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The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey



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JUNE 2002

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THE CALIFORNIA WELLNESS FOUNDATION



UCLA CENTER FOR HEALTH POLICY RESEARCH

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summary

An estimated 4,519,000 Californians lacked health insurance at the time they were interviewed in 2001 based on data from the new California Health Interview Survey (CHIS 2001). An additional 1,753,000 persons were insured when interviewed, but were uninsured during at least some of the preceding 12 months. Thus, a total of 6.3 million Californians experienced lack of coverage during at least some part of a year.

- Employment-based health insurance remains critically important, covering nearly two-thirds of all nonelderly adults and children in California (18.7 million).
- Medi-Cal and Healthy Families combined cover 16% of Californian children and adults under 65 — a total of 4.65 million nonelderly persons.
- Despite the important role these sources of coverage play, together with privately purchased insurance and some additional public programs, 15.2% of nonelderly Californians remain uninsured.

## DIFFERENT TIME FRAMES CONVEY POLICY-RELEVANT PERSPECTIVES

This report examines health insurance coverage in California based on CHIS 2001 data. CHIS 2001 provides new time frames and a rich source of data with which to better understand health insurance coverage and the lack of coverage for California's diverse population, both statewide and at the local level. CHIS covers a broad range of public health concerns, including health status and conditions, health-related behaviors, health insurance coverage, and access to health care services. To make CHIS more inclusive and to capture the rich diversity of the California population, the questionnaires were translated and interviews were conducted in six languages: English, Spanish, and four Asian languages. The data provide a level of detail and precision never before available to describe and understand health insurance and uninsurance within California.

The determination of how many Californians are uninsured depends on the time frame used to make the estimate. CHIS asks respondents questions about their health insurance coverage or lack of coverage at the time of the interview, and an additional set of questions that focuses on health insurance coverage and uninsurance during the preceding 12 months. These extensive questions enable researchers to examine coverage from several time frames. Each time frame reflects a different policy-relevant perspective. We focus primarily on three time frames: the 4.5 million persons who were uninsured at the time they were interviewed (the "average monthly caseload" of uninsured persons who at a given time may need to be served by safety-net health care providers or health insurance programs); the 6.3 million persons who were uninsured at any time in the last 12 months (the "annual caseload" of uninsured persons over the course of a year whom the safety net may need to serve); and the 3.6 million persons who were uninsured throughout the last 12 months (the core group with persistent lack of coverage).

## WIDE DIFFERENCES IN COVERAGE ACROSS POPULATION GROUPS

Uninsured rates decline as income rises, falling from 30.0% of nonelderly persons below the federal poverty level to 5.8% for persons with incomes 300% or more above that level.

- More than 3 million Californians who are uninsured have annual incomes that do not exceed 200% of the poverty level — that is, up to $23,118 for a family of two and $28,258 for a family of three.

Differences in access to employment-based health insurance, as well as to Medi-Cal and Healthy Families, result in disparities in health insurance coverage among California's diverse racial and ethnic groups.

- Among the nonelderly population, whites have the highest rate of job-based insurance (75.4%) and the lowest rate of uninsurance (8.6%).
- At the other extreme, Latinos have the lowest rate of job-based insurance (42.3%) and the highest uninsured rate (28.3%).
- Six in 10 African Americans (60.2%) have health insurance obtained through their own or a family member's job, and another one in four (27.6%) is enrolled in Medi-Cal or Healthy Families, leaving a relatively low rate of uninsurance (9.5%).
- Two-thirds of Asian Americans have job-based insurance (66.3%), but they are less likely than African Americans to be covered by Medi-Cal or Healthy Families, resulting in an uninsured rate of 13.0% of nonelderly Asians. Native Hawaiians and other Pacific Islanders have coverage rates similar to those of Asians.
- American Indians and Alaska Natives' relatively low rate of job-based insurance (54.4%) results in a high uninsured rate (17.8%) despite a relatively high rate of Medi-Cal and Healthy Families coverage.

Health insurance disparities are even greater among persons of different citizenship and immigration statuses.

- Half of all nonelderly adults who are noncitizens without "green cards" are completely uninsured (51.2%), one-and-a-half times the rate for noncitizens who have obtained their green cards (32.3%) and nearly five times the rate for U.S.-born citizens (11.3%). Children's coverage also differs based on their own and their parents' citizenship and immigration status.

Finally, uninsured rates vary dramatically by county of residence, reflecting distinct differences among the regions within California.

- Driven by a strong economy and tight labor market, the nine-county Greater Bay Area has the lowest uninsured rate (8.9% of the nonelderly population). Exceptions to this profile are San Francisco County (13.1%) and Sonoma County (11.8%).
- The four-county Sacramento Area also has a low rate of uninsurance (9.1%). The northern and Sierra counties nearly all share moderately high rates of uninsurance, averaging 15.0%.
- The San Joaquin Valley has an uninsured rate (16.4%) that is nearly twice that of the Bay Area, led by Tulare County (20.4%). The Central Coast is also high (15.7%), led by Santa Barbara (20.1%).

- Los Angeles County remains the epicenter of uninsurance in California and the nation. One in five nonelderly residents of the county is uninsured — more than 300,000 children and nearly 1.4 million adults. The rest of Southern California (15.6%) also has high uninsured rates in all the counties that comprise that region.

## THE STATE OF EMPLOYMENT-BASED HEALTH INSURANCE

We identified three main reasons some employees have coverage through their employment while others do not. Do they work in firms that offer health insurance to their employees (offer rate)? For employees that do work in establishments that offer health insurance, do their employers deem them eligible for benefits (eligibility rate)? Even if they are eligible, do employees accept the health benefits offered and pay the required contributions, if any (take-up rate)? While there are variations in offer, eligibility, and take-up rates, the likelihood of working in a firm that offers health insurance is clearly the key contributor to disparate coverage rates.

- California's African Americans and whites have the highest offer rates, 90.7% and 88.8%, respectively.
- Latino employees have the lowest job-based coverage compared to all other race and ethnic groups, largely a result of a low offer rate (70.4%). American Indians and Alaska Natives (81.8%) and Asian Americans and Pacific Islanders (84.1%) also experience low offer rates.
- U.S.-born workers enjoy the highest level of offer (88.6%) and take-up (84.9%) rates. Naturalized citizens experience offer, eligibility, and take-up rates very similar to those of U.S.-born citizens, with even higher eligibility rates (93.9% for naturalized citizens vs. 90.3% for U.S.-born citizens).
- Noncitizens without "green cards" have the lowest offer rate (50.4%) for all sociodemographic and labor market groups. However, if they do work for a firm that offers coverage, these immigrants experience no significant disadvantage in eligibility, and they accept coverage at rates comparable to U.S.-born workers.
- A wide spread exists between the highest and the lowest offer rates by income (43 percentage points), education level (36 percentage points), and wages (22 percentage points).

More than 1.85 million workers (14.5%) are still uninsured, comprising over half (51.1%) of all uninsured adults. Among uninsured employees, 61.6% were employed in firms that did not offer health insurance, and 24.3% worked for firms that offered health benefits but were not eligible for them. Among those who worked for firms that offered benefits for which they were eligible, 14.1% did not take up health insurance coverage from their employers.

- Among uninsured workers, the economically vulnerable groups are most likely to work in firms that do not offer health benefits — Latinos (70.3%), noncitizens without green cards (82.5%), workers earning the lowest wages (65.2%), agricultural industry workers (81.8%), and employees of very small firms (83.5%).

## MEDI-CAL AND THE HEALTHY FAMILIES PROGRAM

The Medi-Cal and Healthy Families programs, along with numerous related health insurance safety-net programs, have been stitched together like a patchwork quilt. This quilt consists of an important, but fragmented and confusing, array of programs that together cover more than one in four children, more than one in 10 nonelderly adults, and nearly one in five elderly Californians.

- Latino children are more than three times as likely as whites to depend on Medi-Cal (34.4%) and Healthy Families (7.6%) for their coverage, with an uninsured rate of 18.7%. Coverage for American Indian and Alaska Native children follows a pattern similar to that of Latinos: fairly high coverage through Medi-Cal (30.3%) and Healthy Families (4.8%) and a high uninsured rate (15.0%).
- A small proportion of African-American children are uninsured (3.2%), a result of a high total enrollment in Medi-Cal and Healthy Families (42.7%).
- Asian-American and Pacific Islander children have lower rates of enrollment in Medi-Cal (18.8%) and greater enrollment in Healthy Families (6.0%), but they are protected by relatively strong employment-based coverage, resulting in an uninsured rate of 6.29% that is statistically the same as that for white children (4.8%).

Of the nearly 1 million uninsured children under age 19 in California, an estimated 355,000 are eligible for Medi-Cal and another 301,000 are eligible for the Healthy Families Program. Approximately one-third are not eligible for these programs either because their incomes exceed the eligibility level for Healthy Families (161,000 children) or because they are not citizens and have no "green card" (180,000 children). Parents of nearly one in four uninsured children eligible for Healthy Families did not know of the program's existence, suggesting a continuing need to give this program visibility among target populations.

Among the nearly 3.5 million uninsured adults ages 19-64, approximately 413,000 parents and 52,000 other adults are eligible for Medi-Cal under existing policies. Altogether, more than 1.1 million uninsured children and adults are currently eligible for coverage through either Medi-Cal or Healthy Families.

## THE CONSEQUENCES OF NOT HAVING HEALTH INSURANCE

A significant relationship exists between insurance status and self-reported health status for adults and children (ages 0-17). In general, those with Medi-Cal rate their health as poorest – which is not surprising given that poorer individuals tend to be less healthy and that the disabled population is over-represented in Medi-Cal. The uninsured also report lower health status compared to the other groups, and among children are the least healthy group.

- Just over one-third of uninsured adults (35.6%) report their health to be excellent or very good, a much smaller proportion than those with job-based insurance (61.2%). One-fourth of adults without insurance report fair or poor health (25.9%), which is much higher than for adults with job-based coverage (10.5%).
- Over three-fourths of children with job-based coverage report their health as excellent or very good (75.5%); this is true of less than half of uninsured children (45.8%). Uninsured children are also more than three times as likely (17.8%) to report fair or poor health status as those with job-based coverage (4.8%).

In spite of their poorer health status, the uninsured are much less likely than the insured to report a usual source of medical care, and among those that do that source is considerably less likely to be a doctor's office.

- Nearly half (45.0%) of uninsured adults list no usual source of care, which is three times as high as any of the other four insurance categories.
- Among all nonelderly, the uninsured and those with Medi-Cal coverage are at least three times as likely to list a clinic or community-based hospital as their major source of coverage as those with job-based or individually purchased coverage. This shows the continuing importance of safety-net clinics and hospitals for the uninsured and those with Medi-Cal and Healthy Families coverage.

## PUBLIC POLICIES TO EXPAND COVERAGE FOR CHILDREN AND ADULTS

Our recommendations focus on the State's process to stimulate public dialogue on ways to improve and expand our public health insurance coverage programs and to move toward universal coverage. We believe that California will achieve its best results if it uses existing and emerging opportunities to expand its public coverage programs.

- Cover entire families, including children and parents, by implementing the Healthy Families expansion to parents and eliminating the assets test for parents applying for Medi-Cal.
- Reduce fragmentation for families by integrating Medi-Cal and Healthy Families.
- More fully engage community-based organizations, churches, and schools in culturally appropriate outreach, and expand funding for these efforts. Local jurisdictions can generate local resources and innovation to expand coverage of their residents.
- Continue the policy dialogue of the State Health Care Options Project established by SB 480 by examining alternative ways to insure all Californians.

California is squeezed by a fiscal dilemma: it has a persistent and large problem of uninsurance, and it faces an extraordinarily large shortfall in tax revenues. The budget problems may discourage the State from expanding its efforts to provide coverage, and this may lead to rescission of already adopted expansions and reform. However, in the longer run California and the nation must commit to extending to all residents affordable coverage that provides good access to high-quality, health-enhancing care. Although there are costs to ensuring that all residents have coverage, there are greater costs associated with a large portion of our population remaining uninsured — lost earnings, lost school days, lost potential, and lost life.

# acknowledgements

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Despite the important contributions of all these colleagues, which made this report possible, any errors or omissions are the responsibility of the authors.

# 1. THE LACK OF HEALTH INSURANCE COVERAGE IN CALIFORNIA: AN OVERVIEW



E. Richard Brown

An estimated 4,519,000 Californians were uninsured in 2001, based on data from the 2001 California Health Interview Survey (CHIS 2001) — none of whom had either private health insurance or coverage through a public program at the time they were interviewed (Exhibit 1, column A). In addition to those who were uninsured at the time they were interviewed, an additional 1,753,000 persons experienced uninsurance at least sometime during the preceding 12 months (Exhibit 1, column B). Thus, a total of 6.3 million Californians experienced lack of coverage for all or some of a year (Exhibit 1, column C). [1]

CHIS 2001 provides new time frames and a rich source of data with which to better understand health insurance coverage and the lack of coverage for California's diverse population, both statewide and at the local level. The data provide a level of detail and precision never before available to describe and understand rates of health insurance and uninsurance within California.

This report examines health insurance coverage in California based on CHIS 2001 data. We pay particular attention to the lack of insurance, sources of coverage, and eligibility for public programs. The report begins with an

**EXHIBIT 1. PERCENT AND NUMBER OF PERSONS UNINSURED BY AGE GROUP, ALL AGES, CALIFORNIA, 2001**

| | UNINSURED AT TIME OF INTERVIEW | INSURED AT TIME OF INTERVIEW BUT UNINSURED AT SOME TIME DURING LAST 12 MONTHS | TOTAL UNINSURED AT TIME OF INTERVIEW OR AT SOME TIME DURING LAST 12 MONTHS* | UNINSURED DURING ALL OF LAST 12 MONTHS** |
|---|---|---|---|---|
| | (A) | (B) | (C) | (D) |
| **AGES 0–64** | **15.2%** | **5.8%** | **21.1%** | **12.2%** |
| | **4,501,000** | **1,719,000** | **6,220,000** | **3,623,000** |
| AGES 0–17 | 9.6% | 4.7% | 14.3% | 7.3% |
| | 880,000 | 428,000 | 1,308,000 | 675,000 |
| AGES 18–64 | 17.7% | 6.3% | 24.1% | 14.4% |
| | 3,620,000 | 1,290,000 | 4,911,000 | 2,947,000 |
| **AGES 65 AND OVER** | **0.5%** | **1.0%** | **1.5%** | **0.5%** |
| | **18,000** | **35,000** | **53,000** | **17,000** |
| **ALL AGES** | **13.7%** | **5.3%** | **19.0%** | **11.0%** |
| | **4,519,000** | **1,753,000** | **6,272,000** | **3,640,000** |

Populations are weighted estimates based on the 2000 Census.

* Includes persons who were uninsured at the time of the interview and persons who had coverage at the time of the interview but were uninsured during all or some of the preceding 12 months (C = A+B)

** Includes persons who were uninsured at the time of the interview and those who were uninsured during all of the preceding 12 months

Note: Numbers may not add to total due to rounding.

Source: 2001 California Health Interview Survey

1 Estimates of the number of persons who are uninsured at any point in time are based on persons who were uninsured at the time of the interview, while estimates of persons who are uninsured for all or part of the year include those were uninsured at the time of the interview or during the preceding 12 months.

overview of health insurance coverage in California. The overview in Section 2 includes a detailed examination of uninsurance and sources of current coverage for children and adults, including who is uninsured, why they are uninsured, and how long their uninsurance lasts. Section 3 examines employment-based health insurance closely, including who has it and who does not. Section 4 focuses on Medi-Cal (California's Medicaid program) and Healthy Families (California's State Children's Health Insurance Program, also called SCHIP); in this section we examine who is enrolled in these public coverage programs and estimate who is uninsured but eligible to enroll. Section 5 assesses the consequences of lack of insurance on the access to health care for uninsured children and adults. Finally, Section 6 offers recommendations to expand coverage to uninsured Californians. Throughout the report we focus on estimates of uninsurance and health insurance coverage at the time of the interview unless otherwise noted.

## HOW MANY CALIFORNIANS LACK HEALTH INSURANCE COVERAGE? DIFFERENT TIME FRAMES CONVEY POLICY-RELEVANT PERSPECTIVES

The determination of how many Californians are uninsured depends on the time frame used to make the estimate. CHIS asks respondents questions about their health insurance coverage or lack of coverage at the time of the interview, and an additional set of questions that focuses on health insurance coverage and uninsurance during the preceding 12 months. This extensive set of questions enables researchers to examine coverage from several time frames.

Each time frame reflects a different policy-relevant perspective. We will focus primarily on three of these time frames. The 4.5 million persons who were uninsured at the time they were interviewed (Exhibit 1, column A) may be regarded as the "average monthly caseload" — the number of uninsured persons at a given time who may need to be served by safety-net health care providers or health insurance programs. The 6.3 million persons who were uninsured at any time in the last 12 months (Exhibit 1, column C) may be thought of as the "annual caseload" — the number of uninsured persons over the course of a year whom the safety net may need to serve. The 3.6 million persons who were uninsured throughout the last 12 months (Exhibit 1, column D) represent the core group with persistent lack of coverage. About one in 10 (9.6%) children under the age of 18 was uninsured at time of interview: a total of 880,000 children (average monthly caseload). Including those who were insured at the time of the interview but who were uninsured for at least some of the preceding 12 months (annual caseload), a total of 1,308,000 (14.3% of the state's children) experienced lack of coverage at some time during the year (Exhibit 1). About half that number of children — a total of 675,000 — were uninsured throughout the year.

Nonelderly adults are more likely than children to be uninsured: 3.6 million (17.7% of all nonelderly adults ages 18–64) were uninsured at the time they were interviewed (average monthly caseload), and a total of 4.9 million (24.1%) were uninsured at some time during the year (annual caseload). More than 2.9 million were uninsured during the entire 12 months leading up to the interview.

The elderly are the least likely to be uninsured at any time — thanks to Medicare, the federal social security health insurance program for the elderly and permanently disabled nonelderly adults. Less than 1% of the elderly were uninsured when they were interviewed, and an additional 1.5% were uninsured during some portion of the previous 12 months.

## THE CALIFORNIA HEALTH INTERVIEW SURVEY

The estimates of uninsurance based on CHIS 2001 data differ from estimates of uninsurance based on the Current Population Survey (CPS). The CPS is the data source previously used by the UCLA Center for Health Policy Research for its annual reports on health insurance coverage, and the lack of it, in California. The CPS differs from CHIS in a number of important ways, which are described and discussed in the Appendix to this report. Below we describe CHIS itself.

This report is based on analyses of data from the CHIS 2001 telephone survey. The findings are based on the CHIS 2001 random-digit dial (RDD) sample which included interviews in more than 55,000 randomly selected households drawn from every county in California. CHIS is the largest health survey ever conducted in any state and one of the largest in the nation. In each household, one adult was randomly selected for interview (the "sample adult"). In households with children, CHIS also interviewed one adolescent age 12–17 (the "sample adolescent") and obtained information for one child under age 12 (the "sample child") by interviewing the adult who is most knowledgeable about the child. The RDD survey began at the end of November 2000 and was completed in October 2001.

CHIS covers a broad range of public health concerns, including health status and conditions, health-related behaviors, health insurance coverage, and access to health care services. To make CHIS more inclusive and to capture the rich diversity of the California population, the questionnaires were translated and interviews were conducted in six languages: English, Spanish, Chinese (both Mandarin and Cantonese dialects), Vietnamese, Korean, and Khmer (Cambodian). Questionnaires were also reviewed by expert teams to ensure that question wording was culturally appropriate for a variety of population groups. In addition, special community outreach campaigns were conducted in appropriate languages targeting communities of color to encourage the participation of populations that often have low participation rates in surveys.

CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. Funding for CHIS 2001 has been provided by the California Department of Health Services, the National Cancer Institute, The California Endowment, the California Children and Families Commission, the Centers for Disease Control and Prevention (CDC), and the Indian Health Service. (For more information on CHIS, please see the Appendix or visit *www.chis.ucla.edu*.)

# 2. WIDE DIFFERENCES IN COVERAGE ACROSS POPULATION GROUPS

E. Richard Brown and Shana Alex Lavarreda

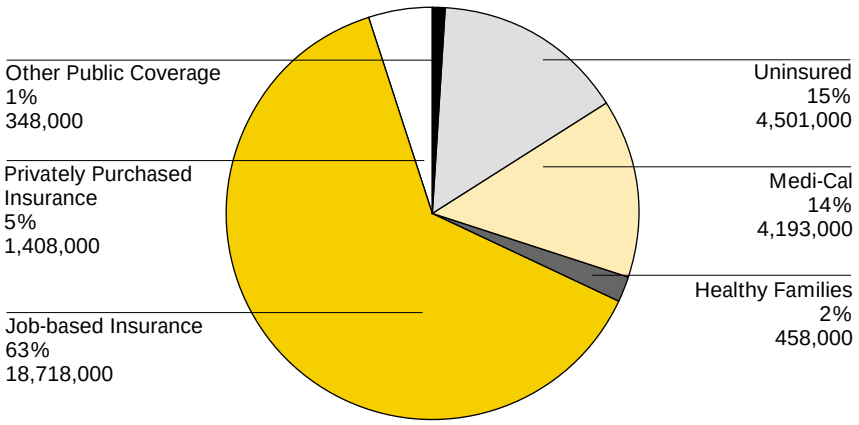
Employment-based health insurance remains a critically important source of coverage for the nonelderly population. Nearly two-thirds of all nonelderly adults and children in California — 18.7 million in all — obtain health insurance through their own or a family member's employment (Exhibit 2). But public programs, mainly Medi-Cal and Healthy Families, are also important sources of coverage for the nonelderly, as Medicare is for the elderly. Together, Medi-Cal and Healthy Families cover 16% of California's nonelderly adults and children — a total of 4.65 million people.

Despite the important role these sources of coverage play, together with privately purchased insurance and some additional public programs, 4.5 million nonelderly Californians remain uncovered for medical expenses. The absence of such coverage is a serious obstacle to people receiving the health services they need, as demonstrated by a large and consistent body of research as well as by evidence from the 2001 California Health Interview Survey presented in Section 5.

