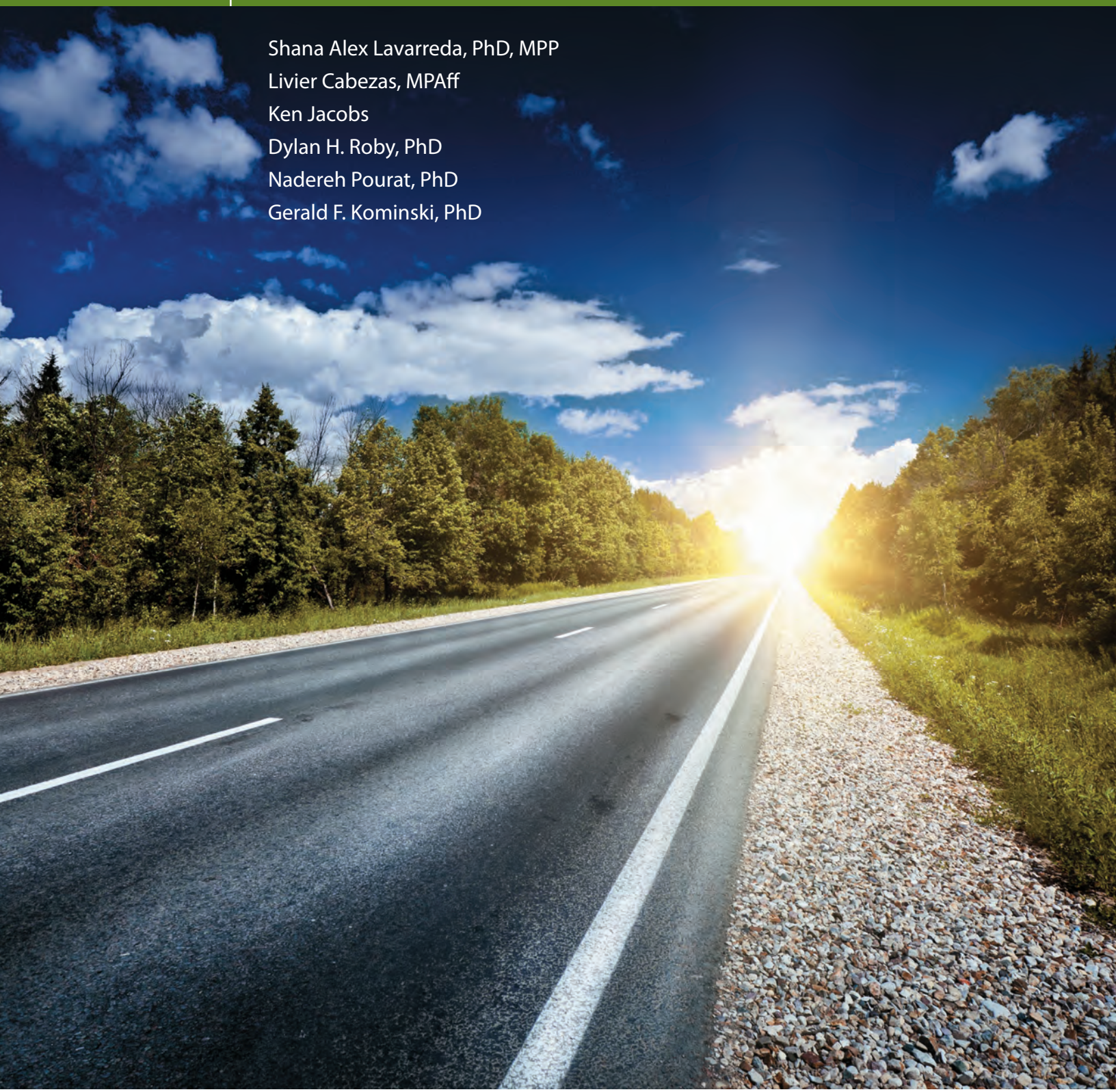
February 2012

The State of Health Insurance in California:

Findings from the 2009 California Health Interview Survey

Shana Alex Lavarreda, PhD, MPP
Livier Cabezas, MPAff
Ken Jacobs
Dylan H. Roby, PhD
Nadereh Pourat, PhD
Gerald F. Kominski, PhD



UCLA CENTER FOR HEALTH POLICY RESEARCH

February 2012

The State of Health Insurance in California:

Findings from the 2009 California Health Interview Survey

Shana Alex Lavarreda, PhD, MPP
Livier Cabezas, MPAff
Ken Jacobs
Dylan H. Roby, PhD
Nadereh Pourat, PhD
Gerald F. Kominski, PhD

The UCLA Center for Health Policy Research is based in the UCLA School of Public Health and affiliated with the UCLA Luskin School of Public Affairs.

www.healthpolicy.ucla.edu

Funded by grants from The California Endowment and The California Wellness Foundation

The views expressed in this report are those of the authors and do not necessarily represent the UCLA Center for Health Policy Research, the Regents of the University of California, The California Endowment, or The California Wellness Foundation.

Suggested Citation:
SA Lavarreda, L Cabezas, K Jacobs, DH Roby, N Pourat, GF Kominski. *The State of Health Insurance in California: Findings from the 2009 California Health Interview Survey.* Los Angeles, CA: UCLA Center for Health Policy Research, 2012.

www.chis.ucla.edu

This study and report were funded by grants from The California Endowment and The California Wellness Foundation. The report is based on data from the 2009 California Health Interview Survey, which was supported by funds received from the California Department of Health Care Services; the California Department of Public Health; The California Endowment; the National Cancer Institute; First 5 California; the California Department of Mental Health; the California Office of the Patient Advocate; Kaiser Permanente; the San Diego County Health and Human Services Agency; the Blue Shield of California Foundation; the California HealthCare Foundation; the Agency for Healthcare Research and Quality; and the National Institutes of Health/Office of Behavioral and Social Sciences Research.

The UCLA Center for Health Policy Research is based in the UCLA School of Public Health and affiliated with the UCLA Luskin School of Public Affairs.

www.healthpolicy.ucla.edu

Preface

Growing Challenges and Future Opportunities

E. Richard Brown

California residents have long faced more challenges in obtaining health insurance coverage than the average American. This disparity was exacerbated by the Great Recession as rising unemployment and foreclosure rates overwhelmed many Californians, who also lost their employment-sponsored health insurance when they, or their spouse or parent, lost a job.

The Challenges

This report, *The State of Health Insurance in California: Findings from the 2009 California Health Interview Survey*, finds that 7.1 million Californians were uninsured in 2009. That amounts to 21.1% of nonelderly Californians who had no health insurance coverage for all or some of 2009, up nearly 2 percentage points from 2007. As the authors point out, uninsurance was pushed up by the loss of employment-sponsored insurance, which fell 3.5 percentage points from 2007, when 55.6% had coverage from their own or a family member's job, to 52.1% in 2009.

The problem is worse in California than in the rest of the nation. California's uninsured rate is about 3 percentage points higher than the U.S. average, driven by an employment-based insurance rate that is about 6 percentage points lower.[1]

The fall in employment-sponsored insurance was driven by rising unemployment. In December 2007, the state unemployment rate was 5.8%; two years later it had more than doubled, to 12.2% – a much greater increase than the national average.[2] As unemployment rose and the housing market bubble popped, many families found themselves with homes worth less than their mortgages. Thirty-five percent of California mortgage holders found themselves "under water," a figure that was the fifth highest rate in the nation.[3] In 2009, with declining income and employment, 3.2% of California's housing units were in foreclosure, twice the proportion both in 2007 and in the United States as a whole.[4] These are all indicators of the mounting economic woes that have affected the well-being of the majority of Californians, and that will likely affect the health of Californians as well.

The authors of this report provide evidence that uninsured and low-income Californians are much less likely to be able to afford to visit a doctor or fill a prescription; they are thus more likely not to get the care they need. The report finds that even those with coverage may find it difficult to come up with the required copayments and coinsurance needed to get health care. And if California succeeds in cutting Medi-Cal payment rates to doctors, hospitals, and other health care providers (which is, as of publication, under consideration in Douglas v. Independent Living Center of Southern California in the U.S. Supreme Court), Medi-Cal beneficiaries are likely to find fewer places to obtain health services.

1 Fronstin P. Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey. Employee Benefit Research Institute Issue Brief no. 362. Washington, D.C. September 2011.

2 Unemployment rates from the California Employment Development Department.

3 Underwater Mortgages on the Rise According to First American CoreLogic Q4 2009 Negative Equity Data. CoreLogic. February 23, 2010.

4 Housing foreclosure rates from *RealtyTrac.com*.

The impact of declining health insurance coverage and incomes will leave low-income children and adults, populations of color, and immigrants disproportionately worse off. And disparities in coverage and access to care are likely to exacerbate already disturbing disparities in health outcomes.

A Brighter Future?

Despite this seemingly bleak picture, the new federal health care reform —the Patient Protection and Affordable Care Act (ACA) — offers hope for many Californians. The ACA will transform and greatly expand eligibility for Medi-Cal (California's Medicaid program), which will, the authors estimate, enable more than 3 million nonelderly uninsured Californians to become newly eligible for Medi-Cal.

In addition, California's new Health Benefit Exchange, established in response to the ACA, is expected to create a regulated and accessible marketplace in which residents can find a choice of health plans. The Exchange will provide new opportunities for health insurance coverage to employees, the self-employed, and small firms, many of whom have either struggled in the pricey and volatile individual health insurance market or gone without coverage. As a result of the ACA, the authors estimate that 1.7 million uninsured Californians will be able to enroll through the Exchange and receive subsidies that will help make coverage affordable to them. Another 1.2 million uninsured residents will be able to buy coverage through the Exchange, although their incomes exceed the level at which they would qualify for subsidies. Despite the relief the ACA will provide for many, an estimated 1.1 million uninsured, undocumented California residents will be ineligible for any of these options.

The State of Health Insurance in California report makes clear that with the accelerated decline in health insurance coverage, more people face barriers to obtaining the health services they need. At the same time, the authors also emphasize the relief that will be available for several million Californians with the state's aggressive implementation of the ACA.

Table of Contents

List of Exhibits

Definitions

Uninsured All Year
Had no medical insurance for all of the past 12 months.

Uninsured Part Year
Had no medical insurance for some of the past 12 months. This could include those who:
1) were insured and lost their coverage,
2) were uninsured and gained coverage, or
3) cycled in and out of being uninsured during the past year.
The type of insurance coverage for part of the year is not listed separately.

Employment-Based Insurance All Year
Had medical insurance provided through their own or a family member's current or former employment for all of the past 12 months. This would also include coverage provided through a professional union membership or military coverage.

Medi-Cal or Healthy Families All Year
Had medical insurance through the public Medi-Cal or Healthy Families programs for all of the past year. As this is self-reported, it does not account for whether respondents had full-scope or partial-scope Medi-Cal.

Individually Purchased Insurance All Year
Had medical insurance that was purchased by the policyholder directly from the insurance company for all of the past 12 months. This could include both individual and family insurance. Also called "non-group" coverage.

Other Public All Year
Had medical insurance for all of the past 12 months through a government program that was neither Medi-Cal nor Healthy Families. Examples of such insurance would include Aid to Infants and Mothers (AIM) or Medicare (if not listed separately).

EXECUTIVE SUMMARY

Chapter 1: The Effects of the Great Recession on Health Insurance in California

Beginning in fall 2008, California entered a period of economic recession characterized by high unemployment rates and record numbers of housing foreclosures, both of which dealt major blows to families throughout the state as well as the country. By 2009, the number of nonelderly Californians who were uninsured for all or part of the year reached 7.1 million, or more than one-fifth (21.3%) of all nonelderly Californians – a significant increase from the 6.4 million uninsured in 2007. The uptick in the number and percentage of the nonelderly uninsured was directly attributable to the drop in employment-based coverage, which fell sharply from 55.6% in 2007 to 52.1% in 2009. Statewide, uninsured rates ranged from a low of 9.9% (Marin County) to a high of 29.7% (San Bernardino).

Under the Patient Protection and Affordable Care Act of 2010 (ACA), persons with household incomes less than 133% of the Federal Poverty Level (FPL) will be eligible for the Medicaid program expansion in January 2014, including those who are adults without children. People who are in households with incomes of 133–400% FPL will be eligible for federal subsidies to purchase insurance in the newly created California Health Benefits Exchange; those with incomes that are more than 400% of the FPL will be able to purchase coverage in the Exchange, albeit with no subsidy. In California, these expansions in coverage options will provide assistance to many of those most in need, as it is clear from the data that the lower the household income, the higher the likelihood of being uninsured.

Key Findings

- Those with employment-based coverage remained in the majority in 2009, at 52% of the population.
- Public coverage climbed to insure 31.8% of all children in the state. Uninsurance among children dropped to 9.8%, continuing the declining trend from the past decade.
- Compared to the uninsured in previous years, those who were uninsured for all or part of 2009 were poorer. From 2007 to 2009, the proportion of the uninsured living in poor families (below 100% FPL) climbed from 29% to 33.1%, the highest level in the decade.
- In 2007, 61.8% of the uninsured were in families with a full-time worker, and 17.7% were in nonworking families. In 2009, only 46.3% of the uninsured were in families with a full-time worker, and nearly one-third (30.8%) were in nonworking families.
- Suburban areas as a whole have the highest rate of employment-based coverage (63.7%), and urban areas have the lowest (47.7%). Urban areas as a whole have the highest rate of uninsurance in the state (23.6%).
- When the ACA is fully implemented in 2014, 42.9% of nonelderly uninsured Californians will be eligible to enroll in Medi-Cal under the expanded household income requirements.
- Nearly one-quarter (24.2%) of California's nonelderly uninsured population will be eligible for subsidies in the Exchange, and an additional 17.1% of the uninsured will be able to participate in the Exchange without subsidies.
- The Sacramento Area and San Joaquin Valley have the highest proportions of uninsured populations that will be eligible for the Medi-Cal expansion (46.6% and 48.5%, respectively).
- Nearly half of the uninsured in the Northern and Sierra Counties region will be eligible to participate in the Exchange (49.8%), compared to only 36.1% of the uninsured in Los Angeles County.
- Los Angeles County has the largest proportion of uninsured who will be ineligible to either purchase coverage in the Exchange or enroll in Medi-Cal due to their citizenship and immigration status, with one-fifth of this group being ineligible for both (20.7%).

Chapter 2: Racial/Ethnic Group and Citizenship Disparities in Health Insurance Persist

California is an increasingly multicultural state, and care should be taken to examine health insurance status and type by racial and ethnic groups. The nonelderly population is now a plurality of racial and ethnic groups, with no one group comprising a majority. Race and ethnicity in California are strongly linked with citizenship status, and the Patient Protection and Affordable Care Act of 2010 (ACA) contains citizenship requirements for its coverage expansions. In 2009, U.S. citizens were much more likely than non-citizens without a green card to have health insurance through employment or public coverage. Latinos are less likely to be citizens or to have green cards, and as a result this citizenship/coverage relationship affected non-Latino whites and Latinos at different rates. The exclusions embedded in ACA will likely increase the health insurance disparities between U.S. citizens and non-citizens over time. If these issues remain unaddressed, California runs the risk of increasing racial/ethnic inequities in health care access and outcomes.

This chapter provides an in-depth look at health insurance status and type through two lenses: 1) racial and ethnic group and 2) citizenship status. These differences highlight the importance of examining health insurance status and type by these two categorizations separately, since grouping them could mask the separate impact of each.

Key Findings

- In 2001, the uninsurance rate among nonelderly Latinos was at its height, at 34.6%. That dropped to 28.6% by 2007, but rose again with the 2009 recession, to 30.1%. Nonelderly Latinos continued to have the lowest rates of job-based insurance, with the recession erasing prior gains and dropping the rate to a decade low of 36%.
- In 2001, 55.1% of nonelderly African Americans had job-based health insurance; by 2009, this figure had dropped to 44.8%.
- About four in ten of the uninsured non-Latino White population will be eligible to gain coverage through the expanded Medi-Cal program under ACA (39.5%). Another one-third will be eligible for federal subsidies to purchase insurance through the new Exchange (31.4%), and nearly all of the rest will be able to buy in the Exchange with their own funds (28.5%).
- African Americans will have among the highest rates of eligibility for the Medi-Cal expansion (49.5%), and the rest of these populations will be eligible for the Exchange, either with or without subsidies.
- Only three-fourths of uninsured Latinos will be able to gain coverage under ACA. A slightly higher percentage (43.1%) will be eligible for the Medi-Cal expansion, but far fewer will participate in the Exchange, either with subsidies (21%) or without (9.2%). The rest will be ineligible to participate in the coverage expansions due to their citizenship status (26.8%).
- Non-citizens without a green card are concentrated in Los Angeles County, with just over one-third living in that region (34.9%). In contrast, only 24.9% of U.S.-born citizens live in Los Angeles County.
- The group with the highest rate of public coverage (78.8%) was citizen children whose parents were non-citizens without green cards. Only 6.4% in this group had job-based coverage. These figures highlight the importance of public health insurance as a safety net for children who would otherwise be uninsured.
- U.S.-born citizens comprised 51.3% of the nonelderly uninsured for all or part of the year

in 2001. By 2009, this proportion had grown to 57.3% of the uninsured. Although still the next largest group within the uninsured population, non-citizens without green cards saw their proportion decline from 21.1% in 2001 to 15.9% in 2009. The proportions of both naturalized U.S. citizens and non-citizens with green cards were fairly stable over time (13.9% and 13%, respectively).

Chapter 3: Job-Based Coverage and the Individual Market

Employment-based insurance continues to be the central source of coverage for working adults and their family members in California. Own-employer coverage rates vary significantly across demographic groups. Age, race, ethnicity, citizenship and immigration status, educational achievement, family income, and worker wages are all significantly correlated with the share of workers with own-employer coverage. Firm size also has a strong correlation with offer and coverage rates.

The ACA will make important changes to the landscape for private coverage. The new health insurance exchanges will open new opportunities for the self-employed and for workers without an offer of affordable job-based coverage. The ACA is expected to have important impacts on employer offer, worker eligibility, and take-up of coverage, although the overall impact on the share of workers with job-based coverage is likely to be relatively small.

Key Findings

- The share of nonelderly adults with employment-based coverage fell by 670,000 between 2007 and 2009, a 4 percentage point decline (from 57.3% to 53.3%).
- The main source of the decline was the loss of full-time work in the state. The number of adults with full-time employment fell by 1.4 million between 2007 and 2009.
- The share of nonelderly Californians with employment-based coverage ranged from a low of 36% in Kings County to a high of 73.6% in San Mateo County.
- Of all age groups, young workers saw the largest drop in coverage through their own employment (3.2%). In 2009, 21.4% of workers ages 19–24 had coverage through their own employment, compared to 57.6% of those ages 55–64.
- Latinos were the least likely to have coverage through their own employment (38.8%), compared to 53.6% for non-Hispanic whites.
- College graduates were nearly twice as likely as those with less than a high school education to have employment-based coverage (60.9% vs. 30.9%).
- Workers in lower-income families (i.e., under 200% FPL) were only one-third as likely to have employment-based coverage as workers in higher-income families (above 400% FPL).
- In 2009, 1 million working adults were covered through the individual market; of these, 415,000 were self-employed.
- The number of self-employed individuals reporting that they had employment-based coverage fell by more than 100,000 between 2007 and 2009, an 11.4% reduction.
- In 2009, 1.75 million working-age adults declined employment-based coverage for which they were eligible. Less than a quarter (22.5%) of those declining employment-based coverage (381,000) reported that they had been uninsured for all or part of the year; of these, 126,000 (32%) were ages 19-25.
- Individuals who are uninsured and would be eligible for subsidies under the ACA are younger on average than those currently in the individual market, but they are more likely to report fair or poor health status.
- Californians who would be eligible for the exchange, but not for subsidies, are closer in health status to those in the current private market.

Chapter 4: Medi-Cal, Healthy Families, and Medicare Play a Vital Role in Insuring Californians

Medi-Cal, Healthy Families, and Medicare provided insurance coverage to 9.3 million people in California for all or part of 2009. Despite the presence of these state and federally run public programs, there are still many low-income, uninsured Californians who do not qualify for coverage. Additionally, there are children and their parents, people with disabilities or medical needs, and elderly Californians who are eligible for public insurance programs but who are not enrolled.

With the rise in unemployment during the Great Recession of 2008 resulting in a decrease in the number and proportion of Californians with private insurance, Medi-Cal and Healthy Families benefits provided significant support in keeping children insured, even though their parents had lower rates of coverage.

Key Findings

- Over one-quarter (26.7%) of children ages 0–18 had Medi-Cal coverage in 2009, compared to 24.7% in 2007, prior to the Great Recession.
- The main source of the increase was the loss of full-time work in the state. The number of adults with full-time employment fell by 1.4 million between 2007 and 2009. While their children were able to qualify for and enroll in Medi-Cal or Healthy Families, the percentage of adults who had Medi-Cal all year actually decreased slightly (9.0% to 8.7%), while the proportion of uninsured adults increased from 23.9% to 26.6%.
- Medi-Cal beneficiaries were primarily made up of individuals up to the age of 18 (51%), with the other large groups being younger adults (ages 19–34), representing 13.8% of all beneficiaries, and older adults ages 65 and up (13.6%). The adult population represented only 35.4% of the Medi-Cal population, despite making up 60% of California's population.
- More than three-quarters of the children in Medi-Cal were Latino, with 9.3% non-Hispanic white and 7.8% African American. Latinos represented 55.6% of the nonelderly population in Medi-Cal, but only 35.7% of the adults over 65 in the program. Overall, almost two-thirds (63%) of Medi-Cal beneficiaries were Latino.
- The language needs of the Medi-Cal population were quite diverse, with 40.4% of the beneficiaries age 18 or younger speaking Spanish and having limited English-speaking ability. In the over-65 population, 41.7% of the beneficiaries reported English as their primary language, but a smaller percentage of people who spoke English as their second language had problems understanding and communicating in English.
- Like Medi-Cal, close to three-quarters of the Healthy Families population were Latino (75% of children ages 0–5 and 69.1% of those ages 6–18).
- Among children, 92.7% of those eligible for Medi-Cal were actually enrolled. However, among adults, 85% who were estimated to be eligible were actually enrolled. Children and adults who did not enroll represented almost 500,000 people who could have had public coverage but were currently uninsured.
- Medicare beneficiaries in California had very different characteristics from other publicly insured Californians. The majority (96.2%) had Medicare and other coverage, whether it was supplemented by an employment-based plan, Medigap, or Medi-Cal.

- Medicare beneficiaries without Medi-Cal or a supplemental source of coverage were more likely to report delays in obtaining medical care or necessary prescription drugs.
- Those in the Medicare/Medi-Cal "dual eligible" population were far more likely to report chronic illness, fair or poor health status, and having visited an ER in the past year.

Chapter 5: The Role of Insurance in Access to Care

Health insurance plays a significant role in access to health care in California. Insurance leads to increased use of health services, aids in establishing a usual source of care, and reduces financial barriers to care. However, health insurance does not fully address the financial barriers to access, since many of the insured still report forgoing needed care or delaying it due to costs and the incurring of medical debt. Not all types of health insurance are equal in their impact on access. Significant variations in premiums, cost sharing, and benefits exist between employment-based and individually purchased insurance, further complicated by the high-deductible plans that exist in both markets. Medi-Cal and Healthy Families coverage have very low or no premiums and cost sharing, but funding shortfalls often threaten eligibility, benefits, and provider participation in these programs.

The current dynamics of health insurance and access are likely to change beginning in 2014, when the rates of insurance coverage will increase and the benefits and cost-sharing levels will be standardized to some degree. Continued monitoring of access to care is essential to identify how ACA and other health policies have improved access, what gaps remain, and where modifications are needed to address barriers to access.

Key Findings

- Uninsured children (41.8%) and adults (49.9%) more frequently reported not having seen a provider in the past year than their counterparts with employment-based insurance (8.3% and 13.4%, respectively). In contrast, the employment-based insured children (20.5%) and adults (26%) were more likely than uninsured children and adults to have made five or more visits to providers (4.7% and 6.2%, respectively).
- Lack of access to ambulatory care by the uninsured extended to lower rates of emergency room visits. Uninsured children (5.6%) and adults (11.6%) had significantly lower rates of emergency room visits than children and adults covered by public insurance (20.8% and 33%, respectively).
- Insurance coverage improved access to preventive services such as flu shots, mammograms, and colonoscopies. For example, 49.1% of children and 34.1% of adults with employment-based coverage had a flu shot in the past year, compared to 30.2% and 14.5% of their uninsured counterparts, respectively.
- The uninsured were also more likely than the insured to forgo or delay needed medical care due to costs or lack of insurance; 5.7% of those with employment-based insurance reported such barriers, compared to 19.5% of the uninsured.
- Only 8.9% of adults with employment-based insurance reported not having a usual source of care, compared to 51.9% of uninsured adults. The same pattern was observed among children. The usual source of care for uninsured adults was least often a private practice (16.8%) and more often clinic-based (31.3%), compared to adults with employment-based insurance (74.3% and 16.9%, respectively).

- Those without a usual source of care have reduced access to care even if insured. Among adults without a usual source of care, 33% of those with employment-based insurance, 51% of those with privately purchased insurance, and 40.5% of Medi-Cal beneficiaries had not visited a doctor in the past year. Similar discrepancies existed among children.
- High-deductible plans are less common with employment-based insurance than with privately purchased insurance. High-deductible plans were less frequently accompanied by health savings accounts among the latter (9.5%) than among the former (41.3%).
- Those who had employment-based insurance without savings accounts had lower rates of flu shots (26.6%) than those without high-deductible plans (34.8%).
- Forgoing or delaying needed prescription medications was more likely among those with high-deductible employment-based insurance (33.5%) than among those without high-deductible plans (11.9%).
- More of those uninsured all year (18.4%) and part of the year (23.2%) reported having medical debt than adults with employment-based insurance (9.1%). About half of those with medical debt reported the amount to be below $2,000, and a quarter or more reported amounts equal to or in excess of $4,000.
- Medical debt interfered with the ability to pay for basics, such as food and rent, for nearly a third or lower proportion of those with any debt, depending on type of coverage.

1 The Effects of the Great Recession on Health Insurance in California

Shana Alex Lavarreda

Beginning in fall 2008, the United States entered a period of economic recession characterized by high unemployment rates and record foreclosures, both major blows to families throughout the country. Both major economic trends during the so-called Great Recession manifested strongly in California, particularly in the more rural counties. In 2007, the unemployment rate for the state was 5.4%. By the end of 2009, the statewide unemployment rate had more than doubled, to 12.3%, one of the highest in the nation.[6] Additionally, California had the third-highest foreclosure rate in the nation, and counties such as Riverside and San Bernardino posted extremely high rates.[7] The Great Recession's effects spilled over into health insurance as well, and the number of uninsured swelled in the state, tracking the job loss.

6 California Employment Development Department data, accessed at *http://www.edd.ca.gov/*.

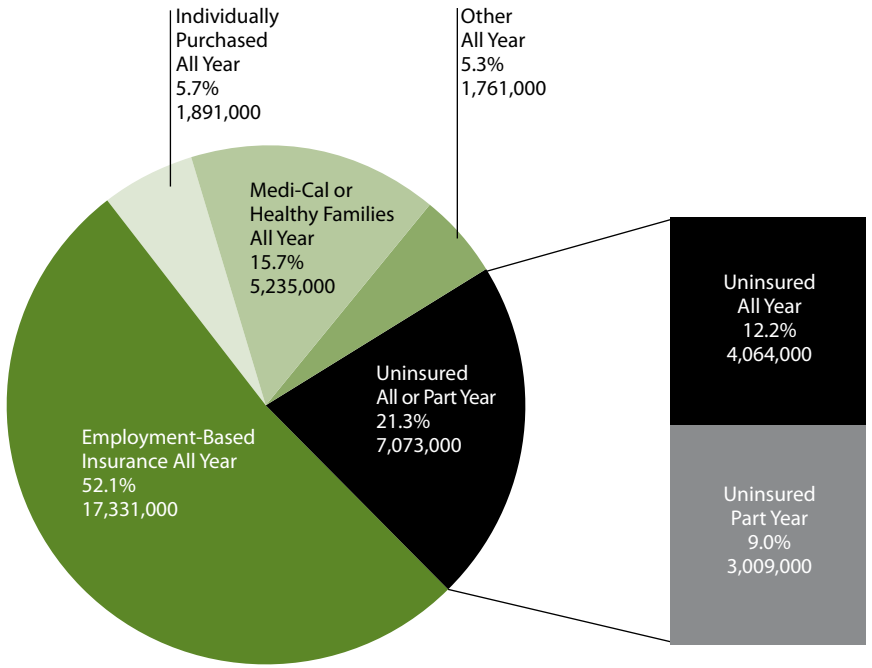
7 RealtyTrac data, accessed at *http://www.realtytrac.com/*.

By 2009, the number of people who were uninsured for all or part of the year topped 7 million (Exhibit 1), a significant increase from the 6.4 million uninsured in 2007. This was more than one-fifth (21.3%) of all nonelderly Californians. Even with the high unemployment, those with job-based coverage remained in the majority, at 52% of the population.

Public coverage expanded slightly, to more than 5 million nonelderly Californians (15.7%). Those with insurance they bought themselves directly from an insurance company or "other" coverage remained small proportions of the overall market (5.7% and 5.3% of the nonelderly population, respectively) (Exhibit 1).

Among the elderly population (ages 65+), the overwhelming majority have Medicare, combined with some other form of insurance that fills in the

Exhibit 1.
Health Insurance Coverage During Last 12 Months Among Nonelderly Persons, Ages 0-64, California, 2009



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

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

Source: 2009 California Health Interview Survey

gaps for what Medicare does not cover (89.6%; Exhibit 2). Only 2% of the elderly were uninsured for all or part of 2009.

Nearly one in five (18.5%) of the elderly have both Medicare and Medi-Cal, according to CHIS 2009, indicating that their incomes are extremely low. It is important to note that CHIS does not interview those in long-term-care institutions, and this figure may underestimate the number of elderly persons with both Medicare and Medi-Cal, because Medi-Cal is the largest payer for long-term care. An additional 28.5% have both Medicare and coverage through their own or a family member's employment.

But the largest group by far is the 42.6% who have Medicare and some private Medigap or HMO coverage that they purchased themselves (Exhibit 2).

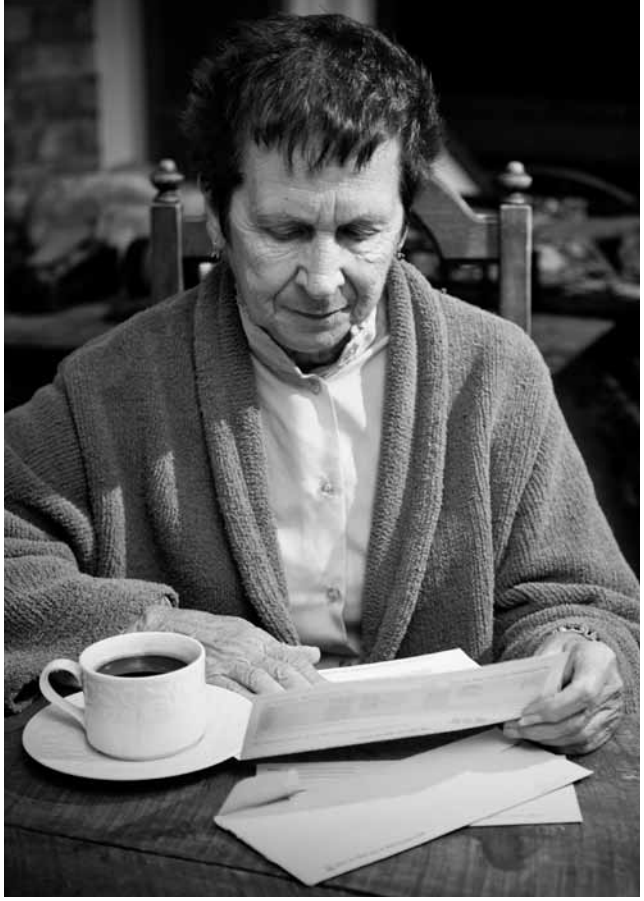
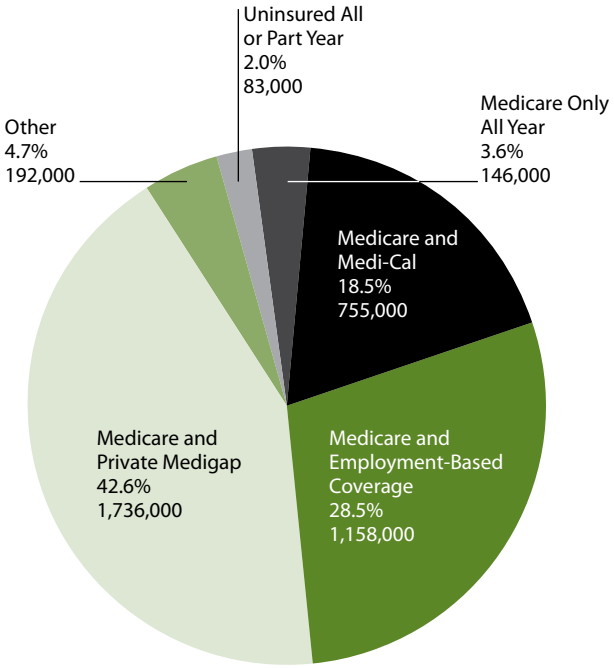


Exhibit 2.
Type of Medicare Coverage Among Elderly Adults, Ages 65 and Older, California, 2009



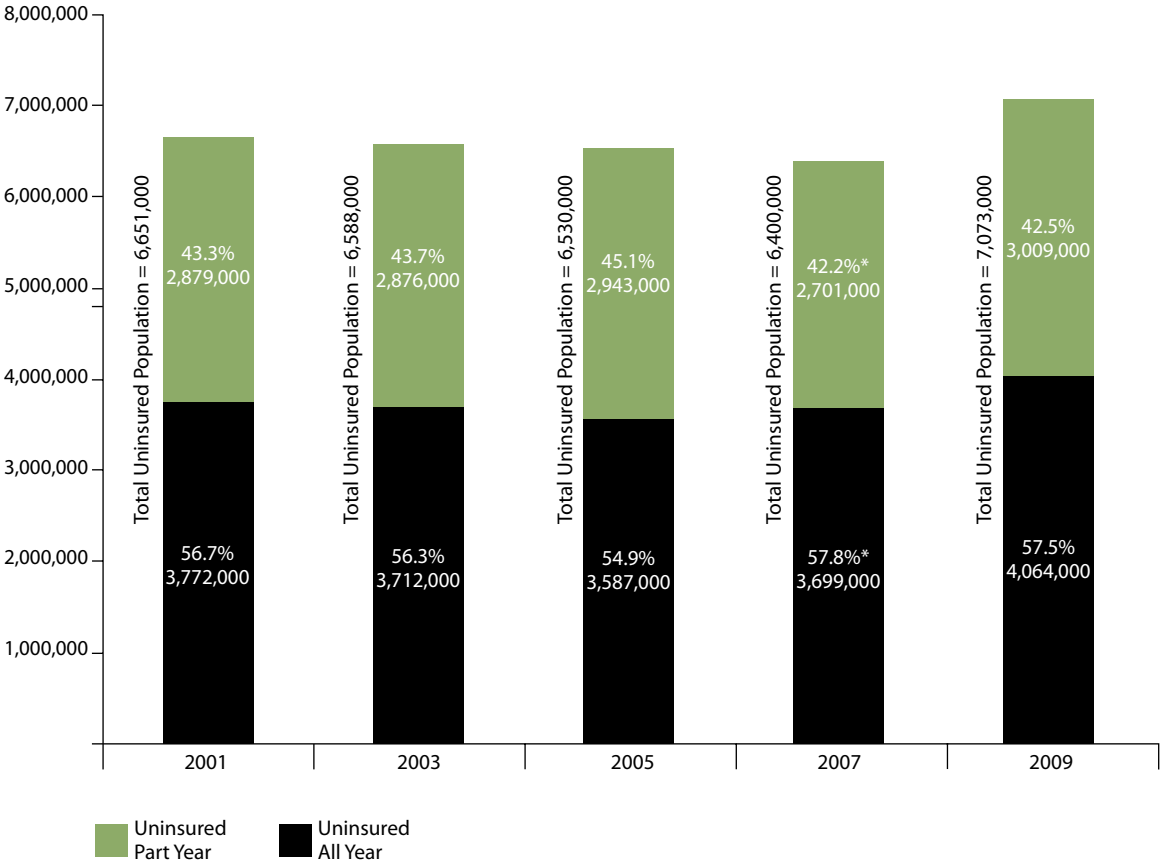
Note: "Medicare and Medi-Cal" includes some Employer-Paid coverage. "Medicare and Employment-Based Coverage" includes some Employment-Paid Medigap or HMO. "Medicare and Private Medigap" includes Privately Purchased Medigap or HMO All Year, or Medigap or HMO and Unknown Payer. "Other" includes Employer-Based Coverage Only All Year, Other Coverage All Year, and Uninsured All or Part Year.

Source: 2009 California Health Interview Survey

These last two categories combined means that 71.1% of elderly Californians with Medicare (a federally funded public health insurance system) still participate in the private market. For the rest of this chapter, when discussing the uninsured, the focus will remain on the nonelderly. For more on Medicare, see chapter 4 ("Medi-Cal, Healthy Families, and Medicare Play a Vital Role in Insuring Californians").

While the overall number of uninsured among the nonelderly did jump between 2007 and 2009, the proportion of uninsured all of the past year compared to uninsured for only part of the year remained fairly stable (Exhibit 3). Nearly six in ten (57.5%) uninsured nonelderly Californians had no insurance at all for at least a year.

