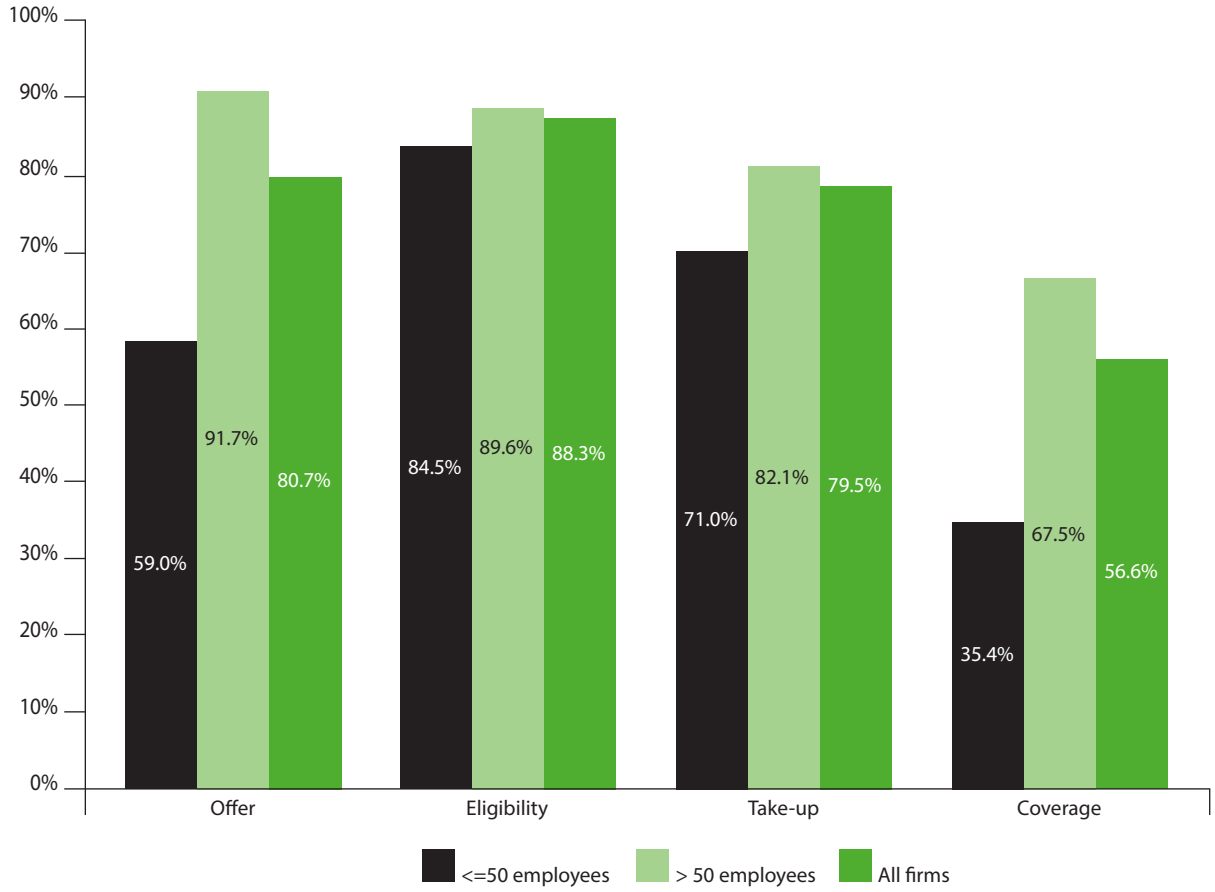
While employment-based coverage was associated with several demographic characteristics, the share of those enrolled in employment-based plans who had their own plan was fairly constant across demographic groups. Overall, 80% of nonelderly adults covered by employment-based insurance had their own plan, a figure that was steady across most demographic groups except those for age and family structure (data not shown). Younger adults were less likely to have their own employment-based coverage, with only 68% of those ages 19 to 25 holding their own employment-based plans. Adults in married couples were also slightly less likely to have their own coverage, presumably because they could receive coverage through their spouse.

## Workers in Larger Firms Were More Likely to Be Offered and to Take Up Employment-Based Coverage

In 2015-2016, 57% of working, nonelderly adult Californians were enrolled in employment-based coverage sponsored by their own employer. However, there was a substantial difference between the coverage rate for workers in firms with fewer than 50 employees (35.4%) and firms with 50 or more employees (67.5%). The difference between coverage rates in small and larger firms is not new, but it remains important because the ACA requires that firms with 50 or more workers offer affordable coverage or pay a fine.

**Exhibit 2.4**

Offer, Eligibility, and Coverage by Firm Size, Working Adults Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

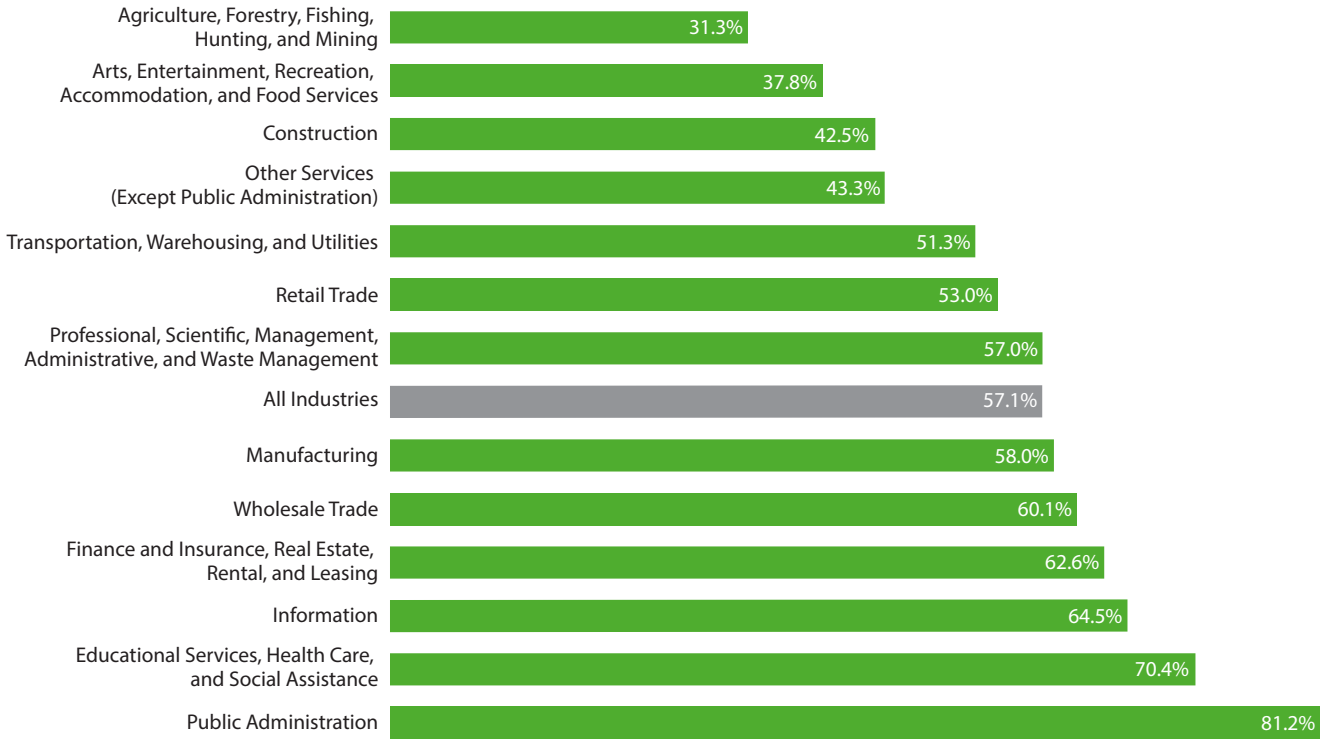
To understand this difference in employment-based coverage, it is helpful to break that coverage rate into three constituent parts: the offer rate, eligibility rate, and takeup rate (Exhibit 2.4). The offer rate measures the share of workers in firms that offered employment-based coverage to any of the firm's employees. Overall, 80.7 percent of California workers were employed in firms that offered employment-based coverage. Again, however, there was a large difference between small and larger firms. In firms with 50 or more employees, 91.7% of workers reported that their employer offered coverage, but only 59% of workers in small firms reported being offered coverage by their employers.

The eligibility rate measures the share of workers in offering firms who were eligible to take up their employer's coverage offer. Not all workers in offering firms were eligible to take up the coverage offer, as the firm may not have offered coverage to part-time workers or may have had restrictions (e.g., waiting periods) for new employees. Overall, 88.3% of workers in offering firms were eligible to take up the offer, with limited differences in eligibility rates by firm size.

The take-up rate measures the share of eligible workers who actually enrolled in their employer's coverage. Across California, 80% of eligible workers chose to enroll in their employer's coverage. There was a small difference in take-up rates between small and larger firms. Among eligible workers in firms with 50 or more employees, 82.1% enrolled in coverage, while only 71% of eligible workers in small firms enrolled. The lower coverage rate for small firms reflected the considerably lower offer and take-up rates at these firms.

**Exhibit 2.5**

Employment-Based Coverage Rates by Industry, Working Adults Ages 19-64, California, 2015-2016



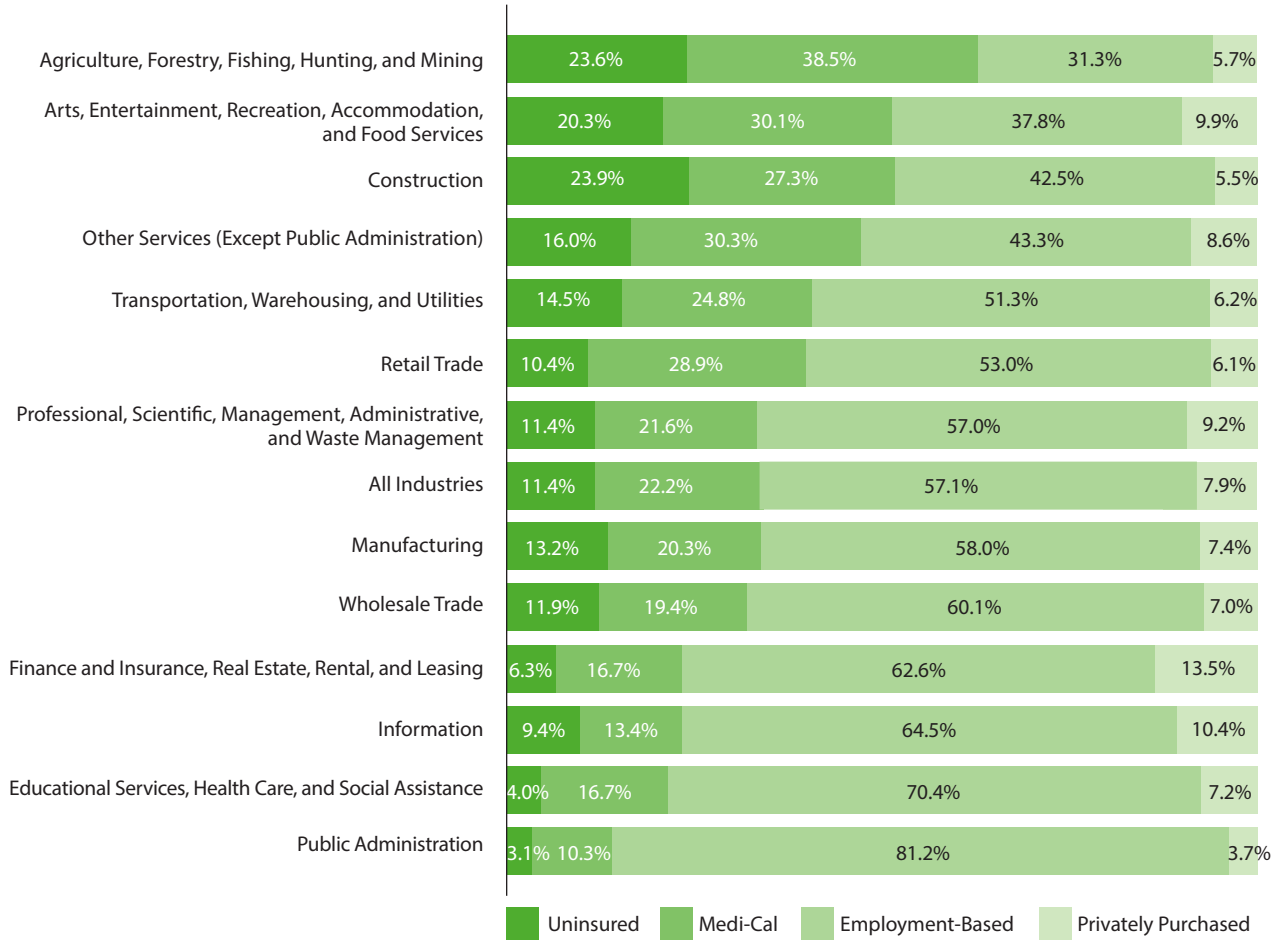

Sources: 2015 and 2016 California Health Interview Surveys

## Uninsurance Was High and Employment-Based Coverage Low in Low-Wage Industries and Occupations

Among all working nonelderly adults in California, 57.1% were insured through employment-based coverage (Exhibit 2.5). There was a wide range across industries in the share of workers covered by employment-based insurance.[9] Industries that traditionally have had a higher fraction of low-wage workers also tended to have lower levels of employment-based coverage. For example, 31.3% of workers in the agriculture, forestry, fishing, hunting, and mining industry and 37.8% of workers in arts, entertainment, recreation, accommodation, and food services were covered by an employment-based plan. Other industries had large portions of their workforce covered by employment-based insurance: 70.4% of workers in educational services, health care, and social assistance and 81.2% of workers in public administration had employment-based coverage.

9 "Industry" refers to the type of work the firm conducts.