## COVERAGE DIFFERENCES ACROSS THE LIFESPAN

Job-based health insurance covers a somewhat larger proportion of nonelderly adults than children: 58.9% for children vs. 65.1% for adults at the time of the interview. But Medi-Cal and Healthy Families protect two-and-a-half times the proportion of children as nonelderly adults: 27.6% of children are covered by Medi-Cal and another

**EXHIBIT 2. HEALTH INSURANCE COVERAGE OF THE NONELDERLY POPULATION, AGES 0-64, CALIFORNIA, 2001**




Populations are weighted estimates based on the 2000 Census.
Note: Numbers may not add to total due to rounding.
Source: 2001 California Health Interview Survey

**EXHIBIT 3. HEALTH INSURANCE COVERAGE BY AGE GROUP, AGES 0–64, CALIFORNIA, 2001**

| | AGE GROUP (IN YEARS) | | |
|---|---|---|---|
| | **0–17** | **18–64** | **0–64** |
| UNINSURED | 9.6 | 17.7 | 15.2 |
| MEDI-CAL | 22.8 | 10.3 | 14.2 |
| HEALTHY FAMILIES | 4.8 | <1.0 | 1.6 |
| JOB-BASED INSURANCE | 58.9 | 65.1 | 63.2 |
| PRIVATELY PURCHASED INSURANCE | 2.9 | 5.6 | 4.8 |
| OTHER PUBLIC COVERAGE | 1.2 | 1.2 | 1.2 |
| TOTAL | 100% | 100% | 100% |
| POPULATION IN 2000 | 9,203,000 | 20,422,000 | 29,625,000 |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

4.8% by Healthy Families compared to just over 10% for nonelderly adults. The net result is that a much smaller proportion of California's children are uninsured than are nonelderly adults — due largely to differences in eligibility for these two federally supported, state-administered public programs. Children are also more likely than nonelderly adults to be insured all year round: 85.3% of children vs. 76.0% of adults.

Uninsured rates vary considerably across age groups as well as across ethnic groups and by income and other social characteristics. Differences in uninsured rates are driven primarily by differences in employment-based insurance and, to a lesser extent, by eligibility rules for public coverage programs like Medi-Cal and Healthy Families. These differences are related to social characteristics, economic factors, and public policies — to a large extent irrespective of individuals' need for health services.

Uninsurance is low among young children, rises into young adulthood, and then declines with increasing age. In California, approximately 536,000 children up to age 11 (8.6% of all children in this age group) are uninsured (Exhibit 4). Children in this age group who do not receive employment-based health insurance through a parent are better protected than any other group by Medi-Cal and the Healthy Families Program. Nearly six in 10 (57.9%) have job-based insurance, but another 24.6% are covered by Medi-Cal and 5.0% by Healthy Families.

Adolescents ages 12-17 also benefit from their parents' job-based insurance, which covers 60.8%, but they are not as well protected by Medi-Cal or Healthy Families as are younger children. As a result, adolescents have a higher uninsured rate, 11.7%, leaving about 334,000 with no private or public coverage.

**EXHIBIT 4. HEALTH INSURANCE COVERAGE BY DETAILED AGE GROUP, AGES 0–64, CALIFORNIA, 2001**

| | AGE GROUP (IN YEARS) | | | | | | |
|---|---|---|---|---|---|---|---|
| | **0–11** | **12–17** | **18–24** | **25–34** | **35–44** | **45–54** | **55–64** |
| UNINSURED | 8.6 | 11.7 | 27.4 | 21.9 | 15.5 | 12.2 | 10.9 |
| MEDI-CAL | 24.6 | 18.9 | 14.8 | 10.4 | 8.9 | 8.1 | 10.8 |
| HEALTHY FAMILIES | 5.0 | 4.3 | 0.6 | N/A | N/A | N/A | N/A |
| JOB-BASED INSURANCE | 57.9 | 60.8 | 50.8 | 62.3 | 69.7 | 72.0 | 68.2 |
| PRIVATELY PURCHASED INSURANCE | 2.9 | 2.8 | 4.5 | 4.5 | 5.2 | 6.6 | 8.2 |
| OTHER PUBLIC COVERAGE | 1.0 | 1.5 | 1.8 | 0.9 | 0.8 | 1.2 | 2.0 |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| POPULATION IN 2000 | 6,252,000 | 2,952,000 | 3,262,000 | 5,106,000 | 5,305,000 | 4,250,000 | 2,498,000 |

Note: Numbers may not add to 100% due to rounding.
N/A = not applicable (age group not eligible for Healthy Families Program at this time)
Source: 2001 California Health Interview Survey

Among young adults ages 18-24, only one in two (50.8%) receives health insurance through their own or a family member's employment, the lowest rate among all age groups. Many young adults are covered by a parent or spouse, but a small proportion of those who enter the workforce obtain their own job-based coverage. Half of young adults with employment-based coverage obtain it as primary enrollees, compared to about three-fourths of adults above age 24. Those who do not receive health benefits from their employer may be covered by privately purchased health insurance, but this is financially out of reach for many young adults who are just entering the labor market or are in college. Medi-Cal and Healthy Families eligibility provisions exclude those in the upper part of this age span, leaving approximately 895,000 uninsured — one in four young adults (27.4%), the highest rate among all age groups.

Coverage of adults improves with increasing age. Employment-based health insurance coverage rises to 62.3% for those ages 25-34, to 69.7% for those 35-44 years of age, and then to 72.0% for those ages 45-54. Eligibility for Medi-Cal declines across this age span, and the private purchase of health insurance increases slightly among those without access to employer health benefits. Among adults ages 55-64, job-based insurance coverage declines to 68.2%, the result of a combination of retirement, disability, and changes in family circumstances, such as divorce or the death of a spouse, that result in loss of employment-based coverage. As these life changes occur, individuals respond by buying private health insurance if they can afford it, enrolling in Medi-Cal if they are disabled and have very low incomes, or going without coverage at a time of increasing need for health care.

Younger men are somewhat more likely than younger women to be covered by employment-based health insurance, but younger women are twice as likely as young men to have Medi-Cal coverage and thus are considerably less likely than young men to be uninsured. The gender difference in uninsured rates disappears with increasing age as job-based coverage increases for both men and women, and as Medi-Cal coverage declines for women.

## UNIVERSAL COVERAGE OF THE ELDERLY — BUT CRITICAL GAPS IN SERVICES COVERED

Nearly everyone age 65 and over receives Medicare. Seven in 10 (70.0%) of the elderly report that they have Medicare and some type of private coverage, including Medicare HMOs, and another 18.5% have both Medicare and Medi-Cal (Exhibit 5). Only 4.4% of the elderly report that they do not have Medicare coverage, including just 0.5% who are completely uninsured. The fact that Medicare is a social insurance program open to virtually all persons who reach age 65 accounts for its universality.

Despite Medicare's near-universal coverage, many elderly Californians are inadequately covered for essential health services, particularly given the growing health-care needs that come with advancing age. Approximately 6.5% of Californians age 65 and over — more than 200,000 seniors in all — have only Medicare coverage, leaving a large gap in their coverage due to Medicare's deductibles and copayments and the lack of prescription drug benefits.

About nine in 10 elderly Medicare beneficiaries report that they have prescription drug coverage, including about half of seniors who have only Medicare coverage (Exhibit 5). Unfortunately, people's knowledge of their health insurance

**EXHIBIT 5. HEALTH INSURANCE COVERAGE AND PERCENT WITH PRESCRIPTION DRUG AND DENTAL COVERAGE, AGES 65 AND OVER, CALIFORNIA, 2001**

| HEALTH INSURANCE COVERAGE | | % OF GROUP WHO REPORT PRESCRIPTION DRUG COVERAGE | % OF GROUP WHO REPORT DENTAL CARE COVERAGE |
|---|---|---|---|
| MEDICARE AND PRIVATE INSURANCE | 70.0 | 83.0% | 47.7% |
| MEDICARE AND MEDI-CAL | 18.5 | 84.8% | 49.2% |
| MEDICARE ONLY | 6.5 | 49.7% | 24.8% |
| OTHER COVERAGE ONLY | 4.4 | 91.0% | 61.1% |
| UNINSURED | 0.5 | N/A | 8.9% |
| TOTAL | 100% | 81.6% | 46.8% |
| POPULATION IN 2000 | 3,426,000 | | |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

benefits is limited. This is true of the working-age population, most of whom do not understand key aspects of their managed care plans. It is even more true of Medicare beneficiaries, who, due to their unfamiliarity with managed care and higher likelihood of cognitive difficulties, have shown particularly low levels of understanding about their coverage.[2] Many seniors with Medicare supplemental coverage, as well as those who have only Medicare, may confuse discount programs with having prescription drug coverage.

A relatively recent trend has been the marketing of so-called "medical savings programs" such as "WellCard," "Affordable Benefit Options," "Chamber Health," and other companies' products that offer PPO-like discounts with pharmacies, physicians, and other providers for a monthly premium, but they do not pay or reimburse for health care expenses. In California, state law enables anyone covered by Medicare to receive the same discount on their prescriptions that the State gets when it buys drugs under the Medi-Cal program, but most elderly residents do not know about this discount program.[3] Although this discount program is helpful, it also does not reimburse seniors for prescription drug expenditures. For these reasons, we believe that the reported proportions of Medicare beneficiaries who say they have prescription drug coverage greatly overstate the actual numbers.

The absence of coverage for prescription drugs is a particularly serious problem for persons with chronic illnesses —cancer, diabetes, asthma, hypertension, or AIDS, for example — for which the cost of drugs can run up to thousands of dollars per year. This problem is exacerbated by rapidly rising prices and expenditures for prescription drugs, a trend that increases the financial burdens on those with no drug coverage, and that is leading Medicare HMOs to limit drug coverage for the elderly and greatly increase copayments for those who have coverage.[4]

A small proportion of the elderly report that they have coverage for dental care — a critical need for many elderly persons. Only one in two elderly persons with Medicare and private insurance or with Medicare and Medicaid and just one in four seniors who have only Medicare report that they have dental coverage (Exhibit 5). As with prescription drug coverage, many respondents to surveys are unable to report accurately on their dental or medical benefits.[5]

## HIGH UNINSURED RATES AMONG LOW-INCOME CALIFORNIANS

Uninsured rates decline as income rises, falling from 30.0% of nonelderly persons below the federal poverty level to 26.2% among the near poor (those with incomes between 101% and 200% of the poverty level), to 15.1% for those

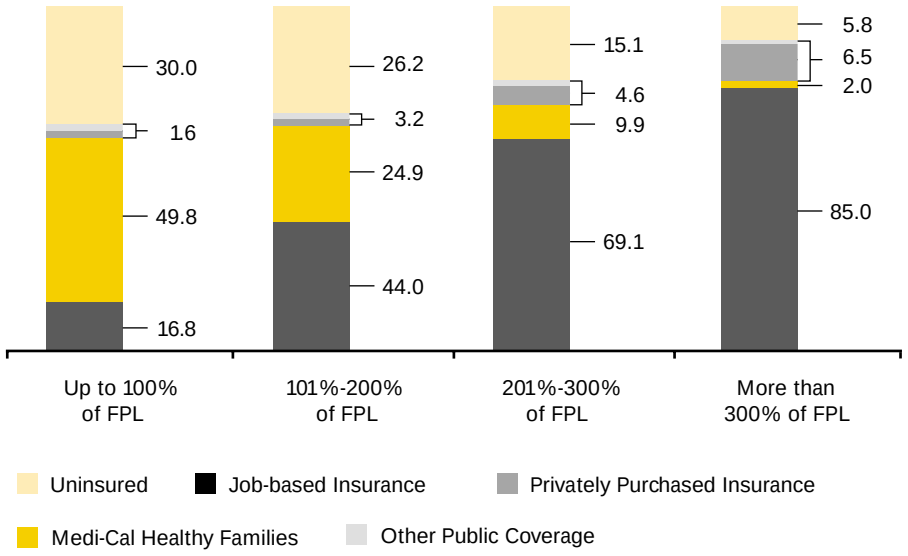
2 Cunningham PJ, Denk D, Sinclair M, "Do Consumers Know How Their Health Plans Work?" *Health Affairs* 2001; 20(2): 159-66; Goldstein E, Fyock J, "Reporting of CAHPS Quality Information to Medicare Beneficiaries," *Health Services Research* 2001; 36(3): 477-88.

3 Rosenblatt, B, "Dwindling Drug Benefits," *Los Angeles Times*, March 25, 2002. For information about California's policy, see *http://www.dhs.ca.gov/mcs/mcpd/mbb/contracting/sb393/index.htm*.

4 Toner R, "Maine at Front Line in Fight Over the High Cost of Drugs," *New York Times*, May 11, 2002.

5 Cunningham PJ, Denk D, Sinclair M, "Do Consumers Know How Their Health Plans Work?" *Health Affairs* 2001; 20(2): 159-66.

**EXHIBIT 6. HEALTH INSURANCE COVERAGE BY FAMILY INCOME RELATIVE TO FEDERAL POVERTY LEVEL, AGES 0–64, CALIFORNIA, 2001**




FPL = federal poverty level
Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

with incomes 201% to 300% of the poverty level, and to 5.8% for nonelderly persons with incomes above that level (Exhibit 6).[6] More than 3 million Californians who are uninsured have incomes that do not exceed 200% of the poverty level — that is, up to $23,118 for a family of two and $28,258 for a family of three. This income level puts the private purchase of health insurance out of financial reach, and even an income up to 300% of poverty would make privately purchased coverage a stretch.[7]

The gradient for employment-based insurance is the opposite, rising from 16.8% of nonelderly persons below poverty to 85.0% for those with incomes above 300% of

6 In 2001, the federal poverty threshold was $9,044 for one person, $11,559 for a family of two, and $14,129 for a family of three.

7 For a twenty-six-year-old male or female, the least expensive plan available in the Los Angeles area through *eHealthInsurance.com* is $408 annually, but that requires a $1,000 deductible and 20% coinsurance for covered benefits, and it does not cover prenatal/postnatal care or delivery, dental care, outpatient prescription drugs, or physical therapy — a questionable value for a generally health young man or woman. The least expensive HMO, one that would provide more comprehensive benefits and much less cost sharing, would cost this person $1,456 annually. For a family of three, including a mother and father age 30 and a two-year-old child, the least expensive HMO, providing comprehensive benefits and standard HMO cost sharing, would be $5,486 annually. These estimates were obtained May 13, 2002 from *https://www.ehealthinsurance.com/ehi/IFPCompareChoose.fs.*

**EXHIBIT 7. PERCENT WITH HEALTH CARE COVERAGE ALL YEAR ROUND BY FAMILY INCOME, CHILDREN AND ADULTS, AGES 0–64, CALIFORNIA, 2001**

| | PERCENT WITH COVERAGE DURING ALL OF LAST 12 MONTHS | |
|---|---|---|
| **FAMILY INCOME** | **CHILDREN AGES 0-17** | **ADULTS AGES 18–64** |
| UP TO 100% OF FPL | 75.2% | 51.7% |
| 101% - 200% OF FPL | 78.2% | 59.7% |
| 201% - 300% OF FPL | 86.8% | 74.7% |
| MORE THAN 300% OF FPL | 95.6% | 88.4% |

FPL = federal poverty level
Source: 2001 California Health Interview Survey

poverty (Exhibit 6). Medi-Cal and the Healthy Families Program partially compensate for the lack of job-based coverage for low-income families and disabled adults, but substantial income-related disparities remain in rates of uninsurance.

**Stability of Coverage**

The probability of having health care coverage throughout the year (through either private health insurance or a public program) rises with family income, as shown in Exhibit 7. However, it is noteworthy that the disparity in year-round coverage between poor persons and those with family income exceeding 300% of poverty is smaller for children (a gap of 20.4 percentage points) than for adults (a difference of 36.7 percentage points). Put slightly differently, poor children are 78% as likely as those with incomes more than three times the poverty level to be insured all year round, while poor adults are only 58% as likely.

This pattern has important policy implications. Employment-based health insurance coverage at the time of the interview is very low for poor children and adults alike: 11.7% and 20.5%, respectively. However, Medi-Cal and Healthy Families cover nearly seven in 10 poor children but less than 4 in 10 poor adults, a difference that is due largely to children's broad eligibility for public coverage programs vs. the very restrictive options available to adults. Children are eligible based on income alone (if they are citizens or legal immigrants), but poor adults must meet strict income and asset limits and, in addition, fit into "categorical" requirements of being members of a family with dependent children, being disabled or blind, or being age 65 or over. Thus, low-income children have more stable coverage than adults as a result of public policies designed to enroll and retain children in Medi-Cal and Healthy Families.

**EXHIBIT 8. HEALTH INSURANCE COVERAGE BY RACE AND ETHNIC GROUP, AGES 0–64, CALIFORNIA, 2001**

| | WHITE | LATINO | ASIAN AMERICAN | NATIVE HAWAIIAN & OTHER PACIFIC ISLANDER | AFRICAN AMERICAN | AMERICAN INDIAN & ALASKA NATIVE | OTHER & MULTIPLE RACE |
|---|---|---|---|---|---|---|---|
| UNINSURED | 8.6 | 28.3 | 13.0 | 12.9 | 9.5 | 17.8 | 16.3 |
| MEDI-CAL/HEALTHY FAMILIES | 8.1 | 26.5 | 13.9 | 13.4 | 27.6 | 24.3 | 16.0 |
| JOB-BASED INSURANCE | 75.4 | 42.3 | 66.3 | 67.2 | 60.2 | 54.4 | 62.0 |
| PRIVATELY PURCHASED INSURANCE | 6.9 | 1.6 | 5.7 | 5.9 | 1.4 | 2.5 | 4.8 |
| OTHER PUBLIC COVERAGE | 1.1 | 1.2 | 1.2 | --- | 1.6 | 0.9 | 1.7 |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| POPULATION IN 2000 | 14,664,000 | 8,837,000 | 3,208,000 | 91,000 | 1,797,000 | 117,000 | 913,000 |

Note: Numbers may not add to 100% due to rounding.
--- Indicates inadequate sample size with which to make estimate

Source: 2001 California Health Interview Survey

## DISPARITIES IN COVERAGE AMONG ETHNIC GROUPS

Differences in access to employment-based health insurance, as well as to Medi-Cal and Healthy Families, result in disparities in health insurance coverage among California's diverse ethnic groups. Among the nonelderly population, whites have the highest rate of job-based insurance (75.4%) and the lowest rate of uninsurance (8.6%; Exhibit 8).

At the other extreme, Latinos have the lowest rate of job-based insurance (42.3%) and the highest uninsured rate (28.3%). The uninsured rates for Salvadorans and Guatemalans are considerably higher (35.0% and 38.0%, respectively) than those for Mexican-origin Latinos (28.1%), a pattern seen for children as well as for adults.

African Americans, Asian Americans, and Native Hawaiians and other Pacific Islanders have job-based insurance rates intermediate between Latinos and whites. Six in 10 African Americans (60.2%) have health insurance obtained through their own or a family member's job, and another one in four (27.6%) is enrolled in Medi-Cal or Healthy Families, giving them a relatively low rate of uninsurance (9.5%) compared to whites.

Two-thirds of Asian Americans have job-based insurance (66.3%), but they are less likely than African Americans to be covered by Medi-Cal or Healthy Families, resulting in an uninsured rate of 13.0% for nonelderly Asians, about one-and-a-half times the rate for whites. Native Hawaiians and other Pacific Islanders' coverage resembles that of Asians, although the sample size is small (as is the population), yielding estimates that are imprecise. The uninsured rate for Japanese-origin Asians as well as for South Asians is lower than for other Asian ethnic groups, but the uninsured rate for Vietnamese, Cambodians, and other Southeast Asians is considerably higher. The uninsured rate for Koreans, however, is far higher than for other groups — 21.7% of children and 33.6% of nonelderly adults — equaling or exceeding the rates for Latinos.

**EXHIBIT 9. HEALTH INSURANCE COVERAGE BY RACE/ETHNIC GROUP AND FAMILY INCOME RELATIVE TO FEDERAL POVERTY LEVEL, AGES 0–64, CALIFORNIA, 2001**

| | WHITE | LATINO | ASIAN AMERICAN & PACIFIC ISLANDER | AFRICAN AMERICAN | AMERICAN INDIAN & ALASKA NATIVE |
|---|---|---|---|---|---|
| UNINSURED | | | | | |
| FAMILY INCOME UP TO 100% OF FPL | 22.4% | 36.7% | 17.9% | 9.1% | 29.7% |
| FAMILY INCOME 101%–200% OF FPL | 18.6% | 32.4% | 26.8% | 13.6% | 19.5% |
| MEDI-CAL/ HEALTHY FAMILIES | | | | | |
| FAMILY INCOME UP TO 100% OF FPL | 48.8% | 47.0% | 54.8% | 69.6% | 52.3% |
| FAMILY INCOME 101%–200% OF FPL | 23.1% | 24.4% | 25.1% | 36.0% | 37.3% |
| JOB-BASED INSURANCE | | | | | |
| FAMILY INCOME UP TO 100% OF FPL | 24.2% | 13.9% | 20.8% | 19.3% | 14.0% |
| FAMILY INCOME 101%–200% OF FPL | 50.1% | 40.5% | 41.7% | 46.4% | 40.5% |

FPL = federal poverty level

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

American Indians' and Alaska Natives' relatively low rate of job-based insurance (54.4%) also results in a high uninsured rate (17.8%) despite a relatively high rate of Medi-Cal and Healthy Families coverage. Among American Indians and Alaska Natives uninsured rates do not seem to differ whether they live in urban or rural areas or whether they are enrolled in a tribe recognized by either federal or state governments (data not shown). Only about one in 10 American Indian and Alaska Native adults in California reports that they obtain any medical care through the Indian Health Service, which is not a substitute for health insurance coverage in any case.[8]

These racial and ethnic disparities in health insurance coverage reflect differences in income, education, and citizenship across these groups. The important role that income plays in determining coverage across ethnic groups is illustrated by the effects of both Latinos' and whites' rates of job-based insurance, coverage by Medi-Cal and Healthy Families, and uninsurance. Among nonelderly persons below the poverty level, there is little difference in rates of coverage by Medi-Cal and Healthy Families: 48.8% for whites and 47.0% for Latinos (Exhibit 9). However, there is a substantial difference in their job-based coverage: 13.9% of Latinos compared to 24.2% of whites. The result of that

8 The United States government has a trust responsibility to provide health care to all federally recognized American Indians and Alaska Natives. Being eligible for the Indian Health Service is not equivalent to being insured, in part because of this legal responsibility to provide care and because most IHS facilities are not accessible to the majority of American Indians and Alaska Natives, who do not live near the facilities they are entitled to use. Thus, American Indians and Alaska Natives who do not have any other coverage are considered by the U.S. Census Bureau to be uninsured.