Exhibit 3.
Total Uninsured by Duration of Uninsurance by Year Among Nonelderly Persons, Ages 0-64, California, 2001-2009

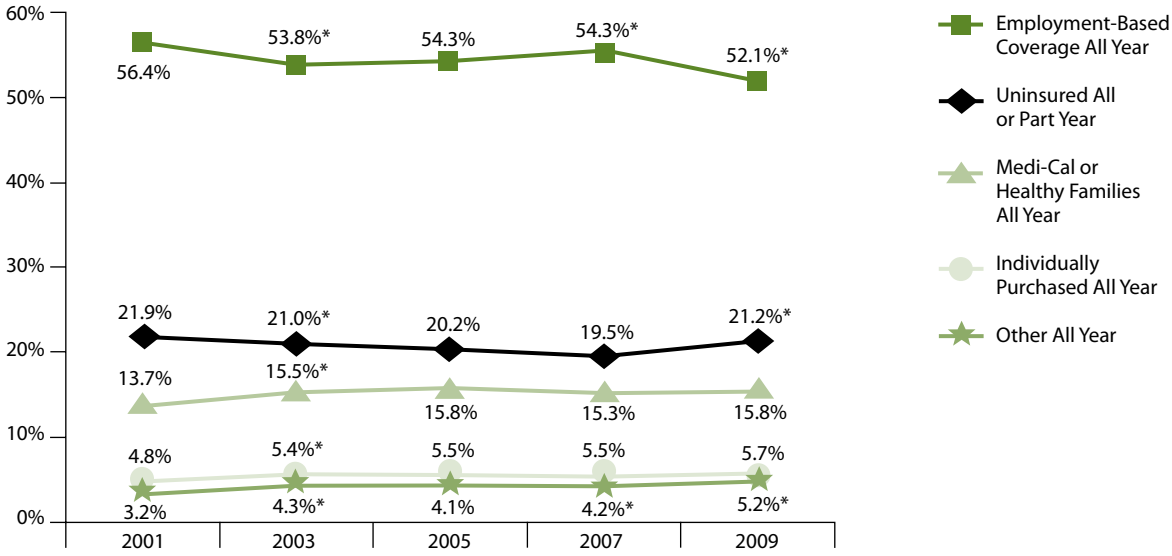


* Data are significantly different from the previous year at the 95% confidence level.

Source: 2001-2009 California Health Interview Surveys

The uptick in the number and percentage of nonelderly uninsured was directly attributable to the drop in employment-based coverage, which fell sharply from 55.6% in 2007 to 52.1% in 2009 (Exhibit 4). Slight increases in the rates of other types of coverage, including military insurance (under the "Other All Year" category), individually purchased, and public health insurance (i.e., Medi-Cal and Healthy Families) mitigated the increase in the uninsured rate.

Exhibit 4.
Health Insurance Coverage During Last 12 Months Among Nonelderly Persons, Ages 0-64, California, 2001-2009



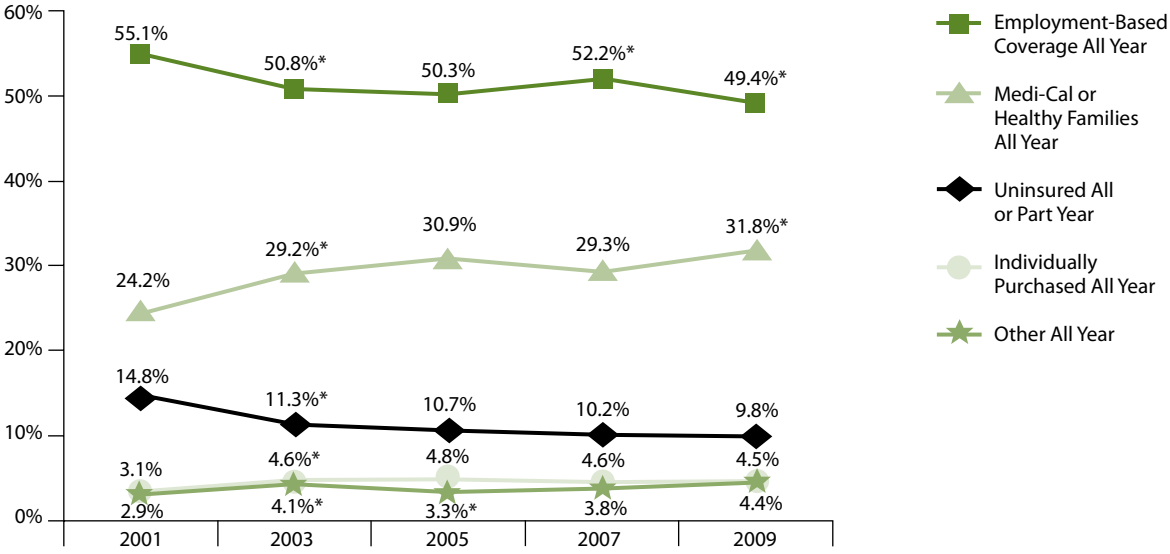
Note: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period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

* Data are significantly different from the previous year at the 95% confidence level.

Source: 2001-2009 California Health Interview Surveys

Among children, a slightly less steep decline in employment-based coverage (from 52.2% to 49.4%) combined with increases in both Medi-Cal/Healthy Families and other coverage actually led to a slight dip in the uninsured rate (Exhibit 5). Public coverage climbed to insure 31.8% of all children in the state. Uninsurance among children dropped to 9.8%, continuing the declining trend from the past decade (Exhibit 5).

Exhibit 5.
Health Insurance Coverage During Last 12 Months Among Children, Ages 0-18, California, 2001-2009



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

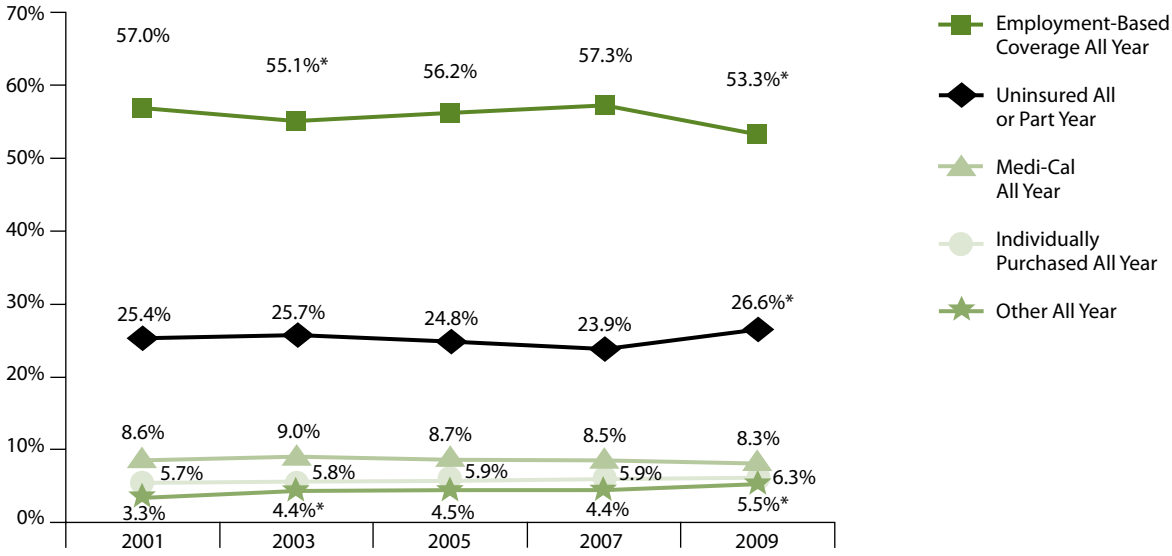
* Data are significantly different from the previous year at the 95% confidence level.

Source: 2001-2009 California Health Interview Surveys

Among nonelderly adults, the drop in job-based coverage from 57.3% in 2007 to 53.3% in 2009 corresponded to a nearly identical increase in the uninsured rate (from 23.9% to 26.6%; Exhibit 6). Existing public programs have much more stringent eligibility requirements for adults compared to children, and they were thus unable to absorb the newly uninsured population. Currently, nonelderly adults must have children in their household and have incomes that are less than 100% of the Federal Poverty Level (FPL) to qualify for Medi-Cal coverage; this group does not qualify for Healthy Families at all.[8]

8 The Federal Poverty Level for 2009 was $10,956 for a single person; $13,991 for a two-person family; and $17,098 for a three-person family.

Exhibit 6.
Health Insurance Coverage During Last 12 Months Among Nonelderly Adults, Ages 19–64, California, 2001-2009



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

* Data are significantly different from the previous year at the 95% confidence level.

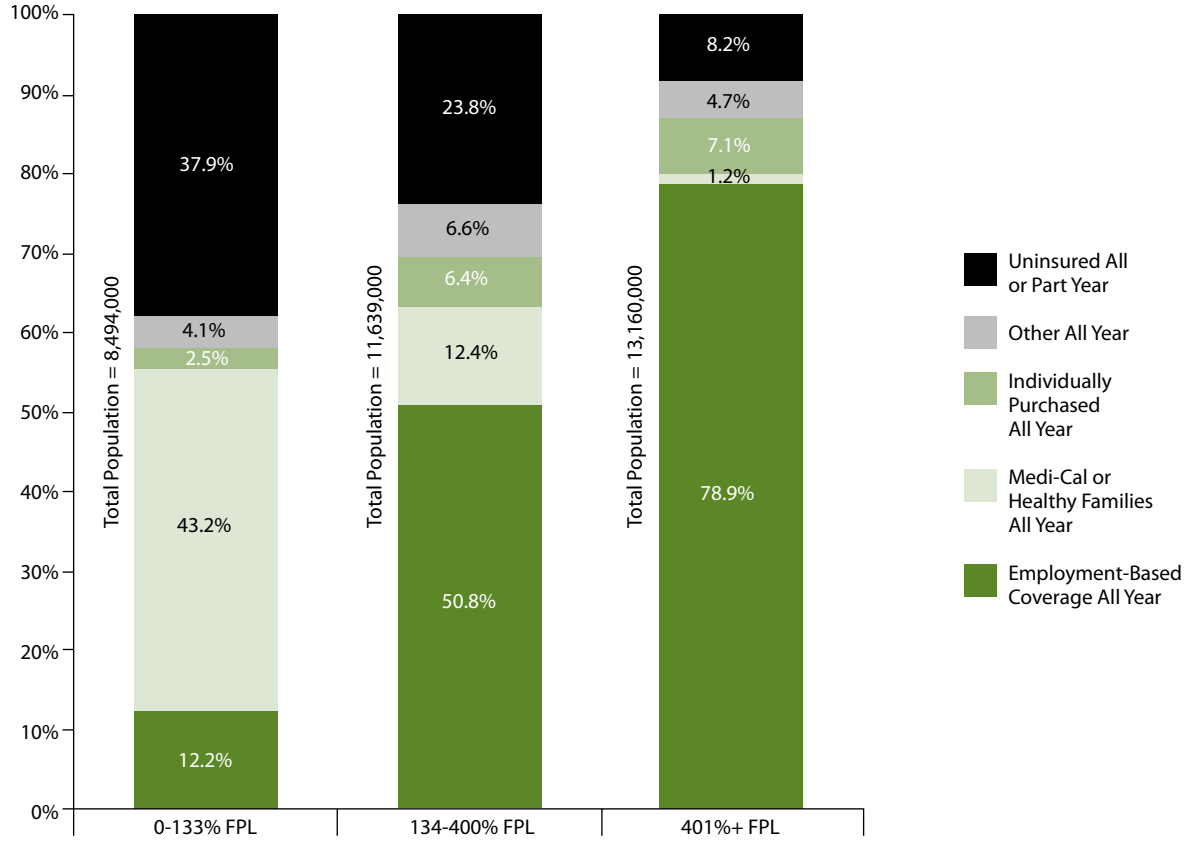
Sources: 2001–2009 California Health Interview Surveys

The Effect of Income on Health Insurance

Under the Patient Protection and Affordable Care Act of 2010 (ACA), persons with household incomes less than 133% of the Federal Poverty Level (FPL) will be eligible for the Medicaid program expansion in January 2014, including those who are childless adults. People who are in households with incomes of 133–400% FPL will be eligible for federal subsidies to purchase insurance in the newly created Health Insurance Exchanges (HIE), and those with incomes over 400% will be able to purchase coverage in the HIE, albeit with no subsidy.

In California, these expansions in coverage options will provide assistance to those most in need, as it is clear from the data that the lower the household income, the higher the likelihood of being uninsured. Among those with household incomes less than 133% FPL, 37.9% were uninsured for all or part of 2009 (Exhibit 7). In contrast, only 8.2% of those with household incomes over 400% FPL were uninsured, statistically significant from those below 133% FPL. Persons in households with incomes between these two levels were closer to the lower income group in terms of their uninsurance rate, with nearly one in four (23.8%) having no coverage for all or part of the past year.

Exhibit 7.
Health Insurance Coverage by Federal Poverty Level Among Nonelderly Persons, Ages 0-64, California, 2009



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

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

Source: 2009 California Health Interview Survey

These uninsurance rates are reflective of the large income disparity in access to job-based coverage. At the lowest income group, only 12.2% have health insurance through their or a family member's employment (Exhibit 7). Among the middle-income group, the job-based coverage rate leaps to 50.8%, and it climbs even further, to 78.9%, among those with the highest income levels.

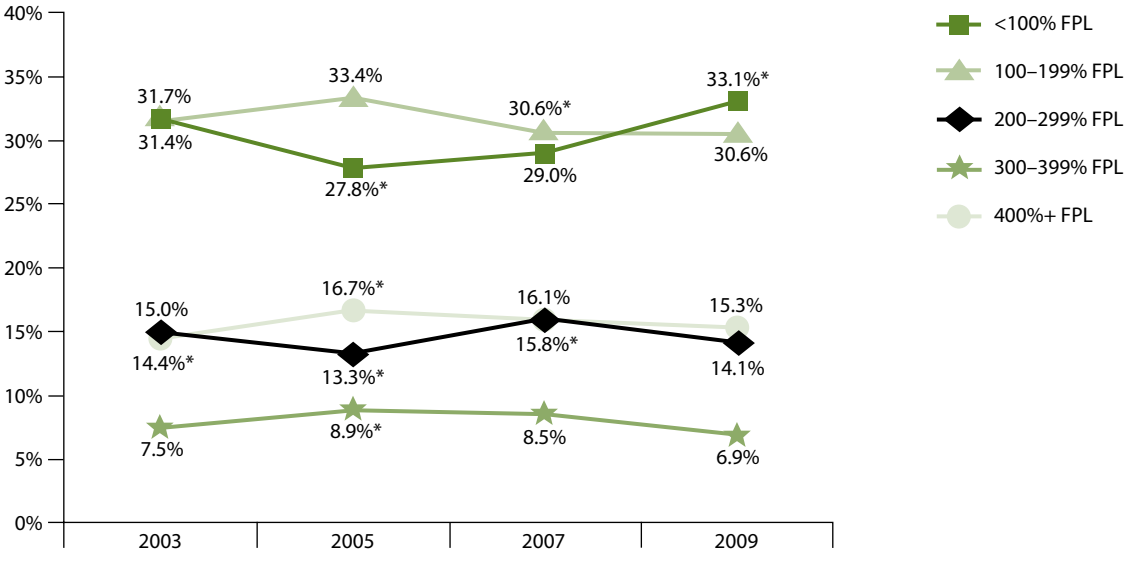
Public coverage has been able to alleviate some of this disparity, and it is in fact already the largest source of insurance for those with the lowest incomes (43.2%; Exhibit 7). The Medi-Cal expansion in 2014 will surely increase this trend, covering those who previously had no access to health insurance.

The Uninsured Became Poorer from 2003 to 2009

Compared to the uninsured in previous years, those who were uninsured for all or part of 2009 were poorer. From 2007 to 2009, the proportion of the uninsured living in poor families (under 100% FPL) climbed from 29% to 33.1%, the highest level in the decade (Exhibit 8).

Conversely, the proportion of uninsured in families with higher incomes declined. From 2007 to 2009, the proportion of uninsured people with household incomes from 200-299% FPL dropped from 15.8% to 14.1%, 300-399% FPL from 8.5% to 6.9%, and over 400% FPL from 16.1% to 15.3% (Exhibit 8). This trend indicates that the number of uninsured people who may be able to afford to purchase non-group coverage is declining, and that the ACA-funded coverage expansions will be even more needed than previously thought.

Exhibit 8.
Household Income as a Percent of the Federal Poverty Level Among Nonelderly Persons Uninsured All or Part Year, Ages 0-64, California, 2003-2009



Note: Chart is for 2003-2009 only, because comparable questions for family income did not exist in CHIS 2001.

* Data are significantly different from the previous year at the 95% confidence level.

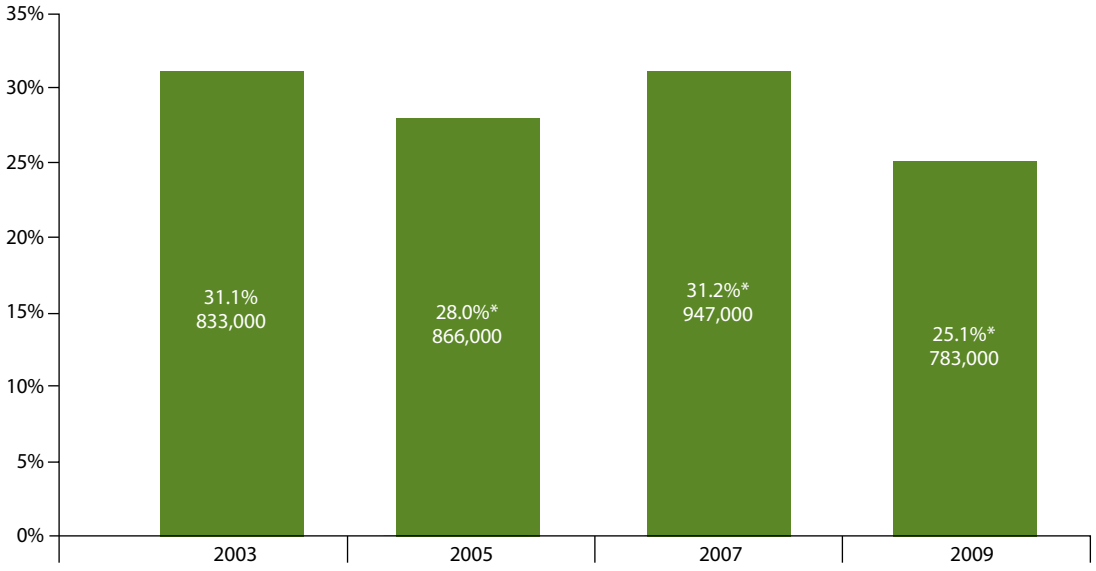
Source: 2003-2009 California Health Interview Surveys

Losing a Job Meant Losing Health Insurance in 2009

The recession in 2009 led to a slight shift in the population that had job-based coverage through their own or a family member's employment. Slightly fewer nonelderly persons with employment-based coverage all year in 2009 (83.6%) were in a family with a full-time worker, compared to 2007 (85.6%; data not shown). The difference shifted to nonworking families, comprising 7.8% of those with employment-based coverage in 2009 compared to 6.1% in 2007, suggesting that COBRA coverage had some small impact on keeping coverage after losing a job.

The self-employed were hit the hardest by the recession, with reported employment-based coverage rates for these families falling from 31.2% in 2007 to 25.1% in 2009 (Exhibit 9), while the rates for the other groups remained fairly stable. This suggests that people who were using their own small businesses to finance their family's coverage were no longer able to do so in the recession period, likely because of the high rate increases during this time.

Exhibit 9.
Employment-Based Coverage All Year for Families with At Least One Self-Employed Adult, Ages 0-64, California, 2003-2009



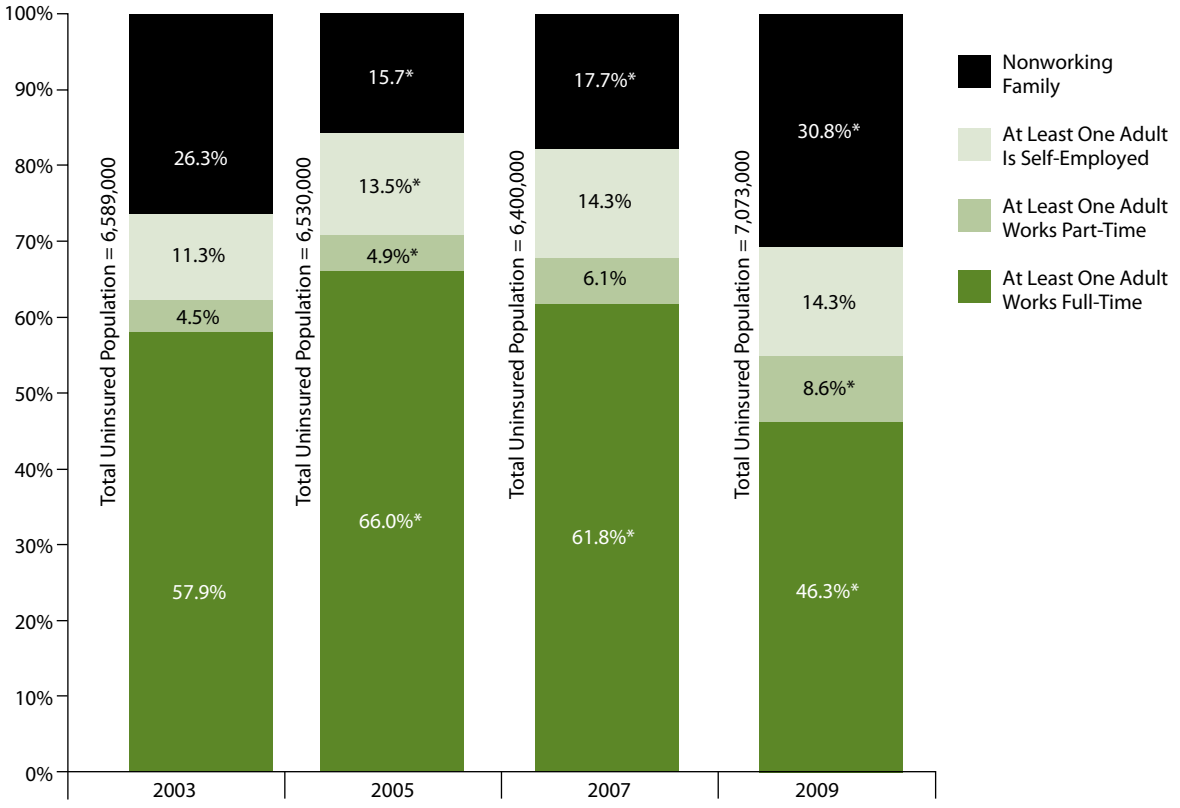
Note: Chart is for 2003-2009 only, because comparable questions for family work status did not exist in CHIS 2001.

* Data are significantly different from the previous year at the 95% confidence level.

Source: 2003-2009 California Health Interview Surveys

Among those who were uninsured for all or part of 2009, however, a very large shift in work status occurred. In 2007, 61.8% of the uninsured were in families with a full-time worker, and 17.7% were in nonworking families (Exhibit 10). With the job losses in 2008 and 2009, these proportions changed dramatically. In 2009, only 46.3% of the uninsured were in families with a full-time worker, and nearly one-third (30.8%) were in nonworking families.

Exhibit 10.
Family Work Status Among Nonelderly Persons Who Were Uninsured During the Past 12 Months, Ages 0-64, California, 2003-2009



Note: Chart is for 2003-2009 only, because comparable questions for family work status did not exist in CHIS 2001.

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

Source: 2003-2009 California Health Interview Surveys

Exhibit 11.

Insurance Status and Type During the Past 12 Months by Region and County Among Nonelderly Persons, Ages 0-64, California, 2009

County	Job-Based Coverage All Year	Medi-Cal/ Healthy Families All Year	Other Coverage All Year	Uninsured All Year	Total Population
All California	**52.1%**	**15.7%**	**11.0%**	**21.2%**	**33,291,000**
Northern and Sierra Counties	**46.0%**	**20.1%**	**12.9%**	**21.0%**	**1,153,000**
Butte	42.0%	21.2%	11.0%	25.7%	183,000
Tuolumne, Inyo, Calaveras, Amador, Mariposa, Mono, Alpine	47.4%	19.6%	17.6%	15.4%	141,000
Shasta	50.8%	16.5%	12.3%	20.5%	152,000
Sutter	47.0%	24.2%	11.3%	17.5%	83,000
Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plumas, Sierra	46.3%	23.7%	12.4%	17.7%	118,000
Humboldt	52.5%	15.1%	14.3%	18.1%	112,000
Tehama, Glenn, Colusa	39.4%	25.0%	7.2%	28.4%	96,000
Nevada	51.6%	9.2%	17.1%	22.2%	79,000
Mendocino	40.4%	23.8%	14.0%	21.8%	75,000
Yuba	40.3%	23.1%	13.8%	22.7%	64,000
Lake	45.3%	23.0%	10.3%	21.5%	50,000
Greater Bay Area	**62.9%**	**10.2%**	**10.9%**	**15.9%**	**6,358,000**
Santa Clara	63.7%	11.0%	11.2%	14.2%	1,618,000
Alameda	62.5%	11.3%	7.3%	18.8%	1,363,000
Contra Costa	65.4%	9.2%	9.8%	15.6%	922,000
San Francisco	59.9%	12.3%	11.4%	16.4%	712,000
San Mateo	73.6%	–	9.3%	12.8%	643,000
Sonoma	54.6%	8.7%	17.0%	19.7%	417,000
Solano	55.6%	14.9%	13.1%	16.4%	364,000
Marin	60.5%	7.4%	22.3%	9.9%	206,000
Napa	52.8%	11.6%	17.6%	18.0%	113,000
Sacramento Area	**61.9%**	**11.4%**	**9.4%**	**17.2%**	**1,870,000**
Sacramento	60.8%	13.6%	7.6%	18.0%	1,251,000
Placer	67.1%	5.1%	12.7%	15.1%	290,000
Yolo	57.8%	9.3%	14.6%	18.3%	174,000
El Dorado	66.3%	8.5%	12.3%	12.8%	154,000
San Joaquin Valley	**44.5%**	**24.9%**	**8.8%**	**21.9%**	**3,518,000**
Fresno	42.4%	25.6%	7.9%	24.2%	836,000
Kern	43.8%	26.6%	9.2%	20.4%	732,000
San Joaquin	45.1%	28.0%	8.9%	18.0%	606,000
Stanislaus	56.0%	17.6%	7.7%	18.7%	465,000
Tulare	37.2%	28.6%	7.4%	26.8%	394,000
Merced	47.5%	19.8%	10.0%	22.7%	231,000
Kings	36.0%	26.9%	16.5%	20.7%	127,000
Madera	42.6%	18.4%	9.2%	29.8%	125,000
Central Coast	**50.8%**	**16.2%**	**13.4%**	**19.6%**	**1,957,000**
Ventura	55.9%	10.4%	15.0%	18.7%	729,000
Monterey	41.5%	26.0%	9.5%	23.0%	371,000
Santa Barbara	47.6%	22.3%	12.2%	17.9%	359,000
Santa Cruz	50.5%	14.3%	14.3%	21.0%	235,000
San Luis Obispo	55.4%	9.4%	16.9%	18.3%	210,000
San Benito	51.4%	19.7%	10.0%	18.9%	53,000
Los Angeles	**47.2%**	**19.1%**	**10.1%**	**23.7%**	**9,090,000**
Other Southern California	**51.3%**	**13.0%**	**12.3%**	**23.4%**	**9,346,000**
Orange	53.9%	13.6%	9.6%	22.9%	2,759,000
San Diego	52.3%	10.7%	18.4%	18.7%	2,751,000
San Bernardino	45.5%	15.4%	9.4%	29.7%	1,832,000
Riverside	52.4%	11.9%	10.7%	25.0%	1,850,000
Imperial	45.6%	27.0%	3.9%	23.5%	154,000

Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance. Not all numbers will add up to 100% or to the total population due to rounding. Differences in rates between counties may not be statistically significant.

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

Source: 2009 California Health Interview Survey

County and Regional Differences in Health Insurance

Statewide, higher rates of employment-based coverage were associated with lower rates of uninsurance (Exhibit 11). However, in some counties and regions, the rate of individually purchased and other government insurance also became a factor. For example, Napa County had a job-based coverage rate of 52.8%, solidly in line with the state average (Exhibit 11). Napa's uninsurance rate was markedly lower than the state's (18% compared to 21.2%), due in large part to the 17.6% of the population who had individually purchased or other public coverage.

Los Angeles County and the Other Southern California Counties had the highest regional uninsurance rates in the state in 2009 (Exhibit 12). Parts of the San Joaquin Valley and the Northern and Sierra Counties also had higher than average uninsurance rates. Statewide, uninsured rates ranged from a low of 9.9% (Marin County) to a high of 29.7% (San Bernardino; Exhibits 11 and 12).

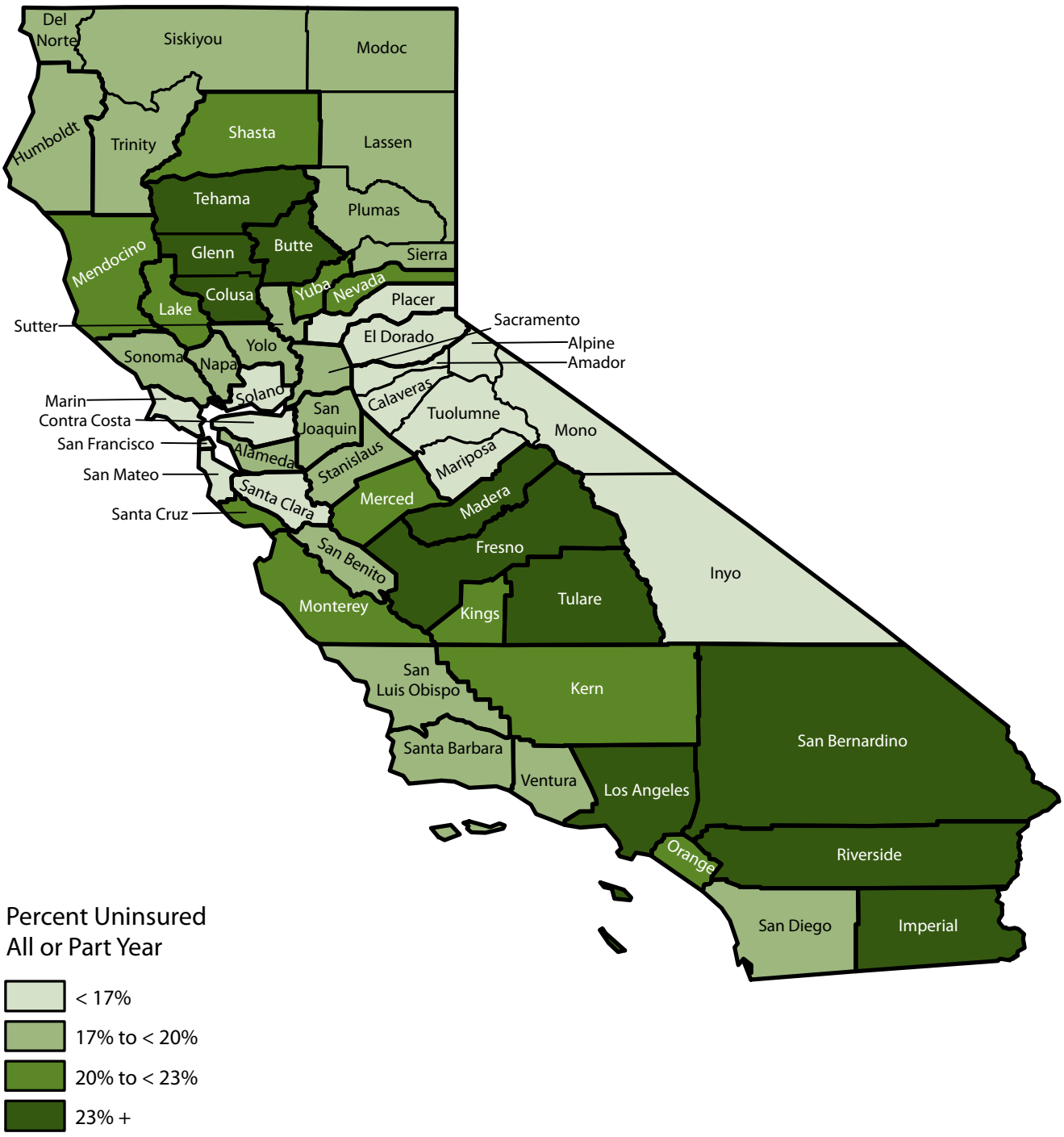
In terms of employment-based coverage, the highest rates in the state were in the Sacramento and Greater Bay Areas (Exhibit 13). Job-based coverage ranged from a low of 39.4% in Tehama, Glenn, and Colusa counties to a high of 73.6% in San Mateo County (Exhibits 11 and 12).

The map of public coverage in California followed a different pattern. The highest rates of Medi-Cal and Healthy Families coverage in the state were concentrated in the San Joaquin Valley and the Northern and Sierra Counties (Exhibit 11). The Inland Empire counties in the Other Southern California region had relatively low rates of public coverage, possibly due in part to the larger proportion of undocumented workers in these counties. This lack of public coverage options and a sagging private coverage market led to the highest uninsurance rates in the state.

A different way of looking at coverage geographically is to compare all urban areas to 2nd city, suburban, and rural parts of the state.[9] Strikingly, suburban areas have the highest rate of employment-based coverage (63.7%), and the urban areas have the lowest (47.7%; Exhibit 13). It must be noted here that CHIS 2009 estimates were based on where a person lived, not on the employment location.

9 This variable is derived from a Claritas classification that divides household residences into these four different categories based on population density of the neighborhood and demographic factors like income and education. For a full description, please see: *http://www.tetrad.com/demographics/usa/claritas/prizmne.html.*

Exhibit 12.
Percent Uninsured by County Among Nonelderly Persons, Ages 0-64, California, 2009

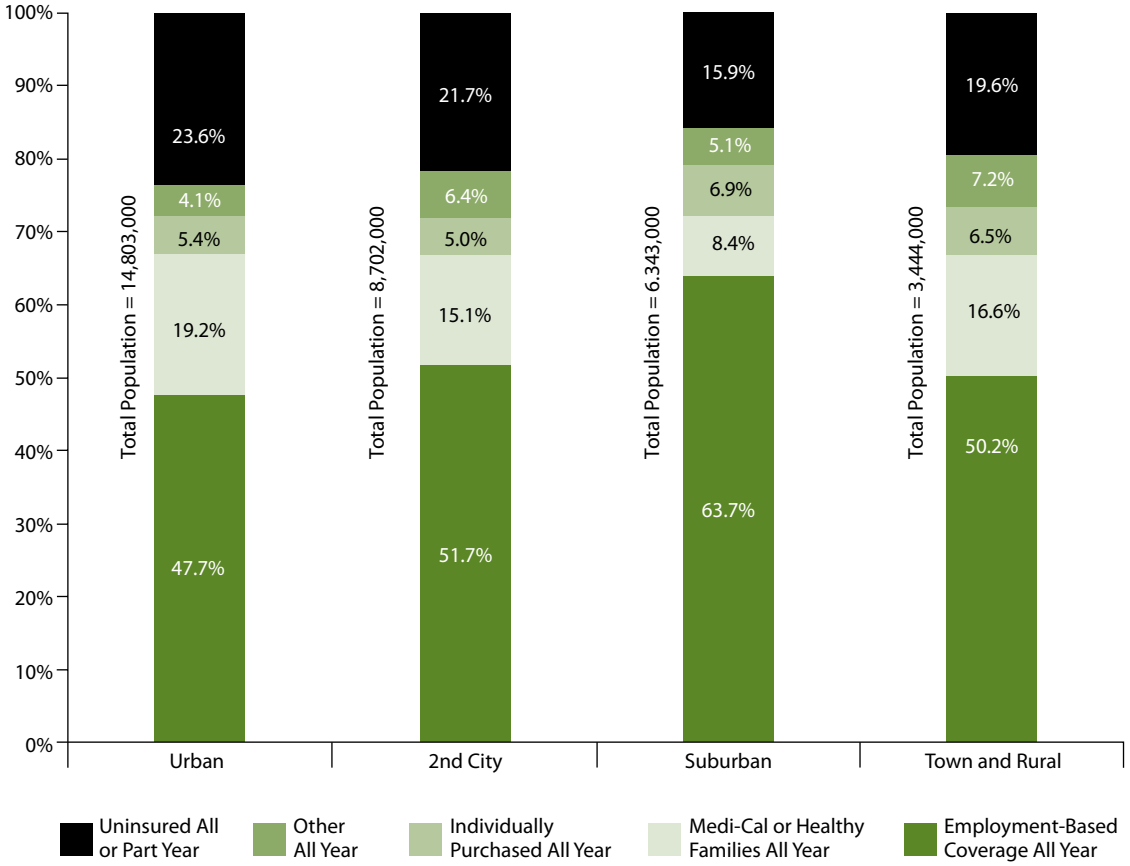


Note: Differences in rates between counties may not be statistically significant.

Source: 2009 California Health Interview Survey

Urban areas, though, have the highest rate of public coverage (19.2%), which makes up for some of this disparity. Still, urban areas have the highest rate of uninsurance in the state (23.6%; Exhibit 13), though it is not statistically significant.