**Exhibit 2.6**
Source of Coverage by Industry, Working Adults Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

Uninsurance rates and Medi-Cal enrollment were highest in the industries where employment-based coverage was least common (Exhibit 2.6). Compared to the 11% rate of uninsurance across all industries, 23.6% of agriculture, forestry, fishing, hunting, and mining workers were uninsured, along with 23.9% of workers in construction. Medi-Cal enrollment was also elevated in these industries, with 38.5% of agriculture, forestry, fishing, hunting, and mining workers and 30% of workers in arts, entertainment, recreation, accommodation, and food services enrolled in Medi-Cal, compared to 22.2% of all working-age Californians.

Workers in industries with high levels of employment-based coverage had the lowest rates of uninsurance. Only 4% of educational services, health care, and social assistance workers and 3.1% of public administration workers were uninsured.

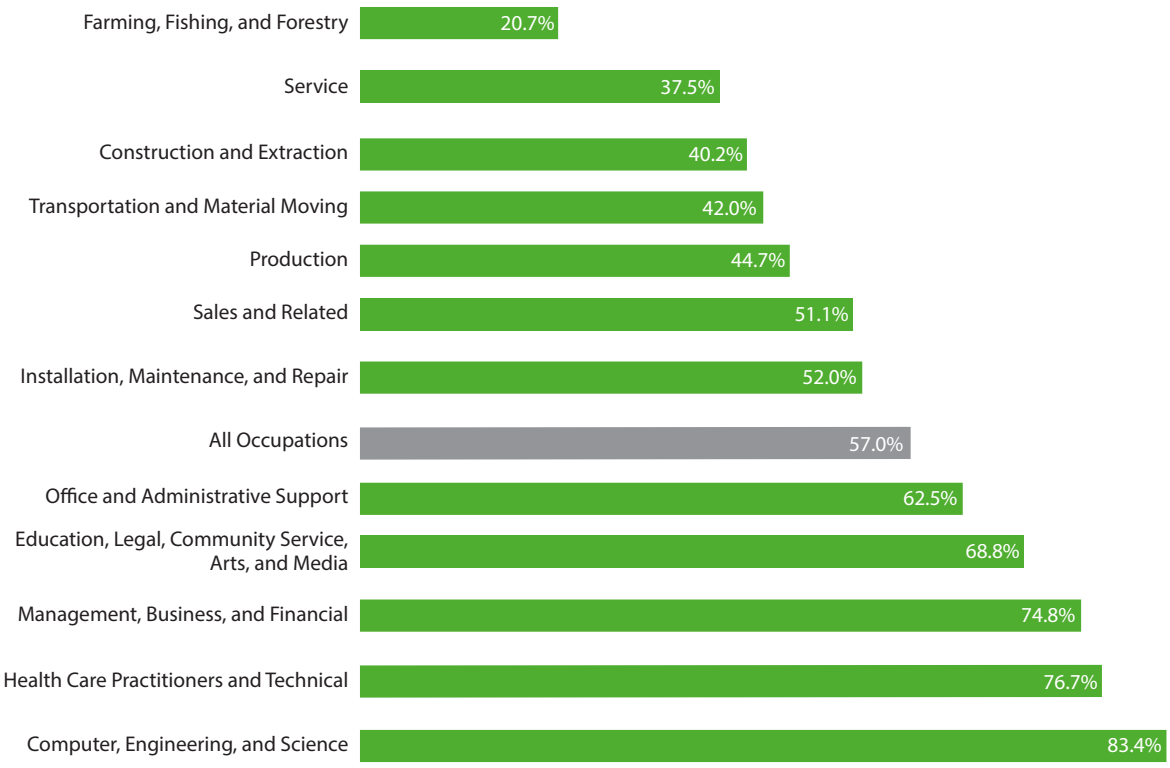
In addition to industry, it is also important to look at coverage trends by occupation.[10] Many industries have a mix of low- and high-wage occupations even if the industry itself predominantly employs lower- or higher-paid employees. For example, the food services industry employs a number of low-wage workers in occupations

10 "Occupation" refers to the type of work the employee performs.

like food preparation or serving, but it also has a portion of higher-paid workers in managerial and executive occupations.

There was also a wide range of levels of employment-based coverage across occupations, as well as of coverage rates associated with the income levels of the occupational groups. Employment-based coverage was lower in traditionally low-wage occupations (Exhibit 2.7). Only 20.7% of workers in farming, fishing, and forestry occupations and 37.5% of workers in service occupations had employment-based coverage. The uninsured rate was also high in these occupations, reaching 25% in farming, fishing, and forestry occupations and 19% in service occupations (not shown).

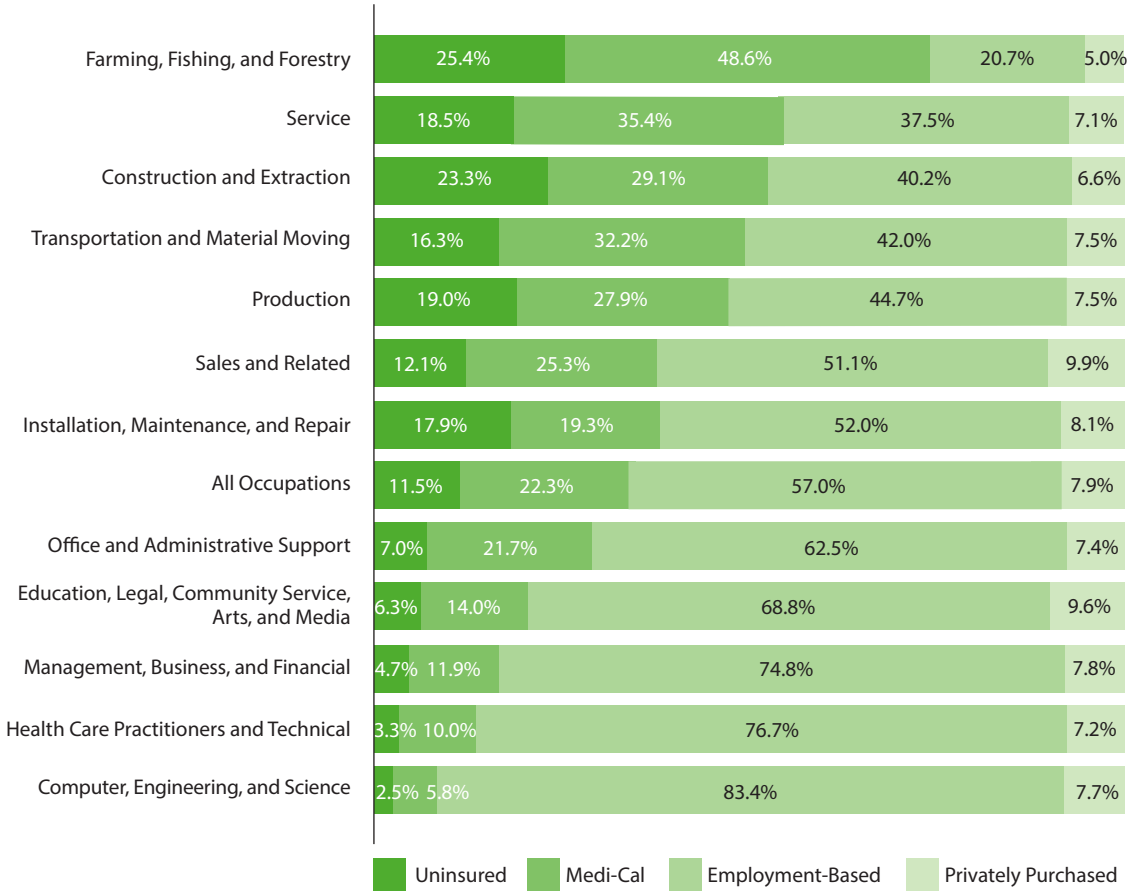
**Exhibit 2.7**
Employment-Based Coverage Rates by Occupation, Working Adults Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

**Exhibit 2.8**

Source of Coverage by Occupation, Working Adults Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

Higher-wage occupations have much higher levels of employment-based coverage (Exhibit 2.8). Among health care practitioners and workers in technical occupations, 76.7% were covered through employment-based plans, as were 83.4% of workers in computer, engineering, and science fields. The uninsured rate was also very low among workers in these occupations, at just 3.3% for health care practitioners and technical workers and for those in computer, engineering, and science occupations.

## Individual Market

The ACA included many reforms that changed the nature of the individual market for privately purchased insurance. The law established subsidies that reduced both premium and out-of-pocket spending for low- and moderate-income consumers. It also prevented insurers from denying coverage due to preexisting health conditions or excluding treatment of those conditions from coverage. Insurers were also no longer allowed to set premiums based on the health of enrollees, and they faced caps on how much higher they could set premiums for older consumers relative to younger consumers.

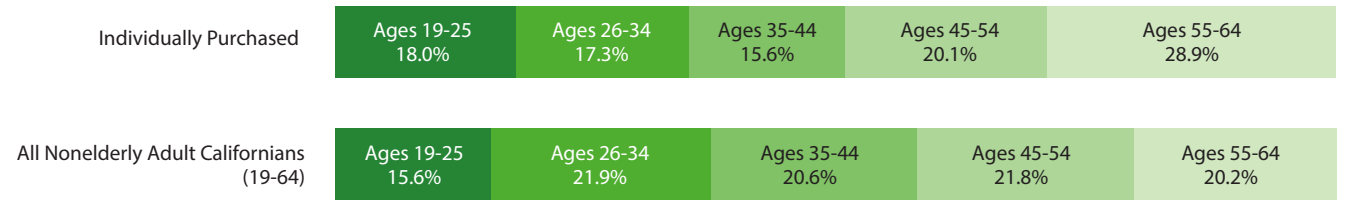
In 2015-2016, two years after the implementation of the ACA's individual market reforms, 8% (1.9 million people) of nonelderly adult Californians (ages 19-64) purchased coverage in the individual market, including those who purchased insurance with subsidies through Covered California. The demographic composition of the individual market differed from the overall nonelderly adult California population, although the extent of those differences varied among the different demographic categories.

The individual market had a larger share of individuals ages 55-64 (28.9%) and a smaller portion of middle-aged (35-54) adults (35.7%) than the overall nonelderly adult California population (Exhibit 2.9). The share of young adults (ages 19-34) in the individual market (35.3%) was similar to their share among the overall population (37.5%).

White enrollees made up a larger share of the individual market (53.4%) than of the overall nonelderly adult population (38%; Exhibit 2.10). Latino adults were underrepresented in the individual market at 23.4%, compared to 38.5% of the adult population.[11]

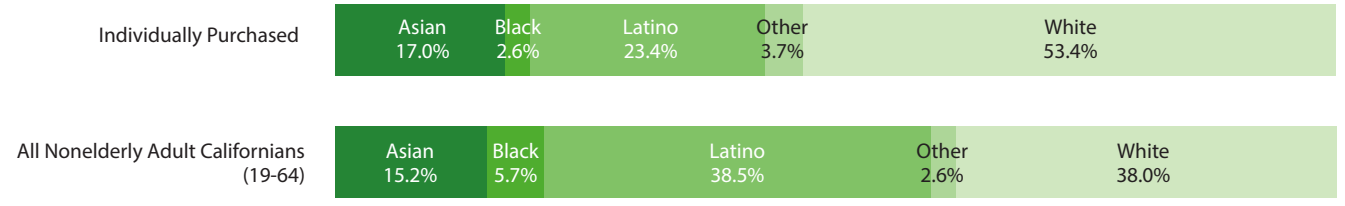
11 The difference in the black share of the individual market and the overall nonelderly adult population is not statistically significant.

**Exhibit 2.9**
Individually Purchased Coverage by Age, Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

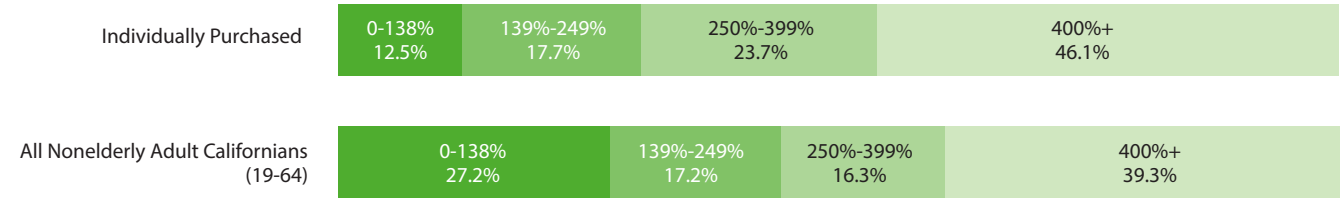
**Exhibit 2.10**
Individually Purchased Coverage by Race and Ethnicity, Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

## Exhibit 2.11

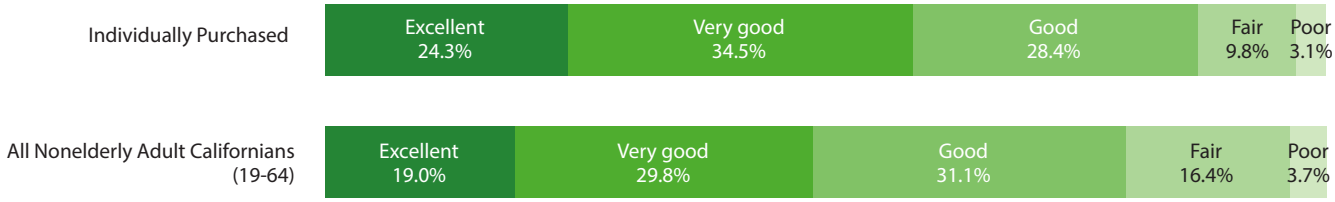
Individually Purchased Coverage by Household Income as a Percentage of the Federal Poverty Level (FPL), Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

## Exhibit 2.12

Individually Purchased Coverage by Health Status, Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

The enrollees in the individual market had higher incomes than the overall nonelderly adult population (Exhibit 2.11). This was to be expected, given the structure of the ACA, which expanded Medicaid eligibility to all nonelderly citizens and qualified immigrant adults with incomes at or below 138% FPL and did not provide individual market subsidies to those eligible for Medicaid.