**EXHIBIT 10. PERCENT WITH HEALTH CARE COVERAGE ALL YEAR ROUND BY RACE/ETHNIC GROUP, CHILDREN AND ADULTS, AGES 0–64, CALIFORNIA, 2001**

| | PERCENT WITH COVERAGE DURING ALL OF LAST 12 MONTHS | |
|---|---|---|
| **RACE/ETHNIC GROUP** | **CHILDREN AGES 0-17** | **ADULTS AGES 18–64** |
| WHITE | 91.9% | 84.5% |
| LATINO | 76.1% | 56.7% |
| ASIAN AMERICAN & PACIFIC ISLANDER | 90.9% | 79.0% |
| AFRICAN AMERICAN | 93.9% | 81.7% |
| AMERICAN INDIAN & ALASKA NATIVE | 83.2% | 72.0% |

Source: 2001 California Health Interview Survey

difference is a wide disparity in uninsurance: 36.7% of Latinos vs. 22.4% of whites. Within each income group, other ethnic groups have rates of employment-based coverage and uninsurance that are intermediate between Latinos and whites.

Latinos suffer a double blow in this relationship. Not only is their uninsured rate higher than any other group at each income level, but a larger proportion of Latinos are poor and near poor: 67% of Latinos have family incomes below 200% of the federal poverty level compared to 19% for whites (data not shown). Again, other ethnic groups have poverty rates between those of Latinos and whites.

The proportion of each group reporting coverage throughout the year reflects a pattern similar to the pattern for current coverage. Latino children and especially Latino adults are considerably less likely than their counterparts in other ethnic groups to be covered throughout the 12-month period preceding the interview, although American Indians and Alaska Natives have rates that are not much higher than those of Latinos (Exhibit 10).

## EVEN LARGER DISPARITIES IN COVERAGE BY CITIZENSHIP AND IMMIGRATION STATUS

Half of all nonelderly adults who are noncitizens without "green cards" are completely uninsured (51.2%), a rate nearly one-and-a-half times that for noncitizens who have

**EXHIBIT 11. HEALTH INSURANCE COVERAGE OF NONELDERLY ADULTS BY OWN CITIZENSHIP AND IMMIGRATION STATUS, AGES 18–64, CALIFORNIA, 2001**

| | U.S.-BORN CITIZEN | NATURALIZED CITIZEN | NONCITIZEN WITH GREEN CARD | NONCITIZEN WITHOUT GREEN CARD |
|---|---|---|---|---|
| UNINSURED | 11.3 | 16.6 | 32.3 | 51.2 |
| MEDI-CAL/HEALTHY FAMILIES | 8.8 | 11.0 | 14.9 | 16.0 |
| JOB-BASED INSURANCE | 72.1 | 66.1 | 48.6 | 29.8 |
| PRIVATELY PURCHASED INSURANCE | 6.4 | 5.2 | 3.7 | 2.3 |
| OTHER PUBLIC COVERAGE | 1.4 | 1.1 | 0.5 | 0.7 |
| TOTAL | 100% | 100% | 100% | 100% |
| POPULATION IN 2000 | 13,610,000 | 2,894,000 | 2,156,000 | 1,765,000 |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

obtained their green cards (32.3%) and nearly five times the rate for U.S.-born citizens (11.3%, Exhibit 11).[9] As with differences by income and by ethnicity, these disparities are the result of wide differences in employment-based coverage, including a more than two-fold difference between noncitizens without green cards at the low end (29.8%) and naturalized and U.S.-born citizens at the high end (66.1% and 72.1%, respectively). The Latino-white difference is also due to higher rates of noncitizenship among Latinos, a point to which we will return shortly.

Compared to whites or African Americans, a much larger proportion of Latinos and Asian Americans and Pacific Islanders are noncitizens. Nearly one-third (30.1%) of Asian adults are not citizens, compared to less than 4% of whites and African Americans, and about one in 10 Asian adults does not yet have a green card (data not shown). Fully half (51.6%) of Latino adults are noncitizens, and approximately one-fourth lack a green card.

The disadvantages related to citizenship and immigration status are also apparent in children's coverage.

9 This refers to immigrants who are neither permanent residents nor in the process of receiving their "green cards." These two groups are combined since having a "green card" makes a significant difference in access to health care for immigrants.

**EXHIBIT 12. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY CITIZENSHIP AND IMMIGRATION STATUS, AGES 0–17, CALIFORNIA, 2001**

| | CHILD AND BOTH PARENTS U.S.-BORN CITIZENS | CHILD CITIZEN, PARENT NATURALIZED CITIZEN | CHILD CITIZEN, PARENT NONCITIZEN WITH GREEN CARD | CHILD CITIZEN, PARENT NONCITIZEN WITHOUT GREEN CARD | CHILD IS NONCITIZEN |
|---|---|---|---|---|---|
| UNINSURED | 4.5 | 13.8 | 16.3 | 15.1 | 39.9 |
| MEDI-CAL/HEALTHY FAMILIES | 18.0 | 42.0 | 44.1 | 65.6 | 30.4 |
| JOB-BASED INSURANCE | 73.2 | 41.3 | 36.5 | 16.0 | 23.3 |
| PRIVATELY PURCHASED INSURANCE | 3.6 | 1.3 | 1.8 | 1.2 | 1.4 |
| OTHER PUBLIC COVERAGE | 0.6 | 1.6 | 1.3 | 2.1 | 5.1 |
| TOTAL | 100% | 100% | 100% | 100% | 100% |
| POPULATION IN 2000 | 5,978,000 | 799,000 | 1,196,000 | 604,000 | 501,000 |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

Children whose parents were both born in the United States have the most advantaged coverage: nearly three-fourths (73.2%) have employment-based insurance and only 4.5% are uninsured (Exhibit 12). However, rates of employment-based coverage are far lower, and uninsured rates are at least three times higher, for children with other family citizenship and immigration statuses. Among the more than 1.1 million U.S.-citizen children in California who have at least one parent who is a noncitizen *with* a green card, only 36.5% have employment-based insurance, 44.1% rely on Medi-Cal or Healthy Families, and 16.3% are uninsured. Job-based insurance is even lower for U.S.-citizen children who have at least one parent who is a noncitizen *without* a green card. And among the half-million noncitizen children in California, only one in four receives employment-based insurance, and only 30.4% are covered by Medi-Cal or Healthy Families, leaving 39.9% completely uninsured.

These low rates of coverage among noncitizen children and citizen children with noncitizen parents are due to multiple factors. Their parents' restricted access to job-based insurance, which will be examined in Section 3, may be compounded by restricted eligibility for public programs if the child is undocumented, or by lingering concerns among noncitizens generally that they may be classified as a "public charge" if they enroll their children in Medi-Cal or Healthy Families.[10]

10 The federal welfare reform and immigration reform legislation in 1996 restricted Medicaid to citizens and to legal immigrants who were in the United States when welfare reform was signed (August 22, 1996). It imposed waiting periods for Medicaid entitlement on immigrants and financial liability on their sponsors. It also led to more widespread potential application of "public charge" classification (someone who is, or is likely to become, dependent on public benefits). This policy generated widespread fear among noncitizens that enrolling themselves or their children in Medicaid might jeopardize their re-entry into the United States. A modification of the policy, issued by the Immigration and Naturalization Service (INS) in May 1999 and widely disseminated by community-based organizations, has eased these concerns, but such fears may linger within the immigrant community.

**EXHIBIT 13. HEALTH INSURANCE COVERAGE BY ENGLISH PROFICIENCY, AGES 0–64, CALIFORNIA, 2001***

| | SPEAK ENGLISH VERY WELL | SPEAK ENGLISH FAIRLY WELL | SPEAK ENGLISH NOT WELL OR NOT AT ALL |
|---|---|---|---|
| UNINSURED | 13.2 | 19.8 | 37.2 |
| MEDI-CAL/HEALTHY FAMILIES | 14.9 | 22.4 | 36.8 |
| JOB-BASED INSURANCE | 66.1 | 52.8 | 23.8 |
| PRIVATELY PURCHASED INSURANCE | 4.6 | 3.7 | 0.9 |
| OTHER PUBLIC COVERAGE | 1.2 | 1.3 | 1.3 |
| TOTAL | 100% | 100% | 100% |
| POPULATION IN 2000 | 4,930,000 | 3,320,000 | 3,222,000 |

* Asked of all respondents who speak languages other than English at home. For adults and for children ages 12-17, English proficiency is for themselves; for children under age 12, English proficiency is for responding adult.

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

Noncitizens without a green card include immigrants in a variety of immigrant categories; among them are undocumented immigrants, whose uncertain immigration status makes them vulnerable in the labor market. This status is often combined with other characteristics, such as low educational attainment or limited English proficiency, that put them at a disadvantage in the labor market. Among adults, 40% of noncitizens with a green card and 52% of those without a green card have less than a high school education compared to 19% for naturalized citizens and just 6% for U.S.-born citizens (data not shown). Many immigrant adults and some adolescents are limited in their English-language proficiency, further impairing their ability to obtain employment that includes health benefits.

The effects of these factors are evident in their relationship to English language proficiency, which is, of course, also related to other factors such as education. Among those who speak a language other than English at home, two-thirds (66.1%) receive job-based insurance and 13.2% are uninsured (Exhibit 13). However, among the 3.2 million Californians with limited English proficiency, only 23.3% have employment-based coverage, more than one-third (36.8%) are covered by Medi-Cal or Healthy Families, and 37.2% are completely uninsured.

Because employers are not required to offer health benefits to their workers, vulnerability in the labor market due to immigration status among a large group of workers may encourage employers in particular labor markets to avoid the added costs of health benefits if they can recruit and retain the workers they need without them. As we will see in a later section, immigrant workers without a green card are more likely to work for employers who do not offer health insurance to any workers.

**EXHIBIT 14. PERCENT OF CHILDREN AND ADULTS UNINSURED AT TIME OF INTERVIEW BY COUNTY, AGES 0–64, CALIFORNIA, 2001**

| | CHILDREN (AGES 0-17) | | ADULTS (AGES 18-64) | | ALL NONELDERLY (AGES 0-64) | | TOTAL NONELDERLY POPULATION (AGES 0-64) CENSUS 2000 |
|---|---|---|---|---|---|---|---|
| | % | (95% RANGE) | % | (95% RANGE) | % | (95% RANGE) | |
| **NORTHERN AND SIERRA COUNTIES** | **9.4** | (7.8-10.9) | **17.4** | (16.1-18.7) | **15.0** | (13.9-16.0) | **1,065,000** |
| BUTTE | **10.2** | (5.2-15.3) | **16.7** | (13.0-20.4) | **14.8** | (11.8-17.8) | **169,000** |
| SHASTA | **9.3** | (5.0-13.5) | **17.6** | (13.7-21.5) | **15.0** | (12.0-18.0) | **136,000** |
| HUMBOLDT, DEL NORTE | **7.2** | (3.7-10.7) | **16.4** | (12.8-20.0) | **13.8** | (11.0-16.6) | **128,000** |
| SISKIYOU, LASSEN, TRINITY, MODOC | **13.3** | (7.3-19.4) | **18.7** | (15.0-22.4) | **17.1** | (13.9-20.2) | **76,000** |
| MENDOCINO, LAKE | **10.0** | (5.1-14.9) | **20.1** | (16.7-24.6) | **17.5** | (14.3-20.6) | **119,000** |
| TEHAMA, GLENN, COLUSA | **11.5** | (7.4-15.7) | **20.7** | (16.6-24.8) | **17.6** | (14.5-20.6) | **85,000** |
| SUTTER, YUBA | **8.9** | (4.0-13.7) | **14.9** | (11.5-18.3) | **12.8** | (10.0-15.6) | **121,000** |
| NEVADA, PLUMAS, SIERRA | **11.2** | (6.5-15.9) | **15.4** | (11.5-19.4) | **14.2** | (11.1-17.4) | **95,000** |
| TUOLUMNE, CALAVERAS, AMADOR, INYO, MARIPOSA, MONO, ALPINE | ** | ** | **16.9** | (13.0-20.8) | **13.6** | (10.6-16.7) | **137,000** |
| **GREATER BAY AREA** | **4.1** | (3.1-5.2) | **10.6** | (9.6-11.7) | **8.9** | (8.1-9.7) | **5,920,000** |
| SANTA CLARA | ** | ** | **12.4** | (9.6-15.1) | **9.7** | (7.7-11.9) | **1,500,000** |
| ALAMEDA | **4.9** | (2.1-7.6) | **9.7** | (7.5-12.0) | **8.4** | (6.6-10.2) | **1,276,000** |
| CONTRA COSTA | ** | ** | **7.1** | (5.1-9.2) | **6.2** | (4.6-7.9) | **835,000** |
| SAN FRANCISCO | ** | ** | **15.0** | (12.7-17.4) | **13.1** | (11.1-15.2) | **655,000** |
| SAN MATEO | ** | ** | **8.0** | (5.6-10.4) | **7.0** | (5.0-9.0) | **612,000** |
| SONOMA | **7.3** | (3.4-11.1) | **13.5** | (9.9-17.1) | **11.8** | (8.9-14.6) | **392,000** |
| SOLANO | ** | ** | **7.9** | (6.0-9.8) | **6.2** | (4.8-7.6) | **343,000** |
| MARIN | ** | ** | **8.1** | (5.3-11.0) | **7.2** | (4.8-9.5) | **204,000** |
| NAPA | ** | ** | **11.1** | (8.1-15.3) | **8.9** | (6.3-11.6) | **102,000** |
| **SACRAMENTO AREA** | **3.5** | (2.0-5.5) | **11.6** | (9.7-13.4) | **9.1** | (7.7-10.5) | **1,566,000** |
| SACRAMENTO | **3.4** | (1.4-5.4) | **12.4** | (9.7-15.0) | **9.5** | (7.6-11.5) | **1,069,000** |
| PLACER | ** | ** | **5.1** | (3.1-7.1) | **3.9** | (2.5-5.4) | **215,000** |
| YOLO | ** | ** | **13.3** | (9.5-17.1) | **10.7** | (7.8-13.6) | **146,000** |
| EL DORADO | ** | ** | **13.7** | (10.1-17.3) | **11.8** | (9.0-14.6) | **136,000** |

continued on next page

**EXHIBIT 14. PERCENT OF CHILDREN AND ADULTS UNINSURED AT TIME OF INTERVIEW BY COUNTY, AGES 0–64, CALIFORNIA, 2001 (CONTINUED)**

| | CHILDREN (AGES 0-17) | | ADULTS (AGES 18-64) | | ALL NONELDERLY (AGES 0-64) | | TOTAL NONELDERLY POPULATION (AGES 0-64) CENSUS 2000 |
|---|---|---|---|---|---|---|---|
| | % | (95% RANGE) | % | (95% RANGE) | % | (95% RANGE) | |
| **SAN JOAQUIN VALLEY** | **10.3** | (8.6-12.0) | **19.9** | (18.3-21.4) | **16.4** | (15.2-17.6) | **2,881,000** |
| FRESNO | **10.2** | (6.0-14.5) | **20.5** | (16.5-24.4) | **16.8** | (13.8-19.8) | **706,000** |
| KERN | **12.8** | (8.8-16.7) | **20.6** | (17.3-23.8) | **17.7** | (15.2-20.2) | **572,000** |
| SAN JOAQUIN | **8.1** | (4.6-11.5) | **18.6** | (15.1-22.2) | **14.9** | (12.2-17.5) | **489,000** |
| STANISLAUS | **11.6** | (6.5-16.7) | **14.4** | (10.9-17.9) | **13.4** | (10.5-16.3) | **396,000** |
| TULARE | **9.8** | (5.9-13.7) | **26.8** | (22.2-31.5) | **20.4** | (17.0-23.8) | **328,000** |
| MERCED | **6.2** | (3.1-9.4) | **20.9** | (16.9-24.8) | **15.3** | (12.5-18.1) | **188,000** |
| KINGS | **11.4** | (7.6-15.2) | **16.7** | (13.0-20.3) | **14.7** | (12.0-17.4) | **100,000** |
| MADERA | **11.3** | (5.8-16.8) | **19.4** | (15.2-23.5) | **16.5** | (13.2-19.8) | **102,000** |
| **CENTRAL COAST** | **12.4** | (9.8-15.0) | **17.2** | (15.5-19.0) | **15.7** | (14.3-17.2) | **1,811,000** |
| VENTURA | **13.5** | (8.3-18.6) | **14.3** | (11.1-17.5) | **14.1** | (11.3-16.8) | **667,000** |
| SANTA BARBARA | **16.0** | (10.5-21.5) | **21.9** | (17.8-26.0) | **20.1** | (16.8-23.5) | **335,000** |
| SANTA CRUZ | **7.0** | (3.5-10.5) | **14.8** | (11.2-18.4) | **12.7** | (9.8-15.5) | **223,000** |
| SAN LUIS OBISPO | **5.6** | (2.5-8.6) | **17.6** | (13.7-21.5) | **14.4** | (11.4-17.4) | **197,000** |
| MONTEREY, SAN BENITO | **13.0** | (7.5-18.4) | **19.4** | (15.2-23.6) | **17.2** | (13.9-20.6) | **390,000** |
| **LOS ANGELES** | **12.3** | (10.9-13.71) | **23.2** | (22.2-24.3) | **19.8** | (19.0-20.7) | **8,464,000** |
| LOS ANGELES | **12.3** | (10.9-13.71) | **23.2** | (22.2-24.3) | **19.8** | (19.0-20.7) | **8,464,000** |
| **OTHER SOUTHERN CALIFORNIA** | **10.4** | (8.9-11.8) | **18.1** | (16.9-19.3) | **15.6** | (14.7-16.6) | **7,918,000** |
| ORANGE | **9.8** | (7.3-12.3) | **17.7** | (15.5-19.9) | **15.3** | (13.6-17.1) | **2,537,000** |
| SAN DIEGO | **11.5** | (8.6-14.4) | **16.6** | (14.6-18.7) | **15.1** | (13.4-16.8) | **2,417,000** |
| SAN BERNARDINO | **9.4** | (6.4-12.4) | **19.8** | (16.9-22.6) | **16.0** | (13.9-18.2) | **1,524,000** |
| RIVERSIDE | **10.3** | (6.7-13.9) | **19.9** | (16.9-22.9) | **16.5** | (14.2-18.9) | **1,322,000** |
| IMPERIAL | **14.1** | (9.8-18.5) | **21.9** | (17.7-26.0) | **19.0** | (15.9-22.0) | **118,000** |

** The estimate is not statistically stable because coefficient of variation is over 30%.

Note: The "95% range" (more commonly called a "confidence interval") provides a more reliable estimate of the uninsured rate for persons in the population group than does the "point estimate." Point estimates with narrower 95% ranges are more precise or reliable than those with wider ranges.

Source: 2001 California Health Interview Survey

## UNINSURED RATES DIFFER DRAMATICALLY BY COUNTY

Counties vary widely in the proportions of children and adults who are uninsured. Driven by a strong economy and tight labor market through much of 2001, the nine-county Greater Bay Area has the lowest uninsured rates (8.9% of the nonelderly population; Exhibit 14). The two Bay Area exceptions to this profile are San Francisco County (13.1%) and Sonoma County (11.8%). The four-county Sacramento Area also has a low rate of uninsurance (9.1%), for similar reasons.

Other parts of the state have much higher uninsured rates. The San Joaquin Valley has an uninsured rate (16.4%) that is nearly twice that of the Bay Area, led by Tulare County (20.4%). The northern and Sierra counties nearly all share moderately high rates of uninsurance. The Central Coast is also high (15.7%), led by Santa Barbara County (20.1%). The rest of Southern California (15.6%) also has high uninsured rates in all the counties that comprise that region (Exhibit 14).

Los Angeles County remains the epicenter of uninsurance in California and, indeed, the nation. One in five nonelderly residents of the county is uninsured — more than 300,000 children and nearly 1.4 million adults. A number of factors contribute to Los Angeles County's high uninsured rate. Three in 10 Latino residents of the county are uninsured, a much higher rate than for other groups; more than six in 10 of Los Angeles's nonelderly residents are Latino, whose low average incomes tend to put health insurance coverage out of financial reach. Los Angeles has a very large immigrant population, many of whom are noncitizens with low incomes. Compared to California as a whole, a larger proportion of the county's residents have low family incomes (43.6% vs. 36.6% have incomes below 200% of poverty), and a larger proportion of poor residents are uninsured (35.2% vs. 30.0% among those with incomes below poverty). Los Angeles County has moderate per capita income (about 95% of the state average in 1999) with moderate average earnings per job as well as a fairly high cost of living.

San Francisco's uninsured rate is high among Bay Area counties. It is low relative to Los Angeles (13.1% vs. 19.8%), but a total of 86,000 uninsured residents must depend on San Francisco's safety net for much of their care. Like Los Angeles, San Francisco has a relatively large immigrant population. However, San Francisco's low-income population is about half the proportion of Los Angeles County's (23.4% have incomes below 200% of poverty vs. 43.6% in Los Angeles), and a lower proportion of San Francisco's poor residents are uninsured (25.1% vs. 35.2% in Los Angeles). San Francisco has high average earnings per job and high per capita income (about 166% of the state average in 1999), both of which are associated with high rates of job-based insurance and low uninsured rates, despite the city's high cost of living.

This brief comparison suggests the important influence of low average income on a county's health insurance profile although other factors also help to account for these variations. These economic indicators (the most recent available from the California Department of Finance) are for 1999, prior to the economic downturn that hit San Francisco hard and Los Angeles more moderately, and thus may not accurately reflect the conditions that influenced health insurance coverage in 2001.[11] The particular set of factors that generate a high uninsured rate in one county compared to another cannot be discerned from a descriptive

11 *California County Profiles*, Sacramento: Department of Finance, February 2002.