Exhibit 13.
Health Insurance Status by Urban/Rural Areas Among Nonelderly Persons, Ages 0-64, California, 2009



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

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

Source: 2009 California Health Interview Survey

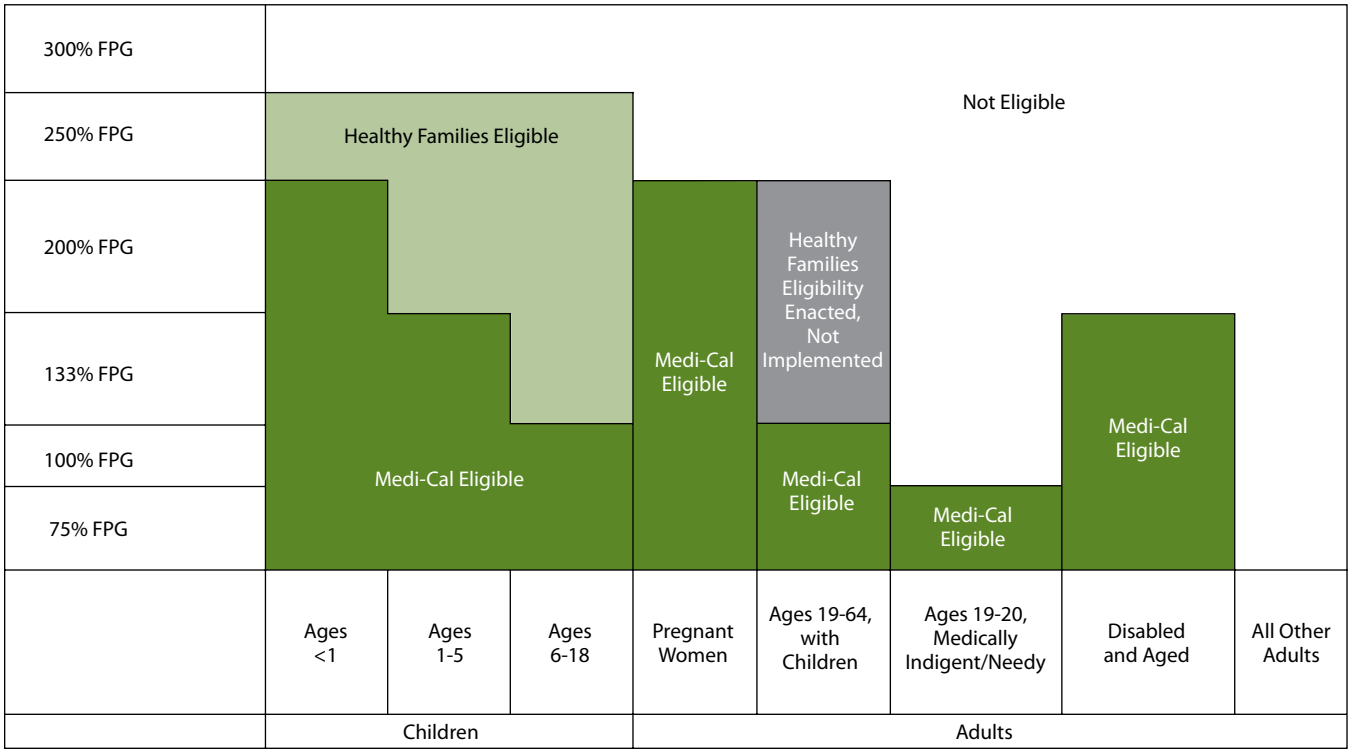
Eligibility for Coverage Under Health Care Reform Provisions

As of 2009, the public health insurance system in California guaranteed eligibility for assistance only for residents who met very strict household income and family status requirements (Exhibit 14). Eligibility for children was more generous; it included the Healthy Families program (California's version of CHIP), which led to the previously discussed disparities in coverage between children and adults.

Among adults, those without children had no public coverage options at all in 2009, unless they were categorized as aged (65+), blind, or permanently disabled (Exhibit 14). Parents of children enrolled in Healthy Families were intended to be allowed into the program in 2004, but the implementation of this expansion was never funded due to the state's worsening, and ongoing, budget crisis.

The Patient Protection and Affordable Care Act (ACA) of 2010 expanded assistance to the uninsured through public funding, both through a major

Exhibit 14.
Current Medi-Cal and Healthy Families Eligibility as Percent of Federal Poverty Guidelines (FPG), California, 2009



Notes: FPG = Federal Poverty Guidelines

Children up to 2 years old with household incomes under 300% FPL and with mothers in the AIM program are automatically enrolled in the Healthy Families program.

In 2009, 21 counties (including county regions) had county-based public-private partnership programs (most often called "Healthy Kids") that insured children through age 18 up to 300% FPL, regardless of immigration status.[10]

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

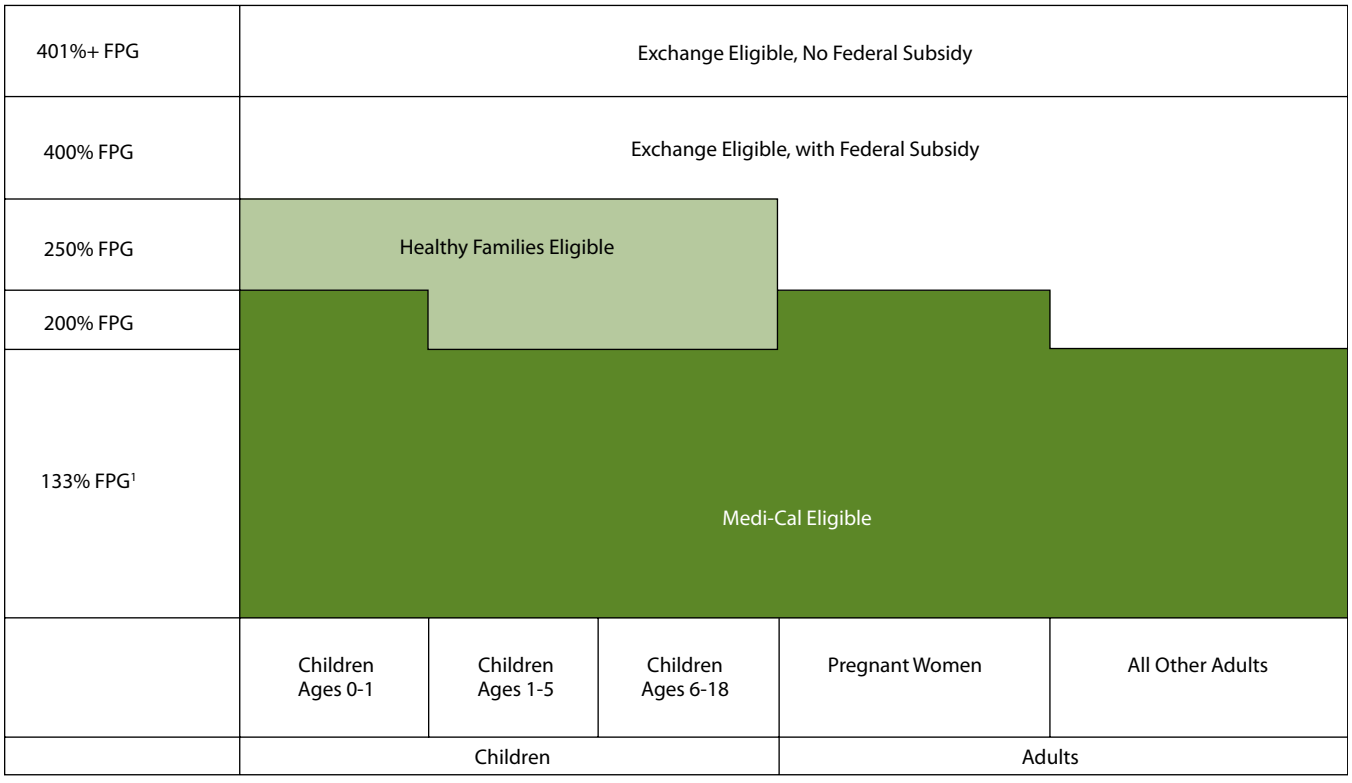
10 California Children's Health Initiatives Current CHI Enrollment as of December 2009. Accessed at *http://www.cchi4kids.org/data.php.*

increase in the eligible population for Medi-Cal and in the creation of Exchanges that would allow the uninsured to purchase private coverage with public subsidy assistance. These expansions do not supersede the original eligibility levels; if the ACA provision is less than the original eligibility for a certain population (such as ages <1 for Medi-Cal), the original eligibility level remains. The end result of these expansions is a much wider swath of the total population eligible for either full public health insurance or public subsidies within the Exchange (Exhibit 15).

When the ACA is fully implemented in 2014, just over 3 million nonelderly uninsured Californians will be eligible to enroll in Medi-Cal under the expanded household income requirements (Exhibit 16). This population includes single adults with no children who have incomes under 133% of the Federal Poverty Level (FPL), a group that has never before been eligible for federally assisted public health insurance programs.

Also in 2014, the newly created California Health Benefits Exchange will become operational. Within this Exchange, people who are uninsured and not

Exhibit 15.
Medi-Cal, Healthy Families, and Exchange Eligibility According to the ACA As Percent of Federal Poverty Guidelines (FPG), California, 2014



Notes: FPG = Federal Poverty Guidelines

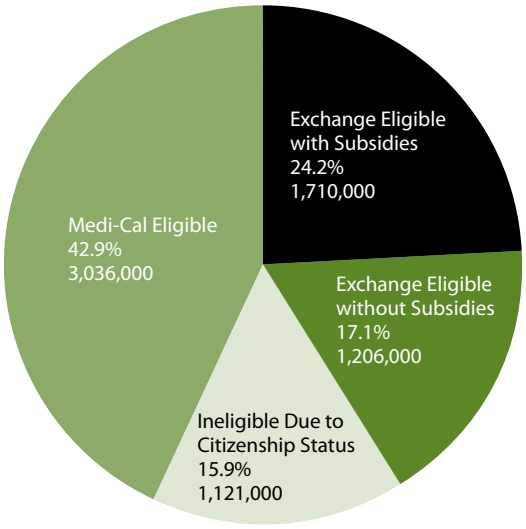
There is a 5% income disregard, so the effective calculation is 138% FPG. However, 133% is the cutoff specified in the ACA.

Pregnant women with household incomes up to 300% FPL are, however, eligible for the Access for Infants and Mothers program (AIM).

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

Exhibit 16.

Eligibility for ACA Health Insurance Expansions Among Nonelderly Persons Who Were Uninsured During the Past 12 Months, Ages 0-64, California, 2009



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

Source: 2009 California Health Interview Survey

Exhibit 17.

Eligibility for ACA Health Insurance Expansions by Region Among Nonelderly Persons Who Were Uninsured During the Past 12 Months, Ages 0-64, California, 2009

	Medi-Cal Eligible	Exchange Eligible with Subsidies	Exchange Eligible without Subsidies	Ineligible Due to Citizenship	Total	Total Population
Northern/Sierra Counties	41.6%	33.0%	16.8%	8.7%	100%	242,000
Greater Bay Area	38.6%	19.7%	26.4%	15.3%	100%	1,012,000
Sacramento Area	46.6%	23.5%	24.8%	5.1%	100%	321,000
San Joaquin Valley	48.5%	20.5%	13.7%	17.3%	100%	769,000
Central Coast	36.1%	27.6%	20.7%	15.5%	100%	384,000
Los Angeles County	43.3%	23.0%	13.1%	20.7%	100%	2,155,000
Other Southern California Counties	43.4%	27.2%	16.1%	13.3%	100%	2,189,000

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

Source: 2009 California Health Interview Survey

eligible for Medi-Cal will be able to purchase their own health insurance in a well-regulated market that offers federal subsidies for those with household incomes under 400% FPL. Nearly one-quarter (24.2%) of California's nonelderly uninsured population will be eligible for those subsidies, and an additional 17.1% of the uninsured will be able to participate in the Exchange without subsidies (Exhibit 16).

Finally, 15.9% of the nonelderly uninsured will not be eligible to participate in these coverage expansions because of their citizenship status.

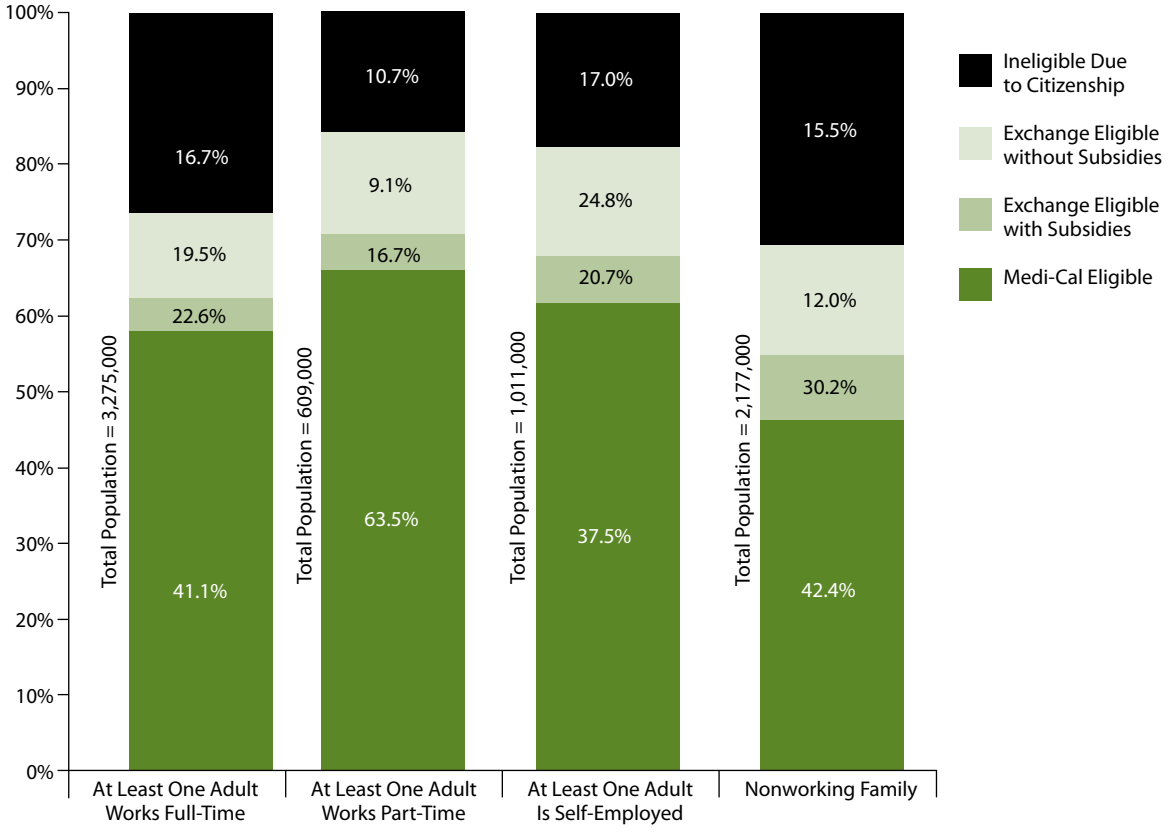
Examining differences by region, the Sacramento Area and San Joaquin Valley have the highest proportions of uninsured populations who will be eligible for the Medi-Cal expansion (46.6% and 48.5%, respectively; Exhibit 17). Nearly half of the

uninsured in the Northern and Sierra Counties will be eligible to participate in the Exchange (49.8%), compared to only 36.1% of the uninsured in Los Angeles County. Los Angeles County has the largest proportion of uninsured who will be ineligible to either buy in the Exchange or enroll in Medi-Cal due to their citizenship status, with one-fifth being ineligible for either (20.7%; Exhibit 17).

More than 3.2 million uninsured nonelderly adults and children are in families that have at least one full-time worker (Exhibit 18). An additional 2.2 million uninsured nonelderly are in nonworking families. Nearly half of each of these groups will be eligible for Medi-Cal under the expansion in 2014 (41.1% and 42.4%, respectively; Exhibit 18). Nearly two-thirds (63.5%) of the uninsured in families headed by a part-time worker will be eligible for Medi-Cal when it expands, but closer to one-third (37.5%) of uninsured self-employed will be eligible (Exhibit 18).

Nearly half of the uninsured in families headed by a self-employed worker will be eligible to participate in the Exchange, either with (20.7%) or without (24.8%) federal subsidy assistance (Exhibit 17). Similarly, four in ten of uninsured adults and children in nonworking (42.2%) or full-time working (42.1%) families will be able to buy their coverage through the Exchange. Only 25.8% of the uninsured in part-time working families will be eligible, due to their lower household incomes and therefore higher rate of Medi-Cal eligibility (Exhibit 18).

Exhibit 18.
Eligibility for ACA Health Insurance Expansions by Family Work Status Among Nonelderly Persons Who Were Uninsured During the Past 12 Months, Ages 0-64, California, 2009



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

Source: 2009 California Health Interview Survey

Conclusion

The ongoing Great Recession that began in 2008 radically changed the uninsured population in California. By 2009, the number of people with no coverage for all or part of the past year had swelled to more than 7 million nonelderly adults and children, the highest total on record. This newly uninsured population was poorer and much more likely to not have a worker in the household, due to a recent loss of employment. Only 17.7% of the uninsured were in nonworking families in 2007; that figure jumped to 30.8% of the uninsured in 2009.

California's public health insurance programs, namely Medi-Cal and Healthy Families, were able to enroll newly eligible children and thus protect them from the consequences of lacking employment-based coverage. The uninsured rate for children in California actually declined from 10.2% in 2007 to 9.8% in 2009. Their parents, however, and adults with no children were not able to enroll in large numbers due to the more restrictive eligibility requirements; the uninsured rate among adults rose from 23.9% in 2007 to 26.6% in 2009.

Different regions of the state experienced the increase in uninsurance at different rates, due to the drop in employment-based coverage resulting from job loss in a given county combined with the ability of public programs to increase their enrollment. Examining these trends by type of metropolitan area (i.e., rural, urban, suburban) revealed an interesting finding: residents of suburban areas fared best compared to all others. The rates of uninsurance were equally high and the rates of job-based coverage equally low for rural and urban areas. The suburban areas, though, had the highest rate of job-based coverage and the lowest rate of uninsurance.

When the coverage expansions under ACA are fully implemented in 2014, successfully enrolling the eligible uninsured in either Medi-Cal or the Exchange (with or without federal subsidies) will require targeted outreach throughout the state. The findings presented in this chapter provide a baseline for future evaluation of ACA provisions (some of which went into effect in 2010), as well as a blueprint that can be useful in strategy mapping for enrollment purposes.

2 Racial/Ethnic and Citizenship Disparities in Health Insurance Persist

Shana Alex Lavarreda

California is an increasingly multicultural state, and care should be taken to examine health insurance status and type by racial and ethnic group. The nonelderly population is now a plurality of racial and ethnic groups, with no one group comprising a majority. Among nonelderly Californians, Non-Latino Whites remained the largest group in the population by a slim margin, with 13.31 million people (40%; data not shown). Another 13.03 million people (39.1%) identified themselves as Latino. The next largest group in the overall nonelderly population was identified as Asian American, Native Hawaiian, or Other Pacific Islander (AA/NHOPI) and totaled 4.16 million people (12.5%). Only 1.84 million people (5.5%) identified as African American, and the remaining 0.76 million (2.3) were either American Indian/Alaskan Native or some other single or multiple race.

Race and ethnicity in California are strongly linked with citizenship status, and the Patient Protection and Affordable Care Act of 2010 (ACA) contains citizenship requirements for its coverage expansions. The exclusions embedded in ACA will likely increase the health insurance disparities between U.S. citizens and noncitizens over time. California runs the risk of increasing racial/ethnic inequities in health care access and outcomes if these issues remain unaddressed.

This chapter provides an in-depth look at health insurance status and type through two lenses: 1) racial and ethnic group[11] and 2) citizenship status.

The findings presented highlight the importance of examining health insurance status and type by these two categorizations separately, since grouping them could mask the separate impact of each. However, the linkages between the two should be kept in mind, as much of the racial and ethnic group disparities are based on access to health insurance differences due to citizenship status.

Disparities in Health Insurance by Racial and Ethnic Group

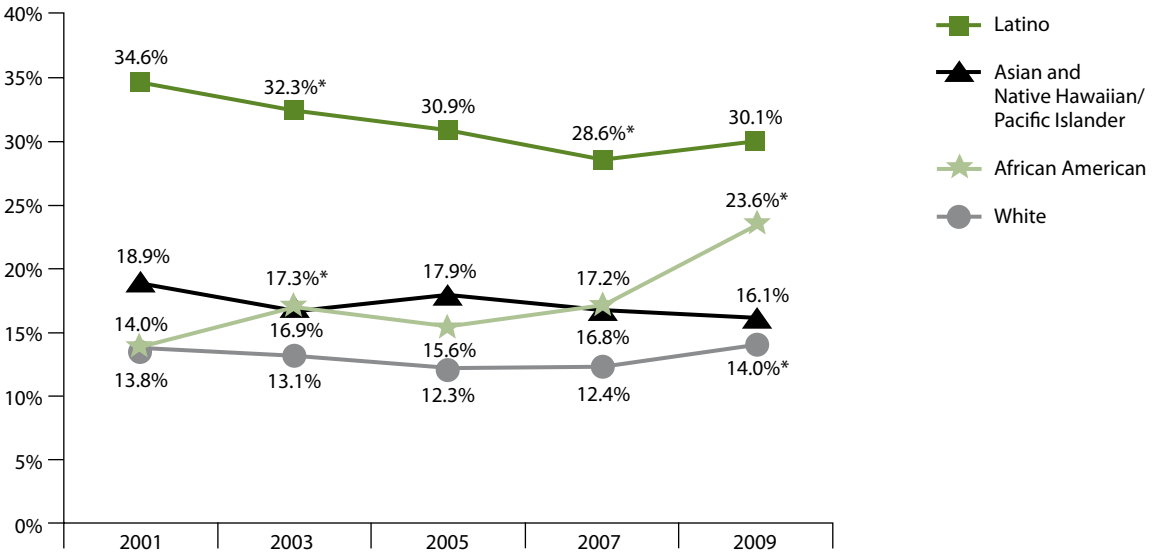
Different racial and ethnic groups experienced widely disparate levels of uninsurance in 2009 (Exhibit 18). Each group also had distinctly different trends in uninsurance over the past decade. Compared to all other racial/ethnic groups, Latinos consistently had the highest rates of being uninsured over the past decade (Exhibit 19). In 2001, the uninsurance rate among nonelderly Latinos was at its height, at 34.6%. That dropped to 28.6% by 2007, but the figure rose again with the recession in 2009 to 30.1% (Exhibit 19). It may not have been the highest rate of uninsurance for Latinos in the decade, but it is nevertheless daunting that nearly one-third of all nonelderly Latinos were uninsured for all or part of 2009.

11 We use the Office of Management and Budget (OMB) classification for race and ethnicity, which counts any mention of Latino heritage as "Latino" and all other categories as "non-Latino." This may not match with other CHIS publications that use other classifications, particularly those generated specifically for American Indian and Alaskan Natives (AIAN), as many in that population list both Latino and AIAN. Counts of the AIAN population, therefore, are highly sensitive to whether Latino is top-coded, as in the OMB classification.

Nonelderly African Americans had one of the lower rates of being uninsured in 2001, at 14% (Exhibit 18). However, nonelderly African Americans were most affected by the recession in 2009. Their uninsurance rate jumped nearly six percentage points, from 16.8% in 2007 to 23.6% in 2009 (Exhibit 19). The Non-Latino White population experienced a less dramatic increase in uninsurance between 2007 and 2009, from 12.4% to 14%. This increase erased all drops in uninsurance that had been seen since 2001. Finally, Asian Americans and Native Hawaiians or Other Pacific Islanders (AA/NHOPI) were the only group to have a flat uninsurance rate, with 16.8% in 2007 and 16.1% in 2009.

In contrast to the patterns seen in uninsurance rates, trends in rates of employment-based coverage rates by racial and ethnic group declined similarly for each group over the course of the past decade (Exhibit 20). Non-elderly Latinos continued to have the lowest rates of job-based insurance, with the recession erasing prior gains, dropping to a decade low of 36%. Non-Latino Whites saw their employment-based coverage rate drop from 68.1% in 2007 to 65.3% in 2009, due to the job loss in the recession. Still, they retained their position as the group with the highest overall rates of employment-based coverage.

Exhibit 19.
Rates of Uninsurance During Last 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California, 2001-2009



* Data are significantly different from the previous year at the 95% confidence level.

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

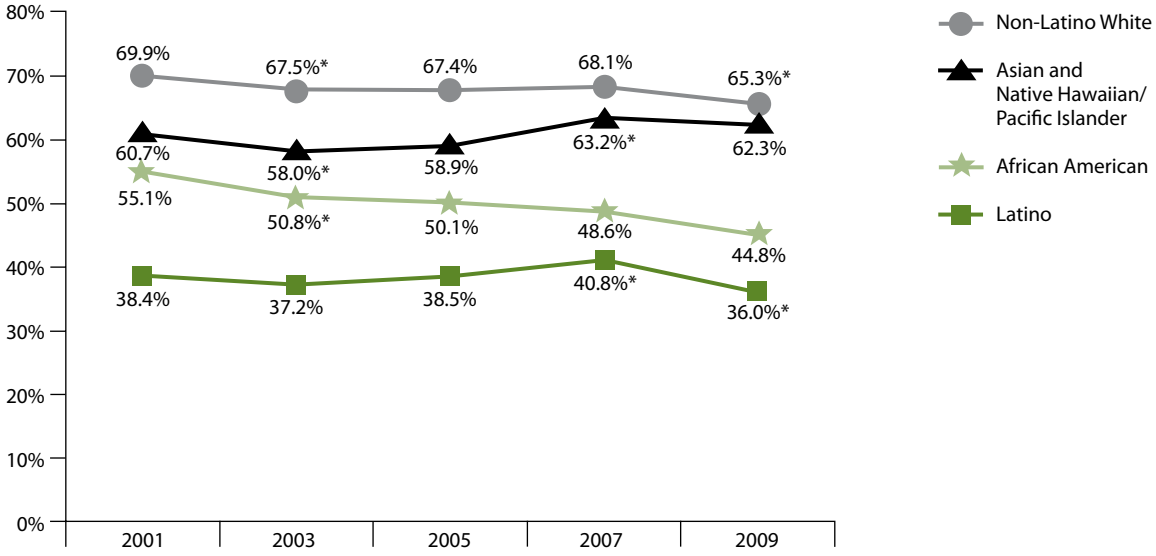
Source: 2001-2009 California Health Interview Surveys

African Americans were the hardest hit over the entire decade, without the gains made by other racial and ethnic groups. The second-highest decline (with Latinos having the highest) in the rate of employment-based coverage from 2007 to 2009 continued this trend. In 2001, 55.1% of nonelderly African Americans had job-based health insurance, with a significant drop to 44.8% in 2009 (Exhibit 20).

AA/NHOPI was the only nonelderly group to have experienced a slight gain in job-based coverage over the decade, although there was a dip from 2007 to 2009. In 2001, 60.7% of AA/NHOPI had coverage through their own or a family member's employment. By 2009, that rate had increased to 62.3% (Exhibit 20).

AA/NHOPI and Non-Latino Whites, with the highest rates of job-based coverage, have the correspondingly lowest rates of public coverage. Only

Exhibit 20.
Rates of Employment-Based Health Insurance During Past 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California, 2001-2009



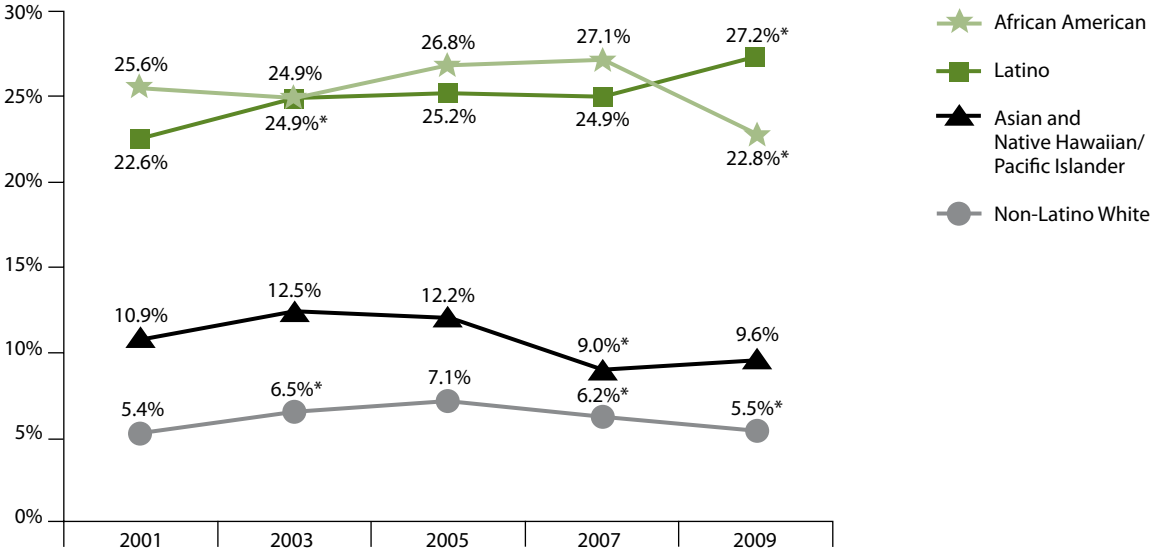
* Data are significantly different from the previous year at the 95% confidence level.

Source: 2001-2009 California Health Interview Surveys

5.5% of Non-Latino Whites had either Medi-Cal or Healthy Families for all of 2009, which was actually a slight decline from 2007 (Exhibit 21). Among AA/NHOPI, the rate of public coverage in 2009 (9.6%) ended up slightly below the rate for 2001 (10.9%), but this was following a period of growth and then of decline in enrollment, perhaps due to increased job-based coverage.

The public coverage rate for Latinos jumped from 24.9% in 2007 to 27.2% in 2009, giving them the highest rate of Medi-Cal and Healthy Families for the first time since 2001 (Exhibit 21). In contrast, the group that had formerly had the highest rate, African Americans, saw their rate of public coverage decline from 27.1% in 2007 to 22.8% in 2009, though the difference was not statistically significant due to the small size of the population (Exhibit 21). This dip and the drop in employment-based coverage were the primary drivers behind the significantly large increase in uninsurance among nonelderly African Americans (Exhibit 19).

Exhibit 21.
Rates of Medi-Cal or Healthy Families Coverage During Past 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California, 2001-2009



* Data are significantly different from the previous year at the 95% confidence level.

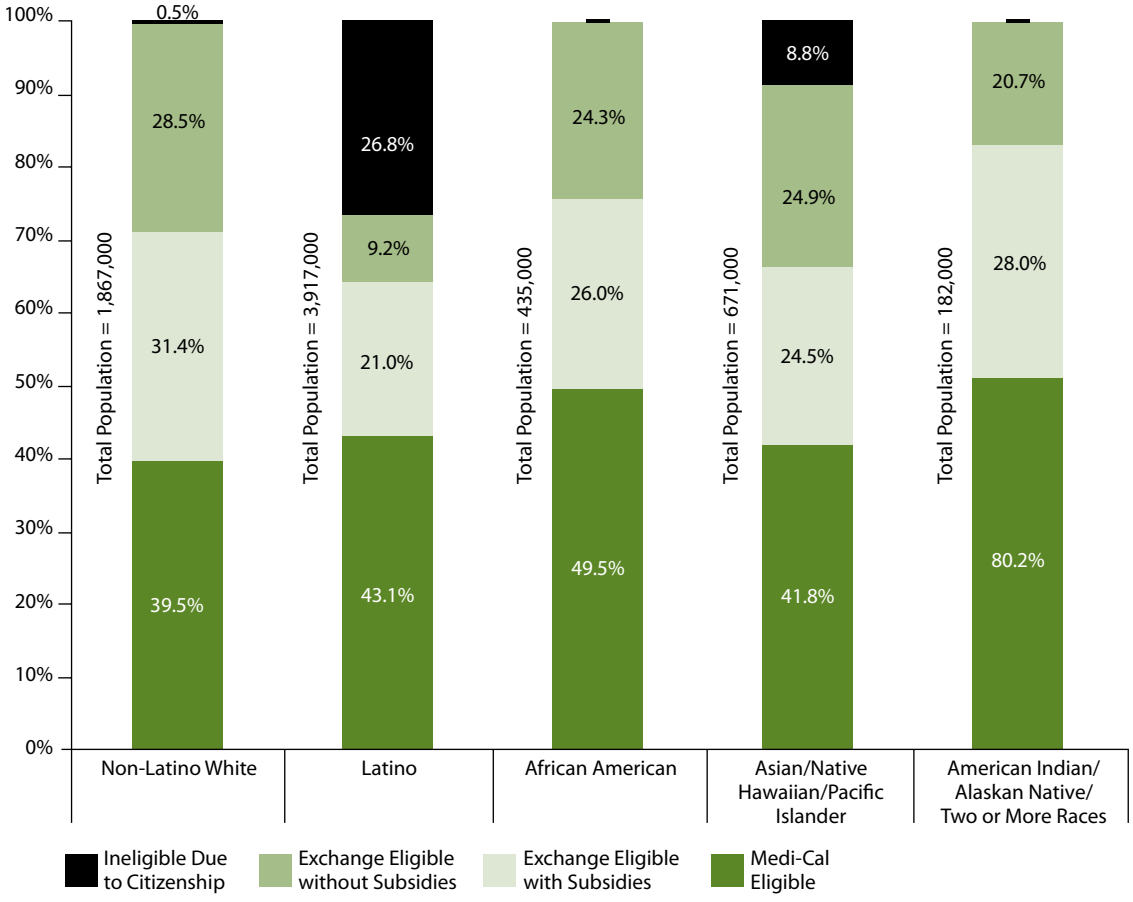
Source: 2001-2009 California Health Interview Surveys

ACA Expansions Have Differing Impact by Race/Ethnicity

The Patient Protection and Affordable Care Act of 2010 (ACA) expands health insurance by increasing eligibility for public coverage and creating "Exchanges" so that uninsured persons can buy private coverage in a well-regulated marketplace, with federal subsidies if their household incomes are below 400% of the Federal Poverty Level (FPL) (see chapter 6, "Policy Implications," for an expanded discussion of the ACA provisions).

Because of the exclusion of undocumented immigrants from any participation in both the Exchanges and the Medi-Cal expansion, there are differences in eligibility for coverage by racial/ethnic group (Exhibit 22). About four in ten of the uninsured Non-Latino White population will be eligible to gain coverage through the expanded Medi-Cal program (39.5%). Another one-third will be eligible for federal subsidies to purchase insurance through the new Exchange (31.4%), and nearly all of the rest will be able to buy into the Exchange with their own funds (28.5%; Exhibit 22).

Exhibit 22.
Eligibility for ACA Health Insurance Expansions by Race/Ethnicity Among Uninsured Nonelderly Persons, Ages 0-64, California, 2009



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

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

Source: 2009 California Health Interview Survey

African Americans and those in the Other Single or Multiple Race category had high rates of eligibility coverage through the expanded Medi-Cal program (49.5% and 50.9%, respectively; Exhibit 22).

In contrast, only three-fourths of uninsured Latinos will be able to gain coverage under these expansions (Exhibit 22).[12] A slightly higher percentage (43.1%) will be eligible for the Medi-Cal expansion, but far fewer will participate in the Exchange, either with subsidies (21%) or without (9.2%). The rest will be ineligible to participate in the coverage expansions due to their citizenship status (26.8%; Exhibit 22). Uninsured AA/NHOPI also had less than 100% potential coverage through ACA expansions, but only 8.8% of this group were excluded due to their citizenship status.

It is important to note that those who are excluded from the ACA expansions could still theoretically gain coverage through their own or a family member's employment, or by purchasing coverage themselves directly from an insurance company outside of the Exchange. These options currently exist, though, and there is still a large population of uninsured non-citizens without a green card (1.12 million; Exhibit 22), suggesting that this group may remain uninsured without further federal or state assistance.

Disparities in Health Insurance by Citizenship and Immigration Status

ACA's exclusions of undocumented immigrants from both the Exchange and the Medi-Cal expansion will have varying impacts in different regions of California. Non-citizens without a green card (the closest approximation in CHIS to "undocumented" status) are concentrated in Los Angeles County, with just over one-third living in that region (34.9%; Exhibit 23). In contrast, only 24.9% of U.S.-born citizens live in Los Angeles County. The next largest proportion of non-citizens without a green card (26.4%) lives in the Other Southern California counties, including Riverside, Imperial, San Diego, and Orange. A large proportion of the population in these counties will remain uninsured even after the full implementation of health care reform.

12 This estimate does not include emergency Medi-Cal, which is a limited benefits program open to all residents in California regardless of citizenship status.

Exhibit 23.
Citizenship and Immigration Status by Region Among Nonelderly Persons, Ages 0-64, California, 2009

	Northern Sierra Counties	Greater Bay Area	Sacramento Area	San Joaquin Valley	Central Coast	Los Angeles	Other Southern California	Total	Total Population
U.S.-Born Citizen	4.2	18.3	6.5	11.0	6.2	24.9	28.8	100%	24,498,000
Naturalized Citizen	1.1	23.3	4.5	7.0	3.7	33.7	26.8	100%	4,131,000
Non-Citizen with Green Card	1.3	21.3	2.4	11.5	5.2	33.7	24.6	100%	2,622,000
Non-Citizen without Green Card	1.8	17.1	1.8	11.2	6.8	34.9	26.4	100%	2,040,000

Note: Differences between cells may not be statistically significant at the 95% level.

Source: 2009 California Health Interview Survey

In 2009, the disparities in health insurance by citizenship status starkly highlighted the importance of employment-based coverage. Among all U.S. citizens, whether native-born or naturalized, 17.4% were uninsured for all or part of 2009, and 55.7% had coverage all year through their own or a family member's employment (Exhibit 24). Non-citizens who did not have a green card (the closest approximation in CHIS 2009 for undocumented status) had precisely the opposite pattern: 55% were uninsured, and only 17.6% had job-based coverage (Exhibit 24).