Individual market enrollees self-reported better health than the overall population (Exhibit 2.12). Fifty-nine percent of individual market enrollees reported excellent or very good health, compared to 49% of the overall population. This is important, because premiums in the individual market are set based on the overall health of all enrollees, so more enrollees with better health translates into lower premiums for all enrollees, regardless of an individual's health status.

## Discussion

While the ACA expanded eligibility for Medicaid and instituted reforms in the individual market, employment-based coverage remained the most common source of coverage for nonelderly adults in California in 2015-2016, with just over half receiving coverage from an employer. Disparities in access to employer-based coverage also continued after implementation of the ACA. Part-time and unemployed workers, as well as the self-employed, were less likely to have employment-based coverage and more likely to be uninsured. Additionally, employment-based coverage was less common among workers in low-wage industries and occupations. These workers were more likely to rely on Medi-Cal or to be uninsured. Employment-based coverage was also associated with many demographic categories, such as race/ethnicity, citizenship and immigration status, and income. In each of these cases, Californians in more vulnerable groups were less likely to have employment-based coverage. Employment-based coverage was also low in the central and northern areas of the state compared to the coastal regions.

Following the 2014 implementation of the ACA's individual market reforms, 8% of nonelderly adult Californians individually purchased their coverage in 2015-2016. In comparison with the overall nonelderly adult population, the individual market enrollees had higher incomes and were somewhat older, whiter, and more likely to report better health.

# 3 Public Health Insurance Coverage in California

Shana Alex Charles, MPP, PhD, and Maria Mekhaiel, MPH

Medicare and Medicaid are the two major public health insurance programs in the United States, and as of 2016 in California, they insured more than 4 in 10 Californians (42.6%; see chapter 1). Both programs have recently been the subject of intense public attention, with the nation debating the best method to increase health insurance coverage over the past decade. The Patient Protection and Affordable Care Act of 2010 (ACA) gave California the ability to open up enrollment in Medi-Cal (the state's Medicaid program) to any legal permanent resident with household income at or below 138% of the federal poverty level (FPL)[12] as of January 1, 2014. This provision effectively eliminated the requirement that nonelderly adults (ages 19-64) have children in order to enroll in Medi-Cal. Children ages 18 and under maintained their higher income eligibility levels for Medi-Cal enrollment that were already in place. Adults ages 65 and over increased their income eligibility to enroll in both Medi-Cal and Medicare for low-income seniors, from the prior level of 88% FPL to 138% FPL.

For Medicare, the basic structure of medical coverage has remained essentially the same since the addition of prescription drug coverage in 2006. Enrollees can stick with their basic Medicare coverage, but the overwhelming majority add on to their Medicare by: 1) purchasing a supplement plan, 2) enrolling in a managed care Medicare Advantage plan, 3) keeping some job-based insurance through retirement, or 4) enrolling, if income eligible, in Medicaid (they are then referred to as "dual eligibles").

12 In 2016, 138% of the federal poverty level was $16,394 for a one-person household, $22,108 for a two-person household, $27,821 for a three-person household, etc.

This chapter will explore the changing demographics of Medi-Cal following the ACA expansion, as well as the different demographics among the different types of Medicare plans. Who is currently enrolled in these public plans? For some, "Medicare for all" has become a rallying cry. But how do the current Medicare plans compare to Medi-Cal (for nonelderly adults) in terms of satisfaction with health care?

## Changing Demographics of Public Program Enrollment

If the ACA worked to expand public health insurance, we would expect to see differences among increases in Medi-Cal coverage by age group, since the expansion provisions targeted childless adults ages 19-64. Prior to the ACA, these adults had no eligibility for Medi-Cal. Adults 65 and older also expanded their coverage eligibility for Medi-Cal and could be expected to increase their enrollment as well.

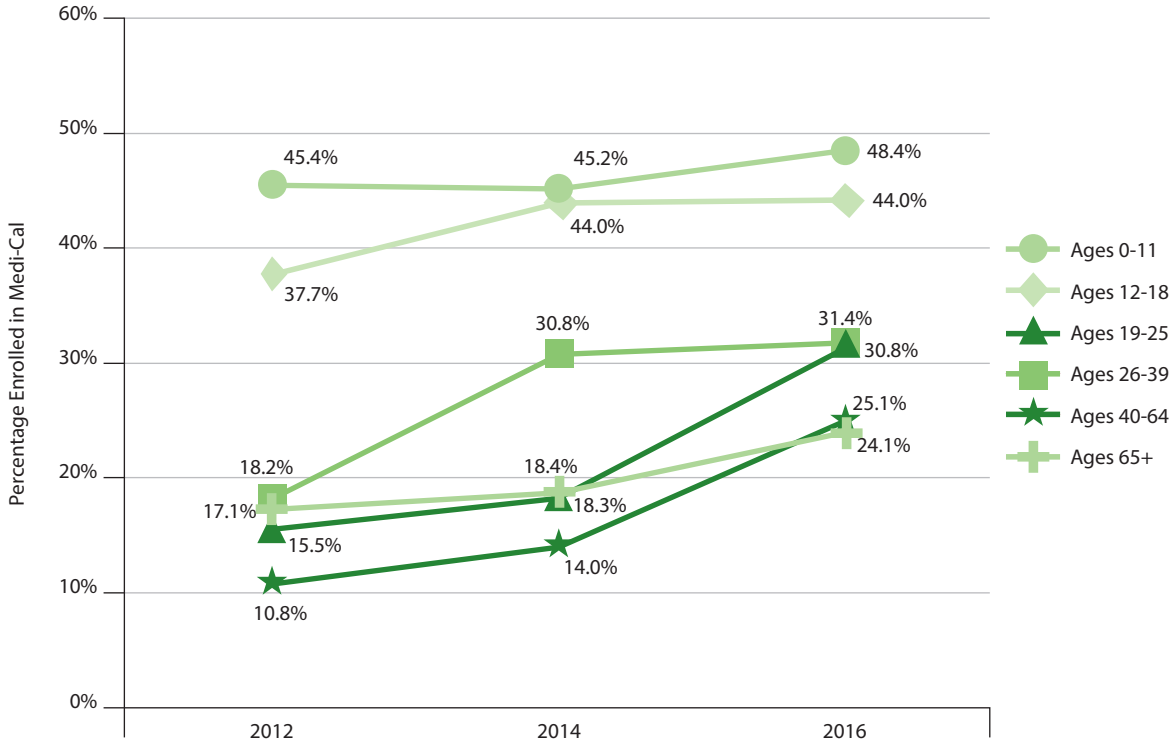
## Age Group

For three age groups, enrollment in Medi-Cal increased slightly from 2012 to 2014 (the first year of the expansion) and jumped higher from 2014 to 2016 (Exhibit 3.1), after the Medi-Cal expansion was fully implemented. Among people ages 19-25, who historically had the highest rates of being uninsured prior to the ACA,[13] enrollment in Medi-Cal rose from 15.5% in 2012 to 18.3% in 2014, then rose sharply to 30.8% in 2016. Among adults ages 40-64, enrollment in Medi-Cal increased even more dramatically, from 10.8% in 2012 to 25.1% in 2016. Medi-Cal coverage for those ages 65 and over also increased, from 17.1% in 2012 to 24.1% in 2016, including those who also had Medicare coverage (Exhibit 3.1).

In contrast, children ages 12-18 and adults ages 26-39 had increases in the percentages with Medi-Cal coverage from 2012 to 2014, but the percentages remained steady to 2016. This may indicate that parents and their teenage children, who gained income eligibility from 100% to 138% FPL, were proactive about enrolling in coverage as soon as possible and were assisted by the extensive enrollment outreach efforts by Covered California. For children ages 0-11, who had the highest income eligibility allowed even prior to the ACA's enactment, coverage remained steady, from 45.4% in 2012 to 48.4% in 2016 (Exhibit 3.1). In other words, nearly half of all children ages 11 and under in California continue to have health insurance coverage through Medi-Cal.

13 Charles SA, Jacobs K, Roby DH, Pourat N, Snyder S, and Kominski G. 2014. *The State of Health Insurance in California: Findings from the 2011/2012 California Health Interview Survey*. Los Angeles, Calif.: UCLA Center for Health Policy Research. Access at: *http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1352.*

**Exhibit 3.1**
Rates of Enrollment in Medi-Cal by Age Group, All Ages, California, 2012-2016

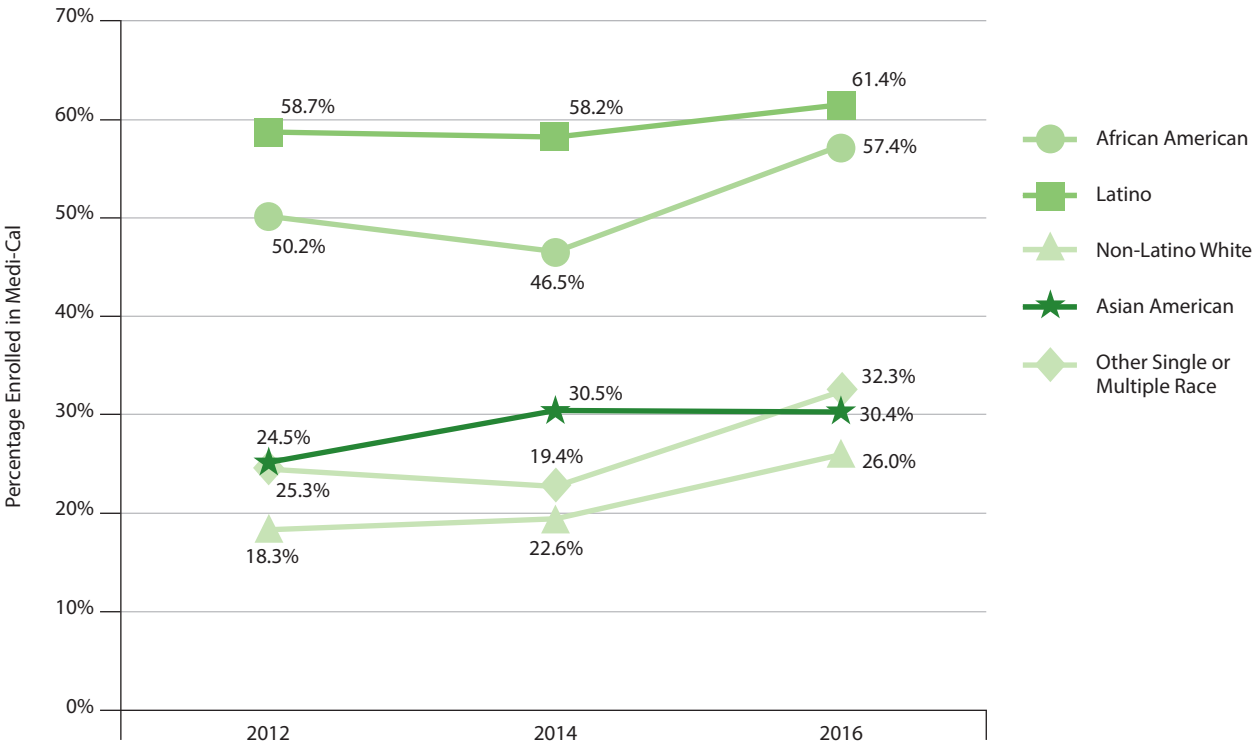



Notes: Numbers are percentages of the total population within each age group and will not add to 100%. Ages 0-18 includes enrollment in the SCHIP program (called Healthy Families), which was integrated into Medi-Cal in 2013. Ages 65+ includes dual enrollees in Medi-Cal and Medicare.

Sources: 2011-2012, 2013-2014, 2015-2016 California Health Interview Surveys

## Exhibit 3.2

Rates of Enrollment in Medi-Cal by Racial/Ethnic Group, Ages 0-18, California, 2012-2016




Notes: Numbers are percentages of the total population within each racial/ethnic group and will not add to 100%. Ages 0-18 includes enrollment in the SCHIP program (called Healthy Families) which was integrated into Medi-Cal in 2013. "Asian American" includes Native Hawaiians and Other Pacific Islanders. "Other Single or Multiple Race" includes American Indian and Alaskan Natives.

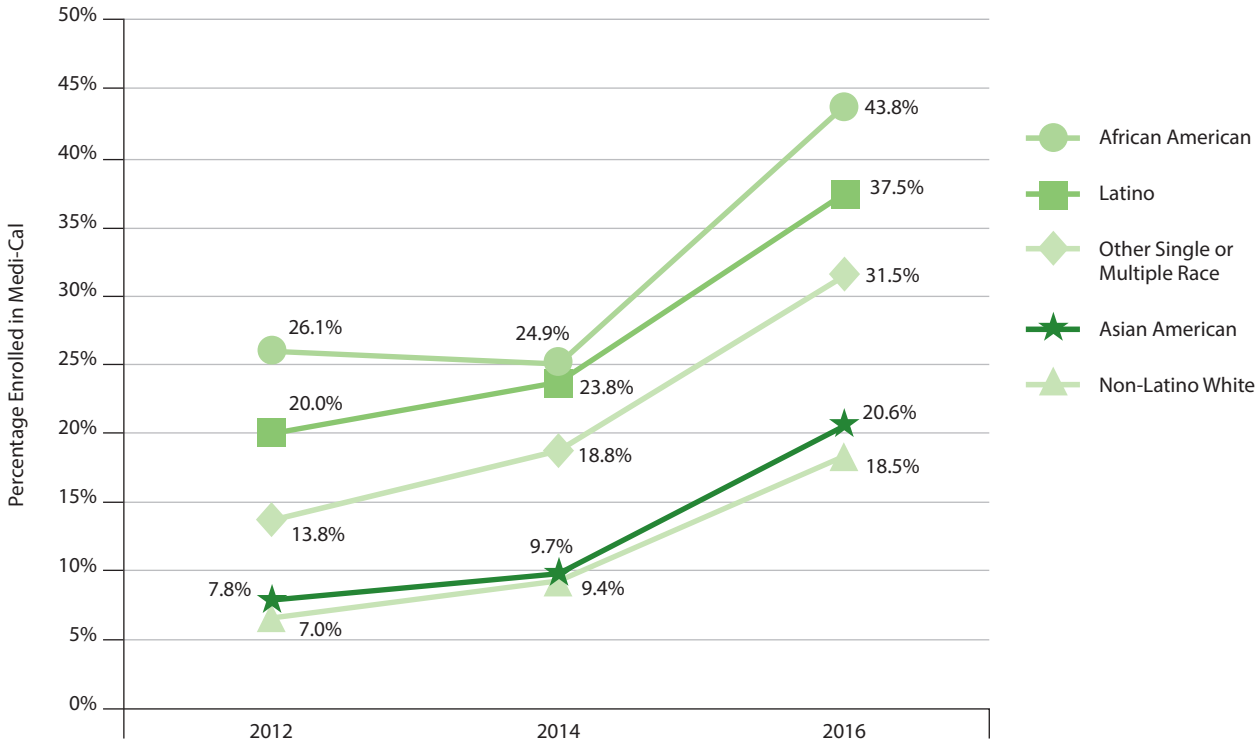
Sources: 2011-2012, 2013-2014, 2015- 2016 California Health Interview Surveys

### Racial/Ethnic Group

The gains in Medi-Cal coverage among teenagers and the maintenance of coverage among children were spread among all racial and ethnic groups, although the gains among Latino children — from 58.7% in 2012 to 61.4% in 2016 — were smaller than for other groups (Exhibit 3.2). Children who were identified by their parent or guardian as non-Latino white, African American, or other single or multiple race had the largest increases in Medi-Cal coverage (Exhibit 3.2).