**EXHIBIT 15. REASONS PERSONS DO NOT HAVE COVERAGE AMONG UNINSURED AT TIME OF INTERVIEW AND UNINSURED AT SOME TIME DURING THE YEAR, AGES 0–64, CALIFORNIA, 2001**

| REASONS FOR NOT HAVING INSURANCE | UNINSURED AT TIME OF INTERVIEW | UNINSURED AT SOME TIME DURING LAST 12 MONTHS* |
|---|---|---|
| **CAN'T AFFORD/TOO EXPENSIVE** | 42.6 | 24.6 |
| **EMPLOYMENT-RELATED FACTORS** | | |
| CHANGED EMPLOYER/LOST JOB | 8.2 | 25.4 |
| EMPLOYER DOES NOT OFFER | 6.4 | 7.9 |
| NOT ELIGIBLE DUE TO WORKING STATUS | 6.2 | 8.1 |
| **OTHER BARRIERS** | | |
| NOT ELIGIBLE DUE TO CITIZENSHIP OR IMMIGRATION STATUS | 7.4 | 2.3 |
| NOT ELIGIBLE DUE TO HEALTH OR OTHER PROBLEMS | 2.4 | 4.3 |
| FAMILY/PERSONAL SITUATION CHANGED | 1.9 | 5.6 |
| LOST/CAN'T QUALIFY FOR PUBLIC PROGRAM COVERAGE | 1.7 | 2.1 |
| IN PROCESS OF/PROBLEMS WITH GETTING INSURANCE | 1.8 | 5.0 |
| LACK OF INFORMATION ON INSURANCE/FORMS TOO DIFFICULT | 1.8 | 1.4 |
| **OWN ACTION OR INACTION** | | |
| PAYS FOR OWN HEALTH CARE/GETS HEALTH CARE FOR FREE | 2.7 | 1.8 |
| HEALTHY (NO NEED)/DON'T BELIEVE IN HEALTH INSURANCE | 10.5 | 5.8 |
| PERSONAL REFUSAL OR INACTION | 3.7 | 4.1 |
| **OTHER** | 2.7 | 1.7 |
| **TOTAL** | 100% | 100% |

* These individuals had health insurance coverage at the time of the interview, but experienced uninsurance at some time during the past year.

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

analysis such as this; teasing out the factors that account for intercounty variations in health insurance coverage requires further research.

The reader should pay close attention to the "95% range" in Exhibit 14. These are called "confidence intervals," which are a measure of the precision of the estimate shown, based on its sample size and the extent of variation among the respondents who comprise that population group. A wider range, or confidence interval, indicates a less precise estimate. In cases where the range is fairly wide, we encourage the reader to rely on the range because the "true" estimate has a 95% chance of falling within that range. The estimated numbers of uninsured are rounded to the nearest "000" because they are not precise numbers.

## WHY ARE SO MANY CALIFORNIANS UNINSURED?

Among the 4.5 million Californians who lacked coverage at the time they were interviewed, four in 10 (42.6%) said that the main reason they were uninsured was that health insurance premiums were unaffordable (Exhibit 15). Some

were employees who could not afford the contribution required by their employer, as we will see in the next section of this report, but most were people who did not have access to employment-based coverage. Lack of affordability was cited as the main reason for being uninsured by one in four of those who were insured when interviewed but who experienced lack of coverage in the last year (currently insured, but uninsured at some time during the last 12 months).

Another two in 10 (21%) of the currently uninsured reported that the main reason for their lack of insurance was employment-related — changing or losing a job, being ineligible for their employer's plan, or an employer failing to offer any health benefits (although some individuals whose employer did not offer health benefits said that coverage was unaffordable). Employment-related factors were the main reason for lack of coverage during the previous 12 months for four in 10 of those who were insured at the time of the interview, including one in four (25.4%) who said it was due to changing or losing a job.

A substantial proportion of respondents reported other barriers to getting or retaining coverage. Among the currently uninsured, 7.4% reported that their citizenship or immigration status prevented them being covered, a perspective that probably relates more accurately to eligibility for public programs than to job-based insurance. This barrier was reported by only 2.3% of those who were uninsured at some time during the last 12 months. Other reported barriers to coverage included health or other problems that led to being denied coverage, changes in personal situations (such as a divorce or death of a family member who provided the coverage), being ineligible for coverage through a public program (e.g., respondents who were told or believed that they are ineligible or who lost such coverage that they previously had), and problems with getting insurance or lack of information about it.

The reasons for uninsurance vary among people with differing social characteristics (data not shown). For example, compared to most other ethnic groups, Latinos are more likely to cite citizenship or immigration issues and to report that their employer does not offer coverage, but less likely to cite losing or changing employment or unaffordability. Although the reasons cited by noncitizens with green cards do not differ very much from the reasons given by citizens, noncitizens without green cards are more likely to report barriers related to immigration status (one in four) and less likely to cite losing or changing employment or the unaffordability of coverage. Low-income persons (up to 200% of the federal poverty level) are more likely to report citizenship or immigration issues or health problems as the main reason for not being insured, while more affluent persons (those with family incomes above that level) report unaffordability or losing or changing employment as the main reason.

Finally, some reasons appeared to relate to the respondent's own action or inaction. About one in 10 (10.5%) of the currently uninsured and 5.8% of those who were uninsured at some time during the last 12 months reported either that they were healthy and did not need medical insurance or that they do not believe in health insurance. It is noteworthy that the proportion who reported not needing or not believing in health insurance as the main reason for being uninsured varied relatively little by social characteristics. The proportion of uninsured persons who gave such reasons did not differ by income; the proportion of Latinos who gave this reason was just 4 percentage points higher than for whites, and it was about 3 percentage points lower for U.S.-born citizens than for all immigrants.

# 3. THE STATE OF EMPLOYMENT-BASED HEALTH INSURANCE

Ninez Ponce, Thomas Rice,
and Shana Alex Lavarreda

The majority of Americans under the age of 65 receive their health insurance coverage through employment, either through their own job or that of a family member. In this section we examine employment-based coverage among California adults ages 18-64, first focusing on overall job-based coverage rates and then on three components of coverage (defined below): employer offer rates, worker eligibility rates, and worker take-up rates. We then focus on California's uninsured employees to identify where the breakdowns in coverage occur. Specifically, we examine who is most at risk of working in a firm that does not offer health insurance, who tends to not be eligible, and who is most likely to not take up job-based health insurance. We conclude this section by exploring the reasons why workers do not take up their employer's health insurance plan.

## WHO HAS JOB-BASED COVERAGE?

Over two-thirds (65.1%) of California adults obtain health insurance through their own or a family member's employer. Exhibit 16 shows the percentage of California adults with employment-based health insurance coverage according to several demographic and labor force characteristics. In this table, a person is defined as having job-based coverage whether or not he or she obtained it directly from their own employer or received it as a dependent from a working family member. In subsequent tables when examining offer, eligibility, and take-up rates, we will focus only on job-based coverage that a person receives from his or her own job.

Latinos are far less likely than other racial and ethnic groups to have job-based coverage. Less than half of California Latino adults have job-based health insurance compared to three-quarters of whites, about two-thirds of African Americans and Asian American and Pacific Islanders, and three-fifths of American Indian and Alaska Natives and those in other racial and ethnic groups. The rates are particularly low for Latinos because, as a group, they share characteristics that result in low job-based coverage rates: Latinos are less likely to be citizens, they have lower average incomes and education levels, and they work disproportionately in industries and occupations where job-based coverage is low.

Job-based coverage varies considerably by age, with only about half of those between ages 18 and 24 having job-based coverage — a rate far lower than the rates for older individuals. Younger individuals are less likely to have such coverage because many are still in school, and a disproportionate share tend to be in the types of jobs that lack coverage.

Although there is little difference in rates by gender, family composition does have a major impact. Less than half of single individuals with children, and somewhat more than half without children, have job-based coverage. This compares to two-thirds of married individuals with children, and over three-quarters of those married without children.

Citizenship status is one of the most important correlates of job-based coverage. Only three in 10 noncitizens without a green card report coverage, and half of permanent residents — rates far below the about 70% levels for naturalized citizens and U.S. born citizens.

| EXHIBIT 16. PERCENT OF ADULTS WITH JOB-BASED HEALTH INSURANCE, AGES 18-64, CALIFORNIA, 2001 | | | |
|---|---|---|---|
| **TOTAL POPULATION (n = 13,300,000)** | | **SELECTED INDUSTRIES (SMALLEST TO LARGEST)** | |
| ALL ADULTS, AGES 18-64 | 65.1% | AGRICULTURE | 40.3% |
| **RACE/ETHNICITY** | | CONSTRUCTION | 56.6% |
| WHITE | 75.4% | MANUFACTURING OF DURABLE GOODS | 80.9% |
| LATINO | 46.8% | EDUCATIONAL SERVICES | 86.4% |
| ASIAN AMERICAN & PACIFIC ISLANDER | 66.4% | BUSINESS AND REPAIR SERVICES | 67.4% |
| AFRICAN AMERICAN | 63.9% | RETAIL TRADE | 57.3% |
| AMERICAN INDIAN & ALASKA NATIVE | 57.4% | **SELECTED OCCUPATIONS (SMALLEST TO LARGEST)** | |
| OTHER & MULTIPLE RACE | 62.7% | FARMING, FORESTRY, AND FISHING | 39.5% |
| **AGE GROUP** | | PRECISION, CRAFT, REPAIR | 63.7% |
| 18 – 24 YEARS | 50.8% | SALES | 67.9% |
| 25 – 34 YEARS | 62.3% | ADMINISTRATIVE SUPPORT | 77.9% |
| 35 – 44 YEARS | 69.7% | PROFESSIONAL SPECIALTY | 84.3% |
| 45 – 54 YEARS | 72.0% | **FAMILY COMPOSITION** | |
| 55 – 64 YEARS | 68.2% | SINGLE, NO CHILDREN | 57.7% |
| **CITIZENSHIP STATUS** | | SINGLE, WITH CHILDREN | 47.4% |
| U.S.-BORN CITIZEN | 72.1% | MARRIED, NO CHILDREN | 77.5% |
| NATURALIZED CITIZEN | 66.1% | MARRIED, WITH CHILDREN | 68.6% |
| NONCITIZEN WITH GREEN CARD | 48.6% | **FAMILY INCOME AS PERCENT OF FPL*** | |
| NONCITIZEN WITHOUT GREEN CARD | 29.8% | UP TO 100% | 20.5% |
| **EDUCATION LEVEL** | | 101% – 200% | 44.4% |
| LESS THAN HIGH SCHOOL | 34.1% | 201% – 300% | 67.5% |
| HIGH SCHOOL DIPLOMA | 59.9% | 301% + | 83.7% |
| SOME COLLEGE | 69.9% | **EMPLOYMENT STATUS** | |
| COLLEGE GRADUATE OR HIGHER | 80.7% | FULL-TIME EMPLOYED | 74.3% |
| **GENDER** | | PART-TIME EMPLOYED | 56.9% |
| MALE | 66.6% | UNEMPLOYED, LOOKING FOR WORK | 33.7% |
| FEMALE | 63.7% | UNEMPLOYED, NOT LOOKING FOR WORK | 45.7% |

Source: 2001 California Health Interview Survey
* FPL = Federal Poverty Level

One of the greatest disparities occurs in the area of education. Only about one-third of those with less than a high school education have job-based coverage compared to at least six in 10 for all other groups and over eight in 10 for college graduates. Income follows a similar pattern, with only one-fifth of those below the poverty level having job-based coverage. The proportion rises gradually with income up to over the 80% level for those above 300% of the poverty level. It should be kept in mind, however, that many of those below poverty have Medi-Cal or Healthy Families coverage.

Employment characteristics also have a major impact on job-based coverage. Those in certain industries, such as agriculture, construction, and service, are considerably less likely to have employment coverage than those in the manufacturing of durable goods and education. Similarly, certain occupations tend to lack job-based coverage: only two-thirds of those in sales compared to nearly 85% in professional specialties have such coverage. Finally, the percentage of time employed also matters a great deal. Three-quarters of full-time workers have job-based coverage compared to just over half of part-time workers and one-third of the unemployed looking for work.

## WHO WORKS AND IS STILL UNINSURED?

In this section, we begin by examining sociodemographic characteristics and labor market factors of California's nearly 13 million employees to identify groups that are most at-risk for being uninsured.[12] Some workers may face greater barriers in getting job-based coverage not only because of the nature and type of job they hold but also because of age, citizenship status, education level, or other sociodemographic factors. Exhibit 17 shows the connection between the employee's "own," or primary, job-based health insurance coverage and key labor market and sociodemographic characteristics. (Unlike the previous exhibit, we do not consider here dependent coverage from a family member's job.)

We also probe more deeply into the reasons why some employees have coverage through their employment while others do not. Do they work in firms that offer health insurance to their employees (offer rate)? For employees who work where health insurance is offered, do their employers deem them eligible for job-based health benefits (eligibility rate)? Even if they are eligible, do employees accept the health benefits offered and pay the required contributions, if any, that the benefit may entail (take-up rate)?

### Widest Disparities Are in Offer Rates

While there are variations in offer, eligibility, and take-up rates by race and ethnicity, the likelihood of working for a firm that offers health insurance is clearly the key contributor to disparate coverage rates (see Exhibit 17). Offer rates span a considerable range: from 70.4% to 90.7%, while the range is smaller for take-up rates (81.9% to 88.1%), and smaller still for eligibility rates (88.7% to 92.2%).

12 "Employees" are respondents who reported that they are "currently working for an employer for wages," and therefore the category, implicitly, excludes the self-employed.

**EXHIBIT 17. OFFER, ELIGIBILITY, AND TAKE-UP RATES AMONG EMPLOYEES FOR OWN JOB-BASED HEALTH INSURANCE BY DEMOGRAPHIC CHARACTERISTICS, AGES 18-64, CALIFORNIA, 2001**

| TOTAL POPULATION (n = 12,984,000) | OFFER[1] | ELIGIBILITY[2] | TAKE-UP[3] |
|---|---|---|---|
| EMPLOYEES, AGES 18-64 | 83.4% | 90.8% | 84.4% |
| **RACE/ETHNIC GROUP** | | | |
| WHITE | 88.8% | 91.1% | 83.3% |
| LATINO | 70.4% | 88.7% | 81.9% |
| ASIAN AMERICAN & PACIFIC ISLANDER | 84.1% | 92.0% | 84.8% |
| AFRICAN AMERICAN | 90.7% | 91.8% | 88.1% |
| AMERICAN INDIAN & ALASKA NATIVE | 81.8% | 89.5% | 82.1% |
| OTHER & MULTIPLE RACE | 85.8% | 92.2% | 83.3% |
| **AGE GROUP** | | | |
| 18–24 YEARS | 70.8% | 72.3% | 70.5% |
| 25–34 YEARS | 82.9% | 91.7% | 86.1% |
| 35–44 YEARS | 85.3% | 93.7% | 84.8% |
| 45–54 YEARS | 87.6% | 94.6% | 86.0% |
| 55–64 YEARS | 88.8% | 93.9% | 88.5% |
| **FAMILY COMPOSITION** | | | |
| SINGLE, NO CHILDREN | 80.7% | 86.8% | 88.8% |
| SINGLE, WITH CHILDREN | 81.0% | 89.8% | 89.4% |
| MARRIED, NO CHILDREN | 88.8% | 93.9% | 83.4% |
| MARRIED, WITH CHILDREN | 83.3% | 92.8% | 80.1% |

| GENDER | OFFER[1] | ELIGIBILITY[2] | TAKE-UP[3] |
|---|---|---|---|
| MALE | 84.3% | 93.1% | 87.7% |
| FEMALE | 82.3% | 87.8% | 80.0% |
| **SELECTED INDUSTRIES** | | | |
| AGRICULTURE | 54.3% | 84.5% | 81.1% |
| CONSTRUCTION | 69.5% | 91.2% | 83.9% |
| MANUFACTURING OF DURABLE GOODS | 90.4% | 94.8% | 89.7% |
| EDUCATIONAL SERVICES | 93.3% | 87.1% | 84.1% |
| BUSINESS AND REPAIR SERVICES | 80.6% | 93.4% | 85.5% |
| RETAIL TRADE | 71.8% | 81.7% | 74.8% |
| **SELECTED OCCUPATIONS** | | | |
| FARMING, FORESTRY, FISHING | 52.8% | 86.6% | 86.2% |
| PRECISION, CRAFT, REPAIR | 76.3% | 93.6% | 85.0% |
| SALES | 81.5% | 88.3% | 79.7% |
| ADMINISTRATIVE SUPPORT | 89.0% | 86.3% | 82.1% |
| PROFESSIONAL SPECIALTY | 94.3% | 93.6% | 87.4% |
| **HOURS WORKED PER WEEK** | | | |
| 0-20 HOURS | 64.1% | 54.8% | 58.2% |
| 21-34 HOURS | 69.3% | 73.0% | 68.4% |
| 35-39 HOURS | 79.4% | 89.4% | 74.3% |
| 40+ HOURS | 87.3% | 95.1% | 87.3% |

continued on next page

**EXHIBIT 17. OFFER, ELIGIBILITY, AND TAKE-UP RATES AMONG EMPLOYEES FOR OWN JOB-BASED HEALTH INSURANCE BY DEMOGRAPHIC CHARACTERISTICS, AGES 18-64, CALIFORNIA, 2001 (CONTINUED)**

| INCOME AS PERCENT OF FPL* | OFFER[1] | ELIGIBILITY[2] | TAKE-UP[3] | WAGES PER HOUR LAST MONTH | OFFER[1] | ELIGIBILITY[2] | TAKE-UP[3] |
|---|---|---|---|---|---|---|---|
| UP TO 100% | 48.9% | 71.6% | 67.6% | < $9.51 | 63.3% | 76.0% | 71.9% |
| 101% – 200% | 70.7% | 85.1% | 79.9% | $9.51–$14.25 | 85.6% | 89.3% | 83.1% |
| 201% – 300% | 84.4% | 88.3% | 85.3% | $14.26–$19.00 | 91.8% | 95.1% | 87.2% |
| 301% + | 92.3% | 94.2% | 86.2% | $19.01+ | 95.2% | 96.9% | 89.0% |
| CITIZENSHIP STATUS | | | | FIRM SIZE | | | |
| U.S.-BORN CITIZEN | 88.6% | 90.3% | 84.9% | FEWER THAN 10 EMPLOYEES | 42.5% | 83.9% | 73.7% |
| NATURALIZED CITIZEN | 84.2% | 93.9% | 84.5% | 10 – 50 EMPLOYEES | 72.3% | 88.7% | 79.3% |
| NONCITIZEN WITH GREEN CARD | 71.8% | 89.5% | 81.4% | 51 – 99 EMPLOYEES | 84.7% | 91.0% | 81.6% |
| NONCITIZEN WITHOUT GREEN CARD | 50.4% | 90.1% | 81.1% | 100 – 999 EMPLOYEES | 91.7% | 91.4% | 86.2% |
| EDUCATION LEVEL | | | | 1000+ EMPLOYEES | 97.8% | 93.4% | 87.0% |
| LESS THAN HIGH SCHOOL | 57.6% | 86.3% | 79.1% | | | | |
| HIGH SCHOOL DIPLOMA | 79.5% | 88.6% | 81.8% | | | | |
| SOME COLLEGE | 86.0% | 89.3% | 83.1% | | | | |
| COLLEGE GRADUATE OR HIGHER | 93.6% | 94.2% | 87.9% | | | | |

Source: 2001 California Health Interview Survey

* FPL = Federal Poverty Level

1 Offer rate = Total number of employees offered health insurance divided by total number of employees.

2 Eligibility rate = Total number of eligible employees divided by total number of employees offered health insurance.

3 Take-up rate = Total number of people who took up insurance divided by total number of eligible employees.

**Sociodemographic Characteristics**

Latino employees have the lowest job-based coverage compared to all other race and ethnic groups. Although Latino employees' eligibility (88.7%) and take-up (81.9%) rates are low compared to other race/ethnic groups, their eligibility and take-up rates are not statistically significantly different from the next lowest group, American Indians and Alaska Natives, and their low rate of coverage is largely a result of a low offer rate (70.4%).

American Indians and Alaska Natives (81.8%) and Asian Americans and Pacific Islanders (84.1%) also experience low offer rates. California's African Americans

have the highest offer rates (90.7%), one of the highest eligibility rates (91.8%), and the highest take-up rate (88.1%), due in part to education levels and incomes that are higher, on the average, than their national counterparts, and to a high rate of employment in larger firms and in the public sector.[13]

Younger workers, ages 18 to 24, experience lower offer, eligibility, and take-up rates than older workers. Offer and eligibility rates rise substantially for the 25-34 age group and continue to increase for older workers. Greater opportunities for dependent coverage through spouses may explain the much lower take-up rates for female workers (80.0%). Eligibility rates for female workers are also lower than for males, perhaps because more females work part time and therefore do not qualify for health benefits. But employers may also be tacitly encouraging their female employees to take up their spouse's dependent coverage. A study by Dranove, Spier, and Baker (2000) found that employers with more female employees required higher contribution rates from their workers than employers with more male employees.[14] This study's finding seems to apply to California workers: the gender gap in coverage does not stem mainly from an offer gap (only 2.0% difference) but from an eligibility gap (5.3% difference) and, even more so, from a take-up gap (7.7% difference).

The take-up gap is also evident when examining the worker's type of family. Compared to single workers whose take-up rates are near 90%, take-up rates are lower for married workers, especially for those with children (80.1%). This suggests both access to dependent coverage through spouses and, for qualified low-income parents, access to Medi-Cal.

We also see a correlation between gaining job-based health insurance and citizenship/nativity status. As expected, U.S.-born workers enjoy the highest level of offer (88.6%) and take-up (84.9%) rates. For offer, eligibility, and take-up, naturalized citizens experience rates very similar to those of U.S.-born citizens, with even higher eligibility rates (93.9% for naturalized citizens vs. 90.3% for U.S.-born citizens). This is probably because for the select group of employees who work in firms that offer insurance coverage, naturalized citizens are more likely to work full time than their U.S.-born counterparts. Illustrating the variability within the immigrant group, we find that immigrants who are not permanent residents take the hardest hit in terms of offer rates (50.4%), having the lowest offer rate for all socio-demographic and labor market groups shown in Exhibit 17. However, if they do work for a firm that offers, these immigrants face no significant disadvantage in eligibility and take-up rates compared to U.S.-born workers.

**Labor Market Characteristics**

Job-based coverage also increases with education level, income, and wages. But the gulf between the least and most advantaged is most pronounced in the offer rate. Exhibit 17 shows the wide spread between the highest and the lowest offer rates by income (43%), education level (36%), and wages (22%). Low-income, low educational attainment, and low-wage workers are left further behind by low rates in eligibility and in take-up. We note that low job-based coverage for low-income workers who are parents may be offset by Medi-Cal coverage. But coverage is still also low for workers whose incomes are between 101 to 200% FPL. Thus, parents who are in this income category are wedged

13 February 1999 Current Population Survey.

14 Dranove D, Spier KE, Baker L, "Competition Among Employers Offering Health Insurance," *Journal of Health Economics* 2000; 19, 121-40.

between being too poor to afford job-based coverage but having income levels that are too high to be eligible for Medi-Cal. The anticipated parent expansion of Healthy Families, California's Children's Health Insurance Program, would provide a coverage alternative for this group.