Interestingly, non-citizens without a green card reported having either Medi-Cal or Healthy Families at a significantly higher rate (21.6%) than U.S. citizens (15.2%). This coverage was likely emergency Medi-Cal, which provides coverage for hospitalizations for emergency situations only. Another possibility is that this group was receiving prenatal care through Medi-Cal, which offers this coverage regardless of citizenship status. Finally, they may also have been covered through Medi-Cal under the Permanently Residing in U.S. Under Color of Law (PRUCOL) rules, with eligibility available despite their not having a green card.

These same patterns of coverage by citizenship status held true for both children and adults. Among children who were citizens themselves and had citizen parents, only 8% were uninsured for all or part of 2009, and 59.6% had coverage through a parent's employer (Exhibit 25). Children who were non-citizens themselves (both with and without a green card) were three times as likely as children who were citizens to be uninsured (27.4% vs. 8%). Only 19.7% of non-citizen children had coverage through a parent's employment (Exhibit 25).

However, nearly half of non-citizen children were able to gain coverage through public programs (44.5%; Exhibit 25). The group with the highest rate of public coverage was citizen children whose parents

Exhibit 24.
Citizenship and Immigration Status by Health Insurance Coverage During Last 12 Months Among Nonelderly Persons, Ages 0-64, California, 2009

	Insurance Status						
Own Citizenship Status	Uninsured All or Part Year	Employment-Based Coverage All Year	Medi-Cal or Healthy Families All Year	Individually Purchased All Year	Other All Year	Total	Total Population
U.S. Citizen	17.4	55.7	15.2	6.1	5.6	100%	28,629,000
Non-Citizen with a Green Card	37.4	39.0	17.2	3.1	3.4	100%	4,622,000
Non-Citizen without a Green Card	55.0	17.6	21.6	3.0	2.9	100%	2,040,000

Notes: U.S. Citizen includes Naturalized Citizens.

Differences between cells may not be statistically significant at the 95% level.

Source: 2009 California Health Interview Survey

Exhibit 25.
Family Citizenship and Immigration Status by Health Insurance Coverage During Last 12 Months Among Children, Ages 0-18, California, 2009

Family Citizenship Status	Uninsured All or Part Year	Employment-Based Coverage All Year	Medi-Cal or Healthy Families All Year	Individually Purchased All Year	Other All Year	Total	Total Population
Child and Both Parents Citizens	8.0	59.6	22.4	5.0	5.0	100%	7,862,000
Child Citizen and Non-Citizen Parent with Green Card	13.7	30.6	49.8	2.9	3.0	100%	1,232,000
Child Citizen and Non-Citizen Parent without Green Card	10.3	6.4	78.8	–	3.3	100%	967,000
Child Non-Citizen	27.4	19.7	44.5	–	–	100%	538,000

Notes: Child and Parent Citizens include Naturalized Citizens.

Differences between cells may not be statistically significant at the 95% level.

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

Source: 2009 California Health Interview Survey

were non-citizens without a green card (78.8%); only 6.4% of the children in this group had job-based coverage through a parent's employment, with both rates being statistically significant from each other. These figures highlight the importance of public health insurance as a safety net for children who would otherwise have been uninsured.

Among adults, the public safety net is not nearly as strong due to more stringent eligibility requirements. Also, only 18.1% of adult non-citizens without a green card had employment-based coverage (Exhibit 26). Consequently, 60.3% of this group were uninsured for all or part of 2009. In contrast, 21.9% of U.S. citizen adults were uninsured for all or part of the year, and 58.3% had insurance through their own or a family member's employment, with both rates being statistically significant when compared to adult non-citizens (Exhibit 26).

Exhibit 26.
Citizenship and Immigration Status by Health Insurance Coverage During Last 12 Months Among Nonelderly Adults, Ages 19-64, California, 2009

	Insurance Status						
Own Citizenship Status	Uninsured All or Part Year	Employment-Based Coverage All Year	Medi-Cal All Year	Individually Purchased All Year	Other All Year	Total	Total Population
U.S. Citizen	21.9	58.3	6.6	7.0	6.2	100%	18,568,000
Non-Citizen with Green Card	38.2	40.0	15.2	3.2	3.4	100%	2,403,000
Non-Citizen without Green Card	60.3	18.1	17.6	2.4*	1.6	100%	1,722,000

Notes: U.S. Citizen includes Naturalized Citizens.

Differences between cells may not be statistically significant at the 95% level.

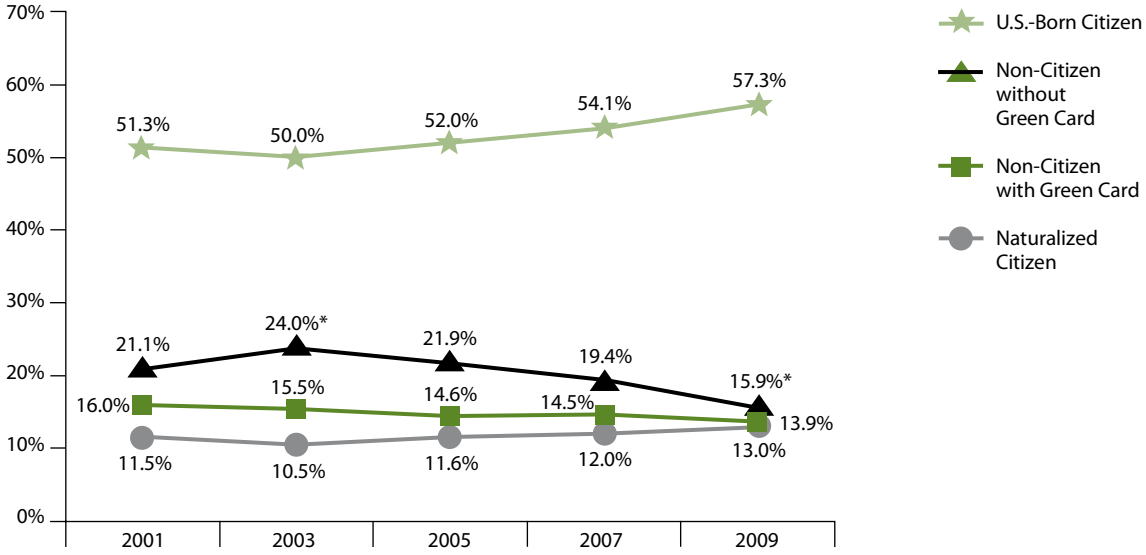
* Unstable estimate due to coefficient of variation greater than 30%.

Source: 2009 California Health Interview Survey

This pattern of non-citizens having worse access to coverage than U.S. citizens has been consistent over time. During the past decade, though, the citizenship statuses within the uninsured population have undergone a dramatic shift. U.S.-born citizens comprised 51.3% of the nonelderly uninsured for all or part of the year in 2001 (Exhibit 27). By 2009, this proportion had grown to 57.3% of the uninsured (change is significant at the 90% confidence level). This jump was likely due to the increased number of previously employed, insured persons who lost both their jobs and their coverage during the recession in 2008 and 2009, as well as to the decline in immigration.

Additionally, the overall total population of non-citizens without a green card experienced a slight decline. Although still the next largest group within the uninsured population, non-citizens without a green card saw their proportion decline from 21.1% in 2001 to 15.9% in 2009 (Exhibit 27). Both naturalized U.S. citizens and non-citizens with a green card were fairly stable over time.

Exhibit 27.
Citizenship and Immigration Status Among Nonelderly Persons Uninsured All or Part of Last 12 Months, Ages 0-64, California, 2009



* Data are significantly different from the previous year at the 95% confidence level.

Source: 2009 California Health Interview Survey

Conclusion

Although non-citizens without green cards comprise only 6.1% of California's nonelderly population, the misconception exists that they are the driver behind the increase in the uninsured. As shown here, the data prove otherwise. The largest and also fastest-growing group within the uninsured is U.S.-born citizens, a trend that began in 2003 but was undoubtedly exacerbated by the recession in 2008 and 2009.

This group will be fully eligible for the ACA coverage expansions in 2014, which will benefit non-Latinos disproportionately due to the exclusion of non-citizens without a green card from any of the ACA provisions. The existing racial and ethnic disparities in health insurance coverage and resulting access to the health care system will be exacerbated as health care reform is implemented, with the very serious possibility that more than one million California residents (including non-citizen children) will be left to rely on safety net providers who may not receive enough money to care for the residual uninsured.

3 Job-Based Coverage and the Individual Market

Ken Jacobs

Employment-based insurance continues to be the central source of coverage for working adults and their family members in California. In 2009, 12.1 million Californians between the ages of 19 and 64 (53.3%) were covered through their own or a family member's employment, a decline of 670,000 (four percentage points) from 2007. Individually purchased insurance covered 1.4 million adults (6.3%) in 2009, a small increase over 2007.

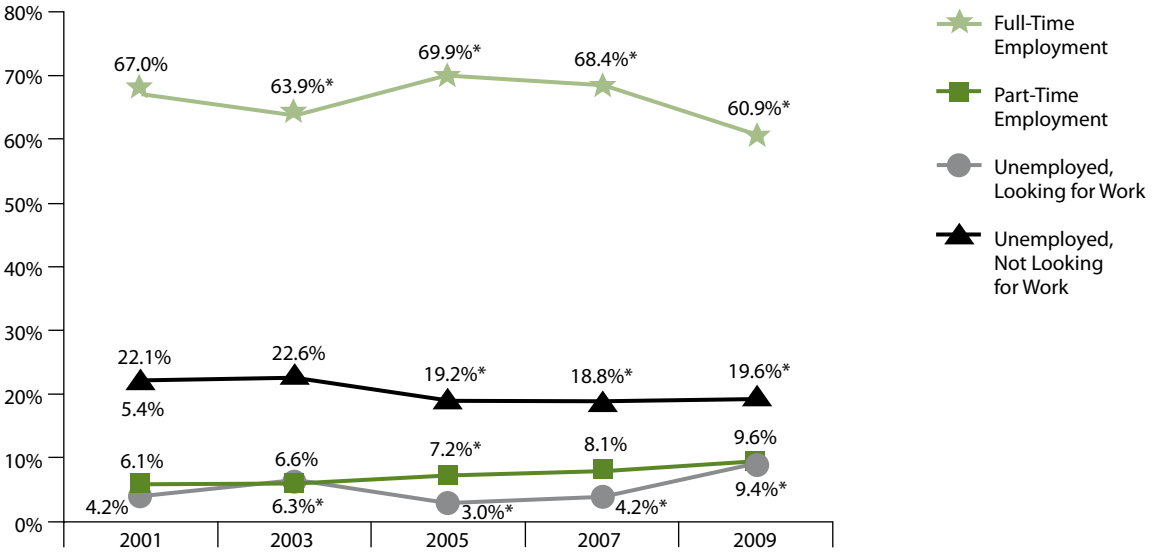
Job-based Coverage Fell Along with Full-time Employment

The main source of the decline in employment-based coverage was the economic recession and resulting decline in full-time work. The number of nonelderly adults in California with full-time employment fell by 1.4 million between 2007 and 2009, a 7.5 percentage point decline, while the number with part-time jobs rose by 370,000 (Exhibit 28), a 1.5 percentage point increase. In 2009, 2.1 million California adults between the ages of 19 and 64 (9.4%) were unemployed and looking for work, compared to 900,000 (4.2%) in 2007. The share of California nonelderly adults who were not in the labor force (i.e., who were unemployed and not looking for work) also increased, from 18.8 to 19.6 percent (Exhibit 28).

Looking at a breakdown of employment-based coverage by county, the highest rates in the state were in the Sacramento and Greater Bay Areas (Exhibit 29). Agricultural counties in the San Joaquin Valley and the Northern and Sierra Counties had the lowest rates in the state. Los Angeles County also had a low rate of job-based coverage, which has been consistent over the past decade. The share of Californians under 65 with coverage through their own employer or through a parent's or spouse's employer ranged from a low of 36% in Kings County to a high of 73.6% in San Mateo County.

The total share of nonelderly adults with employment-based coverage fell by 670,000 between 2007 and 2009, a four percentage point decline (from 57.3% to 53.3%; data not shown).

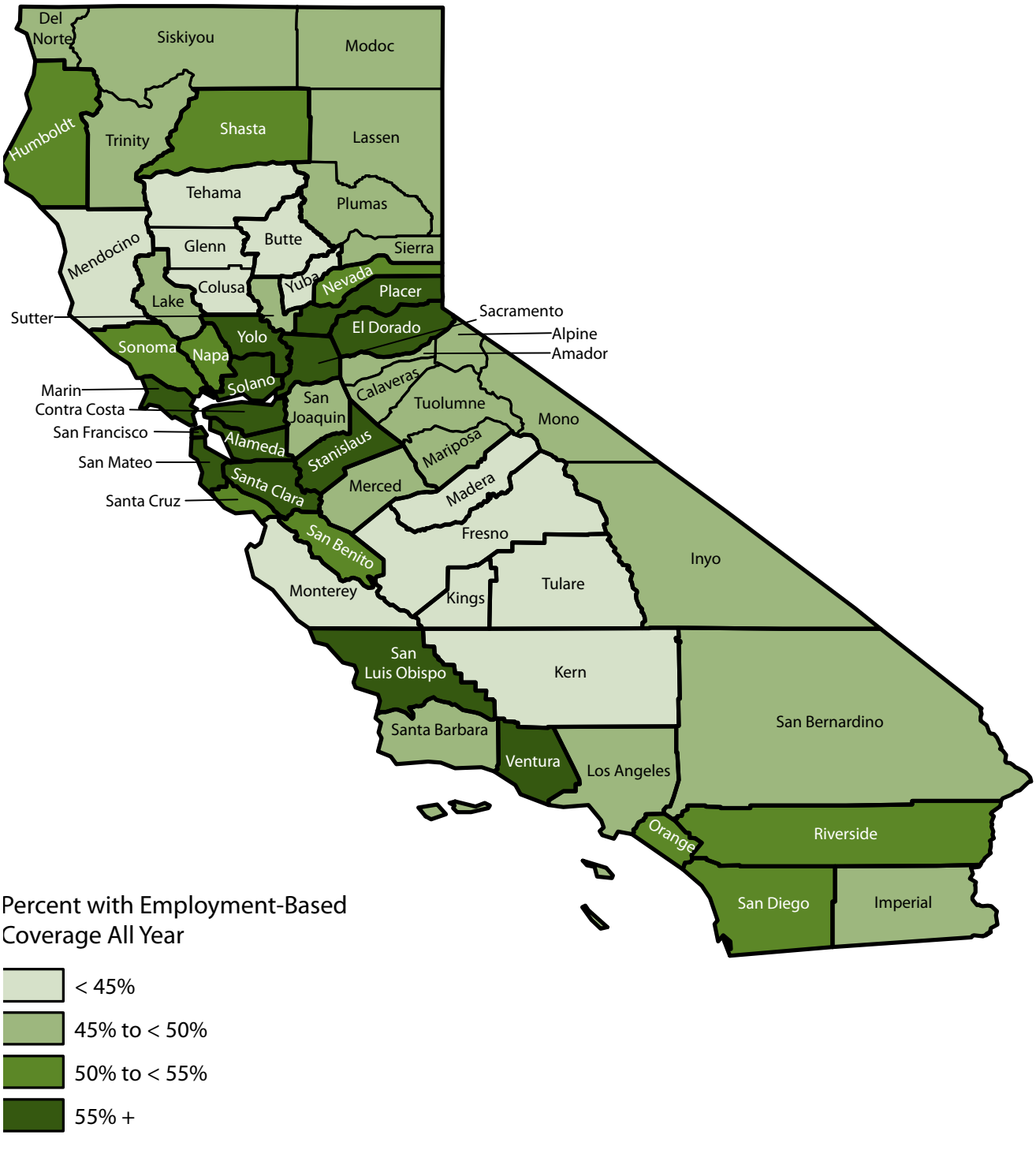
Exhibit 28.
Work Status of Nonelderly Adults, Ages 19-64, California, 2001-2009



* Data are significantly different from the previous year at the 95% confidence level.

Sources: 2001-2009 California Health Interview Surveys

Exhibit 29.
Percent with Employment-Based Coverage Among Nonelderly Persons, Ages 0-64, California, 2009



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

Source: 2009 California Health Interview Survey

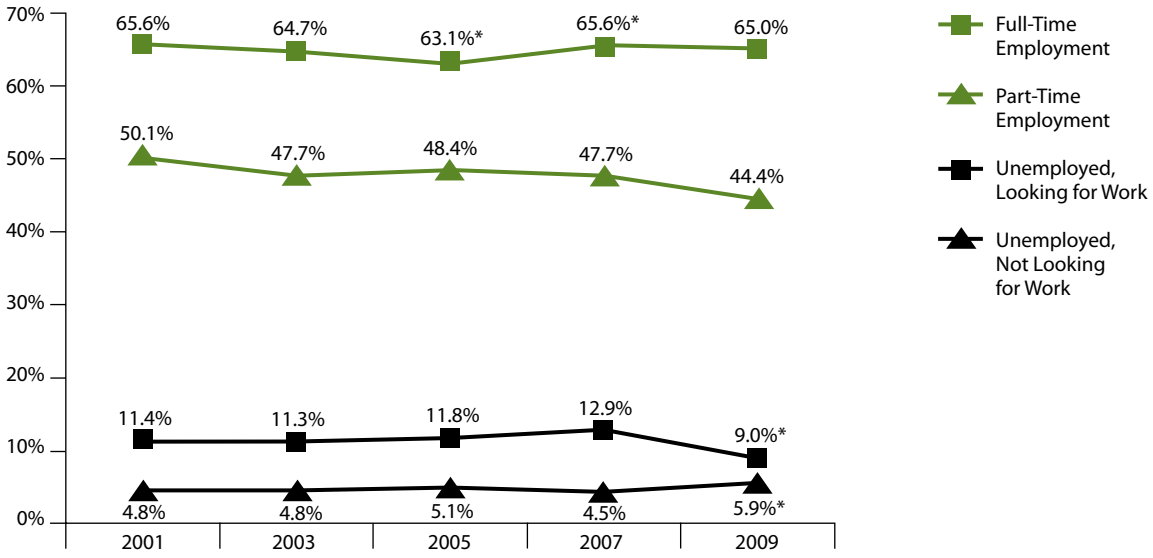
The *number* of full-time workers with job-based coverage fell by slightly over 10%, from 10 to 9 million between 2007 and 2009 (data not shown). This decline can be almost entirely explained by the reduction in full-time work. The *percentage* of full-time workers with employment-based coverage fell only 0.6 percentage points, from 65.6% in 2007 to 65% in 2009 (Exhibit 30).

The number of part-time workers with job-based coverage actually rose by 102,000, from 865,000 to 967,000, as a result of the increase in part-time employment. The *share* of part-time workers with coverage through an employer continued to fall: 44.4% of part-time workers were covered through their employer or a family member's employer in 2009, compared to 47.7% in 2007 and 50.1% in 2001 (Exhibit 30).

The Consolidated Omnibus Reconciliation Act (COBRA) is the federal law that enables individuals leaving an employer with 20 or more workers to continue that coverage by paying the cost of the premium plus a 2% administrative fee. The number of people who were unemployed and looking for work and who were covered through a family member's employer or through COBRA more than doubled between 2007 and 2009, from 220,000 to 470,000 (not shown). The federal government provided a subsidy of up to 65% of COBRA premiums from February 2009 to June 2010 as part of the American Recovery and Reinvestment Act (ARRA). Without the premium assistance, COBRA take-up is normally low due to the high cost of coverage. Families USA estimates that in California, the average individual receiving unemployment benefits would need to spend 28.8% of her or his benefits to pay for coverage through COBRA.[13]

13 Families USA. Squeezed! Caught Between Unemployment Benefits and Health Care Costs. January 2009.

Exhibit 30.
Employment-Based Coverage and Individually Purchased by Full- and Part-Time Work Status Among Nonelderly Adults, Ages 19-64, California, 2001-2009



* Data are significantly different from the previous year at the 95% confidence level.

Sources: 2001-2009 California Health Interview Surveys

The Individual Market Remains Small Prior to ACA Implementation

The individual market continued to be a relatively small source of coverage for working adults in California. In 2009, 1 million working adults were covered through the individual market; of those, 415,000 were self-employed. The share of full-time workers with individual coverage rose from 4.5% to 5.9% between 2007 and 2009, while the share of part-time workers with individual coverage fell sharply, from 12.9% to 9% (Exhibit 30). Combined with the declining size of the workforce, the net effect was a small (80,000) increase in the number of workers with individually purchased coverage.

Group coverage provides significant advantages over the individual market. Premium costs for employer-based insurance are not considered taxable income. The same level of benefits is generally less costly with employer-based insurance than in the individual market due to lower administrative, marketing, and enrollment costs and to greater bargaining power with insurers.[14] Group coverage serves to share risk and minimize adverse selection, in which people with greater health needs are more likely to purchase insurance, raising the average cost. In the current non-group market, individuals with preexisting conditions are regularly denied coverage.

When key provisions of the ACA are implemented in 2014, the individual market should grow substantially. Subsidized coverage will be available for low- and moderate-income families that are not offered affordable coverage on the job. Individuals will no longer be denied coverage due to preexisting conditions, and health care exchanges will bring some of the benefits of group coverage (greater purchasing power and economies of scale) to the individual market.

14 Ken Jacobs and Jacob Hacker. How to Structure a "Play-or-Pay" Requirement on Employers. Advancing National Health Reform Policy Brief. 2009.

Own-Employer Coverage Rates Vary Significantly Across Demographic Groups

In past years, shifts between "own" and dependent coverage for working adults were largely compensatory—when one declined for a specific demographic group, the other would increase.[15] Between 2007 and 2009, however, this effect was much more muted. For many groups, both own and dependent coverage fell.

Own-employer coverage for working adults fell from 49.5% in 2007 to 48.4% in 2009 (Exhibit 31). The largest decline was among young workers between 19 and 24 years of age, a drop of 3.2 percentage points, from 24.6% to 21.4%. Workers in this age group were much less likely than all other age groups to have coverage on the job. While there was a 10.5 percentage point gap between workers ages 25-29 and those ages 55-64 in job-based coverage (47.1% and 57.6%, respectively), the gap was greatest for those under age 25. Young workers (ages 19-24) were significantly more likely to have dependent coverage than their slightly older counterparts (ages 25-29), reflecting the ability of college students to stay on a parent's plan. They were less likely to have dependent coverage than workers ages 30 and older. Older workers were more likely to be married or to have a domestic partner, and the spouse or partner was more likely to have a job offering family coverage than were their younger counterparts. There is already evidence that dependent coverage for young adults is increasing due to the ACA provisions requiring insurers and self-insured firms with family coverage to allow children to stay on a parent's plan until the age of 26.[16]

15 E. Richard Brown, Richard Kronick, Ninez A. Ponce, Jennifer R. Kincheloe, Shana Alex Lavarreda, Erin Peckham. *State of Health Insurance in California*. 38-39. 2007.

16 The National Health Interview Survey found that the percentage of uninsured adults aged 19-25 fell nationally from 33.9% in 2010 to 30.4% in 2011.

Robin A. Cohen and Michael Martinez. Health Insurance Coverage: Early Release of Estimates from the National Health Insurance Survey, January-March 2011. Centers for Disease Control and Prevention. 2011.

Exhibit 31.

Employment-Based Insurance (EBI) by Demographics Among Working Nonelderly Adults, Ages 19-64, California, 2003-2009

	EBI Own Coverage All Year				EBI Dependent Coverage All Year			
	2003	2005	2007	2009	2003	2005	2007	2009
All Workers	51.1%	49.2%	49.5%	48.4%	12.0%	12.4%	14.1%	13.8%
Age Group								
Ages 19-24	26.0%	22.0%	24.6%	21.4%	13.0%	10.9%	14.3%	11.1%
Ages 25-29	42.9%	43.5%	47.0%	47.1%	6.2%	8.6%	6.0%	7.9%
Ages 30-44	54.8%	52.7%	52.3%	50.6%	11.3%	12.2%	13.3%	13.5%
Ages 45-54	59.2%	57.7%	56.7%	54.9%	14.4%	14.1%	16.3%	16.8%
Ages 55-64	61.3%	59.4%	57.1%	57.6%	13.4%	14.3%	17.0%	15.4%
Race and Ethnicity Group								
White	57.4%	56.8%	54.7%	53.6%	14.7%	15.4%	17.7%	17.5%
Latino	38.9%	36.9%	39.8%	38.8%	8.6%	85.0%	9.8%	9.4%
African American	59.0%	52.5%	51.7%	43.6%	7.6%	9.3%	8.5%	8.3%
Asian/Native Hawaiian/Pacific Islander	54.6%	52.1%	54.0%	54.1%	12.2%	12.1%	14.6%	14.9%
American Indian/Alaskan Native	44.5%	42.2%	49.9%	44.5%	12.7%	15.3%	10.4%	–
Two or More Races	49.1%	49.5%	49.2%	54.8%	15.4%	17.9%	13.0%	10.7%
Family Composition								
Single Adult	46.1%	44.0%	43.5%	43.5%	5.8%	5.0%	6.1%	5.5%
Single Parent	45.4%	45.5%	40.8%	45.0%	2.7%	2.7%	3.1%	–
Married without Children	59.4%	58.0%	56.7%	55.7%	18.5%	19.4%	21.8%	21.3%
Married with Children	51.8%	49.5%	52.2%	48.4%	15.9%	16.7%	19.0%	18.8%
Citizenship and Immigration Status								
U.S. Citizen	55.9%	53.9%	53.6%	51.6%	13.5%	13.8%	15.4%	15.0%
Non-Citizen with a Green Card	37.6%	37.1%	35.2%	35.3%	8.5%	10.0%	11.0%	11.9%
Non-Citizen without a Green Card	22.5%	18.9%	21.8%	24.8%	2.6%	1.4%	–	0.9%
Highest Level of Education								
Less Than High School	30.3%	26.1%	25.8%	30.9%	4.5%	4.9%	6.8%	7.8%
High School Graduate	44.0%	43.6%	41.7%	39.6%	12.1%	12.4%	13.7%	12.1%
Some College	50.2%	45.5%	45.5%	42.5%	16.8%	15.4%	17.1%	15.1%
Vocational School, AA, AS	54.6%	52.1%	52.9%	47.8%	14.6%	13.2%	16.7%	15.0%
College Graduate or Higher	64.3%	62.3%	63.7%	60.9%	12.7%	13.7%	15.2%	16.0%
Federal Poverty Level								
Less than 200% FPL	24.7%	21.2%	21.6%	22.7%	5.3%	4.5%	5.2%	5.6%
200-399% FPL	51.8%	50.5%	48.6%	49.5%	12.6%	12.9%	15.0%	13.4%
400%+ FPL	65.3%	63.4%	63.7%	61.8%	15.5%	62.4%	18.1%	18.6%
Hourly Wage								
Less than $9.00	23.0%	21.7%	20.8%	23.2%	11.6%	11.3%	13.9%	11.9%
$9.00-$12.99	36.5%	36.4%	37.6%	37.2%	11.4%	11.9%	12.6%	12.4%
$13.00-$14.99	46.8%	47.0%	50.2%	44.3%	12.6%	9.6%	14.9%	12.5%
$15.00-$18.99	56.7%	54.9%	55.7%	51.6%	11.9%	12.4%	15.1%	15.8%
$19.00-$23.99	63.0%	61.6%	63.2%	59.5%	13.2%	12.1%	15.2%	15.5%
$24.00 +	70.0%	66.4%	68.2%	66.5%	12.2%	13.5%	14.0%	14.8%

Note: Hourly wage is in 2009 dollars.

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

Sources: 2003-2009 California Health Interview Surveys

Examining the trends by race and ethnicity, we find that own-employer has fallen for African American workers over the last decade. In 2001, 59% of African American workers reported coverage through their own employer; by 2009, this had fallen to 43.6%. While the direction of change is statistically significant, the magnitude may be overstated. The Current Population Survey (CPS) shows a significant but smaller drop in coverage over the same period and a leveling off in more recent years. Further research is warranted.[17]

Latinos continued to have the lowest rate of own-employer coverage at 38.8%, significantly lower than other groups and virtually unchanged from 2001. Own-employer coverage for Asian Americans/ Native Hawaiians and Pacific Islanders in 2009 was statistically indistinguishable from Whites, 54% compared to 53.6% (Exhibit 31). At the same time, white working adults were significantly more than twice as likely as African Americans to have dependent coverage through an employer in 2009.

Own-employer coverage is largely a function of education, family income, and wages. Only 30.9% of workers with less than a high school education had coverage on the job in 2009, compared to 60.9% of those who were college graduates or higher. The same held for dependent coverage, where 7.8% of workers with less than a high school education had coverage through a parent, spouse, or domestic partner, compared to 12.1% of high school graduates and 16% of those with a college education or greater. The effect is even more pronounced by wage, where there is a strong relationship between wages and own-employer coverage rates. Only 23.2% of workers earning under $9 an hour had coverage through their own employer, compared to 66.5% for those earning more than $24 an hour (Exhibit 31).

While education and family poverty levels are good predictors of dependent coverage, wage level is much less so. Working adults with low-wage jobs are more likely to have coverage through a family member's employer than workers with lower educational achievement or low family income.

Citizenship status is highly correlated with both own-employer and dependent coverage. In 2009, 51.6% of U.S.-citizen working adults had own-employer coverage, which was significantly higher compared to non-citizens either with a green card (35.3%) or without (24.8%). Fewer than 1% of non-citizen working adults without a green card reported dependent coverage, compared to 11.9% of those with a green card and 15.0% of U.S. citizens.

Married working adults in families without children were significantly most likely to have own-employer coverage (55.7%); however, they were not significantly likely to have dependent coverage (21.3%).

Offer, Eligibility, and Take-up

Coverage rates for insurance through one's own employer are the product of the offer, eligibility, and take-up rates. *Offer* refers to whether or not the firm offers coverage to any employee in that firm. If a firm offers coverage, an employee may or may not be *eligible* for that coverage, depending on how long the employee has been at the firm or the number of hours he or she works.[18] Employees who are eligible for coverage may choose not to *take up* that coverage, whether due to cost or because they have coverage elsewhere. For an employee to have employer-based insurance, he or she must work for a firm that offers coverage, be eligible for that coverage, and choose to take up the plan.

17 Analysis of March Current Population Survey 2003-2009.

18 Individuals in a survey may not always know the difference between *offer* and *eligibility*. Employer surveys generally find higher offer rates and lower eligibility rates than surveys of individuals.

Offer, eligibility, and take-up all vary significantly by age (Exhibit 32). Younger workers are less likely to work for firms that offer coverage. They are also less likely to be eligible for coverage, and for those who are eligible, a smaller share take up coverage on the job compared to their older counterparts. As a result, employees between the ages of 19 and 25 are half as likely to have coverage on the job as those between the ages of 55 and 64 (36.6% vs. 72.7%; Exhibit 32).

Larger firms are much more likely to offer coverage than medium-sized or smaller firms. In 2009, 94.4 percent of employees working in firms of 1,000 or more reported that their employer offered coverage, compared to 87.2% and 88.8%, respectively, for

Exhibit 32.
Rates of Offer, Eligibility, Take-Up, and Coverage of Employment-Based Coverage by Age and Firm Size Among Working Nonelderly Adults, Ages 19-64, California, 2009

	Offer	Eligibility	Take-Up	Coverage
Age				
19 to 25	69.6%	71.6%	73.4%	36.6%
26 to 29	79.2%	88.4%	84.4%	59.1%
30 to 44	84.6%	90.8%	83.1%	63.8%
45 to 54	85.5%	92.4%	84.9%	67.0%
55 to 64	88.4%	94.7%	86.8%	72.7%
Firm Size				
Fewer than 10	43.6%	85.4%	78.8%	29.3%
10 to 50	73.5%	86.2%	75.3%	47.7%
51 to 99	87.2%	92.2%	85.6%	68.8%
100 to 999	88.8%	88.3%	82.2%	64.4%
1,000 or More	94.4%	90.3%	86.3%	73.6%

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

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

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

Coverage rate = The product of the offer, eligibility, and take-up rates.

Population analyzed excludes self-employed individuals who are in firms with fewer than 10 employees.

Source: 2009 California Health Interview Survey

firms of 51-99 and 100-999; 73.5% for firms of 10 to 50; and 43.6% for firms of fewer than 10 (Exhibit 32). Eligibility and take-up were also lower for firms of 50 or fewer, but showed little variation above 50 workers.

The ACA will notably change the landscape for job-based coverage. Provisions in the act will change the incentives for firms to provide coverage and for individuals to take up that coverage. Starting in 2010, low-wage firms with 25 or fewer full-time equivalent employees are eligible for subsidies for providing job-based coverage. In 2014, firms with 100 or fewer employees will have access to the new Small Business Health Options Program (SHOP) Exchanges.

Demand for job-based coverage among workers will be affected in multiple ways. The individual mandate will increase the demand for coverage overall. Demand for employment-based coverage will be reduced for lower-income families, who will now have the option of receiving subsidized coverage in the new health insurance exchange if affordable job-based coverage is not offered. Employers who do not provide affordable coverage on the job and whose employees received subsidized coverage in the exchange will be required to pay a penalty to help cover the cost of subsidies. New rules barring waiting periods of more than 90 days will increase eligibility for coverage among offering firms, while a requirement that firms with 200 or more full-time workers automatically enroll workers in coverage is expected to increase take-up by workers in larger firms.

As a result of the interaction of each of these elements, most analysts predict a modest decline in job-based coverage as the ACA goes into effect, with the greatest declines for workers in small firms. Job-based coverage actually increased slightly in Massachusetts following the implementation of similar reforms in that state.[19]

19 See, for example, Peter Long and Jonathan Gruber. "Projecting the Impact of the Affordable Care Act on California." *Health Affairs*. January 2011. Vol. 30 (1): 63-70.

Fewer Than One-Quarter of Those Not Taking Up Job-Based Coverage Were Uninsured

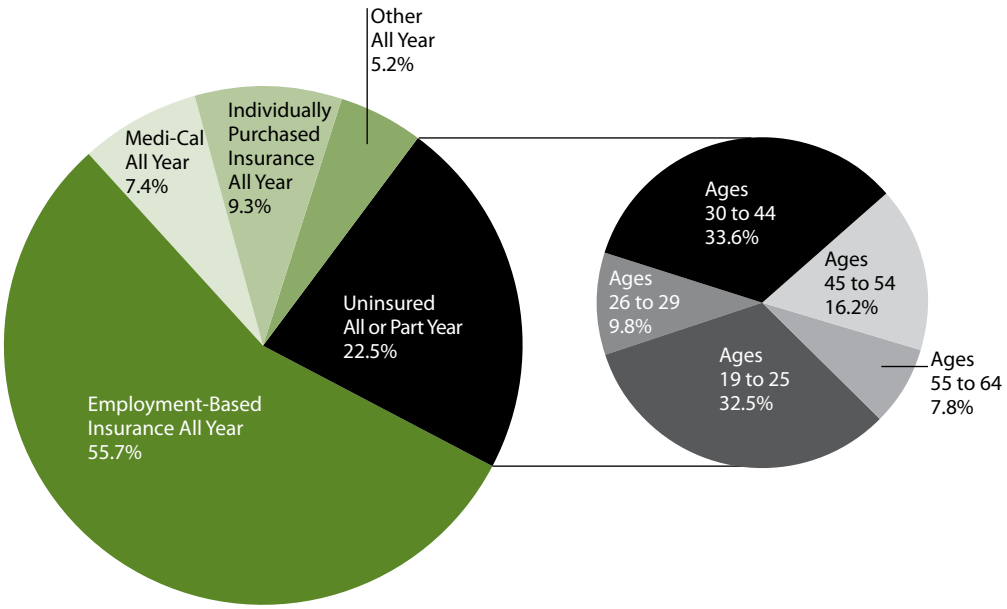
In 2009, 1.7 million working-age adults declined coverage on the job. Of those, 946,000 (55.7%) reported having dependent coverage through another employer for the full year (Exhibit 34). Almost 1 in 10 (9.3%) purchased individual insurance on the private market. An additional 7.4% had coverage through Medi-Cal or Healthy Families. Fewer than one-fourth (22.5%) of those declining job-based coverage (381,000) reported that they had been uninsured for all or part of the year. Workers decline coverage for a variety of reasons, with cost being the reason most commonly cited.

Young workers (19-25) were not only more likely to choose not to take up coverage, but they were also significantly more likely to become uninsured when they made this choice (42%; data not shown). Of the 381,000 workers who remained uninsured after declining coverage on the job, 126,000 (32.5%) were between the ages of 19 and 25. Young workers were the least likely to have employment-based insurance through another source (31.5%) and the most likely to have individually purchased coverage (16.5%). As noted above, coverage rates for young adults have increased since the survey was taken due to provisions in the ACA enabling young adults to remain on their parents' plans until the age of 26.

Coverage Declined for Self-Employed Workers

In 2009, 2.1 million California adults between 19 and 64 were self-employed (data not shown). The self-employed do not have access to own-employer coverage.