**Exhibit 3.3**

Rates of Enrollment in Medi-Cal by Racial/Ethnic Group, Ages 19-64, California, 2012-2016



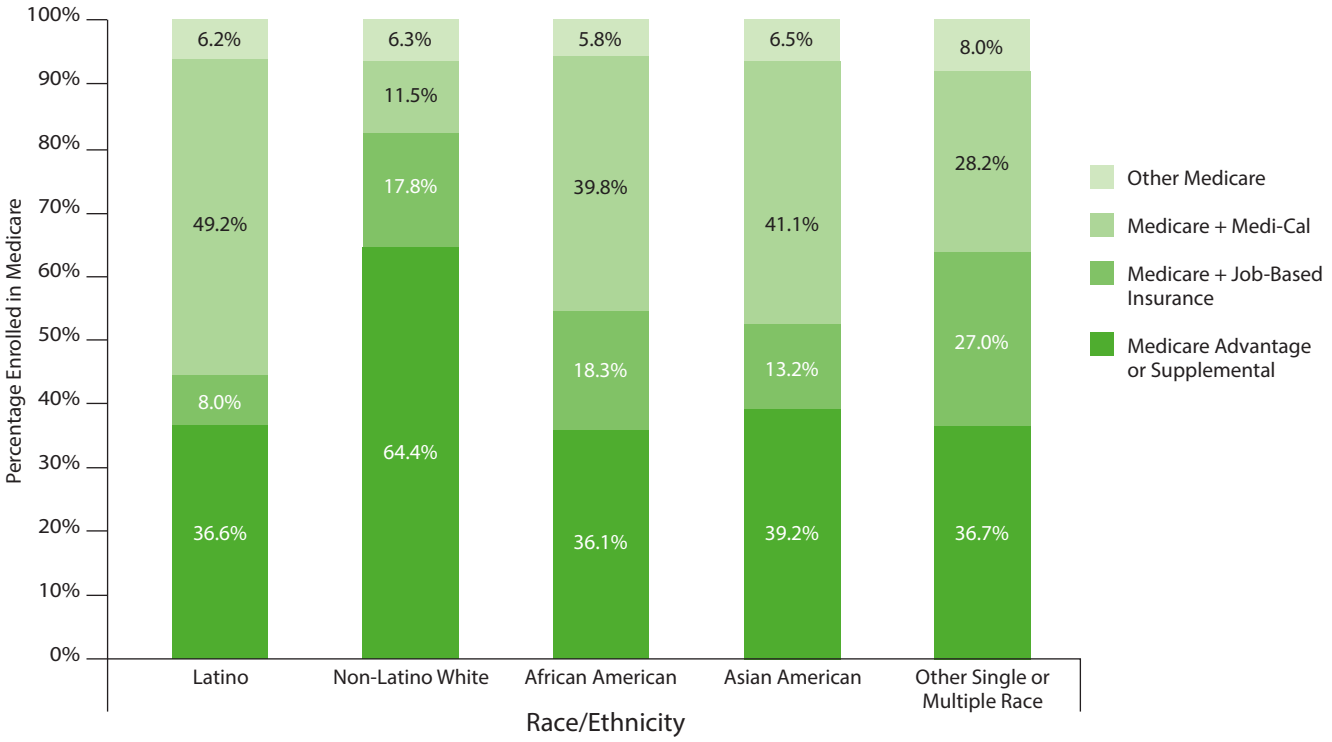

Notes: Numbers are percentages of the total population within each racial/ethnic group and will not add to 100%. "Asian American" includes Native Hawaiians and Other Pacific Islanders. "Other Single or Multiple Race" includes American Indian and Alaskan Natives.

Sources: 2011-2012, 2013-2014, 2015- 2016 California Health Interview Surveys

Among adults ages 19-64, however, the gains in Medi-Cal coverage followed the same pattern more equally among all racial/ethnic groups (Exhibit 3.3). Adults who self-identify as African American reported the highest rate of Medi-Cal coverage by 2016, at 43.8%, but they also had the highest rate in 2012, at 26.1%. Adults who self-identify as non-Latino white had the lowest rate of Medi-Cal coverage, at 7.0%, in 2012, and they experienced a similar jump in coverage to 18.5% in 2016.

**Exhibit 3.4**

Medicare Enrollment by Racial/Ethnic Group, Ages 65+, California, 2015-2016




Notes: Numbers may not add to 100% due to rounding. "Asian American" includes Native Hawaiians and Other Pacific Islanders. "Other Single or Multiple Race" includes American Indian and Alaskan Natives.

Sources: 2015 and 2016 California Health Interview Surveys

Examining the different types of Medicare among racial/ethnic groups shows that the patterns established among younger adults persist among adults 65 and older. Nearly two-thirds of non-Latino white older adults have Medicare Advantage or Medicare plus a privately purchased supplement (essentially, augmented Medicare),[14] compared to just over a third of older adults in other racial/ethnic groups (64.4% compared to a range of 36.1% to 39.2%; Exhibit 3.4).

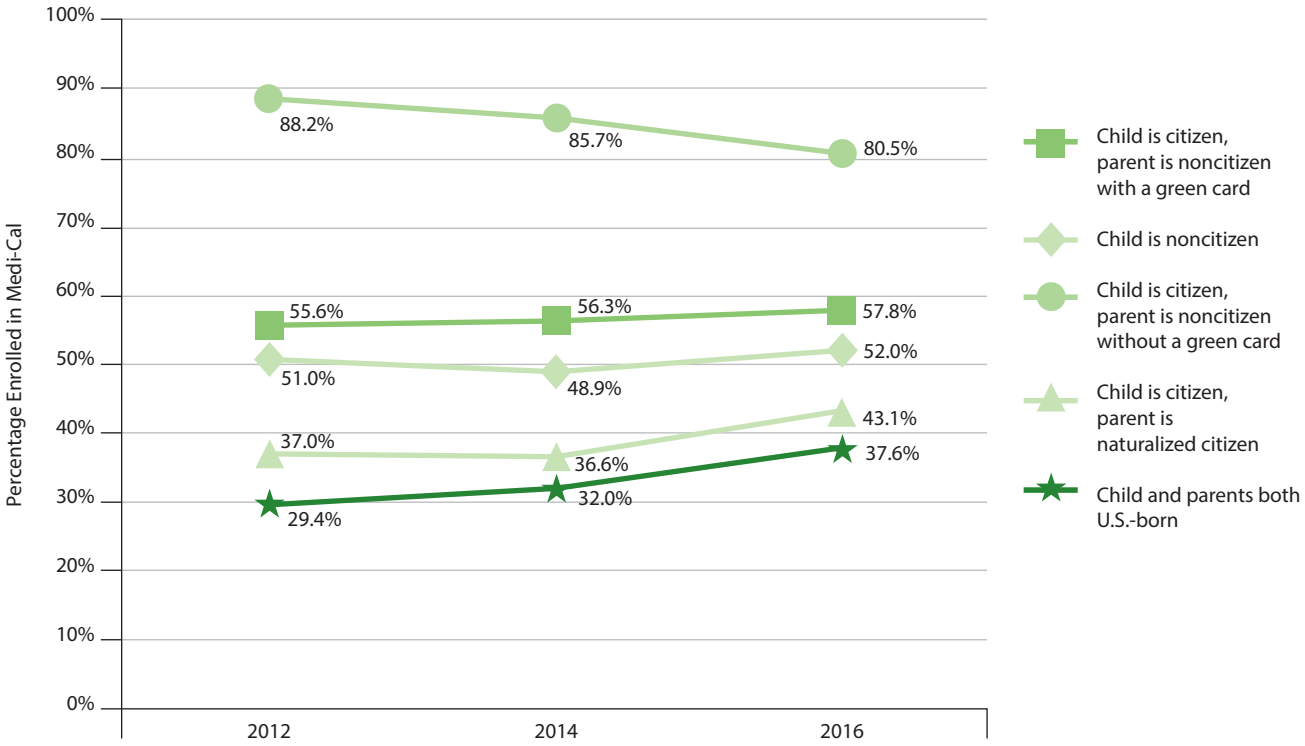
In stark contrast, nearly half of older Latinos (49.2%) have Medicare plus Medi-Cal, compared to only 11.5% of non-Latino white older Californians. Among older African American Californians, nearly one in five (18.3%) have Medicare plus a job-based coverage supplement — a rate similar to that among non-Latino white older adults — compared to only 8.0% of older Latino Californians. These coverage differences, even among a population that is nearly completely insured, illustrate how job-based coverage differences by racial/ethnic group continue to affect coverage options throughout enrollees' retirement years.

14 Enrollment in Medicare Advantage or a private supplement plan is combined in a single question on CHIS and cannot be reported separately.

## Citizenship Status

Among children ages 0-18, rates of having Medi-Cal differ by their own and their parents' citizenship status. Coverage for U.S.-born children with U.S.-born parents increased from 29.4% in 2012 to 37.6% in 2016 (Exhibit 3.5). Most other groups saw their coverage rates in Medi-Cal remain steady, with the exception of citizen children whose parents are noncitizens without green cards. Their rates of coverage dropped from 88.2% in 2012 to 80.5% in 2016 (Exhibit 3.5).

**Exhibit 3.5**
Rates of Enrollment in Medi-Cal by Family Citizenship Status, Ages 0-18, California, 2012-2016




Notes: Numbers are percentages of the total population within each citizenship group and will not add to 100%. Ages 0-18 includes enrollment in the SCHIP program (called Healthy Families), which was integrated into Medi-Cal in 2013.

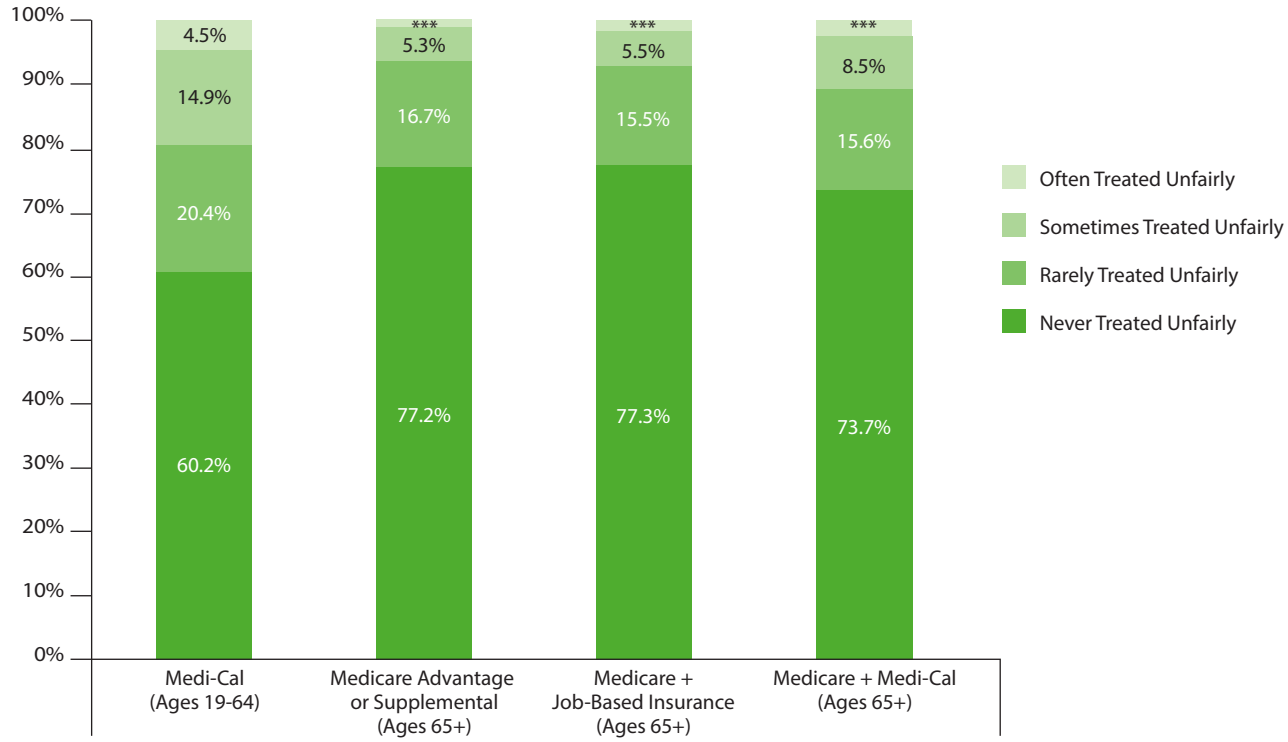
Sources: 2011-2012, 2013-2014, 2015-2016 California Health Interview Surveys

## Satisfaction With Health Care Among Public Coverage Enrollees

Adults with Medicare, whether by itself or with a supplement, were less likely than nonelderly adults with Medi-Cal to report experiencing unfair treatment by health professionals due to their health insurance type (Exhibit 3.6). About one in five adults with Medi-Cal reported "often or sometimes" being treated unfairly, compared to less than 10% of adults with Medicare. Even the dual-eligible group with both types of coverage reported less unfair treatment than those with Medi-Cal only.