Certain industries and occupations typically have low coverage rates, such as agriculture and farming. In Exhibit 17, we highlight selected industries and occupations in California. Combined, these industries employ nearly half of California's workers. The agriculture industry has the lowest offer rate (54.3%) because of its reliance on a seasonal and migrant labor force that may discourage employers from offering health benefits. Retail trade, which includes small establishments such as restaurants and grocery stores, constitutes a large share of California's economy (13%). This sector has both the lowest eligibility rate (81.7%) and take-up rate (74.8%), in part because many retail trade employees work part time and thus are ineligible for health benefits. For California's construction industry workers (6% of workers), low coverage rates are largely a result of low offer rates (69.5%). However, their eligibility (91.2%) and take-up (83.9%) rates are relatively higher compared to other industries.

Consistent with what we found in offer rates for the agriculture industry, the lowest offer rates are for the farming, forestry, and fishing occupations (52.8%). Administrative support, which draws on the part-time and female labor supply, has the lowest eligibility rate (86.3%). Californians employed in sales jobs have the lowest take-up rates (79.7%), largely because they are frequently covered in their family member's job-based health plan.

We find no unusual patterns in offer, eligibility, and take-up rates in terms of hours worked per week. For all components of coverage, the outlook in securing health benefits gets better with increasing hours worked. This is also true for firm size, where there is more than a two-fold gain in the offer rate when a worker who works in a small firm with fewer than 10 employees (42.5%) is compared with a worker in a large firm with more than 1000 employees (97.8%).[15] Costs may prohibit employers in small firms from offering health benefits so that offer rates are low. And even for those small firms that can and do offer, their eligibility rules appear to be slightly more stringent than those of larger employers. Finally, take-up rates for establishments of under 100 employees range from 73.7% to 81.6%, and they are significantly lower than take-up rates for the larger establishments (86.2% to 87.0%). This may reflect a double penalty for low-income workers who work in small firms who have less income to pay for premiums, but have to pay higher contributions. Typically, both average premiums and average employee contributions are higher for small firms.[16]

To summarize, disparities in job-based coverage in California are significant across a range of socio-demographic and labor market characteristics. The widest disparities are in offer rates, particularly for workers who have less education, lower incomes, lower wages, and who are noncitizens. Differences in eligibility are much less significant across all groups, though workers who work part time, who are under twenty-five years old, and who earn low wages have considerably low eligibility rates. Lastly, we find that disparate rates in accepting employer-sponsored

15 Firm size refers to the number of workers in all establishment sites as reported by the employee.

16 William M. Mercer, Inc. *Employer-Sponsored Health Insurance: A Survey of Small Employers in California*, Oakland, CA: California Healthcare Foundation, 1999.

**EXHIBIT 18. DISTRIBUTION OF UNINSURED EMPLOYEES BY ACCESS TO OWN JOB-BASED INSURANCE AND BY SELECTED DEMOGRAPHIC AND LABOR MARKET CHARACTERISTICS, AGES 18-64, CALIFORNIA, 2001**

| TOTAL POPULATION (n = 1,850,000) | NOT OFFERED | NOT ELIGIBLE | DIDN'T TAKE UP | TOTAL |
|---|---|---|---|---|
| UNINSURED EMPLOYEES, AGES 18-64 | 61.6 | 24.3 | 14.1 | 100% |
| **RACE** | | | | |
| WHITE | 47.1 | 37.9 | 15.0 | 100% |
| LATINO | 70.3 | 15.7 | 14.0 | 100% |
| ASIAN AMERICAN & PACIFIC ISLANDER | 60.9 | 23.9 | 15.2 | 100% |
| AFRICAN AMERICAN | 49.0 | 38.3 | 12.7 | 100% |
| AMERICAN INDIAN & ALASKA NATIVE | 54.6 | 35.2 | 10.2 | 100% |
| OTHER & MULTIPLE RACE | 64.8 | 28.1 | 7.1 | 100% |
| **CITIZENSHIP STATUS** | | | | |
| U.S.-BORN CITIZEN | 46.5 | 39.0 | 14.5 | 100% |
| NATURALIZED CITIZEN | 63.5 | 18.7 | 17.8 | 100% |
| NONCITIZEN WITH GREEN CARD | 66.2 | 17.3 | 16.5 | 100% |
| NONCITIZEN WITHOUT GREEN CARD | 82.5 | 7.4 | 10.0 | 100% |
| **EDUCATION LEVEL** | | | | |
| LESS THAN HIGH SCHOOL | 76.0 | 11.5 | 12.5 | 100% |
| HIGH SCHOOL DIPLOMA | 56.5 | 28.3 | 15.1 | 100% |
| SOME COLLEGE | 54.7 | 30.0 | 15.2 | 100% |
| COLLEGE GRADUATE OR HIGHER | 48.3 | 37.7 | 14.0 | 100% |
| **WAGES PER HOUR LAST MONTH** | | | | |
| < $9.51 | 65.2 | 22.0 | 12.8 | 100% |
| $9.51 - $14.25 | 54.1 | 29.1 | 16.7 | 100% |
| $14.26 - 19.00 | 56.1 | 27.8 | 16.1 | 100% |
| $19.01+ | 45.1 | 36.6 | 18.2 | 100% |

continued on next page

**EXHIBIT 18. DISTRIBUTION OF UNINSURED EMPLOYEES BY ACCESS TO OWN JOB-BASED INSURANCE AND BY SELECTED DEMOGRAPHIC AND LABOR MARKET CHARACTERISTICS, AGES 18-64, CALIFORNIA, 2001 (CONTINUED)**

| | | | | |
|---|---|---|---|---|
| **SELECTED INDUSTRIES (SMALLEST TO LARGEST)** | | | | |
| AGRICULTURE | 81.8 | 12.3 | 5.9 | 100% |
| CONSTRUCTION | 75.2 | 11.4 | 13.4 | 100% |
| MANUFACTURING OF DURABLE GOODS | 56.6 | 29.3 | 14.1 | 100% |
| EDUCATIONAL SERVICES | 38.1 | 53.1 | 8.8 | 100% |
| BUSINESS AND REPAIR SERVICES | 67.6 | 18.9 | 13.5 | 100% |
| RETAIL TRADE | 55.9 | 27.1 | 17.0 | 100% |
| **FIRM SIZE** | | | | |
| FEWER THAN 10 EMPLOYEES | 83.5 | 9.3 | 7.2 | 100% |
| 10 – 50 EMPLOYEES | 70.1 | 16.7 | 13.2 | 100% |
| 51 – 99 EMPLOYEES | 54.9 | 23.5 | 21.6 | 100% |
| 100 – 999 EMPLOYEES | 45.4 | 36.8 | 17.8 | 100% |
| 1000+ EMPLOYEES | 14.7 | 56.7 | 28.6 | 100% |

Source: 2001 California Health Interview Survey

health benefits are most marked by the variables of age, income, wages, and hours worked per week, suggesting both affordability issues and dependent coverage from parents and spouses. We explore the reasons why employees do not take up their job-based health benefits in a subsequent section.

## UNINSURED WORKERS: WHO'S NOT OFFERED, WHO'S NOT ELIGIBLE, AND WHO DOESN'T TAKE UP JOB-BASED COVERAGE?

More than 1.85 million workers (14.5%) are still uninsured. These workers account for over half (51.1%) of uninsured adults in California. We focus on uninsured workers to try to understand if their lack of coverage is a result of working for firms that do not offer health insurance, if it is due to their employers' eligibility rules for extending health benefits, or if they choose not to participate in job-based health plans. Among California's uninsured employees, 61.6% were employed in firms that do not offer health insurance to their employees, 24.3% worked for firms that offer but did not consider them eligible for job-based health benefits, and finally, among those who worked for firms where they were eligible for company health insurance, 14.1% did not take up health insurance coverage from their jobs.

Exhibit 18 shows a general and not surprising pattern among California's uninsured workers, namely, that the economically vulnerable groups are the least likely to work in firms that offer health benefits — Latinos (70.3%), noncitizens without green cards (82.5%), workers earning the lowest wages (65.2%), agricultural industry workers (81.8%), and employees of very small firms (83.5%).

On the other hand, in terms of eligibility, the uninsured workers who are least likely to be eligible for health benefits offered by their firms tend to be more advantaged groups — U.S.-born citizens, college graduates, workers with incomes greater than 300% FPL, and employees of larger firms. There is no clear pattern among those who do not take up employer-based health insurance. They are not overwhelmingly the least disadvantaged group, as they were for offer rates, for example. There is, however, a pattern of higher wage earners not taking up job-based coverage, suggesting that these workers may benefit from dependent coverage from their spouses. Moreover, unlike the patterns in offer and eligibility, we find no startling disparities among those who did not take up among the uninsured.

Our findings suggest that the uninsured worker faces the greatest setback in the prospects for job-based coverage by working for a firm that does not offer coverage. Clearly, the breakdown in coverage occurs predominantly at the employer's decision whether or not to offer such coverage. This means that strategies such as employee tax credits, which only address financing support for employees who cannot afford their job-based benefit contributions, leave out the majority of uninsured workers. Individual financing relief strategies also do little to reduce disparities by socioeconomic characteristics because economically vulnerable groups are the most likely not to work for a firm that offers health insurance coverage at all.

## WHY DON'T EMPLOYEES TAKE UP THEIR EMPLOYER'S HEALTH PLAN?

In this section, we report the main reasons why California's employees do not participate in employers' health plans, even though they are eligible, to understand better if the reasons for not taking up insurance coverage are due to affordability, values, or alternatives in coverage.

Exhibit 19 shows the reasons behind the employees' decisions to not take up health insurance from their employer. We explore the reasons for not doing so for *all eligible employees* and for *uninsured eligible employees*.

For all eligible employees, nearly three-quarters (72%) did not participate in their employer's health plan because they were covered by another plan; 19% reported that their job-based coverage was too expensive; 6% traded insurance for a higher wage or did not want their company's health insurance; and only 3% declared that they do not believe or value health insurance. Thus, for California's eligible employees, the main reason for not taking up coverage is that coverage from another source is available to them. Affordability does remain an issue, though, for approximately 282,000 eligible workers in California.

Affordability is an even larger issue for California's *uninsured* eligible workers. About half of uninsured workers who are eligible to participate in their employer's health plan reported that the plan was "too expensive." Six percent reported that they traded insurance for higher pay or did not like their employer's plan; 9% reported that they do not

**EXHIBIT 19. REASONS ELIGIBLE EMPLOYEES DO NOT PARTICIPATE IN EMPLOYER HEALTH PLANS, EMPLOYEES, AGES 18-64, CALIFORNIA, 2001**

| SELF-REPORTED REASONS FOR NOT TAKING UP OWN EMPLOYER'S OFFERED PLAN | ALL ELIGIBLE EMPLOYEES | UNINSURED ELIGIBLE EMPLOYEES |
|---|---|---|
| COVERED BY ANOTHER PLAN/COVERED BY SAME PLAN AS SPOUSE | 72% | – |
| TOO EXPENSIVE | 19% | 50% |
| TRADED INSURANCE FOR HIGHER PAY/DOESN'T LIKE OR WANT COMPANY INSURANCE | 6% | 6% |
| DON'T NEED/BELIEVE IN HEALTH INSURANCE | 3% | 9% |
| OTHER | – | 35% |
| TOTAL | 100% | 100% |

Source: 2001 California Health Interview Survey

value health insurance. Thirty-five percent reported reasons similar to those discussed at the end of Section 2. Thus, our findings do not support the notion that a considerable number of workers may be uninsured "voluntarily"" because they do not value or need health insurance. Clearly, affordability tops and dominates the list of reasons for lack of coverage among eligible uninsured workers.

## CONCLUSION

We began this section by noting that a majority (65.1%) of California's nonelderly adults secure health insurance through their employer or through their family member's employer. We then focused our analysis on California's nearly 13 million employees and discussed the components of coverage to identify which groups of workers may be more at risk in the offer, eligibility, or take-up phases. Then, focusing on 1.85 million uninsured workers, we found that a substantial proportion (61.6%) work in firms that do not offer insurance, with relatively smaller shares of workers who are not eligible (24.3%) and who do not take up health insurance coverage (14.1%). About half of uninsured workers who had "passed" the offer and eligibility phases of coverage reported that they were priced out in taking up coverage, a group that constitutes only about seven percent of uninsured workers.

Policies, such as employee tax credits, that target financing support for employees could provide relief for some uninsured employees, but such policies would still leave out most uninsured workers. And because economically vulnerable groups are shut out early in the offer phase of coverage, policies that only address incentives to take up job-based insurance are unlikely to reduce disparities by labor market and socioeconomic characteristics in job-based coverage. While eligibility issues still have a bearing on coverage, clearly efforts must focus on improving offer and take-up rates. Policies aimed at increasing the number of employers who offer health insurance, in combination with strategies to help low-income workers afford health insurance, would have a modest impact on California's most economically vulnerable workers.

# 4. MEDI-CAL AND THE HEALTHY FAMILIES PROGRAM

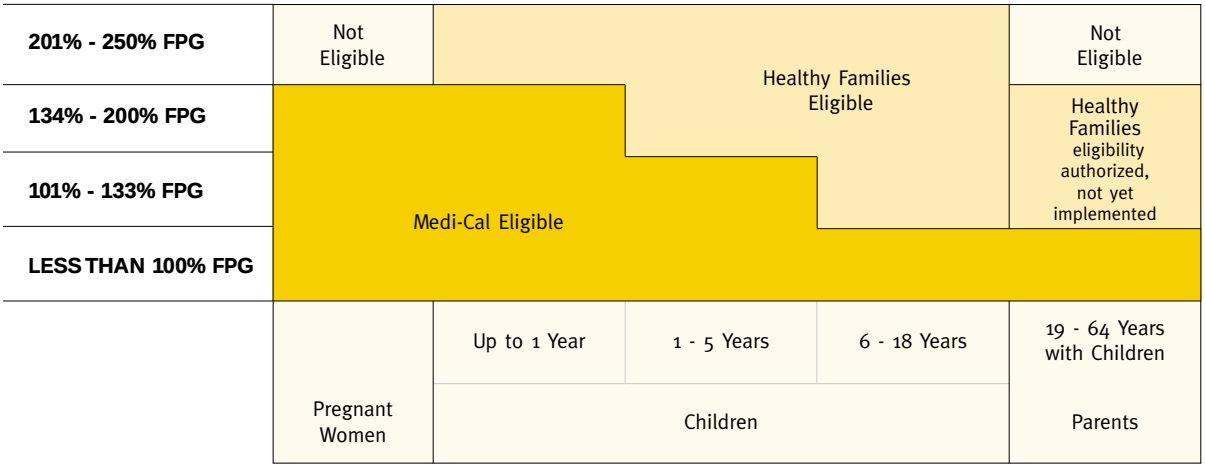
E. Richard Brown, Jeff Luck, Jennifer Kincheloe,
Wei Yen, and Shana Alex Lavarreda

During the last four years, California has expanded its safety-net health insurance programs and taken steps toward making them more user-friendly and more seamless. In 1997, California created the Healthy Families Program as part of its implementation of the federal State Children's Health Insurance Program (SCHIP); at the same time, the State increased income eligibility in Medi-Cal for children up to 18 years of age. The Medi-Cal and Healthy Families programs, along with numerous related health insurance safety-net programs, have been stitched together like a patchwork quilt. This quilt consists of an important, but fragmented and confusing, array of programs that together cover more than one in four children, more than one in 10 nonelderly adults, and nearly one in five elderly Californians.

## THE PATCHWORK QUILT

Under current eligibility rules, children who are citizens, or noncitizens legally residing in the United States, are eligible for either Medi-Cal or Healthy Families up to 250% of the federal poverty guidelines (FPG).[17] The specific program for

**EXHIBIT 20. MEDI-CAL AND HEALTHY FAMILIES INCOME ELIGIBILITY AS A PERCENT OF FEDERAL POVERTY GUIDELINES FOR FAMILIES WITH CHILDREN AND FOR PREGNANT WOMEN, CALIFORNIA, 2001**




FPG = Federal Poverty Guidelines
Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

17 The federal poverty guidelines, published by the U.S. Department of Health and Human Services (DHHS), are used for administrative purposes to determine financial eligibility for federal programs, including Medicaid and California's Healthy Families Program. The income levels are nearly the same as those for the poverty threshold used by the U.S. Census Bureau, but the poverty guidelines count incomes of the immediate ("nuclear") family members, excluding incomes of other household members. In 2001, the poverty guidelines were $8,590 for one person, $11,610 for a family of two, $14,630 for a family of three, and $17,650 for a family of four. *Federal Register*, 2001; 66(33): 10695-10697.

which they are eligible depends on their age, family income, allowed deductions from income, and family size (see Exhibit 20 for age and income provisions for families with children). For example, children ages 6-18 are eligible for Medi-Cal up to 100% of FPG, and they are eligible for Healthy Families from 101% to 250% of FPG, but children between ages 1 and 5 are eligible for Medi-Cal up to 133% of FPG and for Healthy Families from 134% to 250% of FPG. Thus, children within the same family may be eligible for different programs, adding confusion and fragmentation to what otherwise might be a seamless system of coverage.

Pregnant women and their infants are eligible for Medi-Cal to 200% of FPG, and for the Access for Infants and Mothers (AIM) program between 200% and 300% of FPG. Parents with children are eligible for Medi-Cal up to 100% of FPG; however, in addition to the income provisions that children must meet, parents must list their assets and not exceed a low asset limit established by Medi-Cal (called an "assets test"). California has received approval to implement a new expansion for parents to enable them to enroll in Healthy Families if their incomes do not exceed 200% of the FPG (applicants to the Healthy Families Program will not need to pass an assets test) and if they pay the monthly premiums required of parents. Thus, parents' coverage may differ from that of their children, and many parents may not be eligible at all for the programs that could cover their children — adding to confusion and fragmentation and thereby discouraging enrollment and, potentially, use of services. Moreover, Governor Davis, responding to the State's grim fiscal condition in May 2002, has proposed putting the expansion of Healthy Families to parents on hold and rolling back their eligibility for Medi-Cal from 100% of poverty to 67%.

Other adults are eligible for Medi-Cal *only* if they are disabled or blind adults under age 65 or elderly persons above that age and if they meet severe income and asset limits.[18]

## THE IMPORTANCE OF MEDI-CAL AND HEALTHY FAMILIES TO CHILDREN

In this section, we focus on the extent of Medi-Cal and Healthy Families coverage. We begin by examining health insurance coverage for children up to age 18, a slightly different age group than we considered earlier because children in this age group are the target group for expansions of coverage since 1997.

One in 10 white children up to age 18 was covered by Medi-Cal in 2001 and another 2.2% were enrolled in Healthy Families; their low enrollment rates in these programs reflect their high rates of employment-based coverage (Exhibit 21). Just 4.8% of white children were uninsured.

In contrast, Latino children are more than three times as likely to depend on Medi-Cal (34.4%) and Healthy Families (7.6%) for their coverage. Despite the higher proportion enrolled in these public programs, Latino children are four times as likely to be uninsured (18.7%) because they are less than half as likely to be covered by job-based insurance. There is little difference in Medi-Cal and Healthy Families coverage rates across Latino ethnic subgroups although fewer Salvadoran children may be protected by Medi-Cal than other Central American or Mexican-origin children.

18 For more information about Medi-Cal, see *Understanding Medi-Cal: The Basics* (2nd ed.), Oakland, CA: Medi-Cal Policy Institute, September 2001.

**EXHIBIT 21. HEALTH INSURANCE COVERAGE BY RACE AND ETHNIC GROUP, AGES 0–18, CALIFORNIA, 2001**

| | WHITE | LATINO | ASIAN AMERICAN & PACIFIC ISLANDER | AFRICAN AMERICAN | AMERICAN INDIAN & ALASKA NATIVE | OTHER & MULTIPLE RACE |
|---|---|---|---|---|---|---|
| UNINSURED | 4.8 | 18.7 | 6.2 | 3.2 | 15.0 | 11.7 |
| MEDI-CAL | 10.5 | 34.4 | 18.8 | 40.3 | 30.3 | 23.1 |
| HEALTHY FAMILIES | 2.2 | 7.6 | 6.0 | 2.4 | 4.8 | 4.9 |
| JOB-BASED INSURANCE | 76.9 | 36.4 | 64.5 | 52.5 | 47.0 | 57.4 |
| PRIVATELY PURCHASED INSURANCE | 5.0 | 1.1 | 3.1 | 0.8 | 1.8 | 2.5 |
| OTHER PUBLIC COVERAGE | 0.6 | 1.7 | 1.4 | 0.8 | 1.0 | 0.4 |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% |
| POPULATION IN 2000 | 4,214,000 | 3,619,000 | 965,000 | 646,000 | 46,000 | 265,000 |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

Coverage for American-Indian and Alaska Native children follows a similar pattern to that of Latinos: fairly low employment-based coverage, fairly high coverage through Medi-Cal (30.3%) and Healthy Families (4.8%), and a high uninsured rate (15.0%).

A small proportion of African-American children are uninsured (3.2%), a result of a high total enrollment in Medi-Cal and Healthy Families (42.7%), and despite a relatively low proportion covered by employment-based health insurance.

Compared to African Americans, Asian-American and Pacific Islander children have lower rates of enrollment in Medi-Cal (18.8%) and greater enrollment in Healthy Families (6.0%), but they are protected by relatively strong employment-based coverage, resulting in an uninsured rate that is statistically the same as that for white children. Korean children are far more likely to be uninsured than children in other Asian ethnic groups; they are disadvantaged by a low rate of job-based insurance that is *not* offset by higher enrollment in Medi-Cal or Healthy Families.

## UNINSURED CHILDREN AND ADULTS WHO ARE ELIGIBLE FOR MEDI-CAL OR HEALTHY FAMILIES

Of the nearly 1 million uninsured children under age 19 in California, two-thirds are eligible for one of California's public health care coverage programs: an estimated 355,000 for Medi-Cal and another 301,000 for the Healthy Families Program (Exhibit 22). Approximately one-third are not eligible for either program, either because their incomes exceed the eligibility level for Healthy Families (161,000 children) or because they are not citizens and have no "green card" (180,000 children). The latter group are eligible for emergency services paid for by Medi-Cal and may receive, through the Children's Health and Disability Prevention

(CHDP) program, immunizations, health screenings, and treatment for conditions identified during screening.