Exhibit 33.
Type of Health Insurance Coverage Among Working Nonelderly Adults Who Declined Own Employment-Based Coverage, Ages 19-64, California, 2009



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

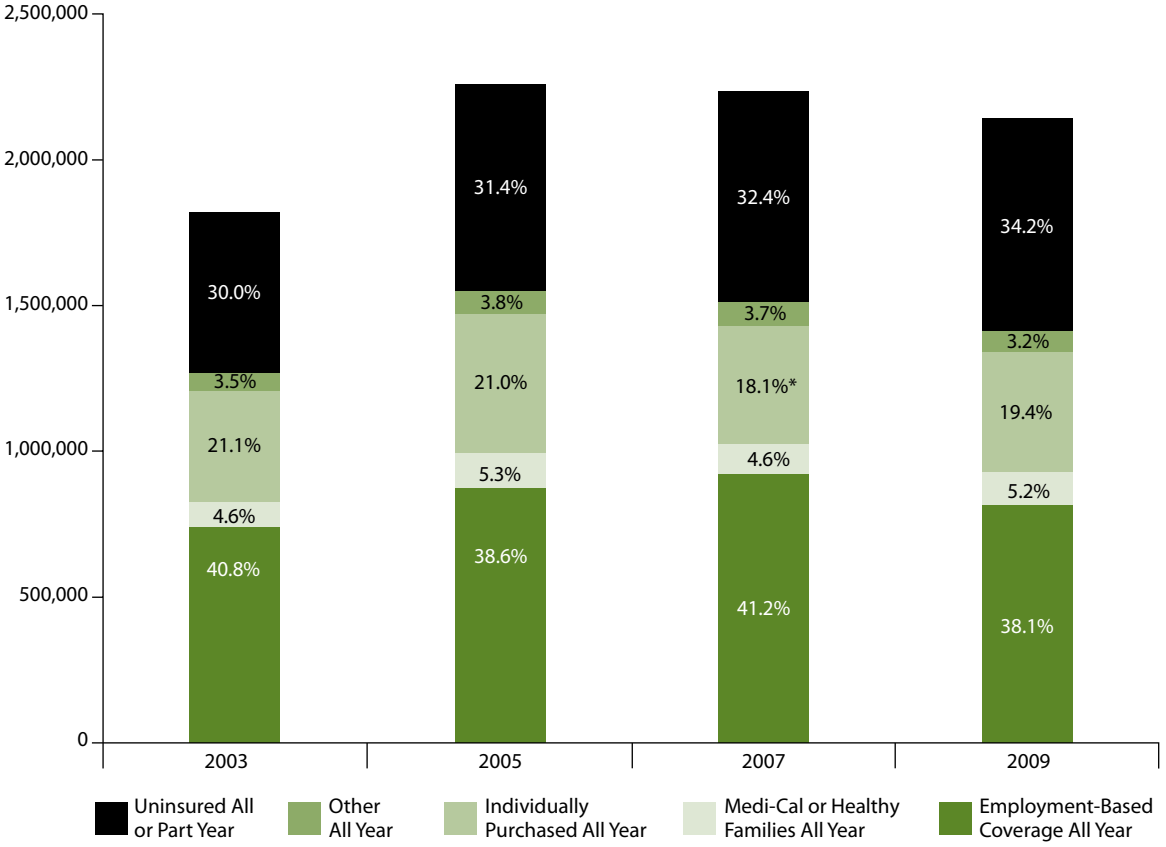
Source: 2009 California Health Interview Survey

If they do not have employer-based coverage through a family member and are not eligible for public coverage, their remaining option is to purchase coverage on the individual market, where they face high costs and may be denied coverage based on preexisting conditions.

The number of self-employed individuals reporting that they had employer-based coverage fell by more than 100,000 between 2007 and 2009, an 11.4% reduction (data not shown). One likely explanation is loss of employment by the primary insurance holder. In 2009, 817,000 self-employed workers (38.1%) reported having coverage through an employer; 415,000 (19.4%) reported having coverage through the individual market; and 734,000 (34.2%) reported that they were uninsured (Exhibit 34).

The lack of coverage options has long provided a barrier to self-employment and entrepreneurship. This group will be among those most affected by the ACA when provisions relating to the individual market go into effect in 2014. Those who are not offered affordable job-based coverage will have the option of purchasing coverage through the new health insurance exchanges, and they may be eligible for subsidies if their family income is under 400% FPL. The law will also prohibit insurers from discriminating in both offer of coverage and price based on preexisting conditions.

Exhibit 34.
Health Insurance Coverage of Self-Employed Adults, Ages 19-64, California, 2003-2009



Note: Self-Employed are self-employed individuals in firms with fewer than 10 employees.

Chart is for 2003-2009 only, because comparable questions for family work status did not exist in CHIS 2001.

* Data are significantly different from the previous year at the 95% confidence level.

Sources: 2003- 2009 California Health Interview Surveys

Demographic Characteristics of the Private Insurance Markets and the Uninsured Exchange-Eligible Population

In preparing for implementation of the ACA, it is useful to examine the demographic characteristics of the different privately purchased insurance markets. Under the ACA, firms with 100 employees or fewer will be eligible to participate in the Small Business Health Options Program, or SHOP, Exchange, where they will purchase coverage as a small business. Starting in 2017, states may opt to open the exchanges to larger firms.

U.S. citizens or non-citizens with a green card who are not offered employer-based insurance and are not qualified for public coverage[20] may participate in the individual exchange. Exchange-eligible individuals with family incomes under 400 percent of the FPL will be eligible for subsidies toward the purchase of coverage in the exchange. Subsidies will be provided only through the exchange. Nonsubsidized individuals may choose between the exchange and the individual market outside the exchange.

We analyzed demographics of those in the individual market, the small group market (firms with 1-99 employees), and the large group market (100+ employees); those who are uninsured and would be eligible for the exchange with subsidies; and those who are uninsured and would be eligible for the individual market or exchange without subsidies. The demographics for the group market are for own-employer coverage only. The vast majority of those currently purchasing coverage in the individual market will be eligible for the exchange, some with subsidies and others without them. The demographic breakdown between these subgroups is not provided. These estimates are for the various insurance markets and uninsured and exchange-eligible as of 2009. They do not take into account changes in coverage source following implementation of the ACA.

The demographics of the small and large group markets in California are quite similar in terms of age, citizenship status, and self-reported health status. Those with own-employer coverage in the large group market were significantly more likely than those in the small group market to be in families whose incomes are more than 400% of the FPL.

The exchange-eligible uninsured are younger, on average, than those with privately purchased coverage. Both the subsidy-eligible and non–subsidy-eligible groups had a smaller share of individuals over 55 than those in the privately purchased markets. The uninsured and exchange eligible but not subsidy eligible had a significantly smaller share of individuals between 45 and 54 than any of the other markets.

Californians who purchase coverage in the individual market are significantly more likely to report that they are in excellent or very good health (69.6%; Exhibit 35). They are the least likely to report asthma, high blood pressure, or being overweight or obese. This is not surprising given the current restrictions on purchasing individual coverage based on preexisting conditions. The uninsured and exchange eligible with subsidies are significantly the least likely to report excellent or very good health (42%) and the most likely to report fair or poor health (23.8%). They are the most likely to be overweight or obese (64%) or to smoke (23.4%).

The health status of the uninsured and non–subsidy-eligible is more on a par with those in the individual, small, and large group markets. This reflects the higher income levels of those who are not subsidy eligible. These individuals are more likely to smoke or to be overweight or obese than those in the individual market, but the differences are not statistically significant.

20 Under the ACA, Medicaid is expanded to citizens, and to non-citizens with a green card and with five or more years in the country, with incomes below 133 percent of the federal poverty level, with a 5 percent income disregard. Individuals who qualify for Medicaid are not eligible for coverage in the Individual Exchange.

Exhibit 35.

Demographics of Individuals with Individually Purchased, Small-Group, or Large-Group Coverage, and the Exchange-Eligible Uninsured Among Nonelderly Adults, Ages 19-64, California, 2009

	Individually Purchased	Small-Group	Large-Group	Uninsured and Exchange Eligible with Subsidies	Uninsured and Exchange Eligible without Subsidies
All Nonelderly Adults	**1,424,000**	**3,416,000**	**6,733,000**	**1,348,000**	**1,082,000**
Age Group					
19 to 25	26.2%	10.0%	7.1%	19.8%	29.4%
26 to 29	6.0%	7.5%	7.5%	11.2%	13.6%
30 to 44	24.8%	35.6%	38.5%	31.4%	28.8%
45 to 54	21.6%	26.8%	29.4%	25.6%	15.4%
55 to 64	21.5%	20.2%	17.5%	12.0%	12.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Citizenship and Immigration Status					
U.S.-Born or Naturalized Citizen	91.8%	86.7%	90.8%	81.2%	89.0%
Non-Citizen with Green Card	5.4%	10.0%	6.9%	18.8%	11.0%
Non-Citizen without Green Card	2.9%	3.3%	2.3%	-	-
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Health Status					
Excellent or Very Good	69.6%	63.4%	60.9%	42.0%	61.5%
Good	21.6%	27.0%	28.4%	34.2%	29.2%
Fair or Poor	8.7%	9.5%	10.8%	23.8%	9.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Chronic Conditions					
Currently Has Asthma	5.5%	6.4%	8.1%	7.1%	7.9%
Diabetes Prevalence	--	5.3%	6.1%	7.1%	1.9%
Heart Disease	1.7%	3.3%	2.9%	2.3%	3.2%
High Blood Pressure	17.6%	21.1%	21.2%	19.6%	17.0%
Current Smoker	13.1%	11.6%	11.5%	23.4%	19.4%
Overweight or Obese	43.1%	55.8%	58.5%	64.0%	52.4%
Federal Poverty Level					
0-133% FPL	11.0%	6.7%	5.6%	4.1%	--
134-200% FPL	9.5%	8.6%	5.4%	40.4%	7.5%
201-300% FPL	14.1%	15.4%	11.8%	38.4%	8.9%
301-400% FPL	14.1%	11.7%	11.2%	17.1%	4.3%
401%+ FPL	51.2%	57.6%	66.0%	-	79.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Work Status					
Full-Time	56.8%	82.4%	91.5%	45.7%	62.6%
Part-Time	13.8%	15.4%	6.5%	8.8%	7.9%
Unemployed, Looking for Work	6.0%	0.9%	1.0%*	27.5%	14.1%
Unemployed, Not Looking for Work	23.1%	0.9%	0.6%*	17.6%	15.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
All Working Adults	**1,008,000**	**3,347,000**	**6,627,000**	**739,000**	**766,000**
Firm Size					
Self-employed and < 10 Employees	41.2%	24.4%	-	22.7%	23.7%
Not Self-employed and < 10 Employees	14.9%	22.2%	-	20.7%	9.0%
10-50 Employees	17.8%	41.4%	-	21.1%	22.0%
51-99 Employees	2.2%	12.0%	-	2.5%	--
100-999 Employees	6.9%	-	24.6%	12.9%	15.0%
1,000 or More Employees	17.0%	-	75.4%	20.2%	28.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Note: "Small-Group" refers to individuals in firms with fewer than 100 employees; excludes dependents.

"Large-Group" refers to individuals in firms with 100 or more employees; excludes dependents.

Population total for "Work Status" will not add up to 100% because "Employed, Not at Work" is not shown.

Population totals may differ between Work Status and Firm Size because those that are "Employed, Not at Work" are excluded from the total population of Firm Size.

- Data unavailable.

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

Source: 2009 California Health Interview Survey

Conclusion

There was a notable decline in the number and share of working-age adults with job-based coverage between 2007 and 2009. This reflects a large drop in full-time work among California adults between the ages of 19 and 64. There was a small decline in the rate of coverage among full-time workers, and a larger decline in the share of part-time workers with coverage on the job. Own-employer coverage fell the most for young workers. The share of Californians under 65 with coverage through either their own employer or a parent's or spouse's employer ranged from a low of 36% in Kings County to a high of 73.6% in San Mateo County.

The rate of job-based coverage is the product of employer offer of coverage, worker eligibility for coverage, and workers' decisions of whether or not to take up that coverage. Each of these varies by firm size and worker age. The ACA is expected to have important impacts on employer offer, worker eligibility, and take-up of coverage, though the overall impact on the share of workers with job-based coverage is likely to be relatively small.

Self-employed Californians are the most likely to rely on the individual market, though it remains a small share of insurance coverage in the state. The rising cost of premiums in the individual market and restrictions based on preexisting conditions put individual coverage out of reach for many of the self-employed. These restrictions will be lifted under the ACA.

The ACA will open new opportunities for coverage in the private market. The health insurance exchanges will be open to families that do not have an offer of affordable coverage and are not eligible for public programs. Families under 400% FPL will be eligible for subsidized coverage in the exchanges. Everyone with an offer of affordable coverage will be required to purchase coverage, and insurance companies will no longer be allowed to discriminate in offer or price of coverage based on health status. A small group exchange will be open to employers with 100 or fewer employees. Young adults are now able to stay on a parent's plan until the age of 26, which has already increased coverage for those in this age group since the 2009 survey was taken.

The demographics of California's small and large group market show little variation, though individuals in the large group market are more likely to be in higher-income families. Those who purchase coverage in the individual market are the most likely to report excellent or very good health and the least likely to report chronic conditions. Those who are uninsured and would be eligible for subsidies under the ACA are younger on average than those currently in the individual market, but they are more likely to report poor health status, to smoke, or to be overweight or obese. Californians who are eligible for the exchange but not for subsidies are closer in health status to those in the current private market.

4 Medi-Cal, Healthy Families, and Medicare Play a Vital Role in Insuring Californians

Dylan H. Roby

Public insurance in California is comprised of multiple federal, state, and local programs. Combined, these programs provide insurance coverage to 9.3 million[21] people in the state. However, it is important to consider that these public programs are not designed to act as a safety net for all uninsured individuals. Instead, in addition to the income-based criteria often used by means-tested programs, individuals and families must qualify for the coverage under specific categories (aged, blind, disabled, children, and mothers). Also, complete Medi-Cal and Healthy Families coverage requires a citizenship or legal residence verification.[22] For this reason, there are still many low-income, uninsured Californians who do not qualify for any public program, while there are also children and parents, people with disabilities or medical needs, and elderly Californians who are eligible for public insurance programs but do not enroll.

In previous chapters, employment-based and individual market insurance products were discussed. One key difference between private and public insurance sources is the presence of family coverage in the private market. When workers are choosing from employment-based insurance plans, they can often choose to cover their spouse and children under one plan and pay one premium for that coverage. With public insurance, the determination of eligibility is based on individual characteristics and enrollment, which often means that members of the same family are either insured through different public programs (such as Medi-Cal or Healthy Families) or are not insured at all.

21 Public Coverage includes all of the following: Medi-Cal Only, Medi-Cal and Employment-Based Insurance, Medi-Cal and Other, Medi-Cal and Healthy Families, Healthy Families Only, Healthy Families and Employment-Based Insurance, Healthy Families and Other, Medicare Only All Year, Medicare and Medi-Cal and Employer-Paid All Year, Medicare and Medi-Cal All Year, Medicare and Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer.

22 In the case of partial-scope "Emergency Medi-Cal," citizenship or legal residency documentation requirements are waived temporarily in order to ensure access to emergency services for a specific episode of care.

Unemployment Increases Burden on Public Insurance Programs

The economic downturn experienced in 2008 and 2009 resulted in a substantial increase in the unemployment rate. As mentioned in earlier chapters, employment-based insurance provides the majority of Californians (50.2%, or approximately 18.7 million people) with health coverage. Increases in the unemployment rate are not only associated with a rise in the number and percentage of people who are uninsured, but they also place a burden on public programs such as Medi-Cal and Healthy Families. This is a risk in a system where employers are relied on to offer affordable private health coverage to their workers. When this does not happen, millions of working individuals from various income and educational levels are faced with unaffordable or nonexistent health insurance options. While changes occurring due to the implementation of the Affordable Care Act may mitigate this problem now and in 2014, the difficult economic climate facing California's employers and residents affects the ability of families to obtain insurance and access health care.

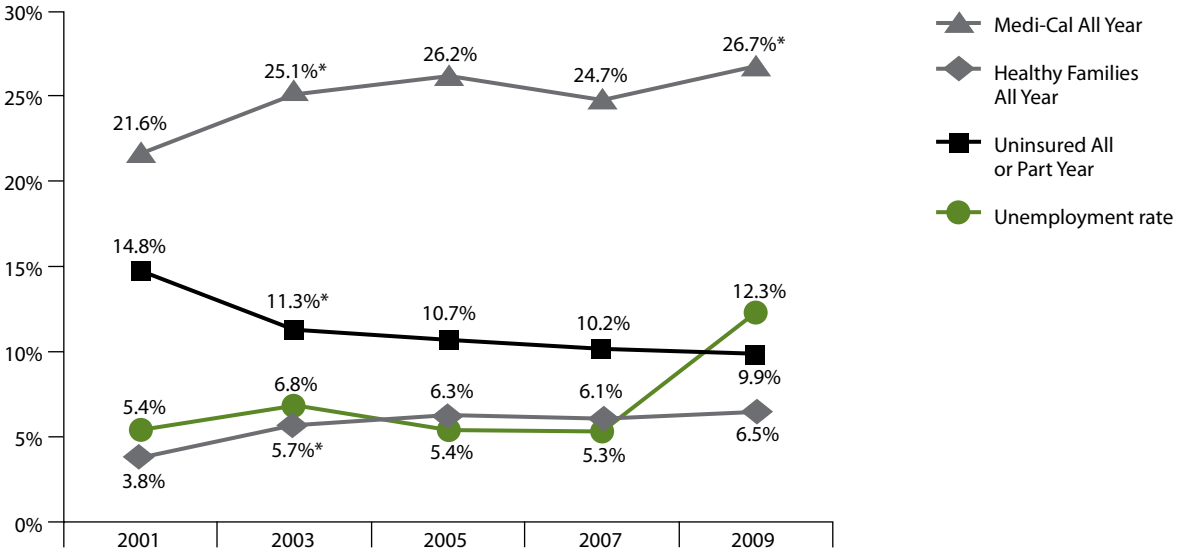
Children Maintained Coverage, but It Came from a Different Source

Public insurance coverage provided through Medi-Cal and Healthy Families has grown since 2001 in terms of both the number and proportion of children enrolled, reaching peaks in 2009 with 26.7% of all children ages 0 to 18 enrolling in Medi-Cal for the entire year, and 6.5% enrolling in Healthy Families for the entire year (Exhibit 36).

Almost 10% of children were uninsured despite the presence of these two public sources of coverage, possibly because they did not meet income eligibility requirements, were undocumented, or did not know about the program. The economic downturn in 2008 potentially contributed to this increase, with parents losing employment-based coverage or not being able to afford individually purchased family coverage. Medi-Cal and Healthy Families are designed to fill in the gap. However, because Medi-Cal uses different income eligibility thresholds for children and their parents, and Healthy Families excludes adults from the eligible population, the percentage of parents who were uninsured while their children were enrolled in Medi-Cal or Healthy Families was 21.6% in 2007, and it increased significantly to 24.5% in 2009. Without these two public programs, there could have been many more uninsured Californians.

Exhibit 36.

Percent of Children in Medi-Cal or Healthy Families or Who Were Uninsured All or Part Year, Ages 0-18, California, 2001-2009



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

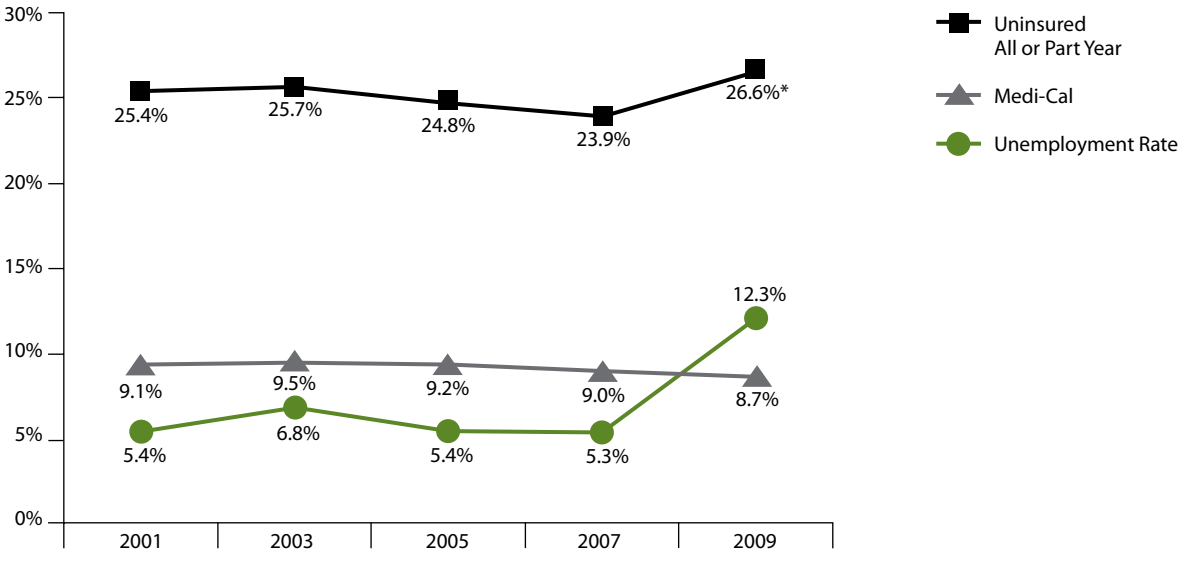
* Data are significantly different from the previous year at the 95% confidence level.

Sources: 2001-2009 California Health Interview Surveys

When parents lose their employer-based insurance coverage due to unemployment or underemployment, their children may either become uninsured or be successfully enrolled in one of these two programs. In the case of Medi-Cal, parents may also be able to qualify for coverage, depending on income status, because of their dependent child. Healthy Families, on the other hand, is designed especially for children, so higher-income (up to 250% FPL) parents are unable to enroll even if their children are current beneficiaries. Parents who are not eligible for public coverage often rely on COBRA continuation coverage through their employer, which tends to be expensive, or else purchase insurance on the individual market on their own. The cost of individual plans can be prohibitive and often comes with limits on benefits, as well as fairly high deductibles and cost sharing. The proportion of adults with Medi-Cal all year is much lower than that seen in children, due in large part to the categorical eligibility standard and lower income threshold that adults must meet. Instead, the percentage of nonelderly adults in California who were uninsured significantly increased from 23.9% in 2007 to 26.6% in 2009, while the proportion of uninsured children did not change significantly (Exhibits 36 and 37).

The percentage of nonelderly residents with either Medi-Cal or Healthy Families coverage varied by county, with San Diego, Ventura, San Luis Obispo, and several Bay Area counties exhibiting a relatively small share of residents participating (Exhibit 38). Imperial, Kern, and other lower-income counties in the Central Valley had a much higher rate of Medi-Cal and Healthy Families coverage (24% or more). Due to the way in which eligibility is structured, the counties with higher use could be lower-income and have more families with children in them, while the

Exhibit 37.
Percent of Adults with Medi-Cal Coverage All Year or Uninsured All or Part Year, Ages 19-64, California, 2001-2009

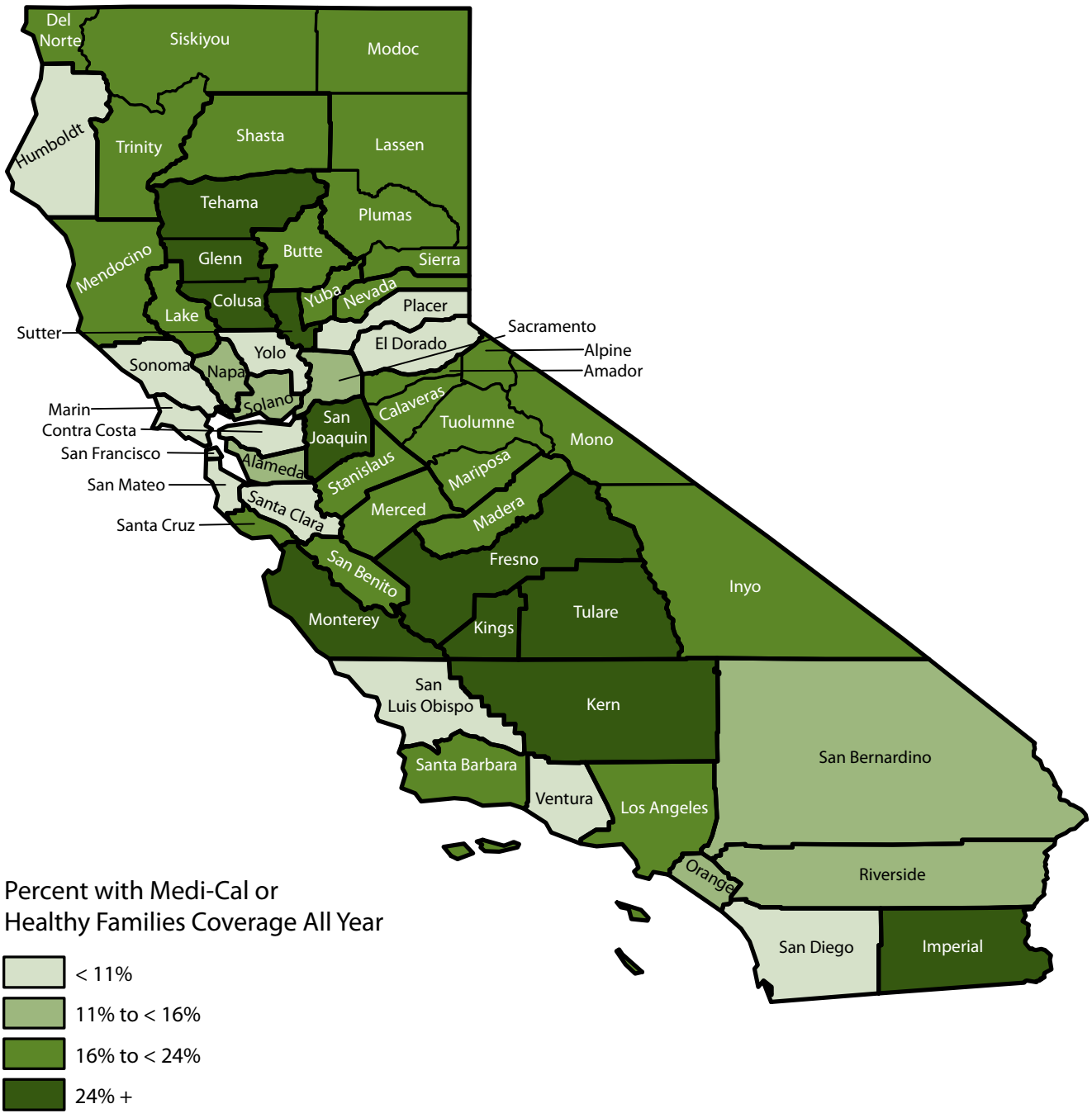


Note: "Medi-Cal" is comprised of Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other, and Medi-Cal and Healthy Families All Year.

* Data are significantly different from the previous year at the 95% confidence level.

Sources: 2001-2009 California Health Interview Surveys

Exhibit 38.
Percent with Medi-Cal or Healthy Families Coverage Among Nonelderly Persons, Ages 0-64, California, 2009



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

Source: 2009 California Health Interview Survey

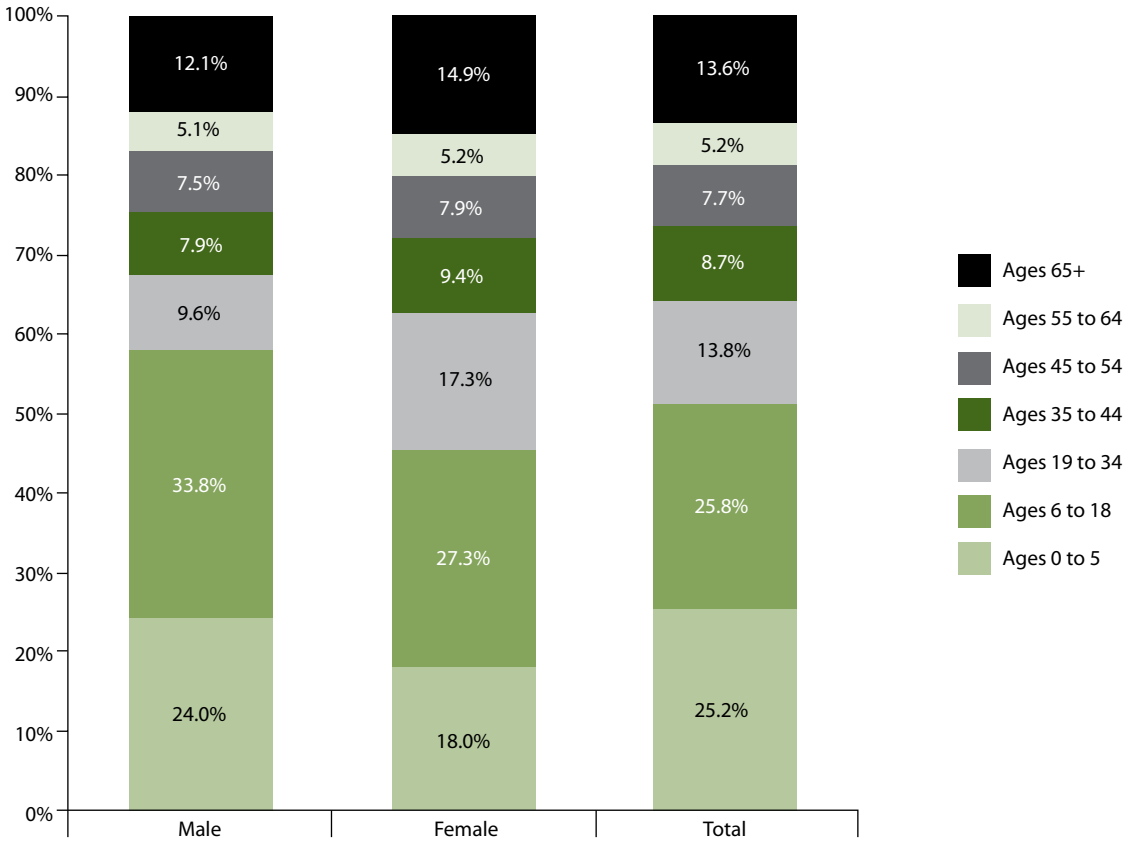
low-participation counties may be higher-income, with fewer families with children. In addition, counties with significant levels of undocumented immigrants may have lower Medi-Cal and Healthy Families participation because legal residence is required for children and parents to fully enroll in the two programs.

Characteristics of Medi-Cal Beneficiaries

In addition to age distribution, there are several other areas in which Medi-Cal beneficiaries differ from the rest of the population, including the uninsured.

Medi-Cal beneficiaries are primarily made up of individuals up to the age of 18 (51%), with the other large groups being younger adults (ages 19 to 34), representing 13.8% of all beneficiaries, and older adults ages 65 and up (13.6%) (Exhibit 39). The 19-64 population represents 60.1% of Californians, but only 35.4% of the Medi-Cal beneficiary population. In addition, because people over the age of 65 are very likely to have either Medicare or Medi-Cal or to be dually enrolled in both, it is apparent that the childless adult population between the ages of 35 to 64 is not only at the most at risk of being uninsured, but also least likely to qualify for Medi-Cal coverage. This will change in 2014, as mentioned in chapter 1,

Exhibit 39.
Medi-Cal Beneficiaries by Gender and Age, All Ages, California, 2009



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

Source: 2009 California Health Interview Survey

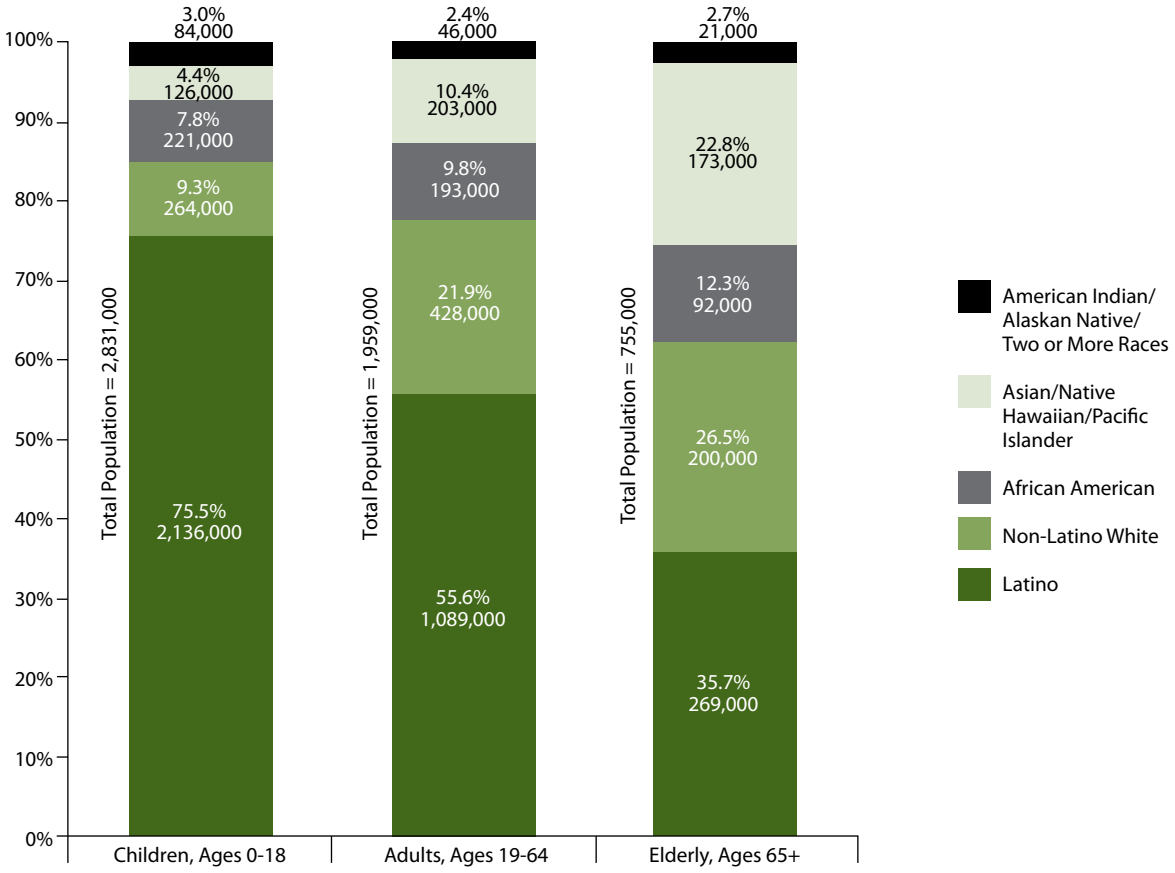
due to the pending expansion of Medi-Cal to individuals earning less than 133% FPL (or 138% FPL when including a 5% income disregard or exemption that is not counted in the calculation), as required by the ACA.

The majority of Medi-Cal beneficiaries are female (53.4%). Several differences appear when gender is compared to age for nonelderly Medi-Cal beneficiaries. While male children ages 0 to 5 (24%) and 6 to 18 (33.8%) make up a larger portion of the overall male Medi-Cal enrolled population than their female counterparts (18% ages 0 to 5; 27.3% ages 6 to 18), females make up a larger share of Medi-Cal enrollment than males when comparing adult age groups. For example, among those ages 19 to 34, the percentage of female Medi-Cal enrollees is significantly almost twice as high as the percentage of their male counterparts in the same age group.

Race/Ethnicity

Medi-Cal, which is designed to cover low-income children and medically needy or disabled adults, has a different mix of racial and ethnic groups than the employment-based and individual insurance markets. More than three-quarters of children ages 0 to 18 in Medi-Cal are Latino, while only 9.3% are white,

Exhibit 40.
Medi-Cal Beneficiaries by Race/Ethnicity Among All Ages, California, 2009



Note: "Medi-Cal" coverage for children and adults is comprised of Medi-Cal only, Medi-Cal and Employment-Based Insurance, Medi-Cal and Other, and Medi-Cal and Healthy Families. "Medi-Cal" coverage for elders is comprised of Medicare and Medi-Cal and Employer-Paid All Year, and Medicare and Medi-Cal All Year.

Source: 2009 California Health Interview Survey

and 7.8% are African American. When examining the adult population, Latinos represent 55.6% of the nonelderly adults but 35.7% of the elderly adults (Exhibit 40). In contrast to white children (9.3% of Medi-Cal beneficiaries ages 18 or under), Non-Latino White adults represent a significantly larger percentage of Medi-Cal beneficiaries (21.9% of the nonelderly and 26.5% of the elderly). In Medi-Cal, Latinos represented 3.49 million (63.0%) of the 5.55 million people enrolled in 2009. African Americans represented 506,000 (9.1%) of Medi-Cal beneficiaries.

The racial/ethnic diversity evident in Exhibit 40 is also reflected in the languages spoken and English proficiency of the Medi-Cal beneficiary population. Language diversity is a well-known characteristic of California's population as a whole, and this is no different in the Medi-Cal program. Approximately 3.48 million people (65.8%) speak a language other than English, with 40.1% having problems understanding and communicating in English. More than one million children, or 40.4% of the child and teen enrollees in Medi-Cal, speak Spanish as their preferred language and have limited English proficiency. Less than one-third of adults and the elderly speak Spanish and have problems understanding and speaking English (30.1% ages 19 to 64 and 22.8% ages 65 and over; Exhibit 41).

Exhibit 41.
Languages Spoken Among Medi-Cal Beneficiaries, All Ages, California, 2009

	Children 0-18	Adults 19-64	Elders 65+	Total Population
English Speaking	29.6%	37.5%	41.7%	1,811,000
Spanish Speaking - English Proficient	22.3%	19.6%	11.1%	1,040,000
Spanish Speaking - Not English Proficient	40.4%	30.1%	22.8%	1,802,000
Asian Language - English Proficient	1.6%	4.1%	4.7%	155,000
Asian Language - Not English Proficient	1.9%	4.8%	13.7%	248,000
Other Language - English Proficient	2.9%	2.9%	3.2%	157,000
Other Language - Not English Proficient	1.4%	1.0%	2.7%	75,000
Total Percent	100%	100%	100%	–
Total Population	2,575,000	1,958,000	755,000	5,288,000

Note: "Medi-Cal" coverage for children and adults is comprised of Medi-Cal only, Medi-Cal and Employment-Based Insurance, Medi-Cal and Other, and Medi-Cal and Healthy Families.

"Medi-Cal" coverage for elders is comprised of Medicare and Medi-Cal and Employer-Paid All Year, and Medicare and Medi-Cal All Year.

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

Children's type of language is identified by the parent (ages 0-11); teens report for themselves (ages 12-17).