**Exhibit 3.6**

Percentage Who Felt They Were Treated Unfairly, by Medi-Cal or Medicare Enrollment, Ages 19-64 and 65+, California, 2015-2016




*** = Percentage is too unstable to report due to coefficient of variation above 30%.

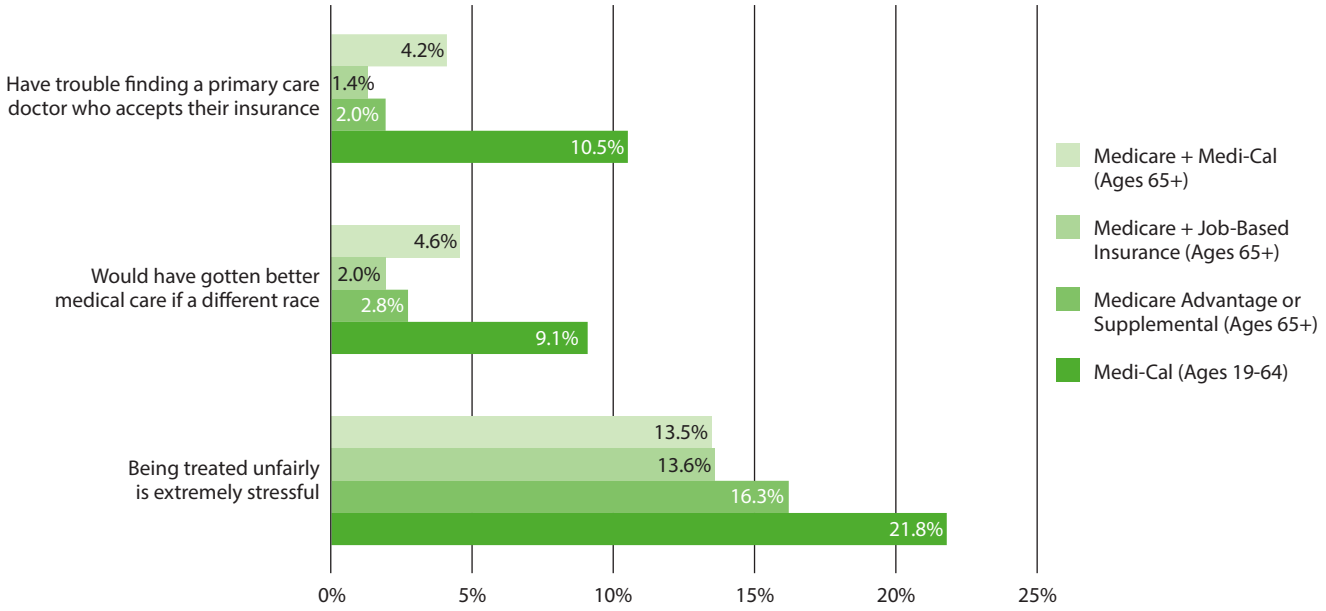
Note: Numbers may not add to 100% due to rounding.

Sources: 2015 and 2016 California Health Interview Surveys

Other health care disparities exist among enrollees with different types of public coverage as well. Nonelderly adults with Medi-Cal reported the highest rate of difficulty in finding a primary care doctor who would accept their insurance (10.5%), along with reporting the highest rate of perceiving that they would have received better health care if they were members of a different racial or ethnic group (9.1%; Exhibit 3.7). Among adults who reported that they had received unfair treatment from health professionals due to their health insurance type, 21.8% of those with Medi-Cal reported that the experience had been extremely stressful, a figure slightly higher than that for adults with any kind of Medicare.

## Exhibit 3.7

Rates of Difficulties in Getting Medical Care by Medi-Cal or Medicare Enrollment, Ages 19-64 and 65+, California, 2015-2016




Note: Numbers are rates and will not add to 100%.

Sources: 2015 and 2016 California Health Interview Surveys

## Discussion

The findings in this chapter examine the trends over time for public coverage in California, both for Medi-Cal, which was greatly impacted by the ACA, and for Medicare, which was less impacted. Significantly, the one group with both public health plans (the dually eligible, with both Medicare and Medi-Cal) reported care much more consistent with that received by those in other Medicare groups, rather than by those with only Medi-Cal.

These dual enrollees are in the Cal MediConnect Plan (Medicaid-Medicare Plan, or CMC), part of a national pilot demonstration program. The program was implemented in 2014 in eight California counties: Orange, Los Angeles, Riverside, San Bernardino, San Diego, Alameda, San Mateo, and Santa Clara. Cal MediConnect stemmed from the Coordinated Care Initiative (CCI), which is the legislation passed in California to improve the delivery of care systems among low-income seniors and persons with disabilities. The federal Medicare program and the state's Medi-Cal program partnered for what was originally a three-year program, developed to create an all-inclusive health plan combing medical, prescriptions, dental, vision, transportation, and long-term services and supports (LTSS).[15]

This extensive slate of health care services does not extend to adults with Medi-Cal only, or — more broadly — to those with either private insurance or no medical coverage at all. But the health care coverage of dual eligibles in California under the Cal MediConnect Plan bears a marked resemblance to the coverage being discussed at the federal level as the "Medicare for All" plan spearheaded in Congress by Representative Pramila Jayapal in the House and Senator Bernie Sanders in the Senate. In 2017, Governor Jerry Brown extended the program until December 31, 2019. The Department of Health Care Services (DHCS) requested extension of the program. In April 2019, the Centers for Medicare and Medicaid Services (CMS) approved a three-year extension for CMC through December 31, 2022.

The data in this chapter represent a baseline look at these enrollees, with an expanded examination of their access to care, compared both to those with private coverage and to the uninsured (see chapter 4). These data can inform both state and federal conversations around moving to a program that covers everyone in a program similar to that for covering dual eligibles in California.

15 *http://calduals.org/wp-content/uploads/2016/10/IMC-Resource-Guide_0916.pdf*

# 4 Access to Care

Nadereh Pourat, PhD, and Maria Ditter, Dr med, MPH

Health insurance is an important predictor of access to care because it reduces or removes financial barriers to receiving health services. In turn, getting needed health services is likely to promote better population health outcomes. Continuous monitoring of changes in access to care for different types of insured and uninsured populations is needed to identify gaps in access associated with insurance coverage. Such data can then be used to inform and identify practice and policy solutions that are for the improvement of population health.

This chapter examines the current state of access to care for California residents by type of insurance to uncover existing and emerging differences in access. Indicators that measure access to care include having a usual source of care and the setting of that usual source, as well as several objective measures of use of preventive, outpatient, and acute services. Subjective measures of access, such as self-reported need for care, provide further insights into access barriers that are not captured through objective measures.

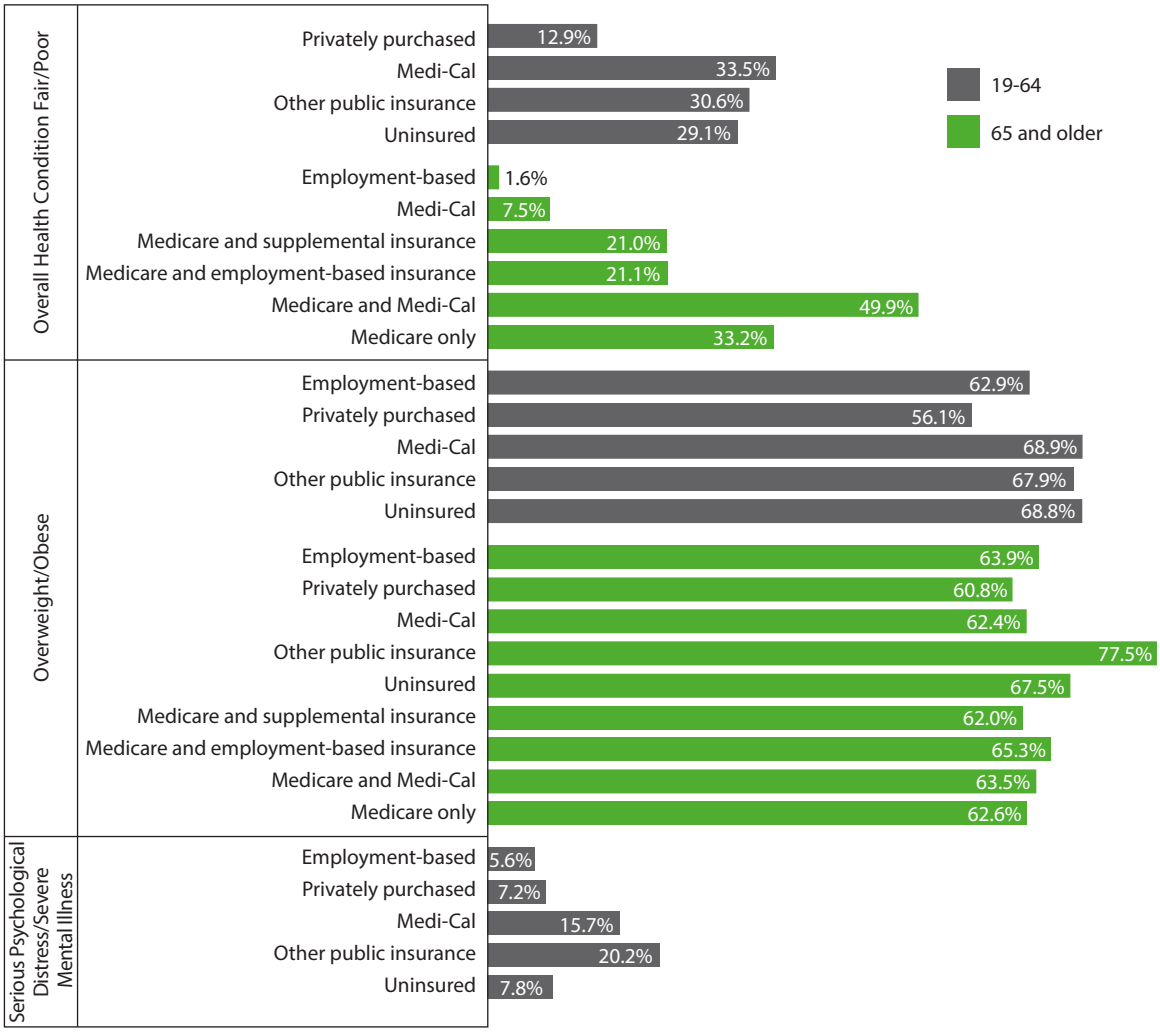
Access to care varies by type of insurance coverage for several reasons, among them eligibility for type of coverage, comprehensiveness of benefits, and cost sharing required by the insured person. The type of insurance determines access through other mechanisms, such as the medical provider networks that dictate which providers are available to give care, reimbursement levels and mechanisms that might prohibit or promote provider participation in medical provider networks, and other nuances. Because access to care is influenced by health status, this chapter includes several measures of health, including self-reported health status, chronic health conditions, and obesity status.

## Poor Health Status Is Most Common Among Those With Medi-Cal and Other Public Insurance

Health status is an important determinant of health service use and access. Individuals with poor self-assessed health or diagnosed chronic conditions or some risk factors are more likely to seek care or to be directed by their providers to various services. Examining self-assessed health status and risk factors among adults ages 19-64 showed that those with Medi-Cal (33.5%) had the highest rates of fair/poor health, and those with privately purchased insurance had the lowest rates (12.9%; Exhibit 4.1). Overweight/obese rates were high for all groups, with the highest rates among the uninsured (68.8%) and those with Medi-Cal (68.9%). The rate of severe psychological distress was highest among those with other public insurance (20.2%), and lowest among those with employment-based insurance (5.6%). Among adults 65 and older, those with Medicare and Medi-Cal (49.9%) had the highest rate of fair/poor health, and those with other public insurance (77.5%) had the highest rate of being overweight/obese.

## Exhibit 4.1

Self-Assessed Health and Risk Factors by Age and Type of Insurance Coverage, California, 2015-2016




Notes: Data with samples of less than five and unstable estimates are not reliable and are not presented.

Data on underweight not included.