Among the nearly 3.5 million uninsured adults ages 19-64, approximately 413,000 parents and 52,000 other adults who are not custodial parents are eligible for Medi-Cal under existing policies. Altogether, more than 1.1 million uninsured children and adults are currently eligible for coverage through either Medi-Cal or Healthy Families.

California has received federal approval to extend enrollment in Healthy Families to parents of eligible children in families with incomes up to 200% of the federal poverty level. Although the Governor has proposed delaying this expansion due to the State's severe decline in tax revenues, if it were implemented an estimated 281,000 parents (about one in five uninsured parents) would be eligible for Healthy Families (see the shaded portion of Exhibit 22). With this important expansion, more than 1.4 million uninsured Californians — three in 10 of the state's uninsured residents — would be eligible for Medi-Cal or Healthy Families.

Despite the opportunities for coverage that are available, nearly 2.2 million uninsured children and adults are citizens, or noncitizens with green cards, who are not (and will not be) eligible for any public coverage program. The 538,000 children and parents in this group are ineligible due to incomes that exceed the Healthy Families limit, or in the case of parents, because they may have assets that exceed the Medi-Cal allowance.

In addition, nearly 900,000 uninsured California adults and children are noncitizens without the legal status that a green card conveys. Neither the federal government nor the State provides adequate options for them. They may receive emergency services paid for by Medi-Cal and, if pregnant, they may qualify for prenatal care as well as delivery paid for by Medi-Cal, but they have few other options for affordable care.

**EXHIBIT 22. ELIGIBILITY FOR MEDI-CAL AND THE HEALTHY FAMILIES PROGRAM, UNINSURED NONELDERLY PERSONS BY AGE GROUP, AGES 0–64, CALIFORNIA, 2001**

| | MEDI-CAL ELIGIBLE | HEALTHY FAMILIES ELIGIBLE | CITIZEN OR NONCITIZEN WITH GREEN CARD, NOT ELIGIBLE | NONCITIZEN WITHOUT GREEN CARD, NOT ELIGIBLE | TOTAL |
|---|---|---|---|---|---|
| CHILDREN, AGES 0-18 | 355,000<br>35.6 | 301,000<br>30.2 | 161,000<br>16.2 | 180,000<br>18.0 | 997,000<br>100% |
| PARENTS WITH CHILDREN IN THEIR HOME, AGES 19-64 | 413,000<br>29.3 | 281,000<br>19.9* | 378,000<br>26.7 | 340,000<br>24.1 | 1,412,000<br>100% |
| OTHER ADULTS, AGES 19-64 | 52,000<br>2.5 | N/A | 1,643,000<br>78.9 | 376,000<br>18.0 | 2,080,000<br>100% |

* Expansion of Healthy Families to include parents of eligible children up to 200% FPG has been approved, but not yet implemented.

Note: Numbers may not add to 100% due to rounding. Numbers may not add to total uninsured counts due to some respondents not answering some questions.

Source: 2001 California Health Interview Survey

## CHARACTERISTICS OF UNINSURED CHILDREN AND ADULTS WHO ARE ELIGIBLE FOR MEDI-CAL OR HEALTHY FAMILIES

Many efforts are underway to enroll eligible families in coverage programs, but more can be done. Many community-based outreach efforts are likely to disappear if such outreach funds are eliminated from the State budget, as proposed in the Governor's "May revise." Nevertheless, information that we present below can help to inform and guide these efforts by establishing clearer profiles of the eligible-but-uninsured population. The analysis below focuses especially on children and their eligibility for Medi-Cal or Healthy Families.

Of the 2.6 million children who are eligible for Medi-Cal, more than eight in 10 are enrolled, based on estimates from the 2001 California Health Interview Survey.[19] About six in 10 of those who are enrolled are Latino, but three-fourths of uninsured children who are eligible for Medi-Cal are Latino (Exhibit 23), underscoring the need for substantial efforts targeted to Latino communities to reach this unenrolled and uninsured group. Latinos represent a large share of the uninsured population because they have a high uninsured rate, low incomes, and account for a large share of the population. One in five Medi-Cal enrollees is white, about one in nine is African American, and one in 12 is

**EXHIBIT 23. NONELDERLY PERSONS BY ELIGIBILITY FOR AND ENROLLMENT IN MEDI-CAL AND THE HEALTHY FAMILIES PROGRAM AND BY RACE/ETHNIC GROUP, AGES 0–18, CALIFORNIA, 2001**

| | MEDI-CAL ELIGIBLE | | HEALTHY FAMILIES ELIGIBLE | |
|---|---|---|---|---|
| | COVERED BY MEDI-CAL | UNINSURED BUT MEDI-CAL ELIGIBLE | COVERED BY HEALTHY FAMILIES | UNINSURED BUT HEALTHY FAMILIES ELIGIBLE |
| WHITE | 20.1 | 16.5 | 20.2 | 21.1 |
| LATINO | 56.5 | 73.1 | 60.4 | 66.5 |
| ASIAN AMERICAN & PACIFIC ISLANDER | 8.2 | 3.9 | 12.7 | 6.6 |
| AFRICAN AMERICAN | 11.8 | 1.5 | 3.4 | 2.5 |
| AMERICAN INDIAN & ALASKA NATIVE | 0.6 | 0.9 | 0.5 | 0.6 |
| OTHER & MULTIPLE RACE | 2.8 | 4.2 | 2.8 | 2.7 |
| TOTAL | 100% | 100% | 100% | 100% |
| NUMBER OF PERSONS | 2,206,000 | 355,000 | 458,000 | 301,000 |

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

Source: 2001 California Health Interview Survey

19 The CHIS estimate of Medi-Cal enrollment for ages 0-18 is 2,206,000, compared to administrative data count of 2,700,000 enrollees (based on data from the California Department of Health Services reports for the midpoint during the period in which CHIS was conducted). Therefore, although CHIS captures a greater number of enrollees than previous surveys (see Appendix for further discussion on this point), CHIS still undercounts Medi-Cal enrollment relative to administrative data, an ongoing concern with population-based surveys.

**EXHIBIT 24. LANGUAGE SPOKEN AT HOME AND ENGLISH PROFICIENCY AMONG UNINSURED CHILDREN AND ADULTS WHO ARE ELIGIBLE FOR MEDI-CAL AND THE HEALTHY FAMILIES PROGRAM, AGES 0–64, CALIFORNIA, 2001**

| | MEDI-CAL ELIGIBLE | HEALTHY FAMILIES ELIGIBLE |
|---|---|---|
| **CHILDREN AGES 0-18** | **355,000** | **301,000** |
| SPEAK ONLY ENGLISH AT HOME | 69,000 | 71,000 |
| ENGLISH AND SPANISH AT HOME | 179,000 | 171,000 |
| SPANISH ONLY AT HOME | 87,000 | 32,000 |
| ASIAN OR OTHER LANGUAGES AT HOME | 20,000 | 27,000 |
| SPEAK ENGLISH VERY WELL* | 61,000 | 94,000 |
| SPEAK ENGLISH FAIRLY WELL* | 69,000 | 56,000 |
| SPEAK ENGLISH NOT WELL/NOT AT ALL* | 149,000 | 78,000 |
| **PARENTS AGES 19-64** | **413,000** | **281,000**** |
| SPEAK ONLY ENGLISH AT HOME | 51,000 | 64,000 |
| ENGLISH AND SPANISH AT HOME | 152,000 | 125,000 |
| SPANISH ONLY AT HOME | 177,000 | 67,000 |
| ASIAN OR OTHER LANGUAGES AT HOME | 33,000 | 25,000 |
| SPEAK ENGLISH VERY WELL* | 28,000 | 39,000 |
| SPEAK ENGLISH FAIRLY WELL* | 63,000 | 42,000 |
| SPEAK ENGLISH NOT WELL/NOT AT ALL* | 163,000 | 64,000 |
| **ADULTS AGES 19-64, WITHOUT CHILDREN** | **52,000** | **NOT ELIGIBLE** |
| SPEAK ONLY ENGLISH AT HOME | 19,000 | |
| ENGLISH AND SPANISH OR SPANISH ONLY AT HOME | 21,000 | |
| ASIAN OR OTHER LANGUAGES AT HOME | *** | |

* Asked of respondents who speak languages other than English at home. For children ages 12-18, English proficiency is for themselves; for children under age 12, English proficiency is for responding adult.

** Expansion of Healthy Families to include parents of eligible children up to 200% FPG has been approved, but not yet implemented.

*** The estimate is not statistically stable because coefficient of variation is over 30%.

Note: The sample sizes on which these estimates are based are small; the estimated numbers should be taken as approximations rather than as precise numbers.

Source: 2001 California Health Interview Survey

Asian American and Pacific Islander. Only 16.5% of Medi-Cal-eligible children are white and small fractions are Asian American and Pacific Islander, African American, American Indian and Alaska Native, and other ethnic groups.

We estimate that of approximately three quarters of a million children who were eligible for Healthy Families in 2001, about 458,000 were enrolled when interviewed.[20] The ethnic group distribution of enrollees in Healthy Families is very similar to the distribution of the eligible-but-uninsured population. Two-thirds of uninsured children who are eligible for Healthy Families are Latino, one-fifth are white, and the remainder are other ethnic groups.

Advocates have emphasized the importance of conducting outreach efforts in languages appropriate to the eligible population. Data from CHIS 2001 suggest that this emphasis has been appropriate. Among the 355,000 uninsured children who are eligible for Medi-Cal, about 69,000 speak only English at home (Exhibit 24). The great majority either speak only Spanish or speak both English and Spanish at home: approximately 266,000 children. The remainder speak some combination of Asian and other languages. (Note that the sample sizes on which these estimates are based are relatively small; the estimated numbers should be taken as approximations rather than as precise numbers.)

For uninsured children who are eligible for Healthy Families, the number who speak only Spanish at home is smaller than for Medi-Cal eligible children. The number who have limited English proficiency is also smaller: 149,000 for Medi-Cal vs. 78,000 for Healthy Families.

As might be expected, uninsured parents who are eligible for Medi-Cal follow a similar pattern of English proficiency as that reported for eligible children. (For children up to 11 years of age, it is the parent who reports on language use and English proficiency, as with other indicators.) Eligible adults ages 19-64, without children living in their home, are more evenly distributed across language groups (the small size of this population makes the estimated numbers even less precise and precludes the analysis by English proficiency).

## WHERE DO ELIGIBLE FAMILIES LIVE?

Where do the children and their parents who are eligible for either Medi-Cal or Healthy Families live? Because resources for outreach efforts need to be used cost-effectively, it is helpful to understand the geographic distribution of uninsured children and parents who are eligible for one of these public programs. Exhibit 25 provides approximations of the eligible-but-uninsured population by region and, where sample size permits, by county. These estimates are based on relatively small sample sizes, and we provide only those estimates that are sufficiently reliable to guide public policy. (Note the wide range estimates, or confidence intervals, that indicate the degree of precision of an estimate.)

Corresponding to the distribution of uninsured residents, the great majority of uninsured eligible children live in Southern California — one-third in Los Angeles and nearly another third in the rest of Southern California. About one in eight lives in the San Joaquin Valley and one in 12 in Central Coast counties. With their low rates of

20 This estimate matches closely with the administrative data from the Managed Risk Medical Insurance Board (MRMIB), which runs the Healthy Families Program.

**EXHIBIT 25. APPROXIMATE NUMBER OF UNINSURED CHILDREN AND PARENTS WHO ARE ELIGIBLE FOR MEDI-CAL OR THE HEALTHY FAMILIES PROGRAM BY COUNTY, AGES 0–64, CALIFORNIA, 2001**

| | CHILDREN (AGES 0-18)* | | ADULTS WITH CHILDREN (AGES 19-64)* | |
|---|---|---|---|---|
| | | (95% RANGE) | | (95% RANGE) |
| **NORTHERN AND SIERRA COUNTIES** | **23,000** | (19,000-27,000) | **11,000** | (8,000-13,000) |
| BUTTE, SHASTA, HUMBOLDT, DEL NORTE, SISKIYOU, LASSEN, TRINITY, MODOC, MENDOCINO, LAKE, TEHAMA, GLENN, COLUSA, SUTTER, YUBA, NEVADA, PLUMAS, SIERRA, TUOLUMNE, CALAVERAS, AMADOR, INYO, MARIPOSA, MONO, ALPINE | | | | |
| **GREATER BAY AREA** | **42,000** | (31,000-53,000) | **32,000** | (18,000-46,000) |
| SANTA CLARA, ALAMEDA, CONTRA COSTA, SAN FRANCISCO, SAN MATEO, SONOMA, SOLANO, MARIN, NAPA | | | | |
| **SACRAMENTO AREA** | **12,000** | (8,000-17,000) | ** | ** |
| SACRAMENTO, PLACER, YOLO, EL DORADO | | | | |
| **SAN JOAQUIN VALLEY** | **80,000** | (68,000-93,000) | **46,000** | (37,000-55,000) |
| FRESNO | **18,000** | (10,000-26,000) | **11,000** | (6,000-16,000) |
| KERN | **23,000** | (17,000-29,000) | **12,000** | (8,000-17,000) |
| SAN JOAQUIN | **11,000** | (6,000-15,000) | **6,000** | (2,000-10,000) |
| STANISLAUS | **10,000** | (6,000-15,000) | ** | ** |
| TULARE | **10,000** | (7,000-14,000) | **7,000** | (4,000-10,000) |
| MERCED | **3,000** | (1,000-5,000) | **3,000** | (1,000-4,000) |
| KINGS | **3,000** | (2,000-4,000) | **2,000** | (1,000-3,000) |
| MADERA | **2,000** | (1,000-4,000) | **2,000** | (1,000-3,000) |
| **CENTRAL COAST** | **56,000** | (43,000-68,000) | **20,000** | (14,000-26,000) |
| VENTURA | **28,000** | (18,000-39,000) | ** | ** |
| SANTA BARBARA | **10,000** | (6,000-14,000) | **4,000** | (2,000-7,000) |
| SANTA CRUZ | **3,000** | (1,000-5,000) | ** | ** |
| SAN LUIS OBISPO | **2,000** | (1,000-3,000) | **4,000** | (1,000-6,000) |
| MONTEREY, SAN BENITO | **12,000** | (6,000-18,000) | ** | ** |
| **LOS ANGELES** | **242,000** | (215,000-268,000) | **175,000** | (153,000-198,000) |
| LOS ANGELES | **242,000** | (215,000-268,000) | **175,000** | (153,000-198,000) |
| **OTHER SOUTHERN CALIFORNIA** | **201,000** | (172,000-231,000) | **123,000** | (101,000-146,000) |
| ORANGE | **51,000** | (37,000-65,000) | **42,000** | (28,000-56,000) |
| SAN DIEGO | **63,000** | (46,000-81,000) | **31,000** | (19,000-43,000) |
| SAN BERNARDINO | **42,000** | (29,000-55,000) | **24,000** | (14,000-34,000) |
| RIVERSIDE | **38,000** | (24,000-53,000) | **23,000** | (14,000-33,000) |
| IMPERIAL | **6,000** | (5,000-8,000) | **3,000** | (1,000-5,000) |

(See Exhibit 25 notes on page 51)

uninsurance, the Bay Area and Sacramento Area account for less than one in 10 uninsured eligible children. Although the northern and Sierra counties have somewhat higher uninsured rates than the Bay Area or Sacramento Area, their low population density is reflected in their relatively small share of the state's uninsured eligible children.

Uninsured parents who are eligible for Medi-Cal are, as might be expected, distributed in approximately the same proportions across the regions. The smaller number of uninsured eligible parents results in an even smaller sample size, permitting even fewer reliable estimates for counties and regions.

## WHY AREN'T ELIGIBLE CHILDREN ENROLLED?

In addition to understanding some of the characteristics of uninsured eligible children and where they live, it is important to understand what their parents perceive as barriers to enrolling in Medi-Cal or Healthy Families. In CHIS 2001, parents of uninsured children who were estimated to be potentially eligible for Medi-Cal were asked why their children were not enrolled, and we followed the same procedure for parents of children potentially eligible for Healthy Families.

Of the 355,000 uninsured children eligible for Medi-Cal, parents of one in three thought that their children were not eligible (Exhibit 26). Another 7.8% reported being unsure about their children's eligibility as the reason for not applying, and less than 1 percent did not know the program existed. These parents reflect opportunities for educational outreach programs. Parents of about one in eight uninsured eligible children objected to some characteristics of the program, particularly the onerous paperwork that has been a hallmark of Medicaid nationally and Medi-Cal in California. It is noteworthy that parents of just 3.3% of uninsured children eligible for Medi-Cal made comments reflecting the perception that Medi-Cal is associated with welfare, suggesting that the program is less stigmatized than many believed. And the parents of very few eligible children — less than 4% — do not perceive a need for coverage for their children. (Responses from parents of about four in 10 Medi-Cal-eligible children could not be classified into meaningful categories.)

* Children ages 0-18 are considered "eligible" if they are eligible for either Medi-Cal or Healthy Families. Adults ages 19-64 are considered "eligible" ONLY if they are eligible for Medi-Cal.

** The estimate is not statistically stable because the coefficient of variation equals or exceeds 30%.

Note: These estimates are approximations, based on relatively small sample sizes; all estimates are rounded to the nearest "000." The "95% range" (also called a "confidence interval") provides a more reliable estimate of the number of eligible persons in the population group than does the "point estimate." Point estimates with narrower 95% ranges are more precise, or reliable, than those with wider ranges.

Source: 2001 California Health Interview Survey

**EXHIBIT 26. REASONS UNINSURED ELIGIBLE CHILDREN ARE NOT ENROLLED IN MEDI-CAL OR THE HEALTHY FAMILIES PROGRAM, AGES 0-18, CALIFORNIA, 2001**

| | UNINSURED CHILDREN | |
|---|---|---|
| **REASONS FOR NOT ENROLLING** | **MEDI-CAL ELIGIBLE (AGES 0-18)** | **HEALTHY FAMILIES ELIGIBLE (AGES 0-17)** |
| **BELIEVE NOT ELIGIBLE** | **31.9** | **19.6** |
| INCOME TOO HIGH, NOT ELIGIBLE | 17.3 | 10.5 |
| NOT ELIGIBLE DUE TO CITIZENSHIP/IMMIGRATION STATUS | 7.3 | 3.5 |
| OTHER REASON NOT ELIGIBLE | 7.3 | 5.6 |
| **DIDN'T KNOW IF ELIGIBLE** | **7.8** | **14.2** |
| **DIDN'T KNOW IT EXISTED** | **0.3** | **23.3** |
| **PROGRAM CHARACTERISTICS** | **13.3** | **2.4** |
| PAPERWORK TOO DIFFICULT | 10.0 | 1.6 |
| DON'T LIKE/WANT WELFARE | 3.3 | 0.8 |
| **DON'T BELIEVE IN/DON'T NEED HEALTH INSURANCE** | **3.8** | **3.7** |
| **OTHER** | 42.8 | 36.8 |
| **TOTAL** | 100% | 100% |

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

* Reasons why potentially Medi-Cal eligible uninsured persons were not enrolled were asked of all children and adults, but the comparable question for Healthy Families was asked only for children.

Source: 2001 California Health Interview Survey

Of the approximately 300,000 uninsured children who are eligible for Healthy Families, parents of nearly one in four did not know of the program's existence, suggesting a continuing need to give this program visibility among target populations. Another one in five knew of it but thought that their children were not eligible, while another 14.2% said they did not know if their children were eligible. Among parents of eligible children, only 2.4% objected to program characteristics, including only 1.6% who perceived the paperwork to be overwhelming (in contrast to 10.0% for Medi-Cal-eligible children).

# 5. THE CONSEQUENCES OF NOT HAVING HEALTH INSURANCE

Thomas Rice and Shana Alex Lavarreda

In this section of the report, we examine the relationship between insurance status and several measures of access to health care. Although previous research has shown that the uninsured have less access to care, the magnitude of this disadvantage is not fully known, particularly in California.[21] Uninsured individuals and families typically can use safety-net facilities, but research is scant regarding the extent to which this allows them to obtain necessary care.

This section is divided into two parts. We first examine several indicators of access for the California population as a whole: self-reported health status, usual source of care, and utilization and delays in care. However, this information is necessarily incomplete because it does not adjust for the fact that those with different insurance status may, on average, have different levels of illness. In the second section, we examine the access consequences for those Californians with particular illnesses or health problems.

## CALIFORNIA'S POPULATION AS A WHOLE

Exhibit 27 shows the relationship between insurance status and self-reported health status for adults (ages 18-64). In general, those with Medi-Cal rate their health as poorest – not surprising given that poorer individuals, on average, tend to be less healthy, and because the disabled population is over-represented in Medi-Cal. The uninsured, however, also report lower health status compared to the other groups. Just over one-third of the uninsured report their health to be excellent or very good compared to over three-fifths of adults with job-based insurance. Similarly, over one-fourth of the insured report fair or poor health, in contrast to only about one-tenth of adults with job-based coverage.

**EXHIBIT 27. SELF-REPORTED HEALTH STATUS BY INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2001**

| | SELF-REPORTED HEALTH STATUS | | | | |
|---|---|---|---|---|---|
| | EXCELLENT | VERY GOOD | GOOD | FAIR OR POOR | TOTAL |
| UNINSURED | 14.5 | 21.1 | 38.5 | 25.9 | 100% |
| MEDI-CAL/HEALTHY FAMILIES | 10.3 | 16.9 | 34.5 | 38.3 | 100% |
| JOB-BASED INSURANCE | 23.0 | 38.2 | 28.3 | 10.5 | 100% |
| PRIVATELY PURCHASED INSURANCE | 30.8 | 38.0 | 23.5 | 7.7 | 100% |
| OTHER PUBLIC COVERAGE | 18.0 | 38.5 | 23.0 | 20.5 | 100% |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

21 Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, DC: Institute of Medicine, 2001; and Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. Washington, DC: Institute of Medicine, 2002.