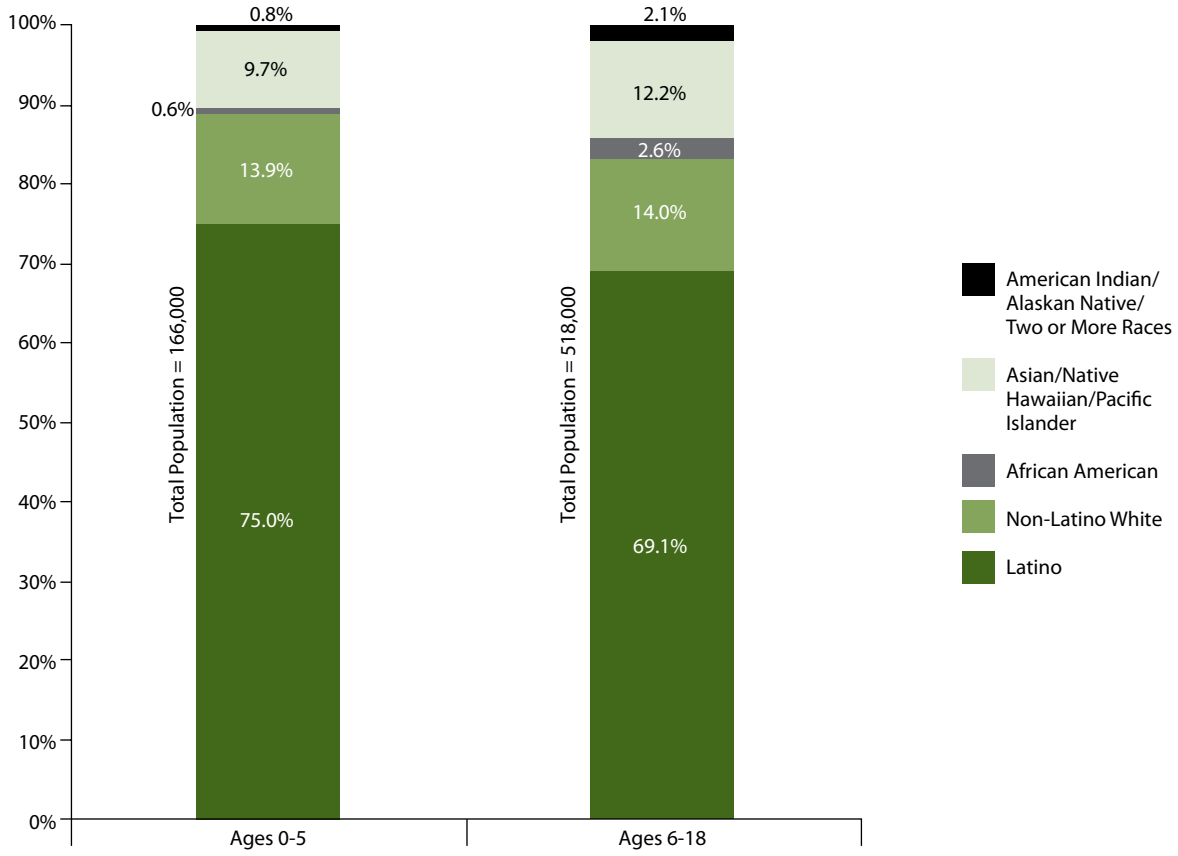
Source: 2009 California Health Interview Survey

Characteristics of Healthy Families Beneficiaries

While Medi-Cal provides insurance coverage to low-income families and individuals with medical needs or disability, Healthy Families is California's Children's Health Insurance Program (CHIP). CHIP programs were implemented to cover children and adolescents ages 0 through 18 whose families earn too much to qualify for Medi-Cal but still cannot afford insurance coverage on their own. Adults are not eligible for Healthy Families if they are over age 18, regardless of family status. As designed, Healthy Families eligibility covers the gap between Medi-Cal's income threshold for each age group up to 250% FPL.

Like Medi-Cal, a portion of the funding for Healthy Families comes from the federal government. The delivery system for Healthy Families is managed care based, while a significant portion of Medi-Cal is delivered in a fee-for-service environment. Like Medi-Cal, there is diversity among the children participating in Healthy Families in terms of race/ethnicity, language, and other characteristics. This information is important to know for managed

Exhibit 42.
Children with Healthy Families All Year by Race/Ethnicity, Ages 0-18, California, 2009



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

Source: 2009 California Health Interview Survey

care plans that provide services to Healthy Families beneficiaries. It is also important for understanding the impact of the potential phase-out of Healthy Families after 2019, which could shift beneficiaries into private coverage offered on the new California Health Benefit Exchange, where parents could enroll children in plans with premium subsidies that would cap spending at 8.05% of household income.

Healthy Families beneficiaries are primarily Latino, with 75% of those ages 0 to 5 and 69.1% of those ages 6 to 18 reporting Latino ethnicity (Exhibit 42). Whites represent approximately 14% of the Healthy Families enrollees in the state, and Asian/Pacific Islanders make up more than 10% of enrollees. African Americans, who make up 5.9% of the overall population, represent only 2% of Healthy Families participants. The majority (76%) of Healthy Families beneficiaries are between the ages of 6 and 18.

Language Spoken and English Proficiency

Although the vast majority of children enrolled in Healthy Families are Latino, language needs in the program are quite different. More than 25% of the beneficiaries overall speak English only, with 38.9% reporting not being able to speak English well or at all across all children and adolescents (Exhibit 43). The largest group with limited English proficiency is Latino children, with 44,000 (26.9%) ages 0 to 5 who have problems communicating in English, while 156,000 (33.1%) ages 6 to 18 could not speak English well or at all. Other languages and Asian languages represent less than 10% of the population covered by Healthy Families.

Exhibit 43.
Languages Spoken Among Medi-Cal Beneficiaries, All Ages, California, 2009

	Ages 0-5	Ages 6-18	Total Population
English Only	25.3%	25.2%	160,000
Spanish Speaking - English Proficient	36.8%	29.2%	197,000
Spanish Speaking - Not English Proficient	26.9%	33.1%	200,000
Asian Language - English Proficient	6.5%	2.3%	21,000
Asian Language - Not English Proficient	1.4%	4.4%	23,000
Other Language - English Proficient	3.2%	0.9%	9,000
Other Language - Not English Proficient	–	4.9%	23,000
Total Percent	100%	100%	–
Total Population	163,000	471,000	634,000

Note: "Healthy Families All Year" is comprised of Healthy Families Only All Year, Healthy Families and Employment-Based Insurance All Year, and Healthy Families and Other All Year. "Spanish Speaking" includes: Spanish Only, and English and Spanish. "Asian Language" includes: Chinese, Vietnamese, Korean, Other Asian Language, English and Chinese, and English and Another Asian Language. "Other Language" includes: Other Non-Asian Language, English and European Language, English and One Other Language, and Other Languages. There were no data for "Other Language – English Proficient" for ages 0-5.

Source: 2009 California Health Interview Survey

Some Californians Eligible for Public Programs Do Not Enroll

Medi-Cal and Healthy Families act as a safety net to insure children and families when they lose their insurance or are unable to afford it on their own. However, there are a number of children and families who qualify for Medi-Cal or Healthy Families but do not enroll. According to the 2009 California Health Interview Survey, approximately 92.7% of all children who were eligible for Medi-Cal actually signed up in 2009, and a lower percentage of adults ages 19 to 64 who were eligible actually enrolled (85.0%). That represents more than 215,000 children who could have had health insurance through a low-cost, public program but who did not enroll. In addition, another 331,000 adults were estimated to be eligible for Medi-Cal but remained uninsured (data not shown).

Although Healthy Families does not enroll adults, a smaller number of uninsured children are eligible for the program. Approximately 189,000 of uninsured children are estimated to be eligible for Healthy Families but are not enrolled – 22.2% of the eligible population (data not shown).

Exhibit 44 suggests many reasons why Californians do not enroll in public programs that they may actually be eligible for. Paperwork appears to be a problem for a small percentage (3.2% for Medi-Cal and 4.5% for Healthy Families eligibles), while lack of knowledge about the program, income variation that may have resulted in ineligibility, dislike of the programs, or reliance on another source of coverage were all more likely to result in Californians' remaining uninsured despite their eligibility for one of the programs. In 2014, the clearer eligibility guidelines and "no wrong door" eligibility called for by the ACA (which states that enrollment in

Exhibit 44.
Reasons for Not Having Medi-Cal or Healthy Families Among Those Who Are Eligible, Ages 0-64, California, 2009

	Medi-Cal All Year	Healthy Families All Year
Paperwork Too Difficult	3.2%	4.5%
Didn't Know If Eligible/It Existed	26.9%	34.1%
Income Too High, Not Eligible	16.2%	23.6%
Ineligible Due to Citizenship/Immigration Status	11.1%	8.8%
Do Not Believe In or Didn't Like or Want Welfare	12.1%	6.9%
Thought Was Insured	7.1%	7.4%
Other, Not Eligible	21.9%	14.2%
Already Have Insurance	1.7%	–

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

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

Source: 2009 California Health Interview Survey

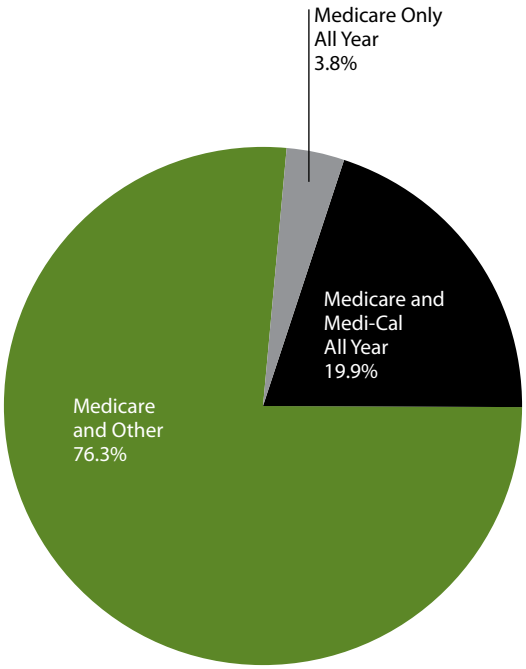
subsidized programs, CHIP, and Medicaid will be made easier by allowing people to enroll through a variety of websites or services) could remove some of the barriers around income, knowledge of the program, and paperwork barriers. However, it is still likely that a portion of Medi-Cal eligibles will continue to be uninsured despite the individual mandate, Medi-Cal expansion, and the creation of the California Health Benefit Exchange.

Medicare Beneficiaries

In addition to Medi-Cal and Healthy Families, the other major public program that provides coverage to Californians is Medicare. Medicare is designed for the elderly (age 65 and over), but it also covers individuals with federally recognized disabilities. As described in the previous section, low-income Medicare beneficiaries may also qualify and enroll in Medi-Cal so that they are covered by both programs ("dual-eligible"). Similarly, retirees and current members of the workforce may also carry dual coverage with Medicare and their existing employment-based policy. Except in certain circumstances, Medicare acts as the primary payer in using and paying for health services when an individual has both Medicare and another source of coverage.

As shown in Exhibit 45, having only Medicare coverage is a fairly rare situation (3.8%). Instead, most Medicare beneficiaries have employment-based insurance as a secondary payer or a Medigap supplemental coverage plan to help defray the out-of-

Exhibit 45.
Medicare Beneficiaries and Additional Insurance Coverage Among Elderly Adults, Ages 65 and Older, California, 2009



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

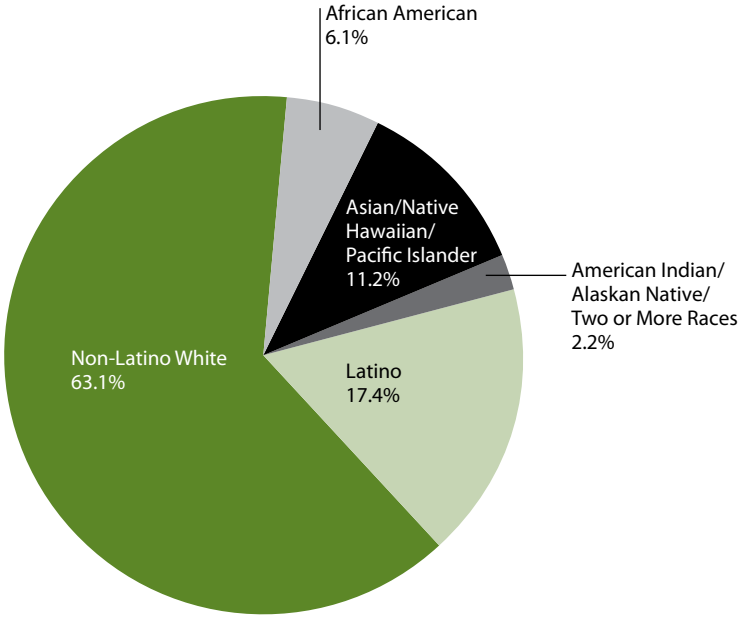
Source: 2009 California Health Interview Survey

pocket cost of using services (76.3%). Another 19.9% of Medicare beneficiaries have dual coverage through Medi-Cal due to low-income status, disability, or medical need. Many Medicare beneficiaries rely on this additional coverage to reduce their out-of-pocket Medicare costs, considering that there is a deductible for both hospital and outpatient services, as well as cost sharing related to outpatient services. The ACA removes cost sharing for certain preventive services, which may remove some access barriers for specific services.

Race/Ethnicity

Medicare's beneficiary population looks substantially different from the Medi-Cal and Healthy Families population, partially because this population has higher incomes on average and because the shift in demographics seen in the overall California population is just beginning to impact people over the age of 65. Sixty-three percent of Medicare beneficiaries are Non-Latino White, with 17.4% Latino, 11.2% Asian/Pacific Islander, 6.1% African American, and only 2.2% American Indian or Alaskan Native (Exhibit 46). This is in contrast to Medi-Cal and Healthy Families, where the vast majority of beneficiaries are Latino. This could be due to demographic differences between age groups (under 65 and over 65), as well as the ability of recent immigrants to pay into Medicare in order to qualify, since eligibility is based upon 10 years (40 quarters) of working in the U.S. and paying Medicare payroll tax or self-employment tax.

Exhibit 46.
Race and Ethnicity of Medicare Beneficiaries, Ages 65 and Older, California, 2009



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

Source: 2009 California Health Interview Survey

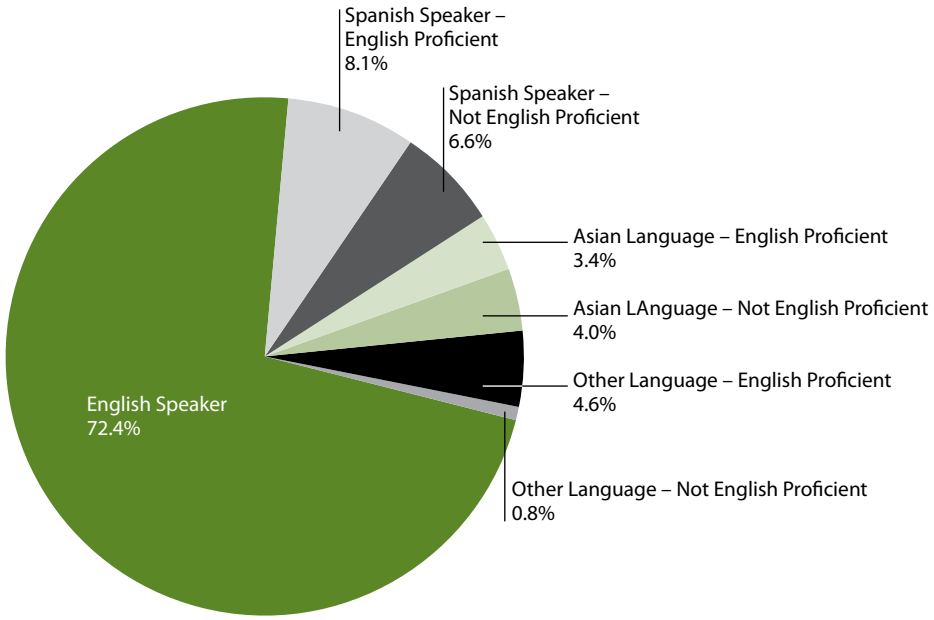
Language Spoken and English Proficiency

Almost three-quarters of all Medicare beneficiaries speak English only (72.4%), and a very small proportion are limited English proficient (11.4%). Spanish speakers make up 14.7% of Medicare beneficiaries, with less than half (44.9%) reporting problems communicating in English (Exhibit 47). This is a very different picture than that seen in Medi-Cal, where the enrolled population is far more diverse in terms of language spoken, English-speaking ability, and race/ethnicity (Exhibit 43 and 44). As populations age, Medicare will face the same diversity and pressures for provision of interpreter services and translated materials as other commercial and Medi-Cal health plans and providers.

Prescription Drug Coverage for Medicare Beneficiaries

A common concern about Medicare coverage has been the availability of prescription drugs for beneficiaries. Until the passage of the Medicare Modernization Act in 2003 and the implementation of the Part D prescription drug benefit in 2006, drug coverage was limited to people with secondary coverage through Medigap, employment-based insurance, and Medi-Cal. In the 2005 California Health Interview Survey, only 104,000 (41.3%) of Medicare Only beneficiaries reported having prescription drug coverage, along with 406,000 individuals (15%) who had Medicare and another type of insurance coverage. In 2009,

Exhibit 47.
Languages Spoken and English Proficiency of Medicare Beneficiaries, Ages 65 and Older, California, 2009



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

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

Source: 2009 California Health Interview Survey

both numbers decreased significantly, to 36,000 (24.8%) for Medicare beneficiaries with no additional insurance coverage, and to 163,000 (6.0%) for those who have Medicare and another insurance source (Exhibit 48). In addition, prescription drug use will become increasingly more affordable for those with Part D plans due to the phase-out of the Medicare prescription drug "doughnut hole" (which could result in seniors paying more than $4,500 out-of-pocket due to coverage gaps for prescriptions) as part of ACA implementation from now until 2020.

Exhibit 48.
Drug Coverage for Medicare Beneficiaries Among Elderly Adults, Ages 65 and Older, California, 2009

	Covered for Prescription Drugs	Not Covered for Prescription Drugs	Total Population
Medicare Only All Year	75.2%	24.8%	146,000
Medicare and Medi-Cal All Year	100.0%	–	755,000
Medicare and Other	94.0%	6.0%	2,715,000

Note: "Medicare and Medi-Cal All Year" is comprised of Medicare + Medi-Cal + Employer-Paid All Year and Medicare + Medi-Cal All Year

Source: 2009 California Health Interview Survey

Health Status and Service Use for Medicare Beneficiaries

Medicare beneficiaries, due to their primarily aged status, are likely to report lower health status levels than the nonelderly population (Exhibit 49). They are also very likely to need health services and to use more health care than their younger counterparts. However, insurance status can reduce or increase the ability of the elderly to receive care when they need it.

Exhibit 49.

Health Care Needs and Status of All Publicly Insured and Uninsured Elderly Adults, Ages 65 and Older, California, 2009

	Medicare	Medicare and Medi-Cal	Medicare and Other	Uninsured All Or Part Year
Health Status				
Excellent or Very Good	44.5%	23.2%	47.2%	34.4%
Good	30.5%	25.7%	31.1%	27.7%
Fair or Poor	25.1%	51.1%	21.7%	38.0%
Chronic Conditions				
Currently Has Asthma	–	0.0%	0.0%	2.1%
Heart Disease	15.8%	23.2%	47.2%	–
High Blood Pressure	56.1%	25.7%	31.1%	40.4%
Diabetes	14.6%	51.1%	21.7%	14.9%
Usual Source of Care				
Doctor's Office/HMO/Kaiser	76.6%	74.3%	87.3%	64.3%
Community or Hospital Clinic	10.4%	16.7%	9.0%	10.3%
Emergency Room/Urgent Care		0.6%	0.2%	
Other Place/No One Place	–	0.1%	0.3%	–
No Usual Source of Care	11.8%	8.3%	3.3%	24.5%
Delays in Health Care				
Had Delay in Getting Any Care	–	8.6%	5.3%	–
Had Delay in Getting Medicine	11.1%	9.3%	6.4%	13.3%
Emergency Room Visits				
At Least One ER Visit in the Past 12 Months	22.4%	27.9%	22.1%	–

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

Analyses on the above characteristics for Medi-Cal and Healthy Families beneficiaries will be discussed in Chapter 5.

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

Source: 2009 California Health Interview Survey

Health Status

Californians who were covered by Medicare all year were significantly more likely to report excellent/very good health status (44.5%) when compared with their lower-income counterparts who qualified for Medicare and Medi-Cal (23.2%), or with those who reported being uninsured at all during the year (34.4%). However, Medicare beneficiaries who had supplemental coverage through an employment-based or Medigap plan had relatively high health status as well (47.2%), though this was not statistically significant. A majority of Medicare/Medi-Cal dual eligibles reported fair or poor health status (51.1%). This indicates that aged Medi-Cal enrollees had a much higher prevalence of medical needs and disabilities. The uninsured reported relatively low health status, with 38% reporting fair or poor health (Exhibit 50). Generally, Medicare beneficiaries have higher self-reported health status than the uninsured or Medi-Cal beneficiaries in the same age group.

Chronic Illness

Due to the age of the Medicare population, the prevalence of chronic illnesses such as asthma, diabetes, and heart disease is much higher than in the general population or in other insurance sources. However, among those ages 65 and over, those with Medicare who had additional coverage from commercial sources reported significantly lower levels of asthma (7.9%; Exhibit 50) than those in other Medicare groups. The Medicare and other coverage group had a significantly higher prevalence of heart disease (20.6%) than the Medicare only group. With diseases such as hypertension and diabetes, the Medicare/Medi-Cal dual eligible group had significantly higher rates of chronic illness than other Medicare beneficiaries and the uninsured over the age of 65.

Delays in Care and Usual Source of Care

As mentioned earlier, cost sharing for Medicare beneficiaries can compromise the ability of the elderly, insured population to access needed care. The Medicare and Medi-Cal only all year population and the uninsured population had higher rates of delays in needed medical and pharmaceutical care, though this was not statistically significant (Exhibit 49). In addition, the Medicare and other insurance coverage group was significantly more likely to report having a usual source of care in a physician office or clinic (96.6%). Over 88% of the Medicare only group reported having a usual source of care, while 91.7% of the Medicare/Medi-Cal group reported a usual place to go for needed care. In the dual-eligible population, there was more reliance on community or hospital clinics as the usual source of care versus Medicare only or Medicare and others beneficiaries, who were more likely to report physician offices as their usual source of care.

Emergency Room Visits

Twenty-eight percent of the Medicare/Medi-Cal dual-eligible group reported having an emergency room visit in the past year. Close to 22% of the other Medicare beneficiaries reported an ER visit in 2009 (Exhibit 49).

Conclusion

Public coverage from Medi-Cal, Healthy Families, and Medicare covers a large proportion of Californians, with almost 9.3 million relying on these state and federal programs to care for their health needs. It is evident that the populations enrolled in Medicare, Medi-Cal, and Healthy Families are some of the more vulnerable groups within the state – children and mothers from low-income families, the elderly and disabled, and children whose parents cannot afford coverage on their own.

The burden on public programs, especially Medi-Cal and Healthy Families, has increased due to the recession of 2008 and the stagnant employment market that has decreased the number of full-time, commercially insured workers. The state funding needed to operate these programs has been supplemented with federal stimulus dollars, but that money is no longer available to support the program as the economy recovers. The next three to four years will be difficult for programs reliant on state and federal funding, as California's legislature and governor struggle to make ends meet and discussions of entitlement reform and possible cuts take center stage in the nation's capital.

These programs will be bolstered by new investment in 2014 and beyond, with the ACA extending the life of Medicare through payroll tax increases for higher-income workers and providing more support for states to operate both their Medicaid and Children's Health Insurance Program. Medi-Cal will be able to cover more children and mothers, as well as currently uninsured childless adults (Exhibit 15), with a large influx of federal funds that will take pressure off the long-term state budget. The strengthening of Medi-Cal, Healthy Families, and Medicare should alleviate pressure on other parts of the safety net, including public hospitals and community health centers that provide the bulk of care for the uninsured and low-income populations.

5 The Role of Insurance in Access to Care

Nadereh Pourat

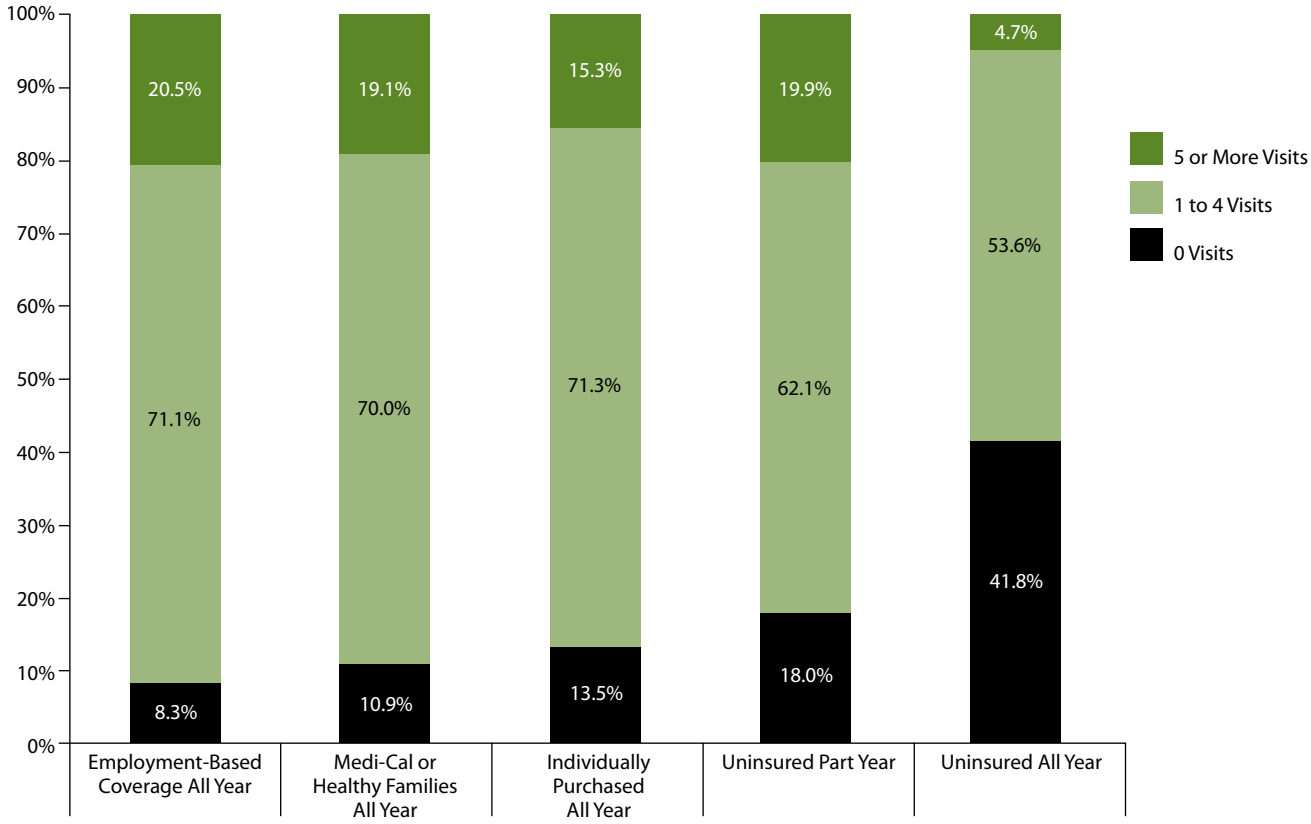
Health insurance plays a significant role in access to health care in California. Insurance leads to increased use of health services, aids in establishing a usual source of care, and reduces financial barriers to care. However, health insurance does not fully address the financial barriers to access, since many of the insured still report forgoing needed care or delaying it due to costs and the incurring of medical debt. Not all types of health insurance are equal in their impact on access. Significant variations in premiums, cost sharing, and benefits exist between employment-based and individually purchased insurance, further complicated by the high-deductible plans that exist in both markets. Medi-Cal and Healthy Families coverage have very low or no premiums and cost sharing, but funding shortfalls often threaten eligibility, benefits, and provider participation in these programs.

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

Health insurance is a significant determinant of access to care because it reduces financial barriers to use of essential health care services, including primary care and emergency services. Health insurance increases the likelihood of health care use in general. At least one doctor visit per year is a proxy for receipt of essential primary and preventive care, while five or more visits per year may indicate a greater level of need for care due to acute or chronic conditions. The national average number of doctor visits for the population as a whole is four.[23]

23 Schappert SM, Rechtsteiner EA. Ambulatory medical care utilization estimates for 2007. National Center for Health Statistics. Vital Health Stat 13(169). 2011.

Exhibit 50.
Number of Doctor Visits in the Last 12 Months by Insurance Type and Status Among Children, Ages 0-18, California, 2009

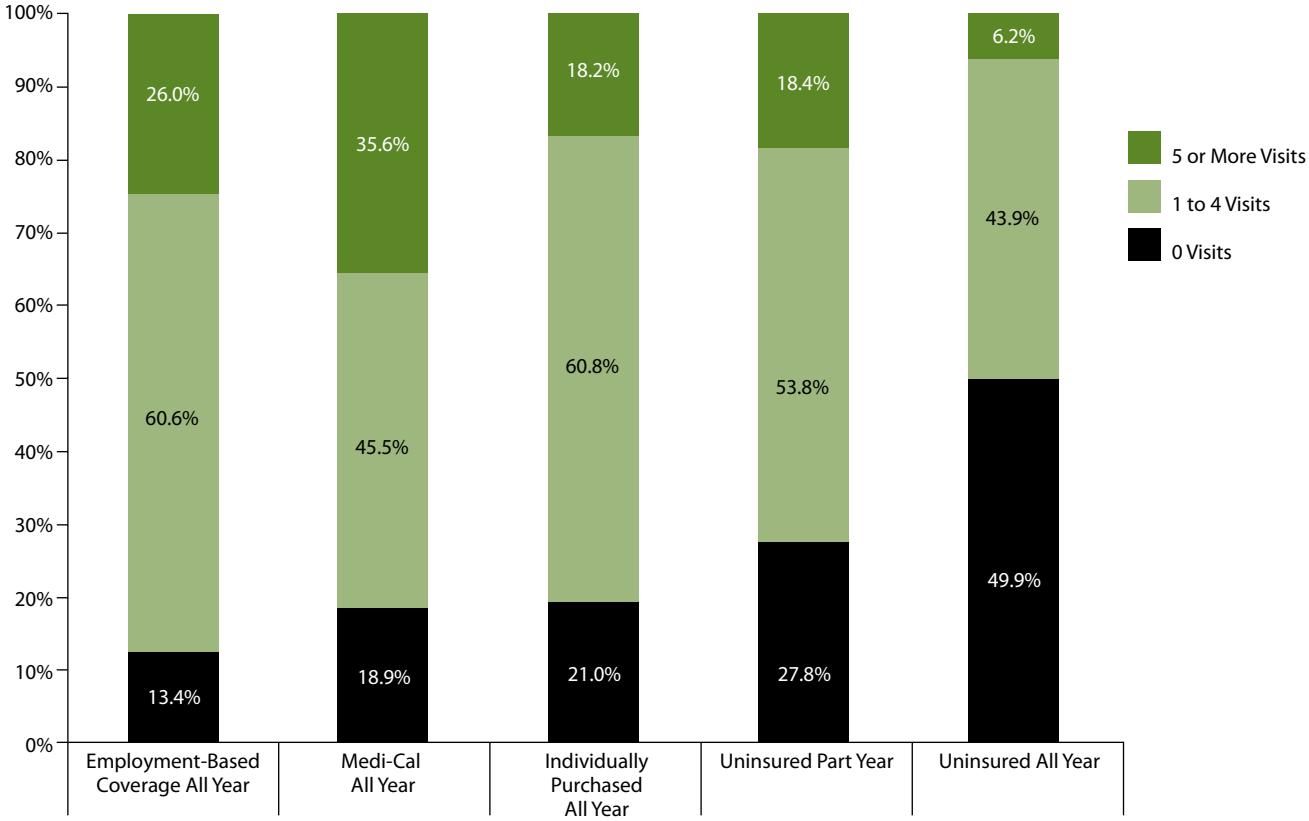


Note: Numbers may not add up to 100% because of rounding.

Source: 2009 California Health Interview Survey

More uninsured children (41.8%) had no doctor visits in the past year compared to insured children (Exhibit 50). The uninsured children (53.6%) also had the lowest rates of having had one to four visits compared to other groups. However, despite apparent differences, the rates of five or more visits in the past year did not differ significantly by insurance.

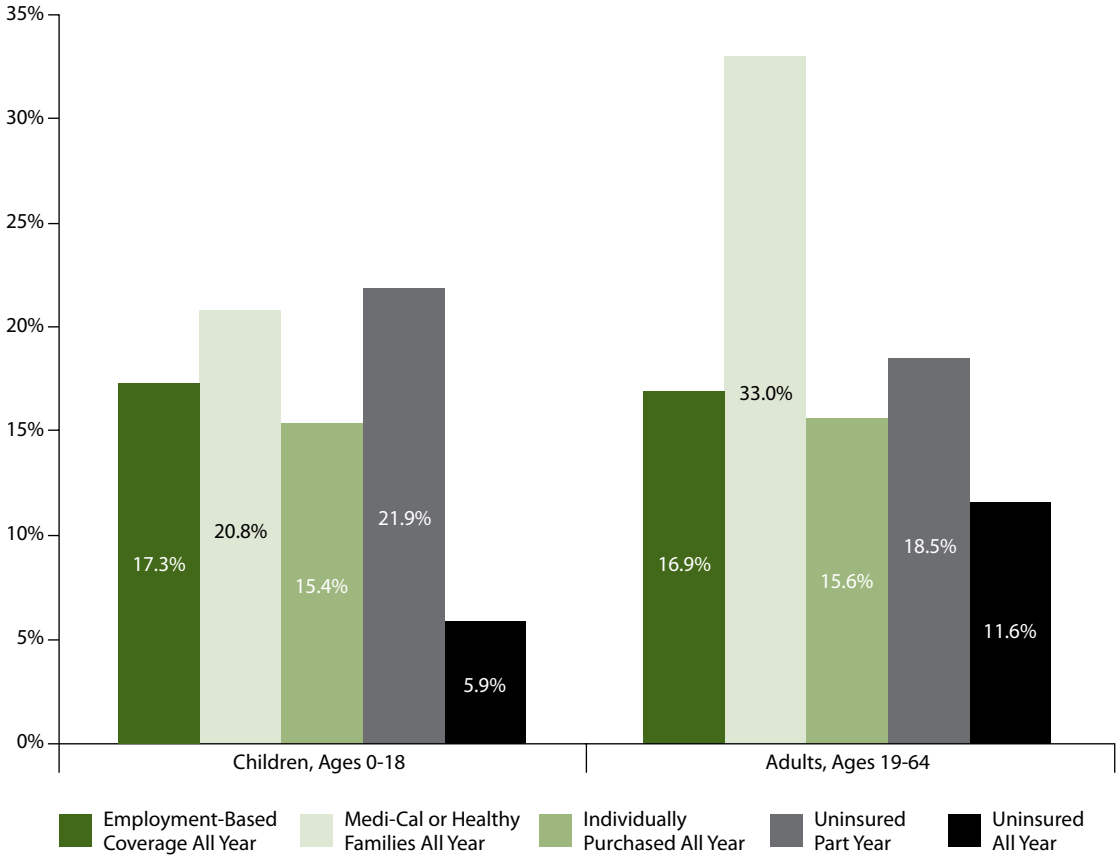
Exhibit 51.
Number of Doctor Visits by Type of Insurance Coverage Among Nonelderly Adults, Ages 19-64, California, 2009



Source: 2009 California Health Interview Survey

Those without any health insurance for the past year were significantly most likely to have had no doctor visits (49.9%), while those with employment-based coverage (13.4%) and Medi-Cal coverage (18.9%) were the least likely to have had no doctor visits (Exhibit 51). Among those who had visited a doctor in the past year, those with Medi-Cal or Healthy Families coverage were significantly most likely to have had five or more visits (35.6%), and those with employment-based (60.6%) and individually purchased (60.8%) health insurance were most likely to have had one to four visits.