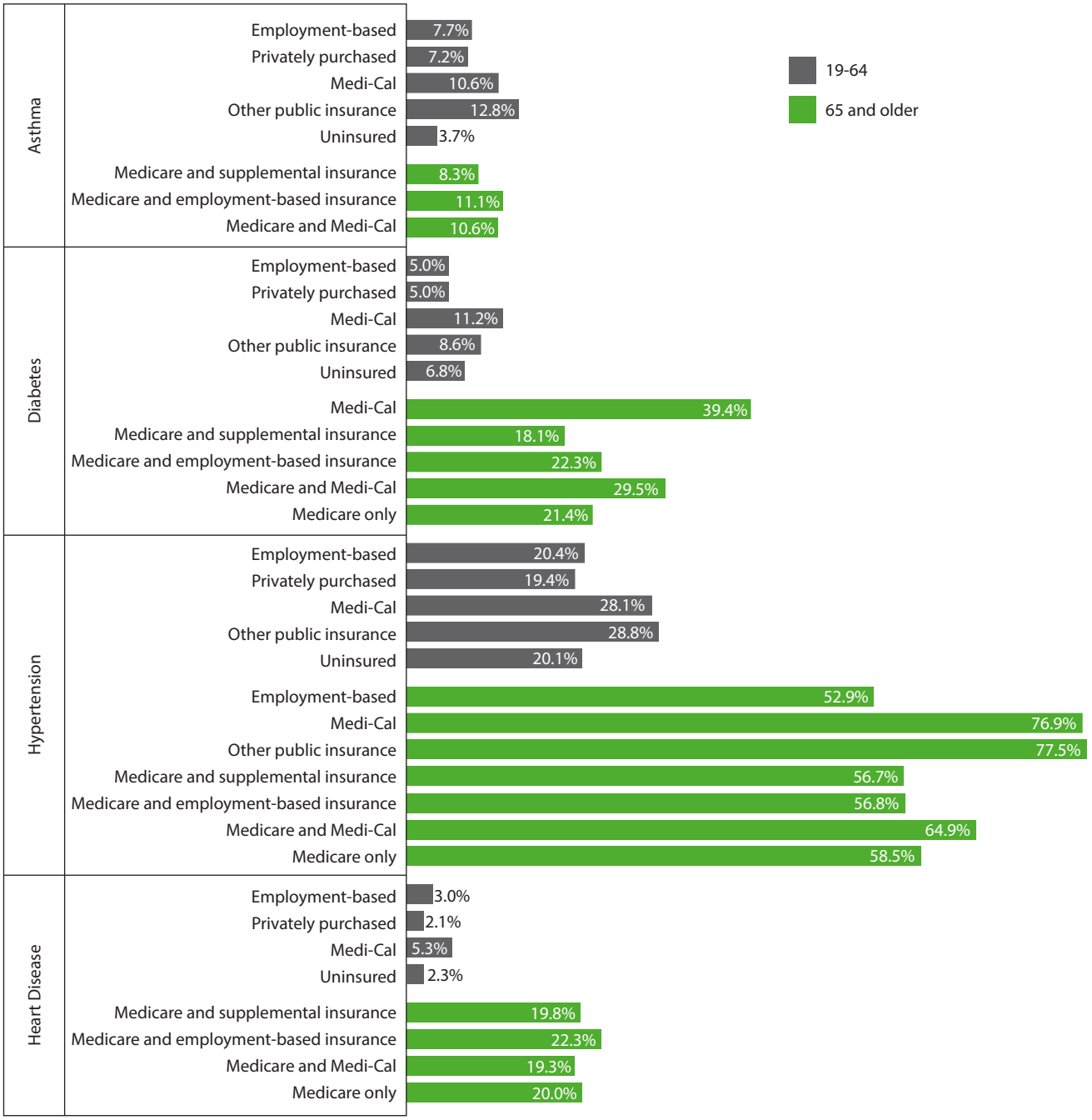
"Other public insurance" includes those with coverage under public programs such as military, Veterans Administration, and county programs.

Sources: 2015 and 2016 California Health Interview Surveys

Examining the rates of chronic conditions among adults ages 19-64 shows similar rates of heart disease regardless of type of insurance (Exhibit 4.2). The rates of hypertension (28.8%) and asthma (12.8%) were highest for those with other public insurance, and diabetes rates were highest for those with Medi-Cal (11.2%). Among older adults, heart disease rates were statistically similar among different insurance types. However, hypertension rates were highest among those with other public insurance (77.5%), diabetes rates were highest among those with Medi-Cal (39.4%), and the asthma rate was highest among those with Medicare and employment-based insurance (11.1%).

## Exhibit 4.2

Chronic Conditions by Age and Type of Insurance Coverage, California, 2015-2016




Notes: Data with samples of less than five and unstable estimates are not reliable and are not presented.

"Other public insurance" includes those with coverage under public programs such as military, Veterans Administration, and county programs.

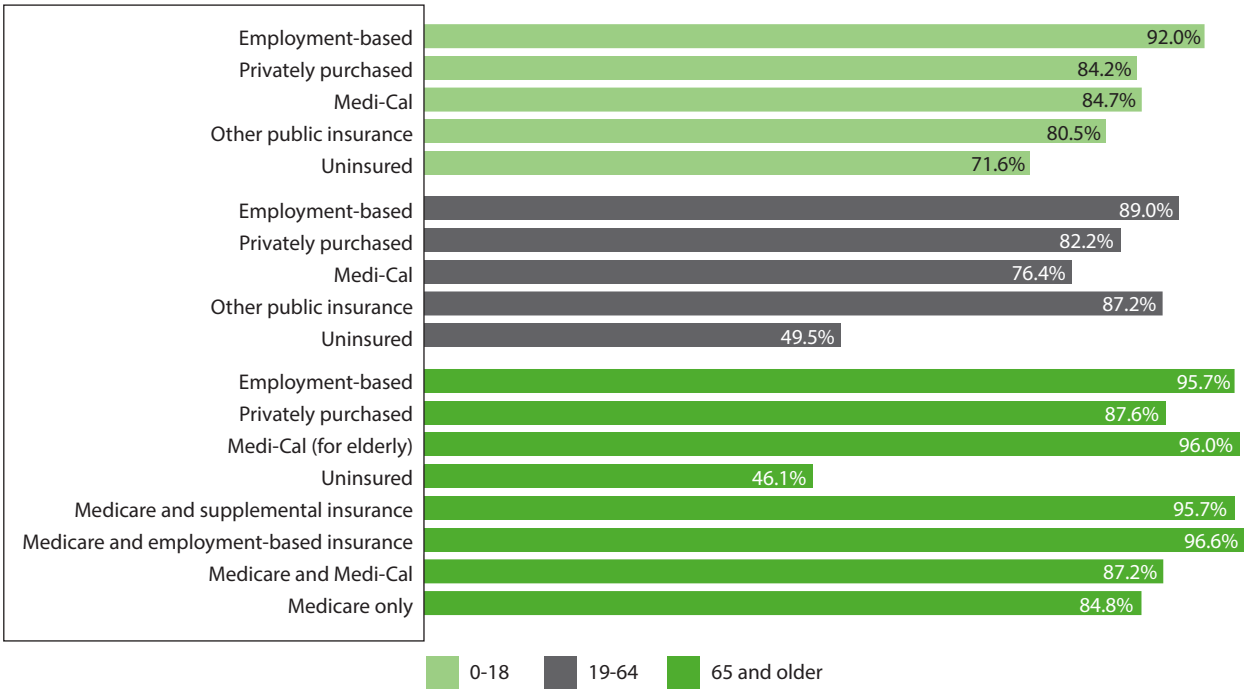
Sources: 2015 and 2016 California Health Interview Surveys

## Usual Source of Care Is Lowest for the Uninsured

Having a usual source of care highlights the ability of a person to have continuity with a medical provider who is familiar with that individual's health history and has developed a rapport with the patient, and it increases the likelihood of timely access to needed services. Timely access can in turn reduce the likelihood of future emergency department (ED) visits and hospitalizations, because many health problems that are addressed early on can be prevented from becoming severe enough to require urgent and intensive care.

Examination of the combined 2015 and 2016 California Health Interview Survey data showed that among children ages 0-18, those who were uninsured were least likely to have a usual source of care (71.6%), and those with employment-based insurance (92.0%) were most likely to report a usual source of care (Exhibit 4.3). The same pattern was observed for adults ages 19-64, but with a greater contrast between those with employment-based insurance (89.0%) and the uninsured (49.5%). Among this group, those with the second-lowest usual source of care were those with Medi-Cal (76.4%), although enrollees are often assigned a primary care physician if they don't choose one themselves. Among individuals 65 and older, those with various forms of Medicare and another form of coverage, those with employment-based insurance, and those with Medi-Cal equally reported very high rates of having a usual source of care (ranging from 95.7% to 96.6%). Those with privately purchased coverage, both Medicare and Medi-Cal, or Medicare only were in the next tier (ranging from 84.8% to 87.6%). The group with the lowest likelihood of having a usual source of care was the uninsured (46.1%).

**Exhibit 4.3**
Usual Source of Care by Age and Type of Insurance Coverage, California, 2015-2016




Notes: Data with samples of less than five and unstable estimates are not reliable and are not presented.

"Other public insurance" includes those with coverage under public programs such as military, Veterans Administration, and county programs.

Sources: 2015 and 2016 California Health Interview Surveys

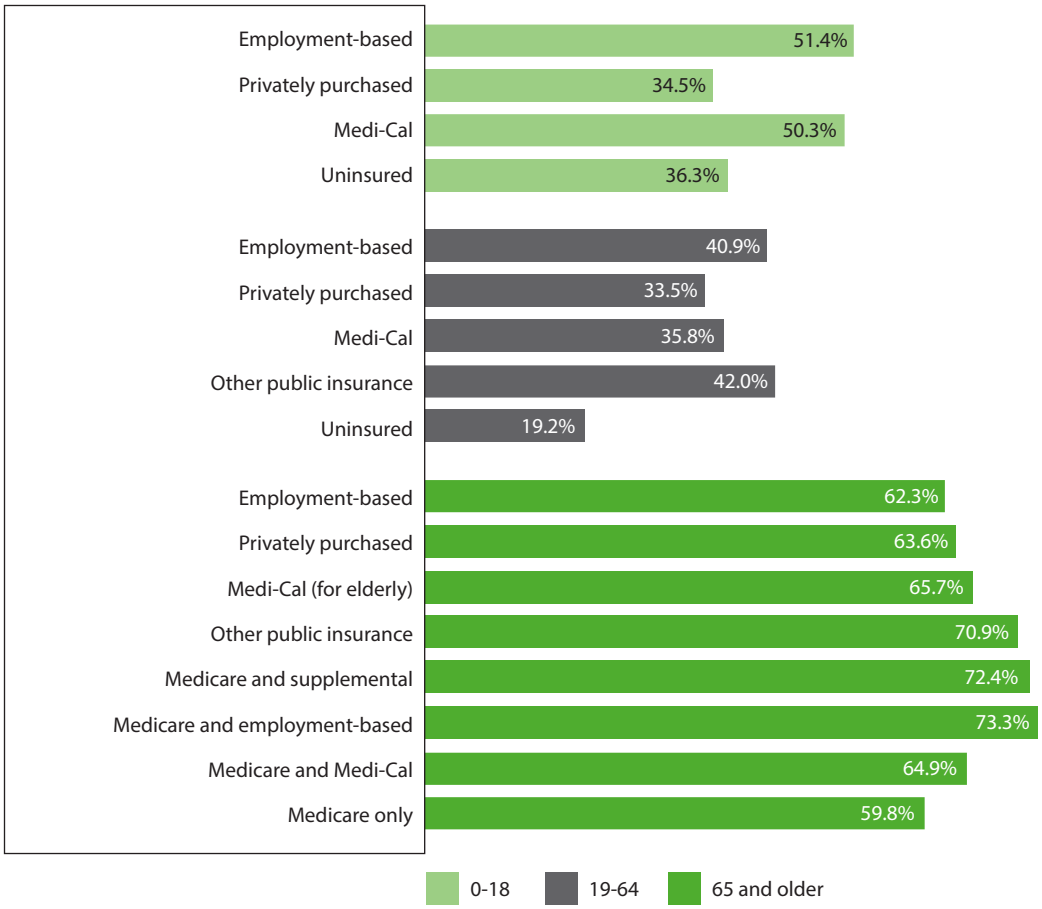
## Access to Preventive Care Was Lowest for the Low-Income and Uninsured

Access to preventive care is essential in reducing mortality and morbidity. Preventive care is considered an effective mechanism in ensuring population health, reducing avoidable emergency department visits and hospitalizations, and reducing overall health expenditures.

### Flu Shot Rate Was Lowest for Uninsured

Flu shots are now recommended for all age groups, but they are particularly recommended for children, the elderly, and those with specific chronic conditions or with compromised immune systems. Preventing flu is important for avoiding potentially serious complications that could lead to emergency department (ED) visits and hospitalizations. Efforts to vaccinate against the flu can differ by types of insurance coverage due to the level of emphasis on provision of important preventive services. Among children ages 0-18, the uninsured (36.3%) and those with privately purchased insurance (34.5%) had the lowest rates of flu shots compared to children who were enrolled in Medi-Cal (50.3%) or covered by employment-based insurance (51.4%; Exhibit 4.4). Among adults 19-64, the rate was lowest for the uninsured (19.2%). But among those ages 65 years and older, the rate was lowest among those with Medicare only (59.8%).

**Exhibit 4.4**
Flu Shot by Age and Type of Insurance Coverage, California, 2015-2016



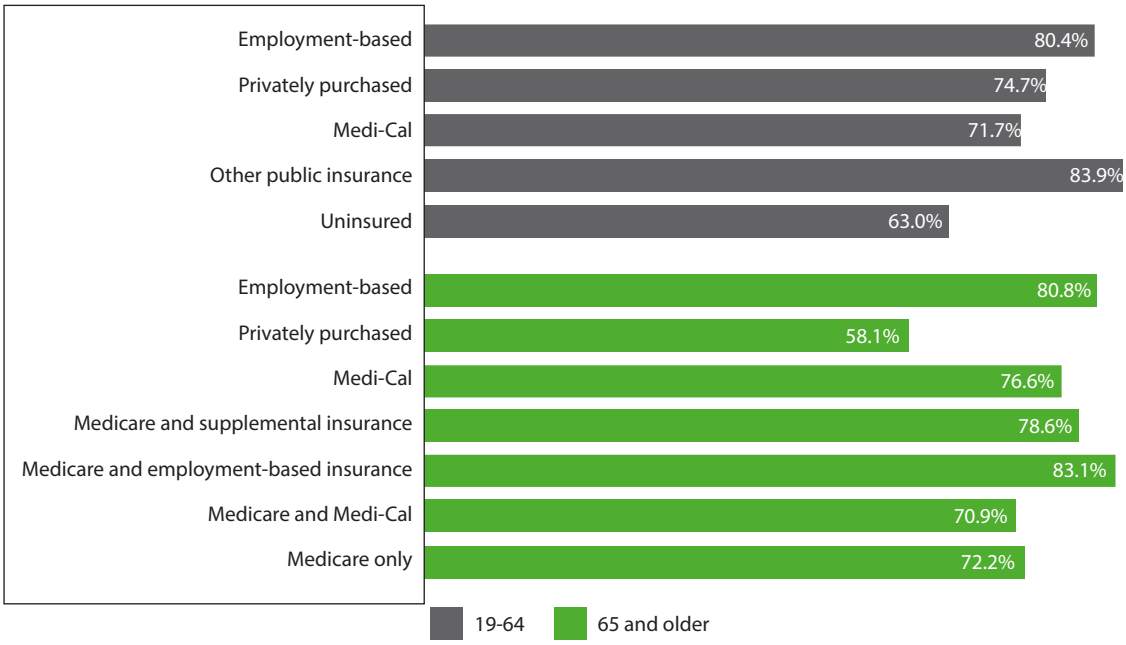

Notes: Data with samples of less than five are not reliable and are not presented.