**EXHIBIT 28. SELF-REPORTED HEALTH STATUS BY INSURANCE TYPE, AGES 0-17, CALIFORNIA, 2001**

| | EXCELLENT | VERY GOOD | GOOD | FAIR OR POOR | TOTAL |
|---|---|---|---|---|---|
| UNINSURED | 23.5 | 22.3 | 36.4 | 17.8 | 100% |
| MEDI-CAL/HEALTHY FAMILIES | 30.0 | 23.8 | 32.0 | 14.2 | 100% |
| JOB-BASED INSURANCE | 43.9 | 31.6 | 19.7 | 4.8 | 100% |
| PRIVATELY PURCHASED INSURANCE | 48.7 | 31.1 | 16.8 | 3.4 | 100% |
| OTHER PUBLIC COVERAGE | 18.1 | 23.7 | 37.2 | 21.0 | 100% |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

Exhibit 28 provides similar information for children (ages 0-17). The patterns are similar here, with the exception that uninsured children report slightly *lower* health status than those on Medi-Cal or Healthy Families. Note that responses for children ages 12-17 were given by the adolescents themselves, while responses for children ages 0-11 were given by the "most knowledgeable adult" (MKA). Again, there are large differences between the uninsured and those with job-based coverage. Whereas over three-fourths of the latter report their health as excellent or very good, this is true of less than half of uninsured children. Uninsured children are also more than three times as likely to report fair or poor health status than those with job-based coverage.

In spite of their poorer health status, the uninsured are much less likely than the insured to report a usual source of medical care, and among those who do, that source is considerably less likely to be a doctor's office. Exhibit 29 shows the relationship between insurance status and usual source of care for adults. Nearly half of the uninsured list no usual source of care, which is three times as high as any of the other four insurance categories. The uninsured are only half as likely as those with Medi-Cal to list a doctor's office or HMO as their usual source of care and only one-third as likely as those with job-based coverage or individually purchased private insurance. Both the uninsured and those with Medi-Cal coverage are about three times as likely to list a clinic or community-based hospital as their major sources of coverage than those with job-based or individually purchased coverage.

The CHIS survey queried adults about their major reason for lacking a usual source of care. The main pattern, shown in Exhibit 30, is that over half of the uninsured cite lack of insurance or costs, compared to about one-third of those with Medi-Cal or other public coverage and less than one-tenth of those with job-based or individually purchased coverage. Probably because of their poorer health status, the uninsured are less likely than those with Medi-Cal or job-based or individually purchased coverage to say that it is because they never get sick.

## EXHIBIT 29. USUAL SOURCE OF CARE BY INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2001

| | USUAL SOURCE OF CARE | | | | | |
|---|---|---|---|---|---|---|
| | DOCTOR'S OFFICE/HMO | CLINIC/ COMMUNITY-BASED HOSPITAL | EMERGENCY ROOM | SOME OTHER PLACE | NO USUAL SOURCE OF CARE | TOTAL |
| UNINSURED | 26.5 | 25.3 | 2.6 | <0.1 | 45.6 | 100% |
| MEDI-CAL/ HEALTHY FAMILIES | 53.5 | 28.5 | 2.7 | <0.1 | 15.4 | 100% |
| JOB-BASED INSURANCE | 82.2 | 8.1 | 1.1 | <0.1 | 8.7 | 100% |
| PRIVATELY PURCHASED INSURANCE | 76.7 | 8.6 | 0.9 | <0.1 | 13.9 | 100% |
| OTHER PUBLIC COVERAGE | 28.9 | 58.2 | 3.4 | <0.1 | 9.6 | 100% |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

## EXHIBIT 30. REASONS FOR NO USUAL SOURCE OF CARE BY INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2001

| | REASONS FOR NO USUAL SOURCE OF CARE | | | | |
|---|---|---|---|---|---|
| | NEVER GET SICK | NO INSURANCE | COST OF CARE | OTHER | TOTAL |
| UNINSURED | 24.3 | 34.1 | 21.1 | 20.5 | 100% |
| MEDI-CAL/HEALTHY FAMILIES | 32.0 | 18.9 | 15.3 | 33.8 | 100% |
| JOB-BASED INSURANCE | 47.0 | 3.4 | 2.4 | 47.2 | 100% |
| PRIVATELY PURCHASED INSURANCE | 49.9 | 3.0 | 5.5 | 41.6 | 100% |
| OTHER PUBLIC COVERAGE | 25.1 | 23.3 | 8.7 | 42.9 | 100% |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

**EXHIBIT 31. USUAL SOURCE OF CARE BY INSURANCE TYPE, AGES 0-17*, CALIFORNIA, 2001**

| | USUAL SOURCE OF CARE | | | | | |
|---|---|---|---|---|---|---|
| | DOCTOR'S OFFICE/HMO | CLINIC/ COMMUNITY-BASED HOSPITAL | EMERGENCY ROOM | SOME OTHER PLACE | NO USUAL SOURCE OF CARE | TOTAL |
| UNINSURED | 31.2 | 40.3 | 1.1 | 1.2 | 26.2 | 100% |
| MEDI-CAL/ HEALTHY FAMILIES | 54.6 | 37.9 | 1.3 | 0.3 | 5.9 | 100% |
| JOB-BASED INSURANCE | 85.3 | 10.2 | 0.5 | 0.4 | 3.6 | 100% |
| PRIVATELY PURCHASED INSURANCE | 80.9 | 10.9 | 0.5 | 0.7 | 7.0 | 100% |
| OTHER PUBLIC COVERAGE | 32.8 | 47.6 | 0.2 | 2.3 | 17.1 | 100% |

* Ages 0-11 received a follow-up question regarding type of clinic. However, since both ages 0-11 and ages 12-17 were asked the same initial question about type of usual source of care, the two have been combined into a single dataset.

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

Exhibit 31 shows the relationship between insurance status and usual source of care for children. Although the differences between children and adults in reporting a usual source of care are not statistically significant, uninsured children are significantly more likely than others to have no usual source. Like adults, uninsured children are also much less likely to have the doctor's office or HMO as their usual source of care than are members of these other groups. The other interesting pattern in the table is that only about 10% of children with either job-based or privately purchased individual coverage list a clinic or community-based hospital as their usual source of care, whereas one-third with Medi-Cal or Healthy Families, and nearly half of those with other public coverage, cite this source. Thus, even among the insured, those with public insurance are far more likely to seek their care from clinics or community-based hospitals. This shows the roles of the safety net for the uninsured and the continuing importance of community health and county clinics among families with Medi-Cal and Healthy Families coverage.

The next two tables provide measures of usage or lack of usage of services among California adults. Exhibit 32 shows the relationship between insurance status and number of physician visits for those who report their health as being only fair or poor. The uninsured in fair or poor health are more than twice as likely to forego physician visits. Thirty-five percent did not see a doctor in the past 12 months, more than twice that of any other group. The figures are equally dramatic if one groups the first two columns and looks at respondents with between zero and two visits. Over two-thirds of the uninsured in fair or poor health visited the doctor twice or less during the year, compared to less than half of members of the other insurance groups.

**EXHIBIT 32. VISITS TO A DOCTOR IN THE PAST 12 MONTHS AMONG PEOPLE IN FAIR/POOR HEALTH BY INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2001**

| | NUMBER OF DOCTOR VISITS IN PAST 12 MONTHS | | | | |
|---|---|---|---|---|---|
| | NO DOCTOR VISIT | 1-2 | 3-4 | 5+ | TOTAL |
| UNINSURED | 35.2 | 33.2 | 13.9 | 17.8 | 100% |
| MEDI-CAL/HEALTHY FAMILIES | 9.8 | 18.2 | 17.4 | 54.6 | 100% |
| JOB-BASED INSURANCE | 10.5 | 29.0 | 19.7 | 40.7 | 100% |
| PRIVATELY PURCHASED INSURANCE | 14.0 | 33.0 | 16.0 | 37.1 | 100% |
| OTHER PUBLIC COVERAGE | 10.3 | 8.8 | 21.3 | 59.7 | 100% |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

**EXHIBIT 33. DELAYS OF HEALTH CARE BY INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2001**

| | DELAY GETTING PRESCRIPTION | DELAY HAVING A TEST/TREATMENT | DELAY OF ANY OTHER CARE |
|---|---|---|---|
| UNINSURED | 7.5% | 6.4% | 19.2% |
| MEDI-CAL/HEALTHY FAMILIES | 12.8% | 8.4% | 13.2% |
| JOB-BASED INSURANCE | 9.6% | 8.5% | 11.2% |
| PRIVATELY PURCHASED INSURANCE | 9.9% | 10.0% | 14.1% |
| OTHER PUBLIC COVERAGE | 10.4% | 9.5% | 14.0% |

Note: Numbers may not add to 100% due to rounding.
Source: 2001 California Health Interview Survey

In contrast, the figures in Exhibit 33, which focus on delays in care, do not show much of a pattern. Although the uninsured are somewhat more likely to delay getting other types of care, they do not show longer delays in getting prescriptions or tests than others. The likely explanation is that because they see physicians less frequently, they have fewer opportunities to delay getting prescriptions and tests because physicians are less likely to prescribe/order them.

**EXHIBIT 34. RESPONDENTS WITH SELECTED CHRONIC DISEASES BY ACCESS INDICATOR AND INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2001**

| | SELECTED CHRONIC DISEASES* | ACCESS INDICATOR** |
|---|---|---|
| | **ASTHMA SYMPTOM PREVALENCE** | **TAKING MEDICATION FOR ASTHMA** |
| UNINSURED | 6.4% | 41.3% |
| MEDI-CAL/HEALTHY FAMILIES | 12.2% | 67.8% |
| JOB-BASED INSURANCE | 8.8% | 45.1% |
| | **DIABETES PREVALENCE** | **TAKING INSULIN OR PILLS FOR DIABETES** |
| UNINSURED | 3.5% | 57.8% |
| MEDI-CAL/HEALTHY FAMILIES | 9.5% | 75.4% |
| JOB-BASED INSURANCE | 4.1% | 75.7% |
| | **HIGH BLOOD PRESSURE PREVALENCE** | **TAKING MEDICATION FOR HIGH BLOOD PRESSURE** |
| UNINSURED | 12.4% | 29.5% |
| MEDI-CAL/HEALTHY FAMILIES | 23.9% | 61.3% |
| JOB-BASED INSURANCE | 16.6% | 53.1% |
| | **HEART DISEASE PREVALENCE** | **TAKING MEDICATION FOR HEART DISEASE** |
| UNINSURED | 2.7% | 27.2% |
| MEDI-CAL/HEALTHY FAMILIES | 9.3% | 60.1% |
| JOB-BASED INSURANCE | 3.6% | 42.4% |

* Rate among whole population.
** Rate among those with the chronic disease.

Note: Numbers are individual rates and will not add to 100%.
Source: 2001 California Health Interview Survey

## CALIFORNIANS WITH PARTICULAR HEALTH PROBLEMS

In addition to querying respondents about their overall health and use of services, CHIS asked a battery of questions among those with particular illnesses or health problems. We report selected findings for asthma, diabetes, high blood pressure, and heart disease. The survey asked several questions (depending on the type of illness); in this section we show how the results correlate with health insurance. To simplify the presentation, we provide figures for just the three largest insurance categories: the uninsured, those with Medi-Cal or Healthy Families, and those with job-based coverage.

Exhibit 34 shows these results for ages 18-64. The uninsured show a somewhat lower symptom prevalence of asthma than those on Medi-Cal/Healthy Families or with job-based coverage. Among those reporting asthma, however, the uninsured have similar rates of taking asthma medication as individuals with job-based coverage, but are far less likely than those with Medi-Cal. Just 41.3% of the uninsured with asthma take medications, compared to 45.1% for those with job-based coverage and 67.8% for those with Medi-Cal or Healthy Families.

A similar trend exists among people with diabetes. Again, prevalence rates are lower for the uninsured, but among those who report having diabetes, far fewer are taking insulin or pills: 57.8% of the insured compared to 75.4% and 75.7% of those with Medi-Cal/Healthy Families and those with job-based coverage, respectively.

Among people with high blood pressure, again the pattern is the same. Fewer uninsured report having high blood pressure, but there is a dramatic difference by insurance status in whether they take medication for this problem. Only 29.5% of the uninsured with high blood pressure take medications, about half that for those with Medi-Cal/Healthy Families (61.3%) or job-based coverage (53.1%).

Finally, the data on heart disease exhibits the exact same pattern. Although fewer uninsured report having heart disease, those with this condition are much less likely to take medications. Just 27.2% of the uninsured indicate that they take medication for it, compared to 60.1% of those with Medi-Cal/Healthy Families and 42.4% of those with job-based coverage.

Overall, then, we see that insurance coverage is strongly correlated with taking medication for chronic diseases. In addition, it is noteworthy that for three of the four chronic diseases (asthma, high blood pressure, and heart disease), far more individuals with Medi-Cal take medication than those with private coverage. This indicates how important Medi-Cal coverage can be for improving health behaviors. Although it is not possible to prove that uninsurance *causes* Californians to refrain from taking needed medications without controlling for confounding variables, such a sequence of events is highly likely given the high price of medicines and the relatively low incomes of uninsured individuals and families. Combined with our findings from the previous subsection that showed lower health status, utilization, and lack of regular sources of care, it is clear that the uninsured face numerous obstacles in attempting to use California's health care system.

# 6. PUBLIC POLICIES THAT EXPAND COVERAGE FOR CHILDREN AND ADULTS

6

E. Richard Brown, Thomas Rice, Ninez Ponce, and Shana Alex Lavarreda

California's 4.5 million uninsured residents need the same level of access to health care as the rest of the population but, as we have shown, their access to care is seriously compromised. The uninsured are overwhelmingly moderate- and low-income working men and women and their families, playing by society's rules but without the basic benefit that the majority of employees and others receive. As we have seen, these workers are either not offered health insurance coverage by their employers or they cannot afford the required share of cost for job-based health insurance premiums.

## IS THERE CAUSE FOR OPTIMISM?

Health insurance coverage improved in California over the last several years, but this trend is not likely to be sustained. The rate of uninsurance declined from 21.0% of the nonelderly population in 1999 to 20.0% in 2000, based on data from the Current Population Survey.[22] (Despite its limitations, the CPS provides a useful measure of changes over time in health insurance coverage and uninsurance. CHIS 2001 provides a more comprehensive understanding of these issues during 2001, and it will allow California to more accurately and in-depth track changes over time with CHIS 2003 and surveys in subsequent years.)

This improvement between 1999 and 2000 was driven by California's still-strong economy, which resulted in a substantial increase in employment-based health insurance up to the time the Current Population Survey was conducted in March 2001. The increase in coverage was aided by growing enrollments in Medi-Cal and the Healthy Families Program — a contrast to the period from 1994 to 1998 when Medi-Cal enrollment declined rapidly among adults and children who were receiving cash assistance.[23]

The combination of growing job-based insurance coverage and stable Medi-Cal and Healthy Families enrollments reduced the number of uninsured in California by an estimated 375,000 between 1998 and 2000. The economic contraction in California and nationally that occurred since these data were collected, together with substantial increases in the cost of health insurance, are likely to reverse the downward trend in uninsurance.[24]

## PUBLIC POLICY TOOLS TO EXPAND COVERAGE

California has many policy tools to help it improve coverage for its uninsured residents through effective public policies. In this final section of the report, we offer several recommendations that could help California improve its existing programs and policies and expand them to cover uninsured residents.

Our recommendations focus on the State's process to stimulate public dialogue on ways to improve and expand our public health insurance coverage programs and to move toward universal coverage. Despite the dominance of employment-based health insurance, we believe that efforts to expand job-based insurance to low-wage, low-income employees of small firms are not likely to pay off with

22 For a more detailed look at this change in health insurance in California, see Brown ER, Alex S, Becerra L, *Number of Uninsured Californians Declines to 6.2 Million—2 Million Are Eligible for Medi-Cal or Healthy Families*, Health Policy Fact Sheet. Los Angeles: UCLA Center for Health Policy Research, March 2002.

23 For more on the decline in this period, see Brown ER, Ponce N, Rice T, *The State of Health Insurance in California: Recent Trends, Future Prospects*. Los Angeles: UCLA Center for Health Policy Research, March 2001; Fix M, Passel J, *The Scope and Impact of Welfare Reform's Immigrant Provisions*. Washington, DC: The Urban Institute, 2002; and Lutzky AW, Zuckerman S, *Recent Changes in Health Policy for Low-Income People in California*. Washington, DC: The Urban Institute, March 2002.

24 Lee D, "CalPERS to Raise Health Premiums 25%," *Los Angeles Times*, April 17, 2002; and Abelson R, "Hard Decisions for Employers as Costs Soar in Health Care," *New York Times*, April 18, 2002.

significant expansions. The cost to these employers is great relative to the wages they pay employees, and job-based health benefits are relatively expensive to low-wage workers.[25] Some valuable efforts have been made in this direction, but they yield small results and, frankly, show little promise of bridging the coverage chasm in California. We believe that California will achieve its best results if it uses existing and emerging opportunities to expand its public coverage programs.

### Public Programs to Cover Uninsured Californians

#### Policy Recommendation

- Cover entire families, including children and parents, by implementing the Healthy Families expansion to parents and eliminating the assets test for parents applying for Medi-Cal.

Even opportunities to expand public programs seem distant with the very grim loss of tax revenues that struck California with the collapse of the "dot com" industry and the economic decline in 2001. The budget process remains to be completed, but coverage of families will be severely impacted by current budget proposals to delay implementation of the Healthy Families expansion to parents, cut their Medi-Cal eligibility from 100% of the poverty level to just 67% of poverty, and reinstate quarterly reporting of changes in income and assets for parents in Medi-Cal.[26]

The federal government provides relatively generous matching funds for California to support state-level expansion of coverage for children and for their parents and some other adults. California receives approximately $1 in federal matching funds for every dollar it spends on coverage for Medi-Cal-eligible children and adults. The State receives approximately $2 in federal funds for every dollar it spends on the Healthy Families Program although the State's share of SCHIP funds is capped by the total funds appropriated by the Congress. The availability of a generous federal match makes these effective vehicles for expanding coverage.

California and other states have moved gradually to recognize that children and the State itself are best served by policies that embrace the entire family. The federal welfare reform legislation of 1996 completed the growing separation of Medicaid from cash public-assistance programs and liberalized the provisions by which states could expand coverage to children and families. Many states, including California, have used these options and reformed and expanded their programs to benefit more children and, to a lesser extent, their parents.

California could do more to expand coverage options and complete the transition of Medi-Cal from its welfare origins to a health insurance program that serves families and individuals on the basis of income alone. Implementing parents' coverage in Healthy Families is an important part of this process, and it would have other benefits beyond insuring these adults. There is evidence from other states that children enroll in Medicaid and state programs like Healthy Families at a higher rate when both parents and their children are eligible.[27] Moreover, the federal government would provide two-thirds of the subsidy costs of coverage for these parents, reducing the drain on State and county tax dollars that now subsidize the care of low- and moderate-income uninsured Californians through county-sponsored health services programs, the State's

25 Marquis S, Long SH, "Trends in the Cost of Employer-Sponsored Coverage," Data Bulletin No.14, Center for the Study of Health System Change, Fall 1998.

26 2002-03 Governor's May Revision, Department of Health Services. Sacramento, CA: May 2002.

27 Ku L, Broaddus M, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms*. Washington, D.C.: Center on Budget and Policy Priorities, September 5, 2000.

County Medical Services Program, and support to private hospitals and community clinics.

More than 400,000 uninsured parents are currently eligible for Medi-Cal. If California were to implement the expansion of the Healthy Families Program to parents, an additional 281,000 uninsured parents would have an opportunity to gain coverage (Exhibit 22). With this expansion, nearly half of the 1.4 million uninsured parents with children at home would be eligible for public coverage.

Ironically, however, expanding Healthy Families to uninsured parents with family incomes up to 200% of the poverty level would provide a less stigmatizing and burdensome application process for parents above the poverty level than for those below it. Parents with incomes at or below 100% of poverty who apply for Medi-Cal are currently required to answer a long set of intimidating questions about assets and provide proof that their possessions have little value — while families with incomes above poverty will have no assets test at all when they apply for Healthy Families. Since 1996, 16 states have eliminated their assets tests for Medicaid eligibility, as California has done for children.[28] This step is an important one in enabling all members of a family to be covered, and it would eliminate an inequity that otherwise disadvantages the already disadvantaged.

## Enhancing Enrollment of Eligible Persons in Medi-Cal and Healthy Families

### Policy Recommendation

- The State should more fully engage community-based organizations, churches, and schools in culturally sensitive outreach and expand funding for these efforts.
- Fully implement Express Lane Eligibility to expedite enrollment in health programs for children who are participating in the Food Stamps and the School Lunch Programs.

The fact that 1.1 million uninsured children and adults are eligible for, but not enrolled in, Medi-Cal or Healthy Families underscores the importance of expanded efforts to enroll and retain eligible persons in these programs. Two key steps will enhance enrollment without expanding eligibility.

First, California has already adopted "Express Lane Eligibility" to expedite enrollment in Medi-Cal and Healthy Families for hundreds of thousands of uninsured children who are already enrolled in programs with comparable income-eligibility provisions, such as Food Stamps and the National School Lunch Program. By using the income information already provided to these programs, large numbers of uninsured children can be identified and enrolled in health care coverage more quickly, also avoiding unnecessary red tape. However, in response to the growing revenue shortfall, Governor Davis has proposed deferring implementation of Express Lane Eligibility until 2005, saving the State an expected $26 million in General Fund revenues but missing out on valuable opportunities to cover uninsured children.[29]

28 Maloy KA, Kenney KA, Darnell J, Cyprien S, *Can Medicaid Work for Low-Income Working Families?* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2002.

29 *Express Lane Eligibility: How California Can Enroll Large Numbers of Uninsured Children in Medi-Cal and Healthy Families*, Los Angeles: The 100% Campaign, February 2000; and *Putting Express Lane Eligibility Into Practice*. Santa Monica, CA, and Washington, DC: The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, November 2000. See also Rosenblatt RA, "Uninsured Kids Get a Booster Shot," *Los Angeles Times*, January 7, 2001.

Second, both state and locally funded outreach efforts to inform parents and enroll eligible children could more fully engage community-based organizations, schools, and churches. Community groups and schools have proved very successful in reaching and enrolling eligible children when they have the resources to mount sustained efforts.[30] In the past, California's outreach has relied too heavily on expensive media campaigns and not effectively engaged these other channels of communication. While the state has recently involved these groups through outreach contracts, faced with the enormous deficit the Governor has proposed eliminating these contracts. Such cuts are likely to reduce program participation rates of eligible families, particularly cutting into culturally appropriate outreach efforts targeted to Latino and other immigrant communities — a need that the CHIS data presented in this report confirms.