Exhibit 52.
Emergency Room Visits in the Last 12 Months by Insurance Type and Status Among Nonelderly Persons, Ages 0-64, California, 2009



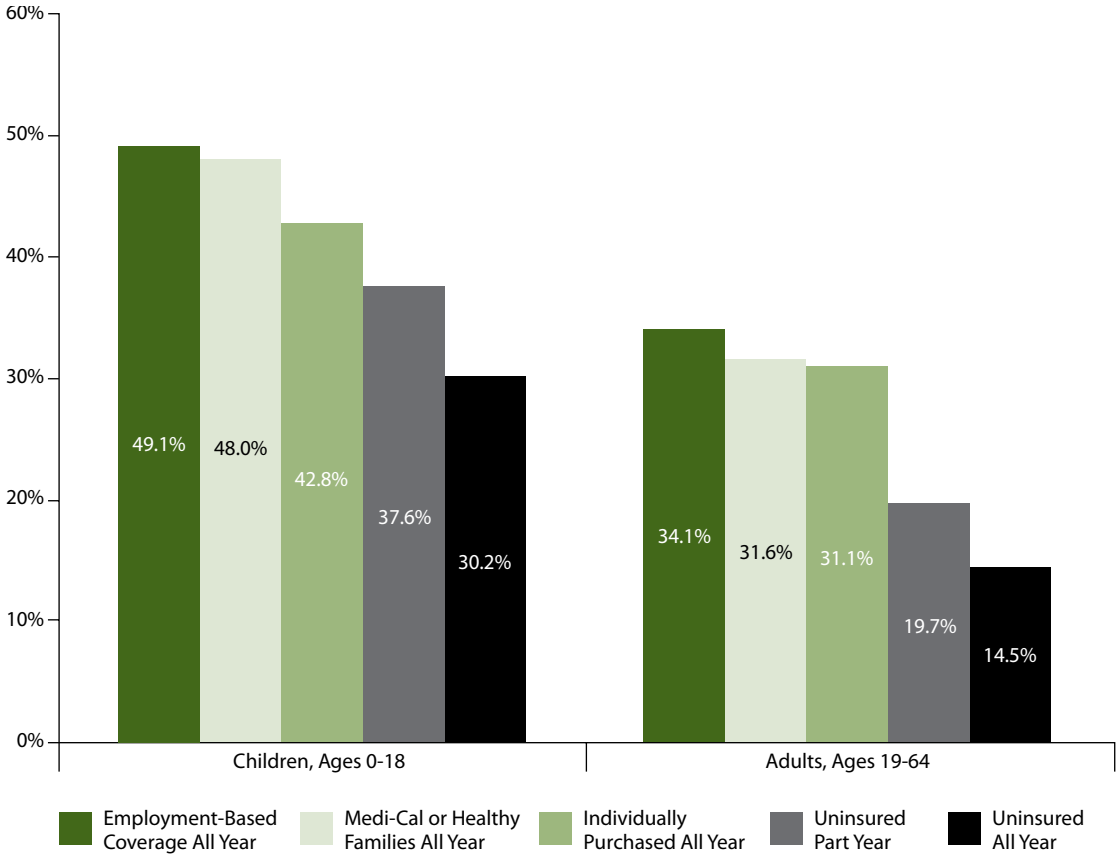
Note: Rate based on adults reporting at least one emergency room visit in the last 12 months for asthma, heart disease, diabetes, or any other reason.

Source: 2009 California Health Interview Survey

About 21% of adults and 20% of children had an emergency room visit in 2009.[24] High emergency room visit rates are associated with poor access to primary care. Contrary to common belief, the rates of emergency room (ER) visits were among the lowest for adults ages 19-64 who were uninsured all year (11.6; Exhibit 52). ER visit rates are similar among those with employment-based insurance (16.9%), individually purchased insurance (15.6%), and uninsured part year (18.5%). The rate is highest and statistically significant among those with Medi-Cal coverage (33%).

24 Schappert SM, Rechtsteiner EA. Ambulatory medical care utilization estimates for 2007. National Center for Health Statistics. Vital Health Stat 13(169). 2011.

Exhibit 53.
Flu Shot Rates by Type of Insurance Coverage Among Nonelderly Persons, Ages 0-64, California, 2009

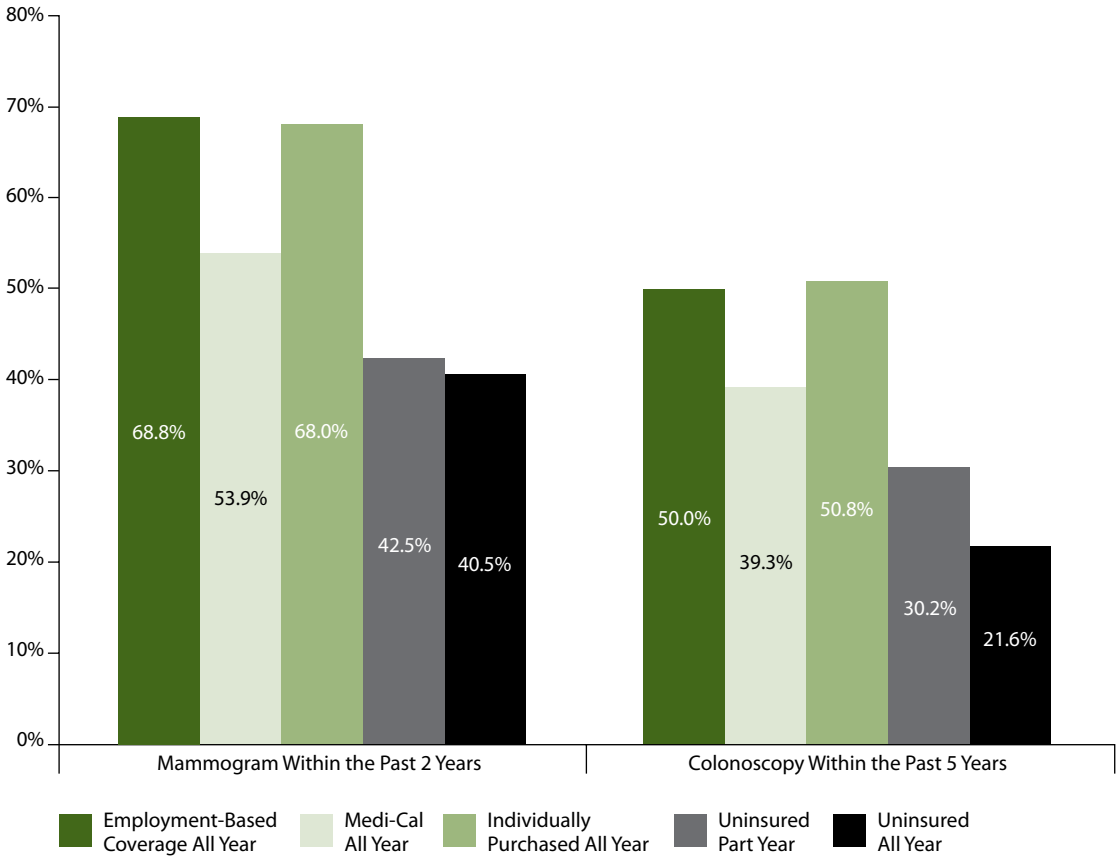


Note: Flu shot was given in the last 12 months. Adults with public coverage were Medi-Cal beneficiaries only and were not covered by Healthy Families.

Source: 2009 California Health Interview Survey

Health insurance is also associated with receipt of important preventive services. Among children, those uninsured all year had a significantly lower rate of receiving a flu shot (30.2%) than children with employment-based coverage (49.1%) and Medi-Cal beneficiaries (48%; Exhibit 53). Among adults, those uninsured all year had the lowest rate of receiving a flu shot (14.5%), although the difference was not statistically significant.

Exhibit 54.
Mammography and Colorectal Cancer Screening by Type of Insurance Coverage Among Age-Appropriate Nonelderly Adults, Ages 19-64, California, 2009

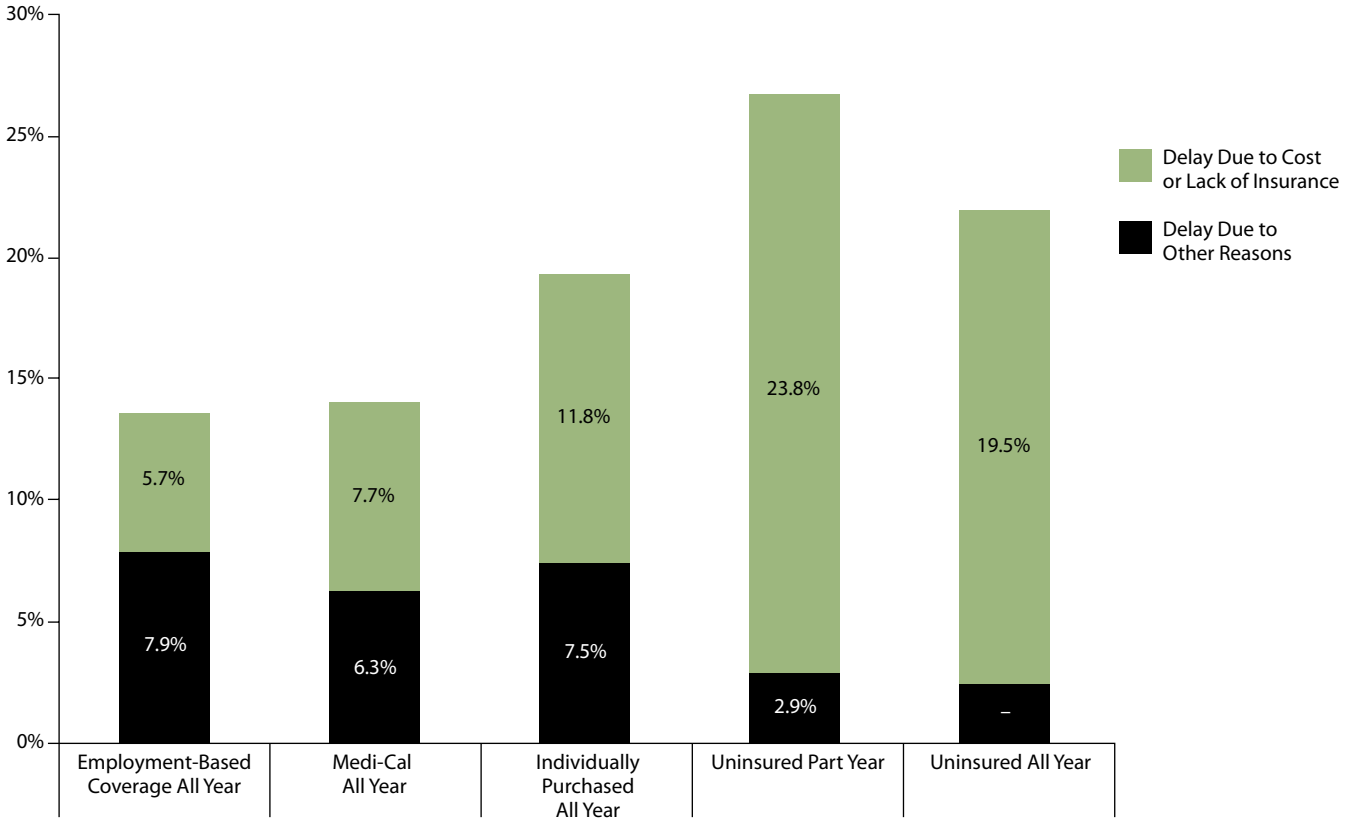


Note: Mammography rates apply to women ages 40-64, and colonoscopy screening rates apply to individuals ages 50-64.

Source: 2009 California Health Interview Survey

Guideline-concordant preventive services also varied by type of insurance coverage. The rate of mammogram screening among women ages 40-64 was significantly highest among those with employment-based coverage (68.8%) and individually purchased insurance (68.0%), but significantly lowest among those uninsured part year (42.5%) and those uninsured all year (40.5%; Exhibit 54). The rates of colorectal cancer screening (including annual fecal occult blood tests and any colonoscopies in the past five years) were highest among persons 50-64 years with employment-based coverage (50.0%) and individually purchased insurance (50.8%), and significantly the lowest among those uninsured all year (21.6%).

Exhibit 55.
Forgone or Delayed Needed Medical Care by Type of Insurance Coverage Among Nonelderly Adults, Ages 19-64, California, 2009



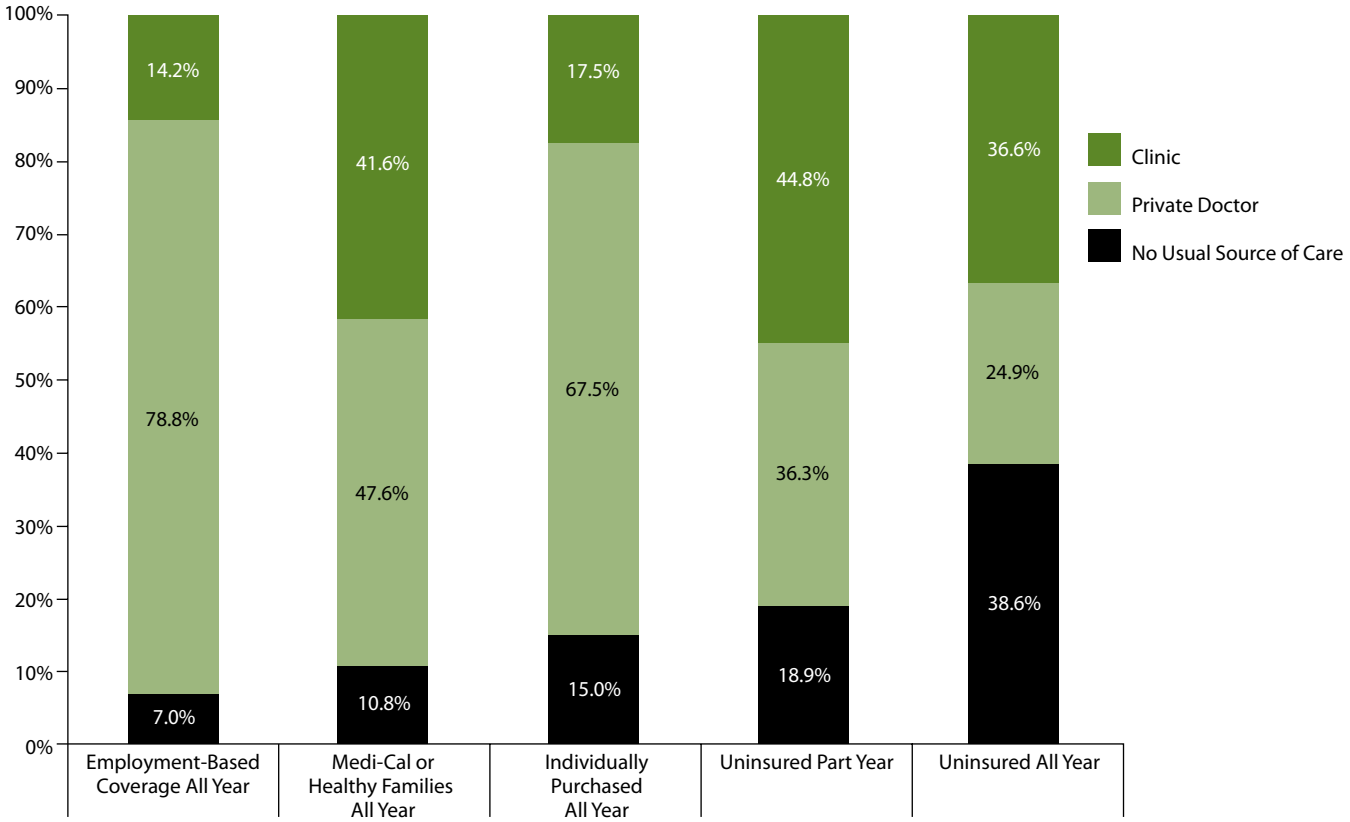
Note: Individuals with Employment-Based Coverage or Individually Purchased Coverage had coverage for the entire year.

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

Source: 2009 California Health Interview Survey

Health insurance makes health care more affordable and accessible. Reporting of having forgone or delayed needed medical care due to costs was highest among uninsured part year (23.8%) and uninsured all year (19.5%), and lowest among those covered by employment-based (5.7%) and individually purchased (11.8%) insurance (Exhibit 55). Reporting of forgone or delayed receipt of prescription medications due to costs did not differ significantly by insurance and is not reported here. Children who were uninsured all year (10.7%) had the highest rate of delays in medical care (data not shown).

Exhibit 56.
Usual Source of Care by Insurance Status and Type Among Children, Ages 0-18, California, 2009



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

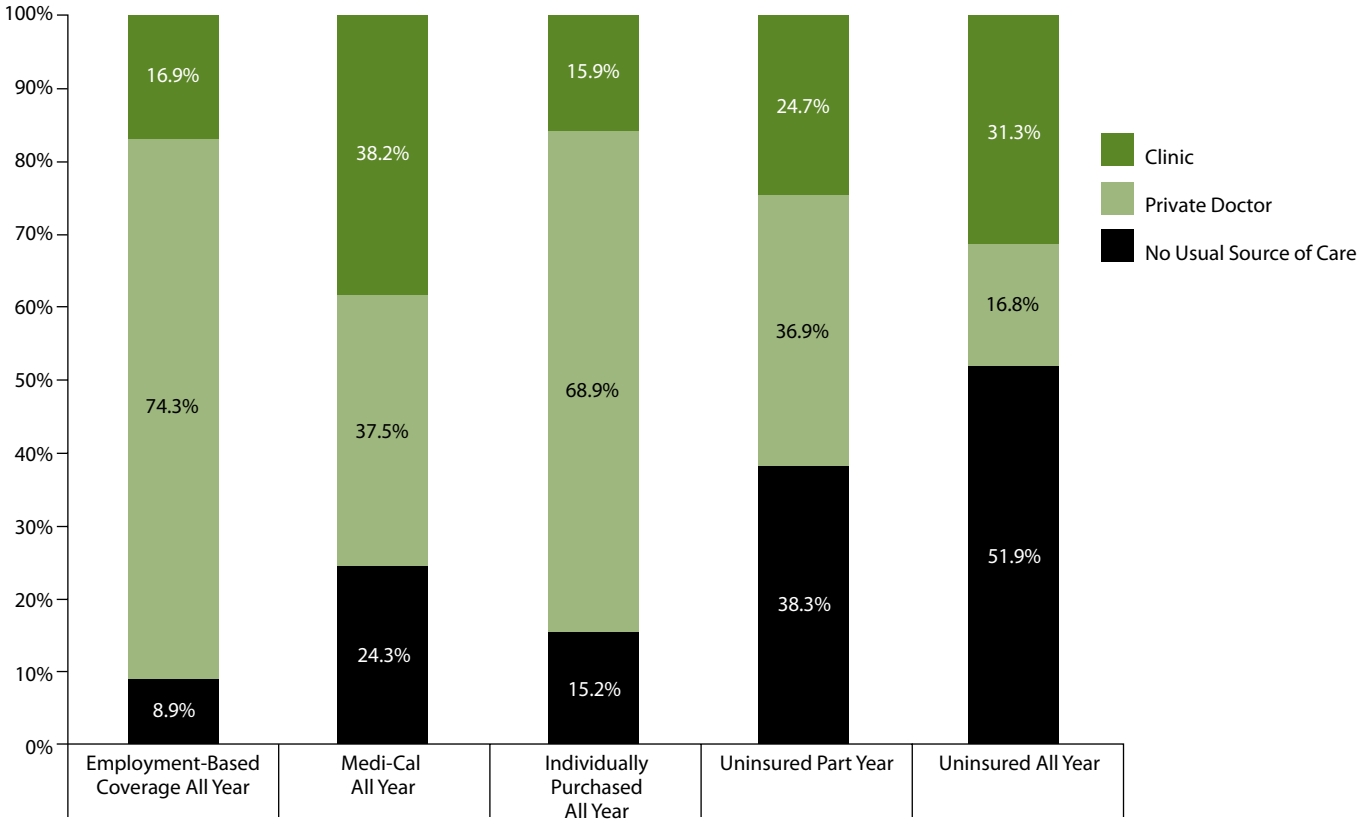
Source: 2009 California Health Interview Survey

The Interplay of Insurance and Usual Source of Care in Access

Insurance allows individuals to establish relationships with primary care providers and improves their continuity of care. The type of insurance is associated with having a usual source of care and the setting in which the usual provider operates. Clinic-based care is most likely to identify safety net providers.

More than one-third (38.6%) of children who were uninsured for all of last year reported not having a usual source of care, but only 7.0% of children with employment-based coverage did so (Exhibit 56). In contrast, 24.9% of uninsured children had a private doctor as the usual source of care, compared to 78.8% of children with employment-based insurance. A clinic-based usual source of care was most common among Medi-Cal beneficiaries (41.6%), uninsured part year (44.8%), and uninsured children (36.6%).

Exhibit 57.
Usual Source of Care by Type of Insurance Coverage Among Nonelderly Adults, Ages 19-64, California, 2009

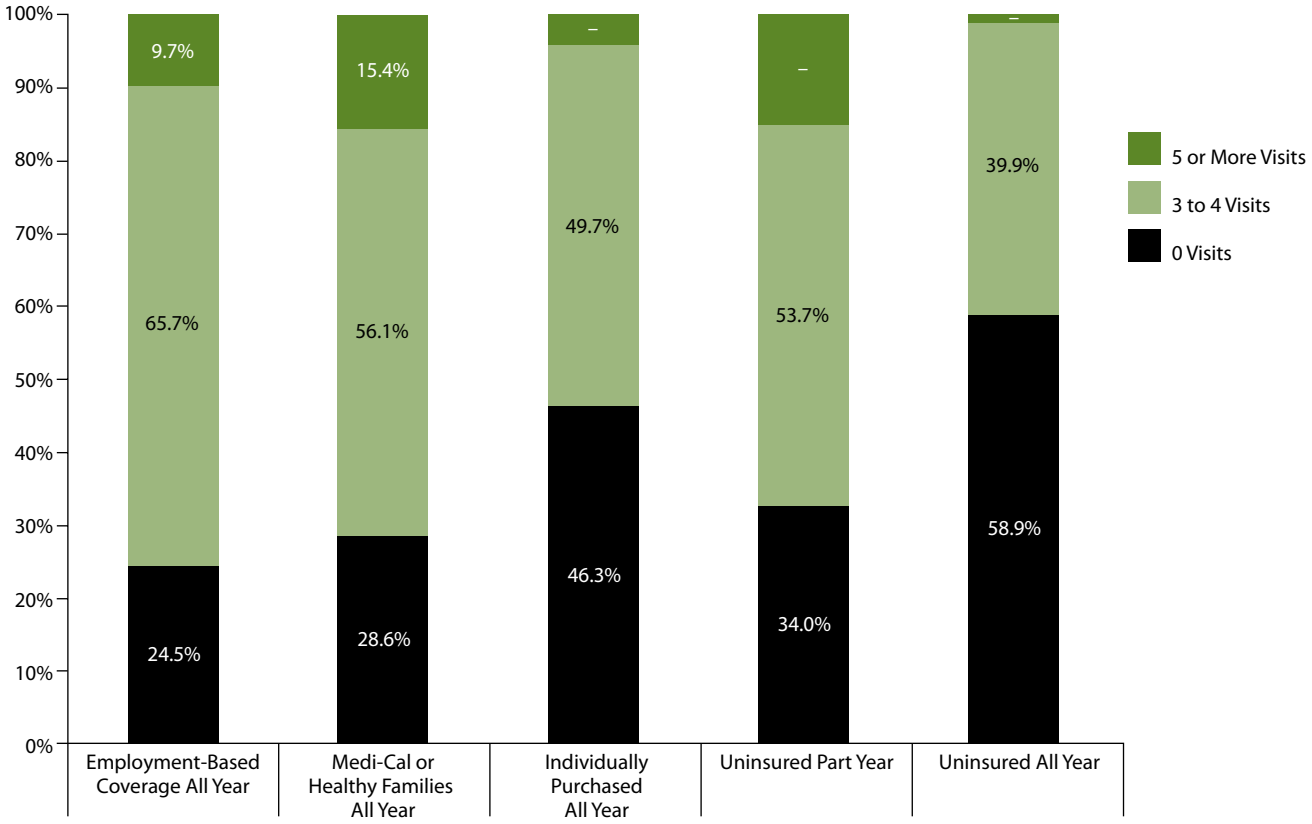


Note: Numbers may not add up to 100% because of rounding.

Source: 2009 California Health Interview Survey

More than half (51.9%) of nonelderly adults who were uninsured for all of the past year reported not having a usual source of care, while only 8.9% of those with employment-based coverage did so (Exhibit 57). Furthermore, individuals who were uninsured for all of the past year reported the lowest rate (16.8%) of having an office-based private doctor as their usual source of care, but most (74.3%) of those with employment-based insurance had private doctors. Clinic-based usual source of care was most common among Medi-Cal beneficiaries (38.2%).

Exhibit 58.
Number of Doctor Visits by Insurance Type and Status Among Children with No Usual Source of Care, Ages 0-18, California, 2009



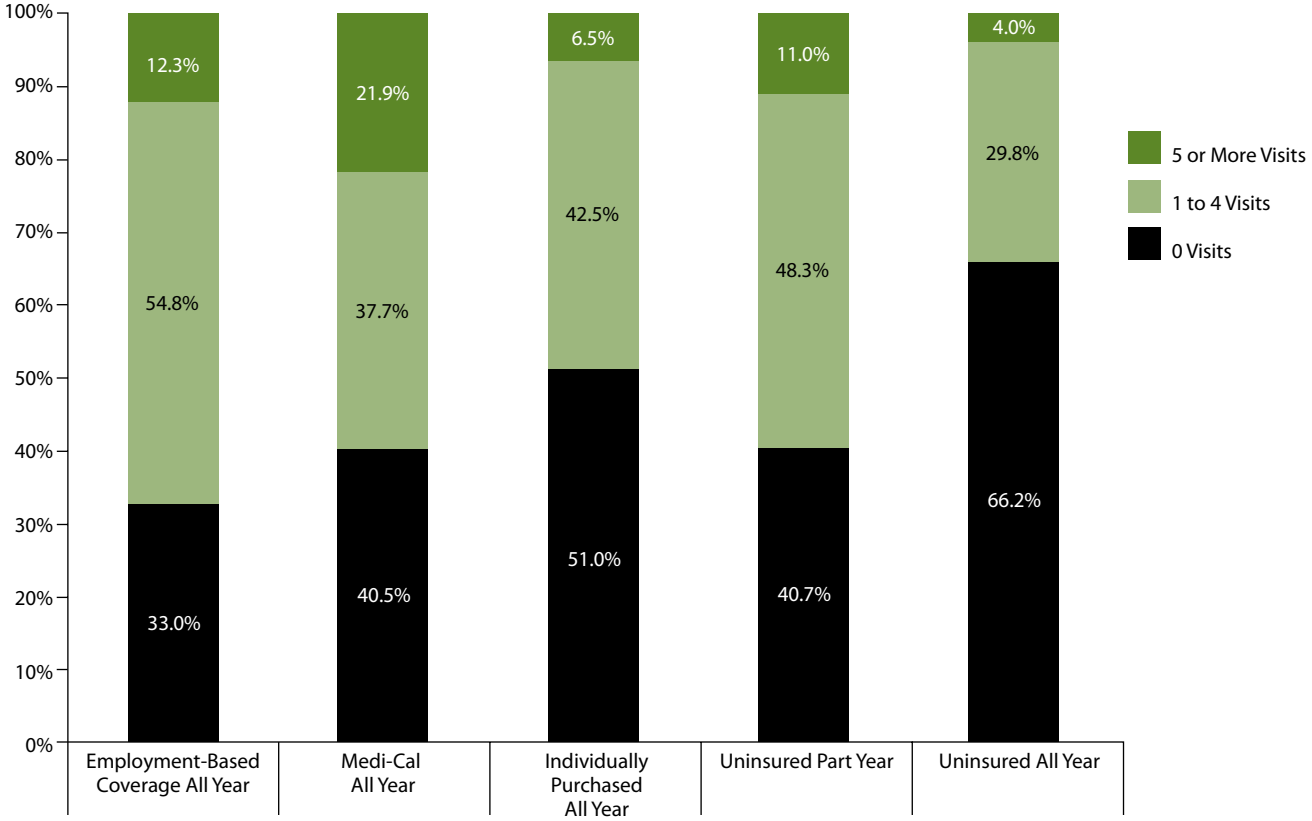
Note: Numbers may not add to 100% because of rounding.
– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2009 California Health Interview Survey

Lack of a usual source of care modifies the relationship of insurance coverage and access to care: those without a usual source of care have reduced access to primary care even when insured. Among children who lacked a usual source of care, 58.9% of the uninsured all year had no doctor visits in the past year, which is significantly higher than the rate for children with employment-based insurance (24.5%; Exhibit 58). Conversely, children with employment-based insurance who had one to four doctor visits within the past year had significantly higher rates (65.7%) than children who were uninsured all of the past year.

Exhibit 59.

Number of Doctor Visits by Insurance Type and Status Among Nonelderly Adults with No Usual Source of Care, Ages 19-64, California, 2009



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

Source: 2009 California Health Interview Survey

Among adults without a usual source of care, more than half (51.0%) of those with individually purchased insurance, 40.5% of Medi-Cal enrollees, and 33.0% of those with employment-based insurance did not have a doctor visit in the past year (Exhibit 59). Nearly two-thirds (66.2%) of those uninsured all year and without a usual source of care also did not have any doctor visits in the past year.

Exhibit 60.
Preventive Care by Type of Insurance Coverage Among Age-Appropriate Nonelderly Adults Without Usual Source of Care, Ages 19-64, California, 2009

	Mammogram within the Past Two Years	Colonoscopy within the Past Five Years	Flu Shots
Employment-Based Coverage All Year	54.8%	28.9%	19.1%
Medi-Cal All Year	42.4%	15.9%	20.6%
Private Coverage All Year	41.1%	25.1%	18.5%
Uninsured Part Year	34.6%	25.0%	12.5%
Uninsured All Year	27.1%	11.4%	9.8%

Note: Mammography rates apply to women ages 40-64, and colonoscopy rates apply to individuals ages 50-64.

"Ever Had a Colonoscopy" includes a colonoscopy, sigmoidoscopy, or a stool test in the past five years.

Source: 2009 California Health Interview Survey

Lack of a usual source of care also has a negative impact on preventive care by type of insurance. Among those without a usual source of care, the rates of mammograms are lowest for uninsured all year (27.1%) and uninsured part year (34.6%; Exhibit 60), but the difference was not statistically significant.

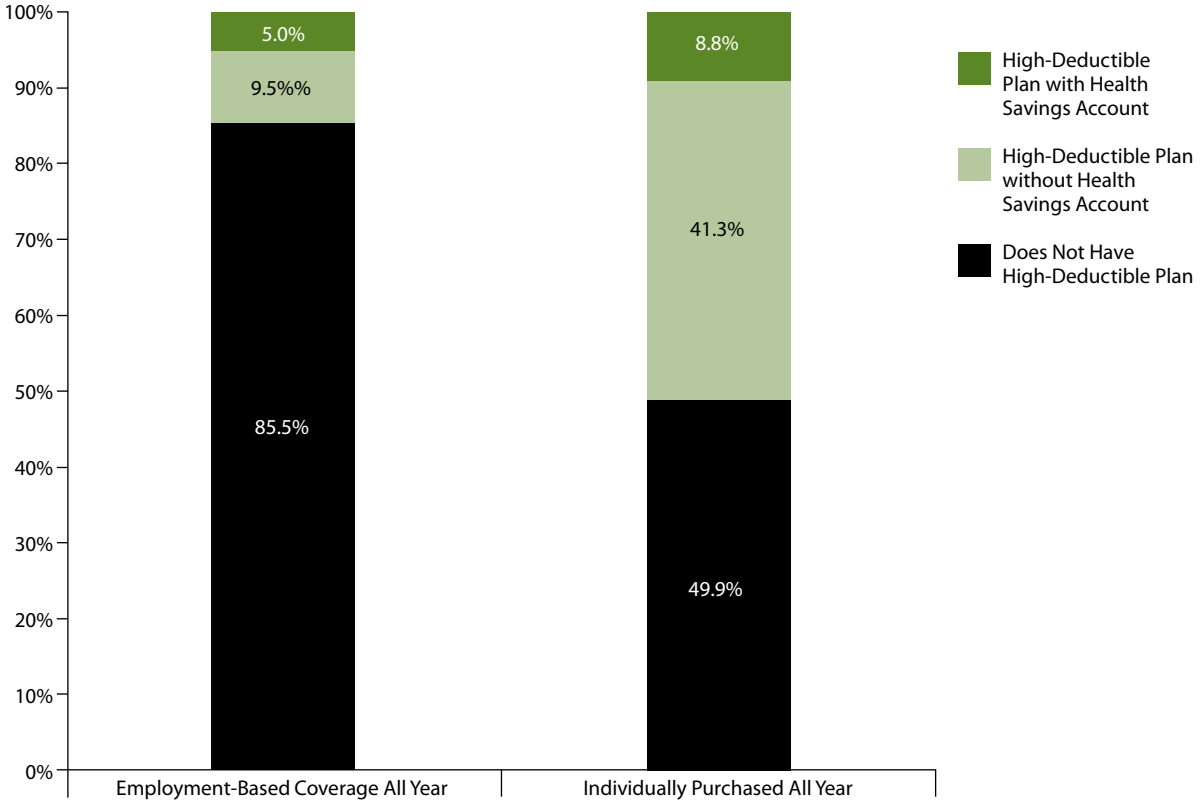
The rates are higher for the insured. The same pattern was observed for flu shots and colonoscopies, with those who were uninsured all year having significantly lower rates of having had a colonoscopy (11.4%) than all other groups.

A Closer Examination of Access to Care Under High-Deductible Plans

At their inception, high-deductible plans were seen as a cost-saving mechanism for the privately insured: high-deductible plans were supposed to make the insured more aware of the costs of care. This was to be achieved by including deductibles of over $1,000 for an individual and over $2,000 for a family to discourage unnecessary use of health care. Establishment of a voluntary savings account was allowed in 2003 to be used for services that are subject to the deductible to insure access to necessary care.

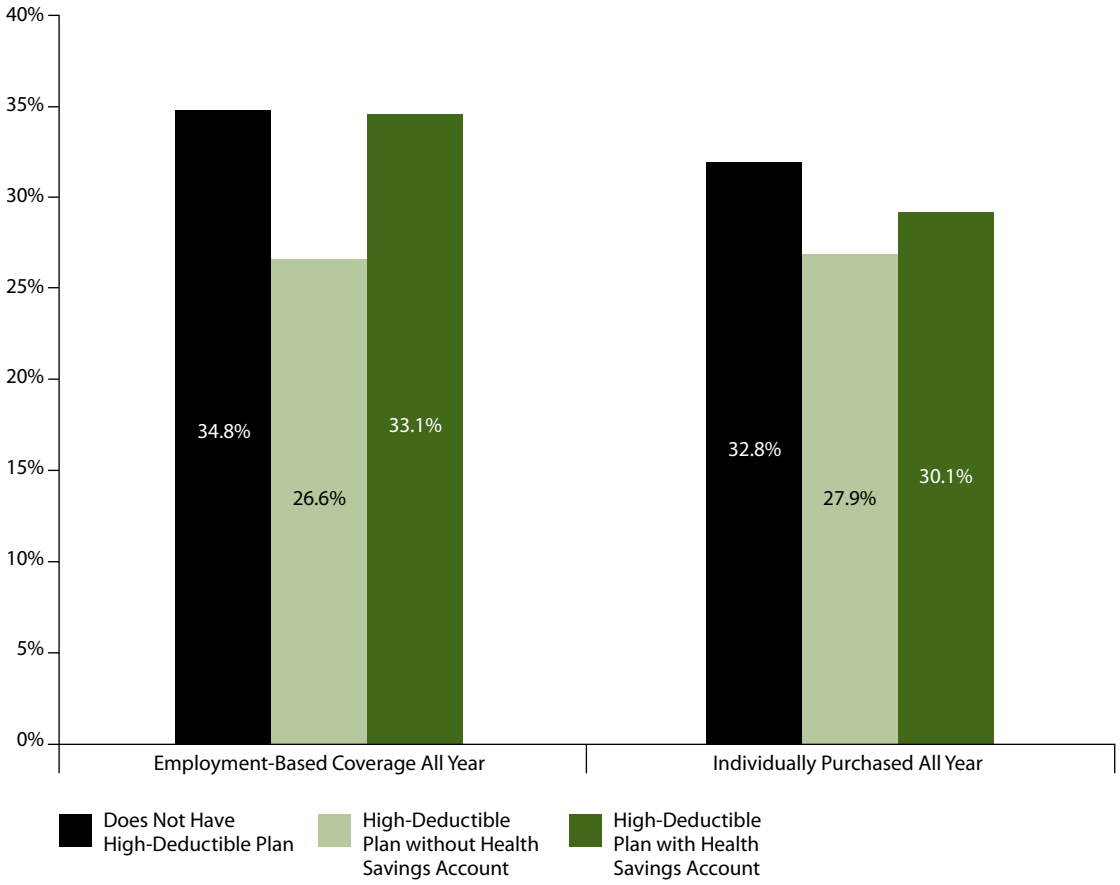
Fewer individuals are covered by high-deductible plans among those with employment-based coverage than among those with individually purchased coverage (Exhibit 61). Of those with employment-based coverage, 9.5% have high-deductible plans without savings accounts. But among those with individually purchased insurance, 41.3% do not have accompanying savings accounts.