"Other public insurance" includes those with coverage under public programs such as military, Veterans Administration, and county programs. Privately purchased insurance includes people with Covered California coverage.

Sources: 2015 and 2016 California Health Interview Surveys

**Exhibit 4.5**

Rates of Mammogram Screening by Type of Insurance Coverage, California, 2015-2016




Notes: Data with samples of less than five and unstable estimates are not reliable and are not presented.

"Other public insurance" includes those with coverage under public programs such as military, Veterans Administration, and county programs.

Sources: 2015 and 2016 California Health Interview Surveys

## Timely Mammogram Rates Were Lowest for Those With Privately Purchased Insurance and for the Uninsured

Mammogram screening is generally recommended for women 50-74 years of age. It is an important preventive measure, because breast cancer is the most common cancer among women in the United States.[16] Early stages of breast cancer are significantly more treatable, giving patients a higher chance of survival. Thus, access to timely breast cancer screening is crucial. Among women ages 19-64, those with other public insurance (83.9%) or employment-based insurance (80.4%) were most likely to have received a mammogram screening within the past two years, and the uninsured were least likely (63.0%; Exhibit 4.5). Among those 65 and older, those with both Medicare and employment-based insurance (83.1%) were most likely to have had the screening, and those with privately purchased insurance were least likely (58.1%).

## The Uninsured Most Often Had No Doctor Visits

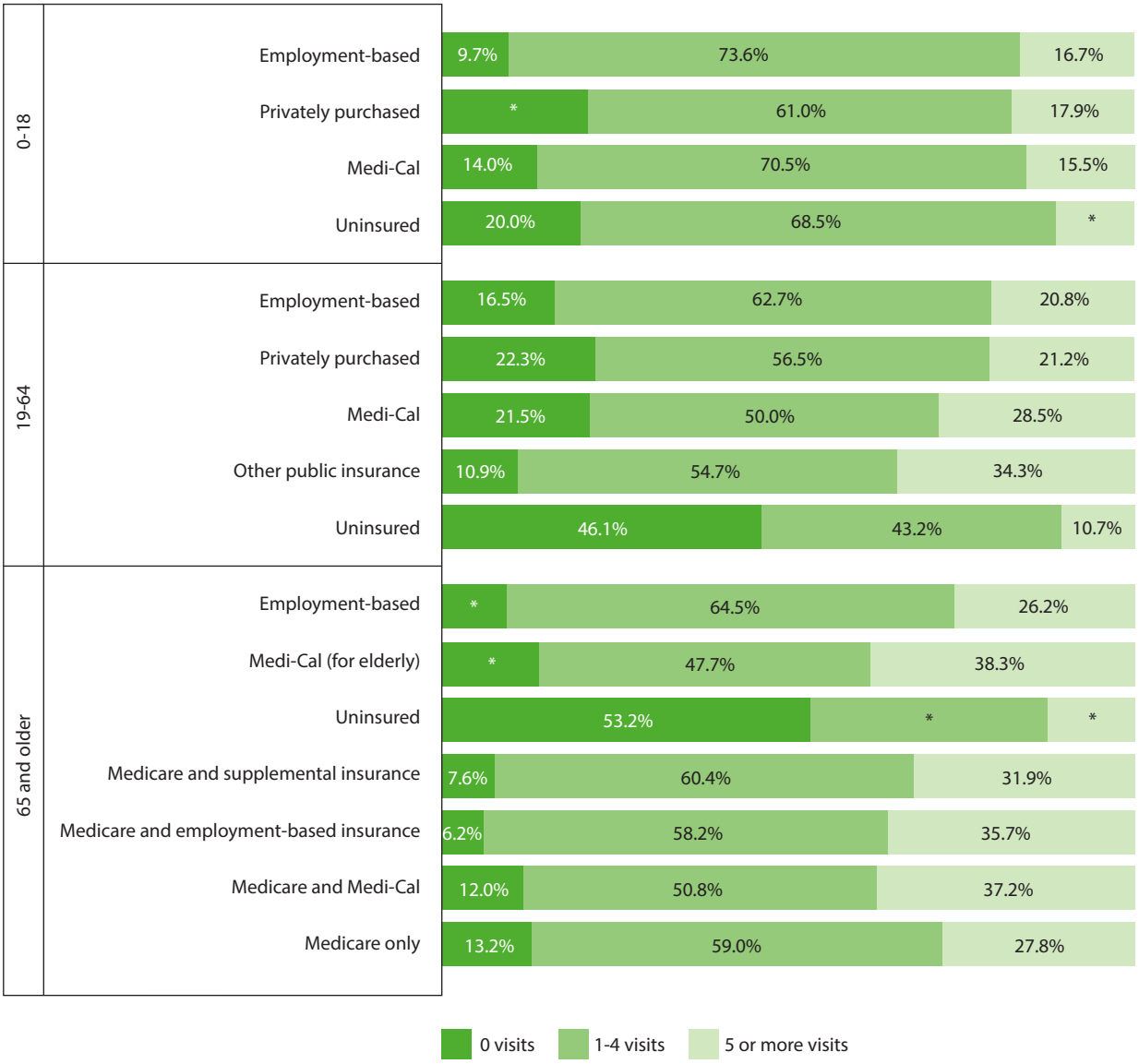
Access to care often starts with a visit to a primary care provider, who identifies existing and emergent health conditions, delivers preventive and primary care, and connects the patient with specialists or other types of providers who can address the individual's needs. Not having any visits in a year is an indicator of not receiving any preventive care; having one to four visits indicates receipt of preventive care and management of existing and chronic conditions; and having five or more visits is likely an indicator of more serious and/or complex conditions that require multiple visits to one or more providers.

16 American Cancer Society. 2019. Cancer Facts & Figures 2019. Atlanta: American Cancer Society. *https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf* ; Siegel R, Ma J, Zou Z, Jemal A. 2014. Cancer Statistics, 2014. *CA: A Cancer Journal for Clinicians* 64(1): 9-29. *https://onlinelibrary.wiley.com/doi/full/10.3322/caac.21208*.

Among children ages 0-18, those with employment-based insurance were least likely to have had no doctor visits (9.7%) and most likely to have had one to four visits (73.6%) in the last year (Exhibit 4.6). Uninsured children were most likely to have had no doctor visit in the last year (20.0%). The proportion of children who had five or more doctor visits did not vary significantly by type of insurance. Among adults ages 19-64, the uninsured were the most likely to have had no doctor visits (46.1%); those with other public insurance (10.9%) were least likely. In contrast, those with other public insurance were most likely to have had five or more doctor visits (34.3%), and the uninsured were least likely (10.7%). Among those 65 years and older, the uninsured (53.2%) were the most likely to have had no doctor visits, and those with Medi-Cal only were the most likely to have had five or more doctor visits (38.3%).

**Exhibit 4.6**

Number of Doctor Visits by Age and Type of Insurance Coverage, California, 2015-2016




Notes: Data with samples of less than five and unstable estimates are not reliable and are marked with an "*".

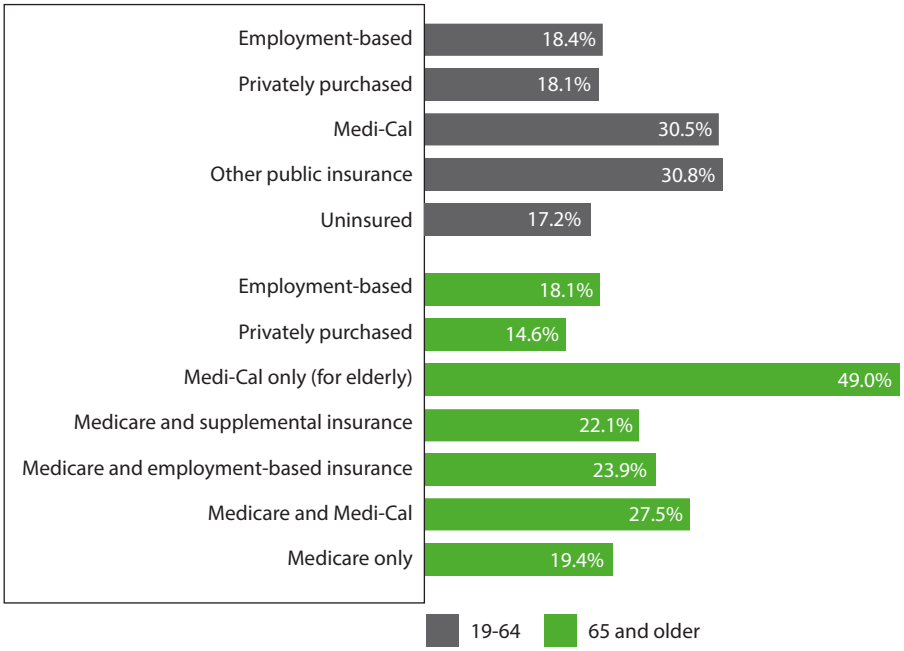
"Other public insurance" includes those with coverage under public programs such as military, Veterans Administration, and county programs.

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

Sources: 2015 and 2016 California Health Interview Surveys

**Exhibit 4.7**

At Least One Emergency Room Visit in the Last 12 Months by Age and Type of Insurance Coverage, California, 2015-2016




Notes: Data with samples of less than five and unstable estimates are not reliable and are not presented.

"Other public insurance" includes those with coverage under public programs such as military, Veterans Administration, and county programs.

Sources: 2015 and 2016 California Health Interview Surveys

## Rates of Emergency Department Visits Were Highest Among Those With Medi-Cal

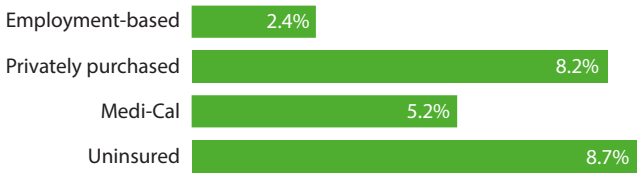
Access to an ED is important for addressing urgent and acute conditions. Yet, reducing potentially avoidable ED visits is a national priority, as ED is often used by patients who lack access to care or who do not receive needed services for chronic conditions. Some patients with poor access to services for mental health and substance use disorders or who have negative social determinants of health, such as homelessness and hunger, may also turn to ED frequently in lieu of other needed care. Among adults ages 19-64, those with Medi-Cal and other public insurance had the highest rates of ED visits (30.5% and 30.8%), while the uninsured had the lowest rates (17.2%; Exhibit 4.7). This likely relates to the relatively low rate of having a usual source of care among Medi-Cal enrollees, as well as fears among the uninsured that they will be hit with high ED medical bills if they use an ED at all. Among those 65 years and older, those with Medi-Cal only (49.0%) had the highest rate of ED visits, and those with privately purchased insurance had the lowest rate (14.6%).

## The Uninsured Most Often Reported Delays in Care

Financial constraints, unwillingness of providers to accept different forms of insurance, and other access barriers often result in the decision to forgo or delay getting needed care. Such delays highlight access barriers that are not identified by examining service use. However, individuals' perceptions of forgone or delayed care are also influenced by expectations and propensity to seek care. Those who are less likely to seek care are less likely to report forgone or delayed care. Among adults ages 19-64, 8.7% of the uninsured reported delaying needed care, closely followed by those with privately purchased insurance (8.2%; Exhibit 4.8). Those with employment-based insurance reported the lowest rates (2.4%).

### Exhibit 4.8

Rates of Delays in Needed Medical Care by Type of Insurance Coverage, Ages 19-64, California, 2015-2016



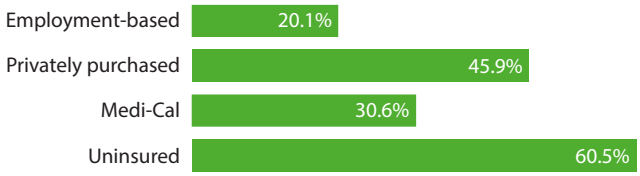

Note: Data with samples of less than five and unstable estimates are not reliable and are not presented.

Sources: 2015 and 2016 California Health Interview Surveys

Among adults reporting a delay in care, 60.5% of the uninsured reported having delayed or forgone needed care due to cost or lack of insurance, followed by those with privately purchased insurance (45.9%; Exhibit 4.9). Individuals with employment-based insurance (20.1%) reported the lowest rates.

### Exhibit 4.9

Rates of Delaying Care Due to Cost or Lack of Insurance by Type of Insurance Coverage, Ages 19-64, California, 2015-2016




Note: Data with samples of less than five and unstable estimates are not reliable and are not presented.

Sources: 2015 and 2016 California Health Interview Surveys

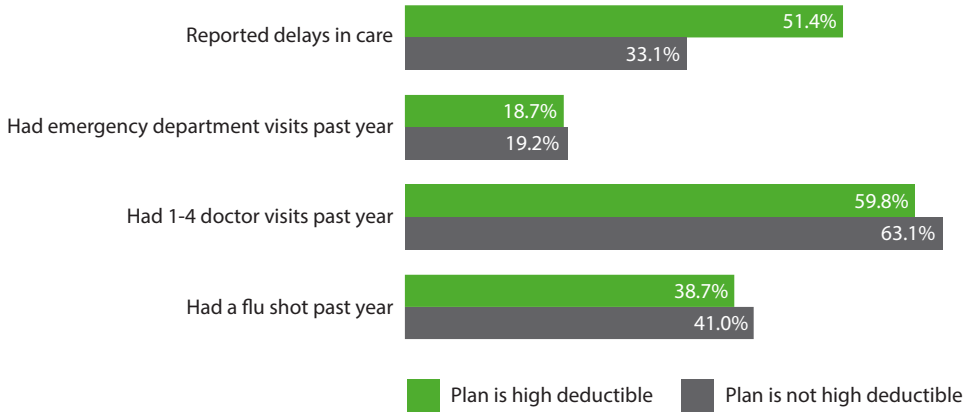
## Most High-Deductible Plan Enrollees Reported Delays in Care

The higher cost sharing required by high-deductible plans may reduce the affordability of preventive, primary, and specialty care services that must be covered out of pocket until the deductible is filled. The Affordable Care Act required coverage of preventive care and a limited number of primary care services to reduce the likelihood of individuals forgoing physical examinations and essential preventive services due to affordability.

Yet, monitoring overall use of services among high-deductible plan enrollees is needed to ensure that disparities in service use do not exist. Comparing service use of individuals with and without a high-deductible plan revealed no significant differences in rates of flu shots (38.7% vs. 41.0%), one to four doctor visits (59.8% vs. 63.1%), or ED visits (18.7% vs. 19.2%; Exhibit 4.10). However, individuals in high-deductible plans were more likely to report delays in care (51.4% vs. 33.1%) compared to those in plans without high deductibles.

**Exhibit 4.10**

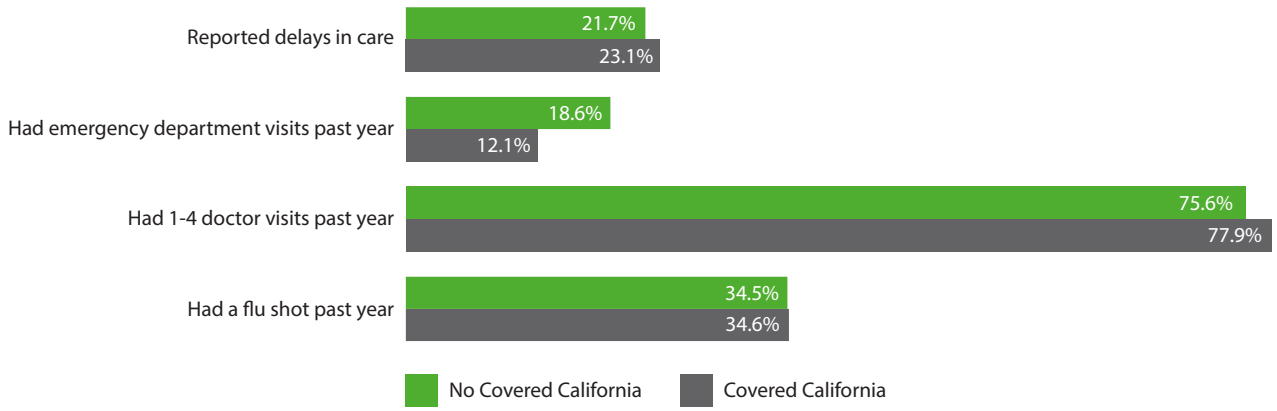
Service Utilization by High-Deductible Coverage, Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

**Exhibit 4.11**

Access to Care Among Individuals With Privately Purchased Insurance by Purchase of Coverage Through Covered California, Ages 19-64, California, 2015-2016




Sources: 2015 and 2016 California Health Interview Surveys

## Access to Care Under Covered California Is Similar to Access Off-Exchange

Covered California is the health insurance marketplace that has been in place since 2014 in the state, established under the Patient Protection and Affordable Care Act. Covered California offers privately purchased individual and small group (100 or fewer employees) insurance. Comparing access to care of those who purchased their insurance through Covered California with those who purchased insurance off-exchange showed no statistically significant differences in the rates of flu shots, at least one doctor visit, delays in care, or ED visits (Exhibit 4.11).

## Discussion

The examination of health status and access to care indicators by type of insurance in 2015 and 2016 showed different patterns. We frequently found that the uninsured and those with Medi-Cal and other public insurance reported fair or poor health, risk factors, and chronic conditions, with minor variations among children, nonelderly adults, and older adults. Individuals in these categories of insurance also frequently reported fewer preventive services, such as flu shots and mammograms; lower likelihood of doctor visits; and higher likelihood of both ED visits and delays in care due to costs or lack of coverage.

The combination of poor health and limited access to care poses significant challenges to efforts directed at improving population health and efficiencies in care delivery. Policy solutions to address these challenges include expanding insurance coverage to the remaining uninsured in California. For those with Medi-Cal, access can be improved by identifying and removing systemic barriers, such as the lack of availability of specialty care, and individual factors, such as social determinants of health. Further research is required to identify these factors and to understand what role they play in limited access and poor health among these underserved populations.

# 5 Policy Conclusions

Gerald F. Kominski, PhD

This report documents the ongoing success of the ACA in improving health insurance coverage for Californians through the end of 2016. In general, the initial significant impacts of the ACA, documented in our last report, continued through the period covered by this report, resulting in historically low levels of Californians without health insurance. However, since 2017 and the change in administrations in Washington, the ACA has been under continual attack. Although efforts to "repeal and replace" the ACA in 2018 were unsuccessful and the mid-term elections have put such efforts on indefinite hold, as this report goes to press, the courts are about to litigate yet another challenge to the ACA that could result in the entire law being declared unconstitutional. In the face of these efforts to undermine the ACA, California continues to chart a different course. Governor Gavin Newsom recently signed legislation to institute a state individual mandate (requiring all Californians to have health insurance or pay a penalty) to replace the federal mandate zeroed out by Congress, and to authorize the use of state funds to further expand Medi-Cal to undocumented young adults and to enhance subsidies for those with incomes from 139-399% FPL, as well as to provide new subsidies for those with incomes from 400-600% FPL. California also passed several laws in 2018 to stabilize the ACA and protect the market from federal changes in regulations that might reduce the effectiveness of state marketplaces, including reinstating the individual mandate.

In addition to these efforts to stabilize and enhance the ACA using state funds, single-payer advocates introduced The Healthy California Act (SB 562) in 2017 to create a true single-payer system in California. The fight over SB 562 signified the intensity of support for a stable and equitable health system with unified financing and payment rules, as well as the difficulty in achieving and implementing a single-payer system at the state level without significant support at the federal level. Because the interval since our last report has been so turbulent at the federal level, the remainder of this chapter focuses on the major achievements and remaining challenges facing the state since implementation of the ACA, with a focus on pathways to move the state closer to universal coverage.

Since our last report, health insurance coverage in California has continued to change dramatically, largely due to the significant impacts of the ACA. The availability of subsidies to purchase insurance through Covered California and the expansion of Medi-Cal to include adults below 139% FPL have substantially reduced the percentage of Californians who remain uninsured and changed the type of insurance coverage. Compared to 2014, in 2016, Californians ages 0-64 were much more likely to be enrolled in Medi-Cal, much less likely to be uninsured, and slightly less likely to have ESI.

In our previous report, we noted ongoing disparities between various population groups among those ages 0-64, many of which persisted in 2016, despite further reductions in the rate of uninsurance across most groups since 2014. In 2016, SB 75 authorized the expansion of Medi-Cal to all children ages 0-18, regardless of immigration status. This expansion appears to have contributed to nearly universal coverage for children ages 0-18 in the state — a laudable achievement. However, young adults ages 19-40 continued to be the most likely to be uninsured in 2016, despite ongoing reductions in their rate of uninsurance. As previously discussed, Governor Newson has recently signed legislation expanding full-scope Medi-Cal eligibility to young adults ages 19-25, regardless of immigration status. This expansion should provide further reductions in the percentage of uninsured young adults starting January 1, 2020.

Despite significant improvements in insurance coverage since 2014, several other population groups among those ages 0-64 continued to have high rates of uninsurance in 2016. Men were almost twice as likely to be uninsured as women (10.2% vs. 6.8%), largely because of lower enrollment in Medi-Cal

(31.6% vs. 37.1%). Non-Latino groups had a low rate of uninsurance, ranging between 4.8% and 5.8%, while Latino Californians were more than twice as likely to be uninsured (12.4%). Educational attainment continued to be strongly associated with being uninsured; those with less than a high school degree were almost four times more likely to be uninsured relative to college graduates (22.1% vs. 6.3%). Finally, despite substantial reductions in the rate of uninsurance among those with incomes below 250% FPL, income was still highly associated with the likelihood of being uninsured. Those with incomes below 139% FPL were almost three times more likely to be uninsured relative to those at 400% FPL and above (11.6% vs. 4.3%). Our findings suggest that efforts to achieve universal coverage in the state and to reduce disparities will be best targeted to those with incomes below 400% FPL, particularly those below 250% FPL. These groups have experienced important and historical improvements in insurance coverage under the ACA, but they were still the most disadvantaged relative to higher-income Californians in 2016.

Citizenship status continued to be an important determinant of insurance status. More than one-third (36.8%) of undocumented Californians were uninsured in 2016, but the vast majority of uninsured Californians (69.1%, or 1.94 million individuals) were citizens or legal residents. Efforts to achieve universal coverage must therefore address the challenges of providing meaningful and affordable coverage to all Californians, regardless of immigration status.

Overall, our findings indicate that the ACA led to a small reduction in the rate of Californians ages 0-64 with ESI coverage in 2016. It appears that this is because of the Medi-Cal expansion, which provided a no-cost alternative to some individuals previously covered by ESI. We continue to observe substantial variations across industries and occupations in insurance offer rates. In 2016, part-time and self-employed workers were more likely to be covered by Medi-Cal and individually purchased policies compared to full-time employees. Because of the Employee Retirement Income Security Act (ERISA), state policy options to achieve universal coverage through employer mandates are restricted. But the high rates of uninsurance among part-time and self-employed workers suggest that income-based policies are likely to be the most appropriate mechanism for targeting those who remain more likely to be uninsured.

The Medicaid (called Medi-Cal in California) expansion provision of the ACA continued to have a major impact in California. Since our last report, more than 2.71 million Californians were newly enrolled in Medi-Cal as of 2016. Based on administrative data, Medi-Cal enrollment averaged more than 1.2 million enrollees per month in 2016, consistent with our estimates from the California Health Interview Survey (CHIS) indicating about 12.6 million Medi-Cal enrollees in 2016.[17] Because of this considerable increase in Medi-Cal enrollment, it is difficult to argue that the state should be doing more outreach among the currently eligible. However, as policy options, further expansion of Medi-Cal to undocumented adults ages 26 and older or to those who struggle with affordability by allowing buy-in to Medi-Cal as a public option could yield significant progress toward universal coverage.

Our findings indicate mixed results with regard to access to health care services and health indicators by type of insurance. Self-reported fair or poor health status among Californians ages 0-64 was minimal among those with ESI (2%), but considerably higher among those with privately purchased insurance (13%) or Medi-Cal (34%). Although it is beyond the scope of this report to determine how insurance status might affect health status in the future, it is clear that insurance status is highly correlated with self-reported health status, which has been

17 The CHIS estimates, which are self-reported by respondents and not cross-checked with state eligibility rolls, differ slightly from Medi-Cal administrative data, largely because CHIS interviews only the noninstitutionalized population in California, excluding enrollees in any type of group housing.

shown to be an important predictor of health care utilization and mortality and morbidity. Californians ages 0-64 with privately purchased insurance (46%) and Medi-Cal (31%) were also more likely to report delays in seeking needed care due to cost compared to those with ESI (20%). Our findings are particularly troubling with respect to Medi-Cal, where cost barriers should be essentially eliminated. These figures merit further attention by the state in monitoring access among Medi-Cal enrollees. And among those with privately purchased insurance, the prevalence of Bronze plans in the individual market suggests that affordable monthly premiums nevertheless are creating financial barriers to necessary care.

As we concluded in our last report, California faces ongoing challenges in achieving further progress toward universal access. Based on recent estimates from another study, without recent efforts by the state to stabilize the ACA, the number of uninsured Californians was projected to increase to about 4.02 million by 2020, with 1.48 million uninsured because of immigration status; 610,000 eligible for ESI; 900,000 eligible for Medi-Cal but not enrolled; 500,000 ineligible for subsidies; and 520,000 eligible for subsidies but uninsured.[18] These projections will be lower as a result of recent actions by the state's legislature and governor.

For the first time in decades, true universal coverage seems to be a feasible and achievable goal in the near future, despite ongoing political and judicial threats to the ACA. California has charted a bold course to stabilize and expand the ACA marketplace in the face of these ongoing threats. Meanwhile, at the federal level, a variety of proposals — ranging from Medicare for all, to Medicaid and Medicare buy-ins, to a public option for exchange marketplaces — have been proposed, at least in part in response to the ongoing threats to the ACA.[19] Once again, we stand at a crossroads that could lead to very divergent pathways for the people of California and the rest of the nation, depending on the outcome of the current constitutional challenge to the ACA and the 2020 election. When we next report on the state of health insurance in California, we are likely to be either documenting the further successes and remaining challenges to true universal coverage, or conducting a postmortem on the ACA and documenting the damage done by the courts and an administration determined to eliminate health coverage for millions of low- and middle-income individuals. Should the latter occur, it may be time for California to consider both broad-based taxes as well as creative new taxes[20] to protect the health of California's population from federal policies hostile to vulnerable populations.

18 Dietz M et al. 2018. *California's Health Coverage Gains to Erode Without Further State Action*. UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research.

19 Kaiser Family Foundation. 2019. *Compare Medicare-For-All and Public Plan Proposals.* Issue brief. Accessed on August 17, 2019, at: *https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/*.

20 Scheffler Richard M. et al. California Dreamin': Integrating Health Care, Containing Costs, and Financing Universal Coverage. Health Affairs blog. February 8, 2019.

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