Exhibit 61.
High-Deductible Insurance Plans Among Nonelderly Persons with Employment-Based Coverage or Individually Purchased Insurance All Year, Ages 0-64, California, 2009



Source: 2009 California Health Interview Survey

Exhibit 62.
Flu Shot Rates by High-Deductible Insurance Coverage Among Nonelderly Persons, Ages 0-64, California, 2009



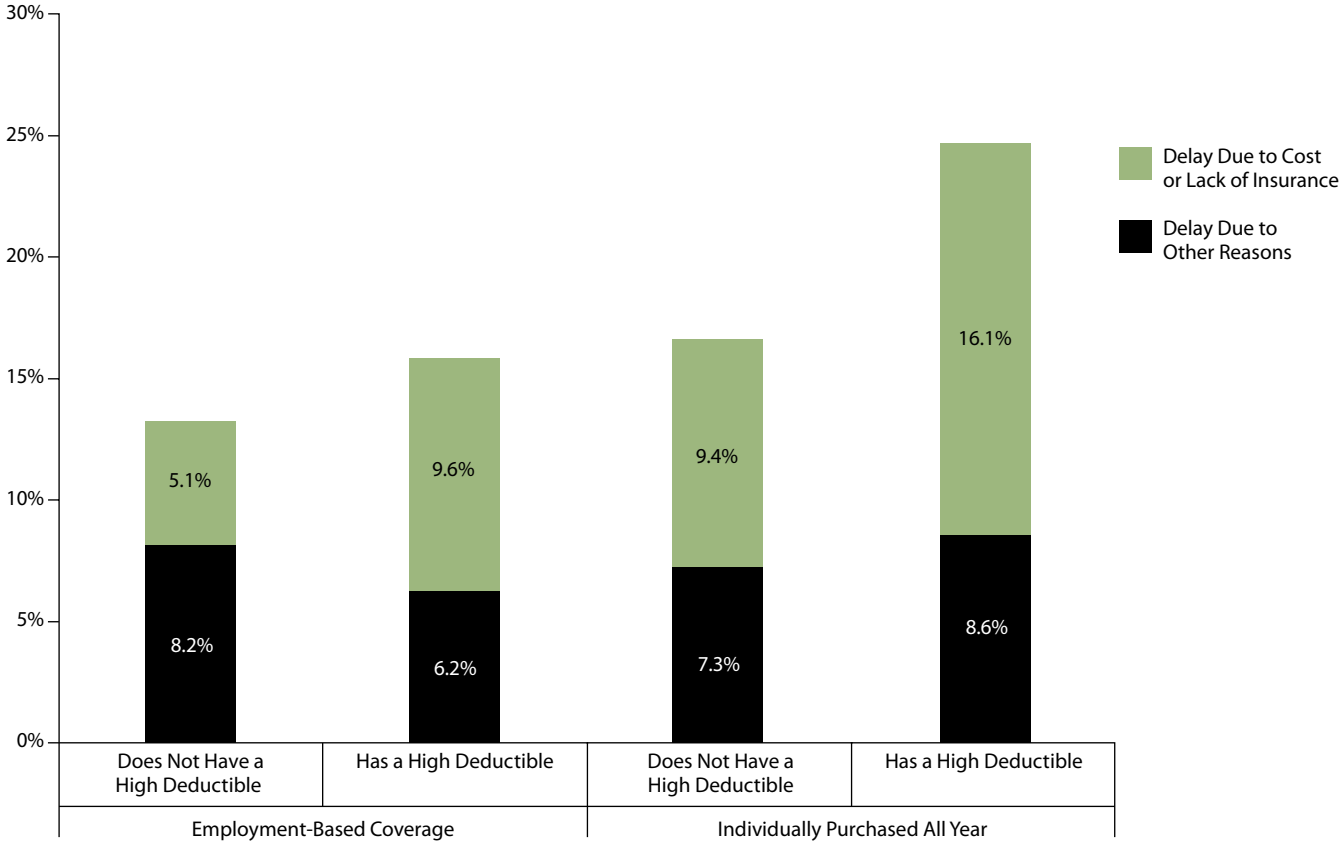
Note: Flu shot was given in the last 12 months.

Source: 2009 California Health Interview Survey

The impact of high-deductible plans on access is yet to be fully understood. Preventive services are not subject to the deductible in these plans to ensure receipt of such care. However, data show that the rates of receipt of flu shots are significantly lower for those with employment-based high-deductible plans but without savings accounts (26.6%) than for those without high-deductible plans (34.8%; Exhibit 62). However, the rates of flu shots for those with individually purchased high-deductible plans, with and without savings accounts, are statistically similar to those who do not have high-deductible plans.

Exhibit 63.

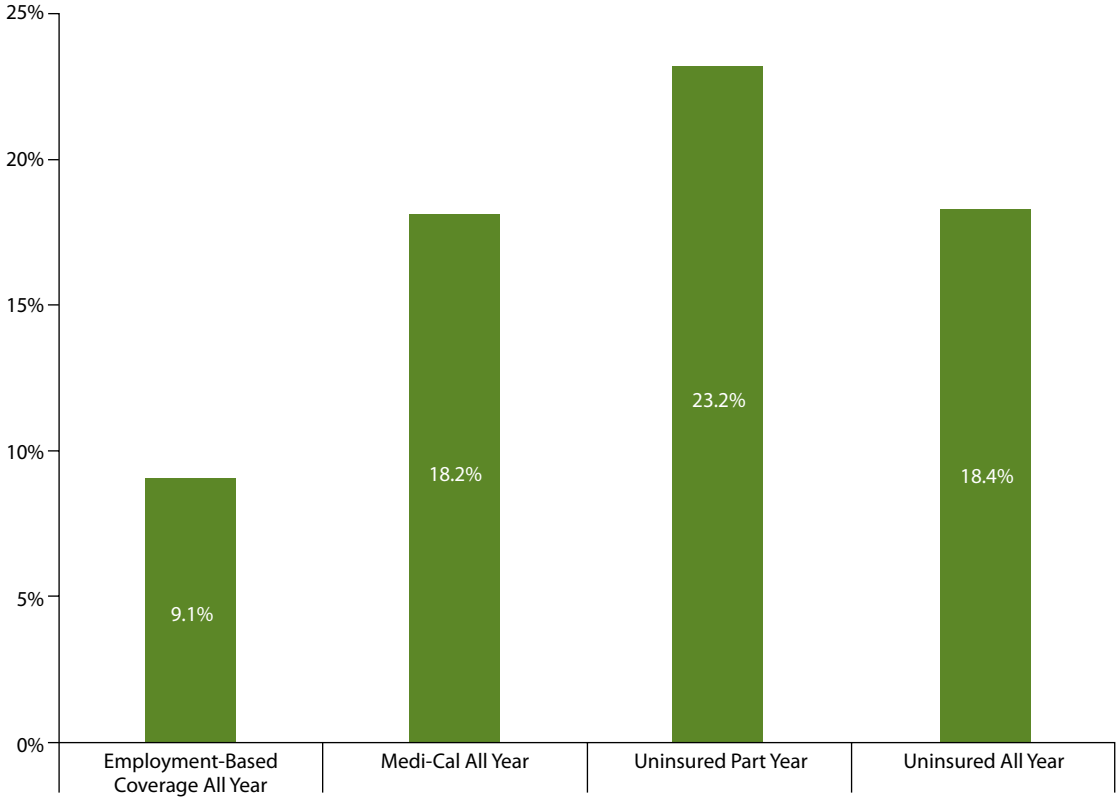
Forgone or Delayed Needed Medical Care by High-Deductible Insurance Coverage Among Nonelderly Adults, Ages 19-64, California, 2009



Note: Rates for Uninsured All Year, Uninsured Part Year, and Medi-Cal All Year were not included due to unstable estimates to coefficient of variation greater than 30%.

Source: 2009 California Health Interview Survey.

Exhibit 64.
Any Medical Debt by Insurance Status Among Nonelderly Adults, Ages 19-64, California, 2009



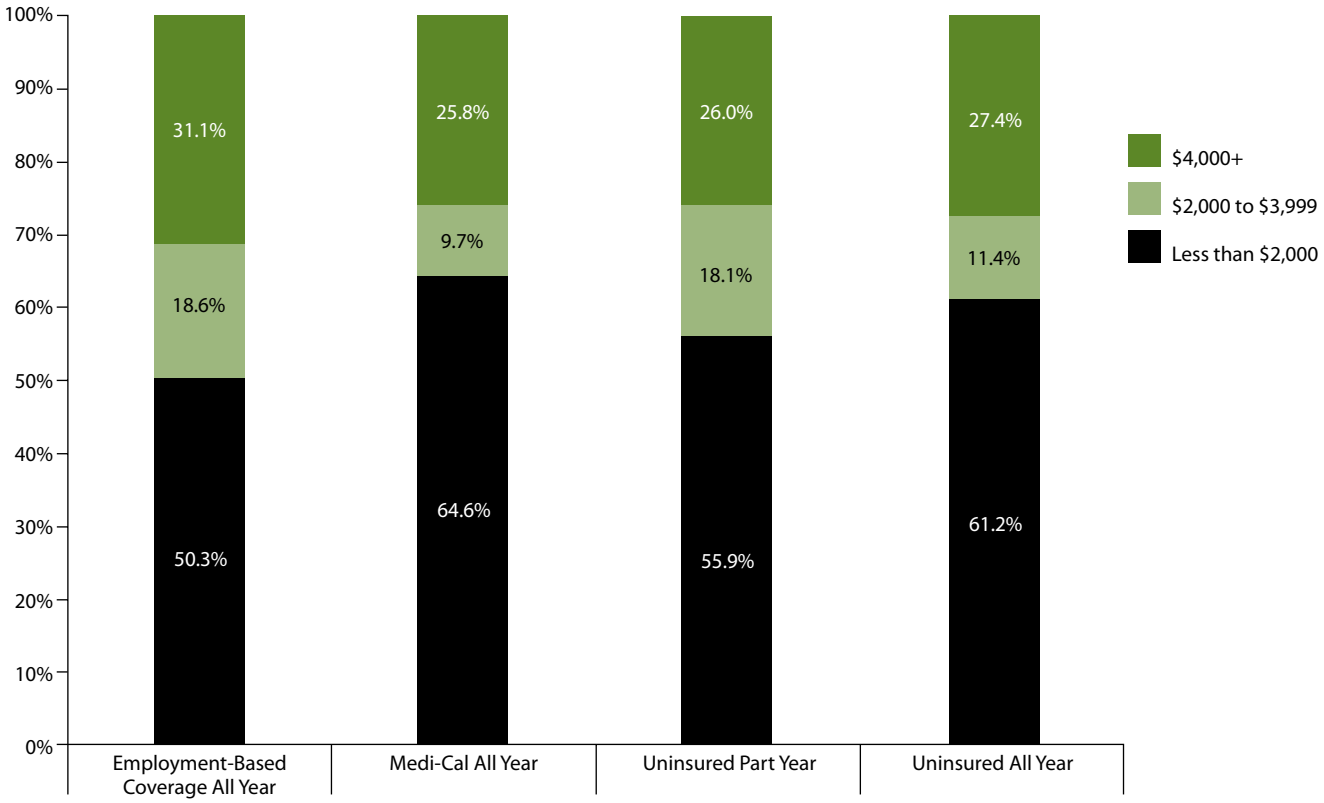
Note: Individually Purchased All Year was not included due to unstable estimates to coefficient of variation greater than 30%.

Source: 2009 California Health Interview Survey.

Medical Debt and Its Negative Association with Access

In 2009, 2.6 million nonelderly Californians had medical debt that they were paying off over time. Even with insurance coverage, paying medical bills may be a problem, since all medical services are not always covered and/or the individual's share of the fees per service may be high. Those with chronic conditions or significant acute episodes may incur substantial debts as they use health care services. The presence of any medical debt is significantly the highest among those uninsured all year (18.4%) and uninsured part year (23.2%) compared to those with employment-based coverage (9.1%; Exhibit 64).

Exhibit 65.
Amount of Medical Debt by Insurance Status Among Nonelderly Adults, Ages 19-64, California, 2009



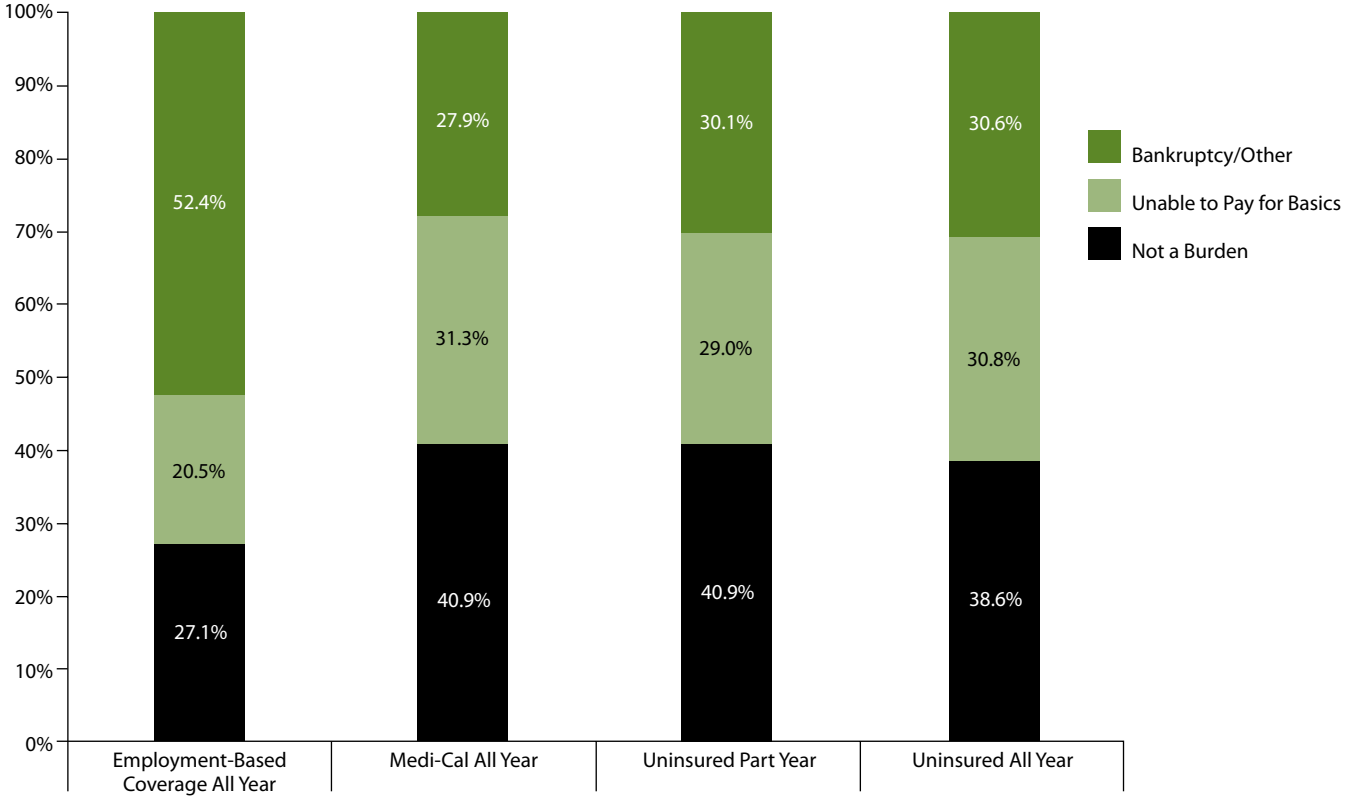
Note: Individually Purchased All Year was not included due to unstable estimates to coefficient of variation greater than 30%.

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

Source: 2009 California Health Interview Survey

Among those with any medical debt, half or more had a debt of less than $2,000, regardless of type of insurance (Exhibit 65). Debt in the amount of $2,000 to $3,999 was incurred by fewer Medi-Cal beneficiaries (9.7%) compared with those who had employment-based coverage (18.6%; statistically significant compared to those with Medi-Cal coverage) and the uninsured all year (11.4%).

Exhibit 66.
Financial Consequences of Medical Debt Among Nonelderly Adults Covered by Insurance Type and Status, Ages 19-64, California, 2009

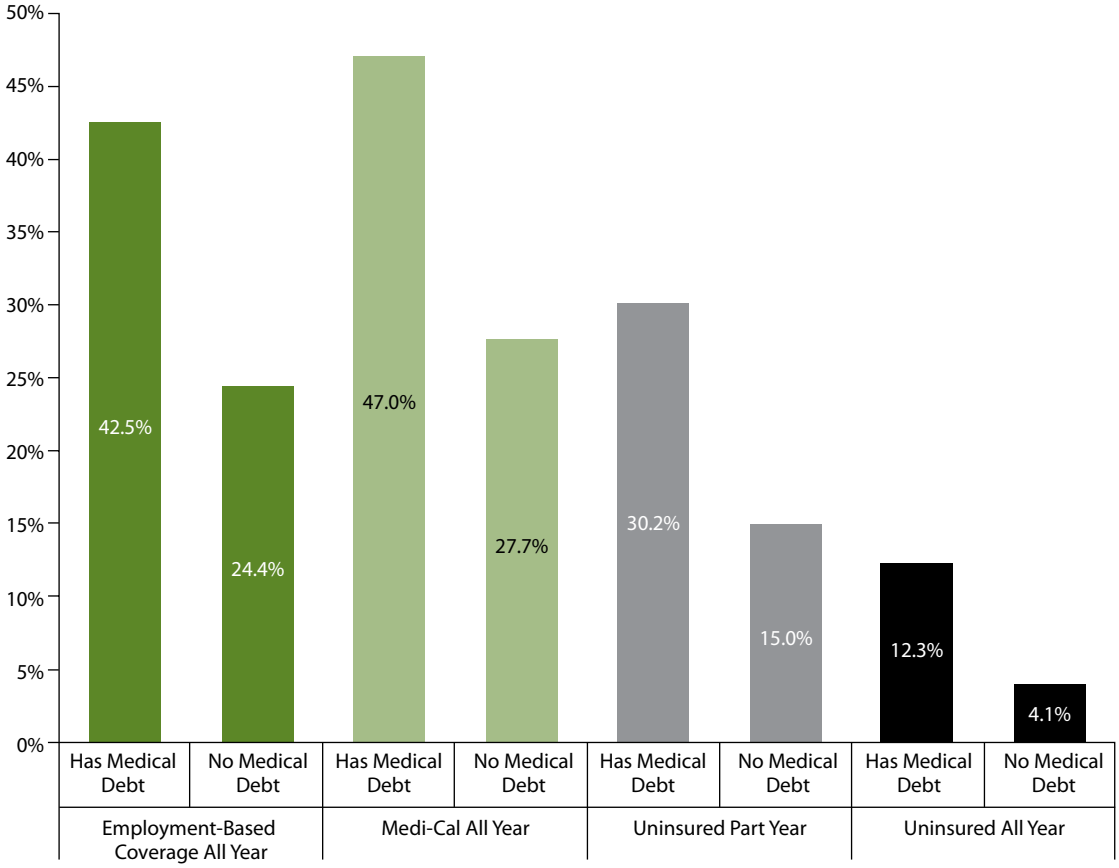


Note: Individually Purchased All Year was not included due to unstable estimates to coefficient of variation greater than 30%. Numbers may not add up 100% because of rounding.

Source: 2009 California Health Interview Survey

Among those with any medical debt, 20.5% of those with employment-based coverage and 31.3% of Medi-Cal beneficiaries reported that they were unable to pay for basics such as food, heat, and rent due to medical debt (Exhibit 66).

Exhibit 67.
Any Medical Debt with Five or More Doctor Visits in the Last 12 Months by Insurance Status Among Nonelderly Adults, Ages 19-64, California, 2009

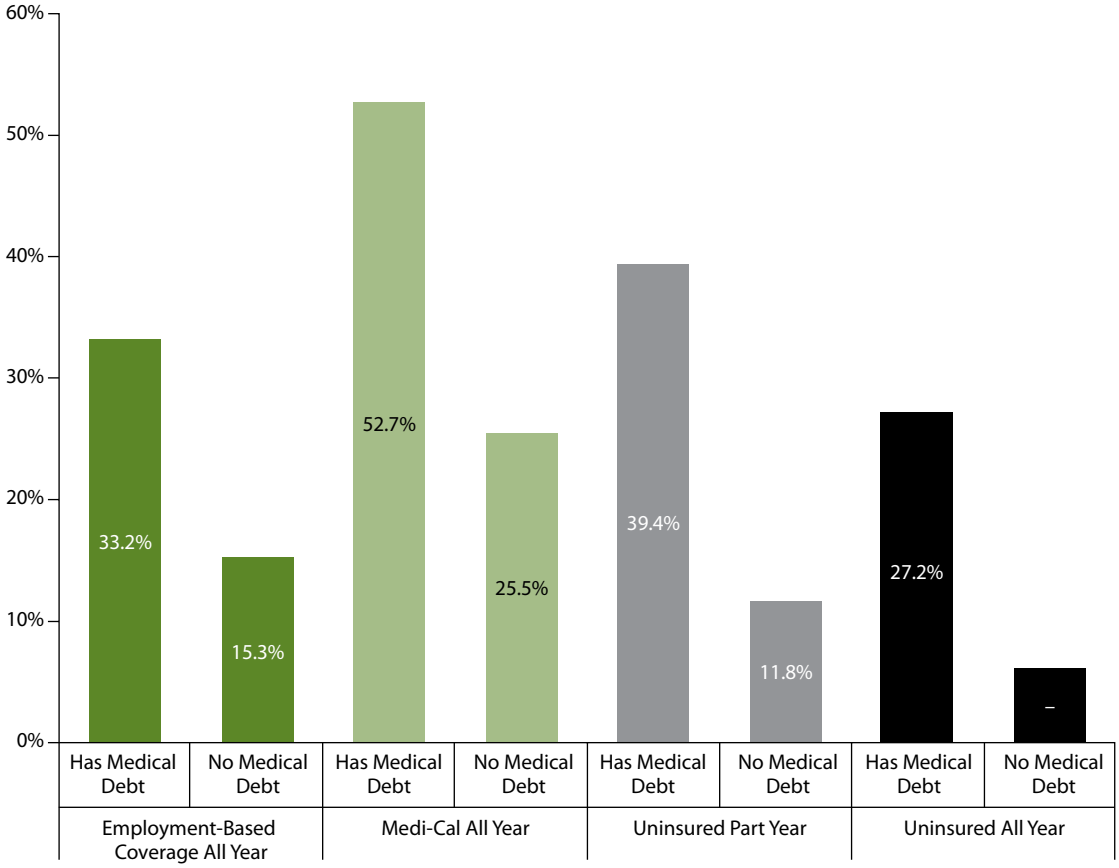


Note: Individually Purchased All Year was not included due to unstable estimates to coefficient of variation greater than 30%.

Source: 2009 California Health Interview Survey

Individuals who use more health care are more likely to have any medical debt. For each category of insurance, those with any medical debt were more likely to have five or more doctor visits than those without any medical debt. For example, among those with employment-based coverage, 42.5% of those with any medical debt had visited the doctor five or more times, which is significantly different when compared to 24.4% of those without any medical debt (Exhibit 67). The percentage of having medical debt with five or more visits was the highest among those with employment-based coverage (42.5%) and Medi-Cal beneficiaries (47%), and the lowest among uninsured all year (12.3%).

Exhibit 68.
Any Medical Debt of Nonelderly Adults with At Least One Emergency Room Visit in the Last 12 Months by Insurance Status, Ages 19-64, California, 2009



Note: Individually Purchased All Year was not included due to unstable estimates to coefficient of variation greater than 30%.

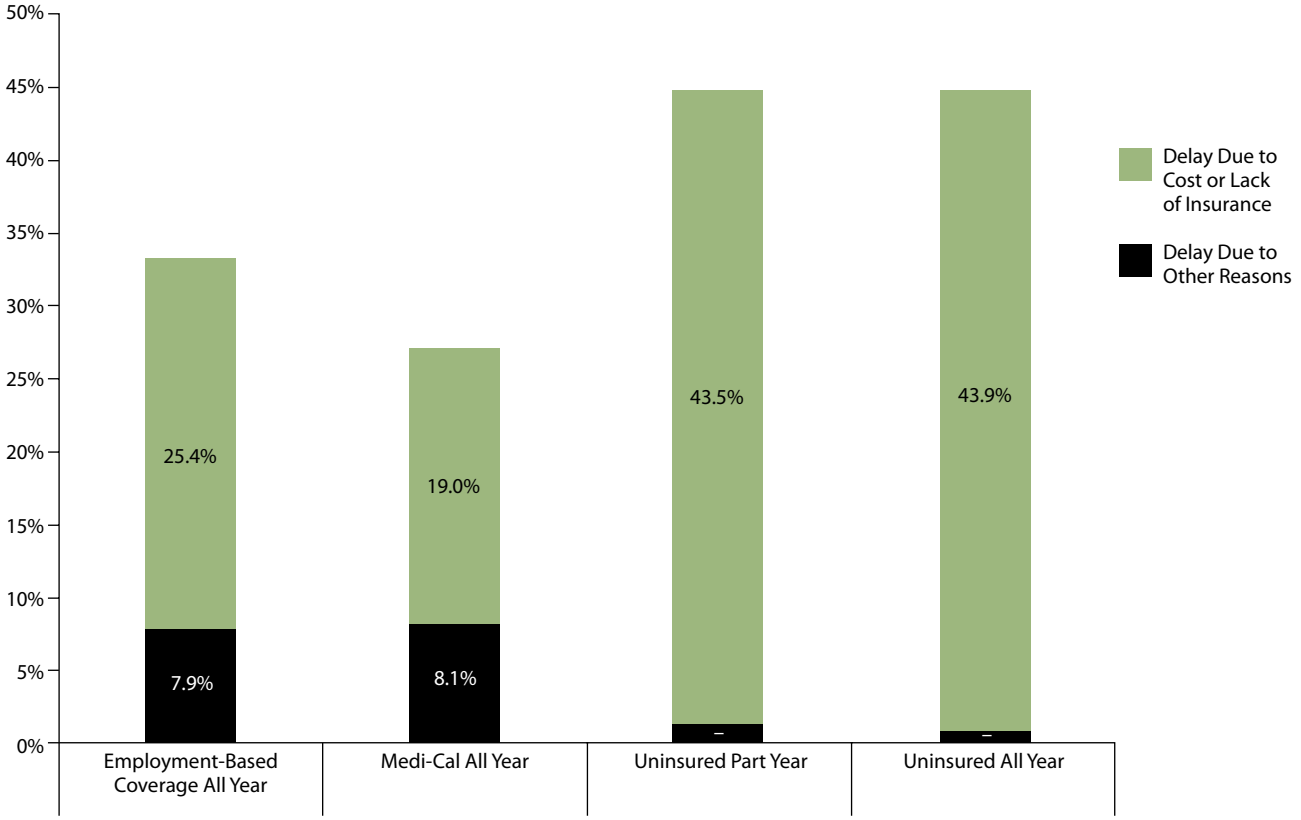
– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2009 California Health Interview Survey.

Similar to doctor visits, individuals with ER visits in the past year were also more likely to have any medical debt. Among individuals with employment-based coverage or public coverage and those uninsured part year, a higher percentage of those with any medical debt had had an ER visit than of those without any such debt (Exhibit 68).

Furthermore, the presence of any medical debt with ER visits was significantly higher among those with public coverage (52.7%) than among those uninsured all year (27.2%), uninsured part year (39.4%), or with employment-based coverage (33.2%).

Exhibit 69.
Forgone or Delayed Needed Medical Care by Insurance Status Among Nonelderly Adults with Any Medical Debt, Ages 19-64, California, 2009



Note: Individually Purchased All Year was not included due to unstable estimates to coefficient of variation greater than 30%.

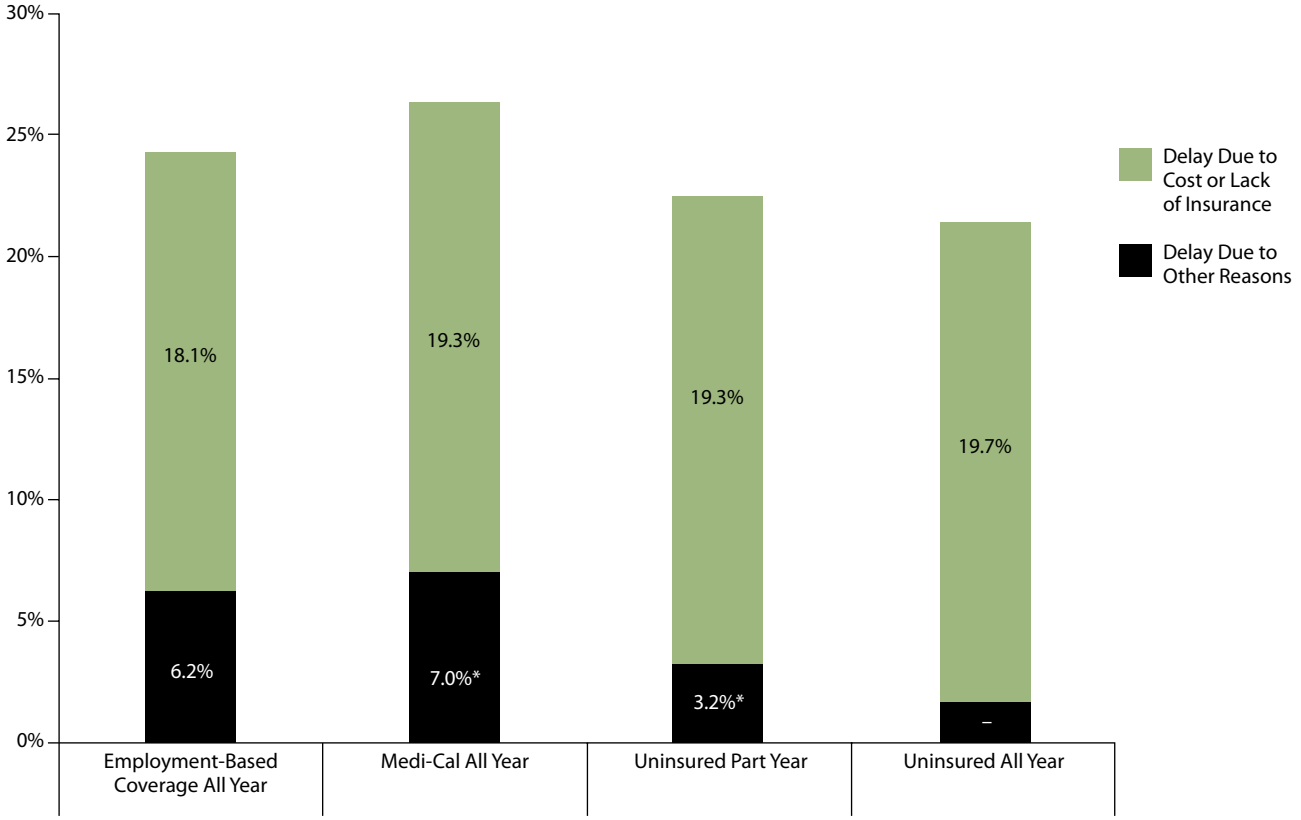
– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2009 California Health Interview Survey

Having medical debt is also associated with lower rates of mammograms in the past two years (54.8%) and colonoscopy screening in the past five years (31.8%) compared to those without medical debt (61.9% and 38.5%, respectively; data not shown). These rates do not vary statistically by type of coverage. However, having medical debt is not associated with lower rates of flu shots for either adults or children.

Medical debt is further associated with forgoing or delaying needed medical care and prescription coverage. Those with any medical debt frequently reported forgoing or delaying needed medical care due more to cost than to other reasons (Exhibit 69). However, significantly fewer individuals with any medical debt and with employment-based coverage (25.4%) and public coverage (19.0%) reported forgoing or delaying medical care compared to those who were uninsured all year (43.9%) or uninsured part year (43.5%).

Exhibit 70.
Forgone or Delayed Needed Prescription Medications by Insurance Status Among Adults with Any Medical Debt, Ages 19-64, California, 2009



Note: Individually Purchased All Year was not included due to unstable estimates to coefficient of variation greater than 30%.

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

Source: 2009 California Health Interview Survey

Similarly, those with any medical debt were more likely to report forgoing or delaying needed prescription medications due to cost, regardless of insurance (Exhibit 70).

Conclusion

Health insurance plays a significant role in access to health care in the United States. The findings in this chapter illustrate the positive role of insurance in increased access to primary, preventive, and emergency services. These results highlight the importance of having a usual source of care not only among the uninsured but also among the insured. Variations in health care use, as well as reports of forgoing needed care or delaying it due to costs and presence of medical debt by type of insurance, are likely due to differences in deductible levels and cost sharing and benefits. These variations indicate that health insurance does not fully address the financial barriers to access. Among the publicly insured, the presence of access barriers and financial debt illustrate the challenges the Medi-Cal and Healthy Families programs have to overcome despite the perennial funding shortfalls that threaten eligibility, benefits, and provider participation in these programs.

Various policy options are available to address access barriers identified here. However, the current economic recession is leading to policies that are likely to deepen access barriers. The continuing increase in premiums is likely to increase the number of high-deductible plans not accompanied by savings accounts, increase cost sharing and lead to more medical debt, increase the ranks of those who forgo or delay needed medical care, and potentially reduce timely doctor visits and increase emergency room visits. Proposed Medi-Cal policies to cap ambulatory care visits, increase cost sharing, and reduce provider payments can also lead to similar problems among the poorest segment of the population and lead to a shift to higher-cost services.

The current dynamics of health insurance and access are likely to change after 2014, when the rates of insurance coverage are to increase and benefits and cost-sharing levels are to be standardized to some degree. The findings provide a snapshot of access to care during a significant recession in the recent history of California and identify the shortcomings of the current health insurance coverage that should be addressed in the coming years. Continued monitoring of access to care is essential to identify how ACA and other health policies have improved access, what gaps remain, and where modifications are needed to address barriers to access.

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

Gerald F. Kominski

The Affordable Care Act of 2010 offers the first opportunity since the enactment of Medicare and Medicaid in 1965 to substantially reduce the high rate of uninsurance in California and the nation. Because the major provisions of ACA do not go into effect until 2014, Californians have experienced higher rates of uninsurance since our last report in 2009 related to the Great Recession that began in late 2008. This crisis has resulted in the loss of employment-based insurance and created unprecedented budget deficits that continue to strain the capacity of the state to pay for services under the Medi-Cal program. As documented in this report, the self-employed have been particularly hard hit, experiencing a 20% decline in their likelihood of being insured between 2007 and 2009. Thus, while uninsured Californians wait for the opportunity to apply for federal subsidies to purchase insurance or to enroll in Medi-Cal under expanded eligibility criteria in 2014, our findings indicate that millions of Californians are likely to face ongoing difficulty in obtaining health insurance between now and then. Furthermore, unless the state and the nation begin to recover from the Great Recession, the number of uninsured will continue to grow. As of this writing in the late summer of 2011, the prospects for economic recovery in the foreseeable future are quite dim.

Nevertheless, despite the severe economic challenges facing the state, there are reasons for optimism between now and 2014. In October 2010, California became the first state in the nation to pass legislation establishing the California Health Benefit Exchange, a fundamental component of the infrastructure of ACA. The enabling legislation – AB 1602 and SB 900 – created a governance structure consisting of a five-member board appointed to oversee implementation and operation of the Exchange. The legislation also specified that the Exchange serve as an active purchaser of health insurance by "selectively contracting" with qualified health plans, similar to the role CalPERS plays on behalf of public employees. The Exchange Board has been meeting regularly since April 2011 and has received federal support under ACA to move forward with the tasks of structuring a market of affordable insurance products for individuals and small businesses beginning January 1, 2014.

The Board faces numerous challenges over the next two years, including how to coordinate eligibility determination and enrollment processes with state and county agencies, whether to standardize co-payments and deductibles within each of the four tiers of health plans to be offered in the Exchange as a means of facilitating comparison shopping by consumers, and providing seamless transitions for individuals between Medi-Cal and the Exchange resulting from changing income, to name just a few.

Other provisions of ACA have also begun to provide expanded health insurance coverage or expanded access to care for California's uninsured population. The requirement that insurers extend coverage for young adults up to age 26 under their parents' policies has reduced the number of uninsured by approximately 70,000 in California since going into effect in September 2010. In addition, federal funding for expansion of community health center services and for construction of new centers became available in fiscal year 2011. Although these funds do not directly reduce the number of uninsured individuals, they nevertheless provide much-needed support for safety net providers who treat the uninsured.

Another major initiative in California is the second phase of a coverage initiative program. As part of its Medi-Cal §1115 waiver with the Centers for Medicare and Medicaid Services (CMS), counties

will extend health care coverage to uninsured adults who are currently not eligible for Medi-Cal, but who will be eligible for either Medi-Cal or for Exchange subsidies in 2014. This coverage expansion program was originally implemented in 10 counties between 2007 and 2010, ultimately providing coverage to about 160,000 adults who would otherwise have been uninsured. Starting in 2011, this program, now known as the Low-Income Health Program (LIHP), has been expanded to every county in the state and is expected to provide coverage for as many as 500,000 uninsured adults by 2013. LIHP allows counties to leverage their expenditures for eligible enrollees – uninsured adults who are citizens or legal residents with at least five years of residency and with incomes less than 200% of the Federal Poverty Level – to qualify for federal matching funds for health care services provided to these LIHP enrollees. LIHP will counter some of the effects of the ongoing Great Recession and will serve as a "Bridge to Reform" (as the plan is named) by providing health care coverage for a substantial number of Californians who would otherwise remain uninsured until 2014.

Based on considerable evidence from previous expansion of public programs, including experience with individual mandates and penalties for remaining uninsured in Massachusetts, ACA will not result in 100% enrollment rates among those who are eligible for Medi-Cal or Exchange subsidies. Furthermore, we estimate that as of 2009, 1.2 million California residents will not be eligible under ACA due to their citizenship status. As a result, despite the significant reductions in the number of uninsured that are anticipated in 2014, those who remain uninsured are likely to strain the capacity of safety net providers in certain areas of the state. Our findings suggest that ACA could have a devastating effect on counties such as Los Angeles, where 20.7% of the currently uninsured, or nearly 450,000 individuals, will not be eligible for insurance under ACA. The net effect of ACA of reducing subsidies to hospitals for uncompensated care, reducing the number of uninsured, and increasing subsidies for community health centers could leave counties such as Los Angeles more vulnerable than they are now in meeting the demand for indigent care. This geographic disparity in the distribution of uninsured Californians may temper some of the considerable overall benefits anticipated under ACA.

In conclusion, the impact of ACA in California will provide both substantial benefits and perhaps some unintended consequences beginning in 2014. It has already provided immediate benefit in reducing the number of uninsured young adults, and it will strengthen safety net provider capacity starting this year. However, for the first time since we began publishing this report on the state of health insurance in California, we are forced to conclude that the most important policy recommendations for addressing California's high rate of uninsurance fall into the realm of economic policy rather than health policy: between now and 2014, economic recovery and growth are likely to have the single most important impact on the number of California's uninsured population. For the sake of all Californians, we hope that recovery begins sooner rather than later.

Our Mission

The UCLA Center for Health Policy Research improves the public's health by advancing health policy through research, public service, community partnership, and education.

Visit our website at **www.healthpolicy.ucla.edu** and discover what we can do for you.

The California Endowment

The California Wellness Foundation

UCLA CENTER FOR HEALTH POLICY RESEARCH

10960 Wilshire Boulevard, Suite 1550
Los Angeles, California 90024
Phone: 310.794.0909
Fax: 310.794.2686
Email: chpr@ucla.edu