### Mobilize Community Resources and Innovation

**Policy Recommendation**

- Local jurisdictions can generate local resources and innovation to expand coverage of their residents.

In the absence of federal and statewide policies that would dramatically expand coverage, a number of counties and cities have committed local resources and mobilized community leadership to address the problem. Alameda, Contra Costa, San Francisco, San Joaquin, Santa Clara, and Solano Counties have all committed local public revenues, usually in collaboration with the the county-sponsored Medi-Cal managed care plan, to subsidize coverage for children and adults. These programs usually target groups that would not be eligible for Medi-Cal or Healthy Families. San Mateo County seems poised to join this group. Both the City and the County of Los Angeles, as well as San Francisco, San Jose, and some other cities and counties have enacted "living wage" ordinances to raise the minimum wage for employees of local government contractors and encourage employers to offer health benefits.[31] These local efforts can make important contributions to addressing the problem of uninsurance.

### Streamlining the Medi-Cal and Healthy Families Programs

**Policy Recommendation**

- Reduce fragmentation for families by integrating Medi-Cal and Healthy Families.

Medi-Cal and Healthy Families benefit millions of Californians, but their patchwork character fragments coverage for families and individuals who must navigate multiple programs. Beneficiaries are divided between two separate programs, Medi-Cal and Healthy Families, that differ in eligibility by age and income. Families may weave in and out of either program as income fluctuates and as children grow older. Their children may also be divided between the two programs because of different income eligibility levels for different ages. This patchwork system increases administrative costs for multiple bureaucracies needed to administer differing programs, rules, and application and eligibility determination processes. And it poses a frustrating and often discouraging experience for families and individuals who must deal with so many bureaucracies.

30 Long P, *Local Efforts to Increase Health Insurance Coverage among Children in California*, Oakland, CA: Medi-Cal Policy Institute, February 2002.

31 Long P, *County Efforts to Expand Health Coverage among the Uninsured in Six California Counties*, Oakland, CA: Medi-Cal Policy Institute, February 2002; and de Sá K, "Supervisors Pledge Funds for Coverage," *San Jose Mercury News*, May 19, 2002.

This fragmentation could be reduced in several ways. It could be ameliorated by establishing a "bright line" between the programs — at, say, 133% of poverty — so that eligible children up to that level would be enrolled in Medi-Cal and those above that level would be enrolled in Healthy Families.[32] Equally important would be to adopt similar eligibility policies for parents in Medi-Cal as the Governor has agreed to do for parents in Healthy Families, which are the same as current policies for children.

Fragmentation could be even more fully remedied by integrating Medi-Cal and Healthy Families into a coordinated or consolidated program. Existing program rules could be coordinated so that gaps and abrupt changes in eligibility and benefits are smoothed out. Although it would be best to fully integrate the programs — including eligibility requirements, application procedures, benefits, and administration — it would also be possible to integrate only their interface with beneficiaries and health care providers. This more limited integration could be accomplished by crafting an administrative overlay that would manage the application and enrollment of the two programs' beneficiaries, creating a system that appears seamless to beneficiaries and providers and thus avoids the fragmentation that currently frustrates families and advocates.[33]

Integrating these programs would make them more streamlined and user-friendly for beneficiaries. Although it is unclear whether reducing fragmentation would directly increase enrollment, there is evidence it would reduce the State's administrative costs, permitting more funds to be redirected to coverage and services.[34]

**The Gap in Coverage Remains Large – The Goal Should Be Universal Coverage**

**POLICY RECOMMENDATION**

- Continue the policy dialogue of the State Health Care Options Project, mandated by SB 480 and vigorously conducted by the Secretary of Health and Human Services, to examine alternative ways to extend health insurance coverage to all Californians.

Even if the Healthy Families expansion to parents were implemented and Medi-Cal and Healthy Families were streamlined, California would continue to have more uninsured residents than the populations of nearly half the states. More than 3 million California residents, including more than 2 million who are citizens or legal immigrants, would be uninsured and have no public coverage options. The United States has the intellectual and financial resources to find a way of achieving universal coverage — following the examples set long ago by other industrialized countries. This goal has wide and deep popular support in the United States although the political means for achieving that goal seem elusive.

Senate Bill (SB) 480, enacted by the Legislature and signed by Governor Davis in 1999, launched a process to develop a study of alternative approaches to reaching universal coverage. Secretary Grantland Johnson, who heads the Health and Human Services Agency, has conducted a far-reaching process, known as the Health Care Options Project, to generate a wide range of proposals for expanding coverage and initiating a public dialogue on them. The process has been informed by nine commissioned reform

32 According to the National Governors Association, 29 states enroll all children up to age 18 with family income up to at least 133% of poverty in their Medicaid programs. This at least avoids fragmenting coverage among children within a family. See *http://www.nga.org/Pubs/IssueBriefs/2000/000120MCHUpdate.asp#1* (Jan. 11, 2001).

33 Integration of Medi-Cal and Healthy Families has been proposed in a number of legislative proposals in California, including AB32 by Assemblymember Keith Richman and SB 1414 by Senator Jackie Speier.

34 See Rabovsky D, *A Model for Health Coverage of Low-Income Families*. Sacramento, CA: Legislative Analyst's Office, June 1, 1999.

proposals, quantitative and qualitative comparative analyses of the reform proposals, and public symposia held in a variety of locations throughout the state. The proposals include public program expansions, individual and employer tax credits, employer and individual mandates, single-payer models, and combination approaches.[35]

Although it is a long road from generating reform ideas to achieving universal coverage, the Health Care Options Project can generate a needed political dialogue on the best and most feasible ways to reach that goal. We recommend that the Governor continue that process, engaging the Legislature and a wide range of constituencies.

## CONCLUSION

California's 4.5 million uninsured residents face tremendous obstacles to obtaining needed care. California's uninsured children and adults face barriers to obtaining the care they need to manage their chronic conditions (such as asthma, diabetes, and high blood pressure), care that can help reduce disability and increase productive years of life. They are more likely to delay seeking care for acute conditions (such as infections and injuries), resulting in more lost earnings and increasing the risk of spreading communicable diseases. And they receive fewer preventive services that help reduce the risk of disease and detect diseases at an earlier stage.

California is squeezed by a fiscal dilemma. It has a persistent and large problem of uninsurance, and it faces an extraordinarily large shortfall in tax revenues. The budget problems may discourage the State from expanding its efforts to provide coverage, and it has led to rescission of already adopted expansions and reform.

In the longer run, California and the nation must commit to extending to all residents affordable coverage that provides good access to high-quality, health-enhancing care. Although there are costs to ensuring that all residents have coverage, there are great costs associated with a large portion of our population remaining uninsured — lost earnings, lost school days, lost potential, and lost life.

35 For more information on the Health Care Options Project and for copies of the papers and analyses, visit the Web site at *http://www.healthcareoptions.ca.gov/*.

# APPENDIX. SURVEY METHODS AND EFFECTS ON RESULTS

appendix

This report is based on data from the 2001 California Health Interview Survey (CHIS). In this Appendix, we describe the survey, discuss the relationship of its estimates to those of other surveys, and compare its method to those of other surveys.

## CALIFORNIA HEALTH INTERVIEW SURVEY

CHIS 2001 randomly selected 55,428 households drawn from every county in California for its random-digit dial (RDD) telephone survey, providing a sample that is representative of the state's noninstitutionalized population living in households. Data were weighted to the 2000 Census, at both the stratum and statewide levels. CHIS interviewed one sample adult in each household. In households with children, CHIS interviewed one adolescent age 12-17 (a total of 5,801), and obtained information for one child under age 12 by interviewing the adult who was most knowledgeable about the child (a total of 12,592). The interviews were conducted between November 2000 and September 2001 by Westat, a highly respected survey research organization. In addition to the RDD sample, CHIS conducted an oversample of American Indians and Alaska Natives residing in both urban and rural areas and oversamples of Japanese, Vietnamese, South Asians, Koreans, and Cambodians; this report does not include data from these oversamples.

All CHIS questionnaires were translated and interviews were conducted in six languages: English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, Korean, and Khmer (Cambodian). Questionnaires were also reviewed by expert teams to ensure that question wording was culturally appropriate for a variety of population groups. Community outreach campaigns were conducted in communities of color to encourage the participation of populations that often have low participation rates in surveys. These campaigns used media and materials that were both culturally and linguistically appropriate to particular communities.

CHIS covered a broad range of public health concerns, including health insurance coverage, eligibility for and participation in public health care programs, access to and use of health care services, health and mental health status, chronic conditions (asthma, cancer, cardiovascular disease, arthritis, and diabetes), health behavior (including diet and physical activity, alcohol and tobacco use, and cancer prevention), dental health, women's health, and demographic characteristics (including employment, income, and extensive information on race, Latino, Asian, and Pacific Islander ethnicity; nativity of the respondent and his/her parents, citizenship, immigration status, and English proficiency).

For more information on CHIS, please visit *www.chis.ucla.edu*.

## CHIS AND THE CURRENT POPULATION SURVEY

The estimates of uninsurance based on CHIS 2001 data differ from estimates of uninsurance based on the Current Population Survey (CPS). The CPS is the data source previously used by the UCLA Center for Health Policy Research for its annual reports on health insurance coverage, and the lack of it, in California.

The CPS is a national cross-sectional survey of persons living in households, administered in person and by telephone. The California sample of the March 2001 CPS includes 4,338 households, collecting information on approximately 12,966 persons. The CPS is conducted by the U.S. Bureau of the Census to obtain information on employment, unemployment, and demographic status of the noninstitutionalized, U.S. civilian population. The March CPS also asks about health insurance coverage, employment, and sources of income during the previous calendar year as well as ethnicity, immigrant and citizenship status, and nativity of each household member. The most recent CPS data that are available come from the March 2001 CPS, which asks about health insurance coverage in 2000. We use the CPS to compare recent estimates with those from some previous years for which comparable questions were asked.[36]

Using data from the March 2001 CPS, we would estimate that 6.27 million Californians were uninsured in 2000 — 2.6 million more than the CHIS 2001 estimate of the number of Californians who were uninsured throughout the preceding 12 months and 1.8 million more than the estimate of persons who were uninsured at the time of the CHIS interview (Exhibit A-1). The estimate of uninsurance at the time of the interview or during at least some of the preceding 12 months (6,272,000) is much closer to the CPS estimate (6,273,000).

Among children up to age 18, the March 2001 CPS estimate (15.4%) is twice the CHIS 2001 estimate of those who were uninsured throughout the previous 12 months (7.3%) — the period of time that appears to be most similar in the two surveys, based on the wording of the questions. The March 2001 CPS estimate is also one-and-a-half times the CHIS 2001 estimate (9.6%) of children who were uninsured at the time of the interview, but it is closest to the estimate of those who were uninsured at some time during a period of 12 months (14.3%).

For nonelderly adults (ages 18–64), the March 2001 CPS estimated uninsured rate is 22.1%. This rate is one-and-a-half times the CHIS 2001 estimate that 14.4% were uninsured throughout the preceding 12 months; well above the CHIS 2001 estimate of adults who were uninsured at the time they were interviewed (17.7%); and slightly lower than the CHIS 2001 estimate of nonelderly adults who were uninsured at some time during a period of 12 months (24.1%). Both surveys find very low uninsured rates for persons age 65 and over: 1.6% based on the March 2001 CPS compared to CHIS 2001 estimates of less than 1% at the time of the interview, less than 1% uninsured throughout 12 months, and 1.5% uninsured at some time during a period of 12 months.

36 CPS added a "verification" question in 2000 which identified more respondents who have coverage. This change limits much of our trend analysis to 1999 (March 2000 CPS) and 2000 (March 2001 CPS). We have extrapolated a slightly longer time trend to measure the magnitude of change.

**EXHIBIT A-1. UNINSURED PERSONS BY AGE GROUP BASED ON 2001 CALIFORNIA HEALTH INTERVIEW SURVEY AND MARCH 2001 CURRENT POPULATION SURVEY, ALL AGES, CALIFORNIA**

| | 2001 CALIFORNIA HEALTH INTERVIEW SURVEY | | | MARCH 2001 CURRENT POPULATION SURVEY |
|---|---|---|---|---|
| **PERCENT UNINSURED** | **UNINSURED AT TIME OF INTERVIEW** | **UNINSURED AT SOME TIME DURING LAST 12 MONTHS*** | **UNINSURED DURING ALL OF LAST 12 MONTHS**** | **UNINSURED IN 2000***** |
| AGES 0–17 | 9.6% | 14.3% | 7.3% | 15.4% |
| AGES 18–64 | 17.7% | 24.1% | 14.4% | 22.1% |
| AGES 65 AND OVER | 0.5% | 1.5% | 0.5% | 1.6% |
| ALL AGES | 13.7% | 19.0% | 11.0% | 18.1% |
| **NUMBER UNINSURED IN 2000** | **4,519,000** | **6,272,000** | **3,640,000** | **6,273,000** |

* Includes persons who were uninsured at the time of the interview and those who were insured at the time of the interview but uninsured at some time during the preceding 12 months

** Includes persons who were uninsured at the time of the interview and those who were uninsured during all of the preceding 12 months

*** Persons who reported no coverage at any time during 2000

Source: 2001 California Health Interview Survey and March 2001 Current Population Survey

There are important differences between CHIS and the CPS that are likely to affect estimates of uninsurance as well as estimates of different sources of coverage. CHIS and CPS differ in the time period for which they measure health insurance coverage, the breadth of their questions about health insurance coverage, and differences in their samples and their inclusiveness of California's population.

## DIFFERENCES BETWEEN CHIS AND THE CPS: TIME

CHIS and the CPS ask about coverage for different time frames, they differ in the time period the respondent must recall, and they differ in the time periods they cover.

**Point in time vs. duration of time.** CHIS asks about health insurance coverage at the time of the interview (a "point-in-time" estimate) and about changes in coverage and lack of insurance during the previous 12 months (duration of coverage or uninsurance). The March CPS asks respondents about coverage at any time during the preceding calendar year so that uninsurance ostensibly reflects lack of insurance throughout that calendar year. Although health services researchers disagree about whether CPS is actually measuring the absence of coverage throughout the year, it is clear that CHIS and CPS differ in the time period for which they are measuring coverage, and this difference by itself could produce differences in estimates of coverage.[37] As noted in a U.S. Department of

37 See Lewis K, Ellwood M, Czajaka J, *Counting the Uninsured: A Review of the Literature*, Occasional Paper Number 8. Washington, DC: The Urban Institute, July 1998; and State Health Access Data Assistance Center (University of Minnesota School of Public Health), "State Health Insurance Coverage Estimates: Why State-Survey Estimates Differ from CPS," Issue Brief 3, July 2001.

Health and Human Services analysis of survey differences of uninsurance estimates, "As more time passes, more people will experience a lapse in health coverage. Thus, the total number of people who experience a period of uninsurance over the course of an entire year will be greater than the number of uninsured at a given point in time (such as the time of the survey interview)."[38]

CHIS provides opportunities not previously available in California to assess and track not only how many people are uninsured in California, but how many are uninsured at a given point in time and how many are uninsured over any specified time period. There is no inherently superior reference time for measuring lack of health insurance. The number of people who are uninsured at some time during a period of 12 months is a good measure of the population that is at risk of needing some assistance with coverage or with getting care during the course of a year. The estimate of persons who are uninsured throughout a 12-month period is a useful measure of the population that experiences longer-term uninsurance, for whom special efforts will need to be made to create opportunities to obtain affordable coverage. However, the number who were uninsured at the time they were interviewed may be a better indicator of the magnitude of the need for assistance that State health insurance programs or safety-net providers should have the capacity to serve at any point in time. For most of this report, we use estimates of health insurance coverage and uninsurance at the time of interview as our primary time frame.

**Recall period.** The CHIS questions' focus on the current point in time requires a shorter recall period than the CPS questions' focus on coverage at any time during the previous calendar year. Shorter recall is generally considered to produce a more accurate measure of coverage.

**Changing economic conditions and public programs.** CHIS 2001 asked about coverage and uninsurance at the time of the interview; interviews were conducted between November 2000 and October 2001. The March 2001 CPS asked about coverage during 2000 and its measure of uninsurance ostensibly reflected lack of coverage throughout 2000. Changes in economic conditions and public policy between 2000 (the period asked about by CPS) and any point in time in 2001 (at the time of the CHIS interview) would likely contribute to differences between the surveys in their estimates of health insurance coverage. To the extent that economic conditions continued to improve for the first half or two-thirds of 2001, and to the extent that Medi-Cal and the Healthy Families Program were improving their enrollment and retention during this period, we would expect to see higher estimates of coverage and lower estimates of uninsurance for CHIS than for CPS.

It is evident in Exhibit A-2 that two-thirds of CHIS interviews were conducted before the economy began to sink rapidly in the summer of 2001. The unemployment rate during the period of CHIS data collection averaged 4.5% compared to 4.9% for the period that the CPS asked about. Throughout this period, both Medi-Cal and Healthy Families enrollment rose steadily — with Medi-Cal rising

38 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Understanding Estimates of the Uninsured: Putting the Differences in Context," *http://aspe.hhs.gov/search/progsys/homeless/HIestimates.htm* (n.d.).

**EXHIBIT A-2. PERCENT OF 2001 CALIFORNIA HEALTH INTERVIEW SURVEY COMPLETED, CALIFORNIA UNEMPLOYMENT RATE, AND MEDI-CAL AND HEALTHY FAMILIES ENROLLEES BY MONTH**

| | NOV 2000 | DEC 2000 | JAN 2001 | FEB 2001 | MAR 2001 | APR 2001 | MAY 2001 | JUN 2001 | JUL 2001 | AUG 2001 | SEP 2001 | OCT 2001 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CHIS INTERVIEWS COMPLETED | 0.2% | 4.5% | 8.1% | 9.3% | 10.8% | 16.9% | 16.4% | 13.1% | 11.6% | 6.9% | 1.9% | 0.3% |
| CALIFORNIA UNEMPLOYMENT RATE | 4.7% | 4.4% | 5.2% | 5.1% | 5.0% | 4.8% | 4.7% | 5.3% | 5.7% | 5.4% | 5.4% | 5.7% |
| MEDI-CAL ENROLLEES* | 4,319.6 | 4,336.1 | 4,398.8 | 4,447.9 | 4,508.8 | 4,559.8 | 4,614.4 | 4,655.9 | 4,698.8 | 4,745.5 | 4,787.1 | 4,838.0 |
| HEALTHY FAMILIES ENROLLEES* | 354.9 | 362.9 | 375.4 | 386.5 | 400.9 | 415.0 | 432.5 | 444.6 | 456.2 | 466.4 | 474.5 | 489.1 |

* in thousands

Source: 2001 California Health Interview Survey and Employment Development Department, Labor Market Information Division

from 4,320,000 children and nonelderly adults in November 2000 to 4,838,000 in October 2001, and Healthy Families rising from 354,902 in November 2000 to 489,145 in October 2001. This rapid growth in both programs may not have been measured by the other, older surveys.

## DIFFERENCES BETWEEN CHIS AND THE CPS: FOCUS AND CONTENT

CHIS and the CPS differ in the overall focus of their respective surveys and the form and content of questions on health insurance coverage.

**Focus of Survey.** CHIS asks about health insurance in the context of an interview on an extensive range of health topics and after a series of questions on use of health care services. CPS focuses primarily on labor force issues and asks some health insurance questions toward the end of the interview. The CHIS interview's focus on health status and health-care use is likely to generate better recall about insurance coverage that may be relevant to the respondent's health condition or use of services, thus resulting in higher estimates of health insurance coverage.

**Form of the Survey Questions.** CHIS asks an extensive set of questions about health insurance, whereas CPS asks a relatively brief set of questions that may not elicit as much information about coverage as does CHIS. Starting in 2000, CPS added a "verification" question designed to measure coverage not previously reported by respondents to the basic set of health insurance questions — and it did identify more people with coverage, particularly among more affluent respondents. CPS significantly underestimates coverage by Medicaid relative to enrollment numbers from administrative data; this undercount is due in part to the limited questions asked about Medicaid.[39] CHIS questions achieve a higher estimate for Medi-Cal

39 For the difference between administrative data and CPS estimates of Medi-Cal enrollment, see Brown ER, Yu H, Fong K, Wyn R, Cumberland W, Levan R, *Adjusted Population-Based Estimates of Medi-Cal Coverage*. Los Angeles: UCLA Center for Health Policy Research, August 1997.

coverage and a separate estimate for Healthy Families; when used separately or combined, these CHIS questions yield a higher estimate of public coverage than do the CPS questions (although the estimate is still somewhat lower than numbers found in administrative data).

CHIS also yields a higher estimate of employment-based health insurance than does the CPS conducted in essentially the same time period. One reason for this may be that CHIS asks working respondents who do not report job-based insurance whether their employer offers health benefits and whether they are eligible for offered benefits. These questions may also stimulate recall to a greater degree than the more limited questions asked in the CPS.

## DIFFERENCES BETWEEN CHIS AND THE CPS: SURVEY ADMINISTRATION AND INCLUSION OF THE POPULATION

CHIS and the CPS are administered differently. Several aspects of survey administration affect the inclusiveness of population groups in each survey. Some of these differences would tend to make CPS more inclusive and others would tend to make CHIS more inclusive.

**Inclusion of Households without Telephones in Sample.** CHIS and CPS samples differ in their mode of administration, which influences the inclusion of households without telephones. As a survey conducted only by telephone, the CHIS sample includes only residential households with telephones, whereas the CPS is conducted by telephone and in-person and thus includes residences without telephones. In California, 3.5% of residents live in households without a telephone, although the proportion of households without a telephone is higher in very low-income households (11.3% of persons below 50% of the federal poverty level, based on data from the March 2001 CPS).[40] Persons who live in households without telephones are less likely to be insured than persons who live in households with telephones (32.5% vs. 17.6%, respectively, also based on data from the March 2001 CPS). Despite this difference, because the proportion of the population that lives in households without telephones is so small, the CPS estimate of uninsurance would be less than one percentage point lower if households without telephones were excluded. Nevertheless, CHIS compensates for lack of telephone coverage by asking if the household was without a telephone in the previous 12 months and, if so, for how long. The CHIS results are then statistically adjusted, using special weighting procedures, to compensate for households without telephones.

**Inclusion of Non-English Speaking Groups in Sample.** CHIS and CPS samples differ in their inclusion of persons who do not speak English. All CHIS questionnaires are translated and administered in six languages whereas CPS is only translated into Spanish, but very few interviews are conducted in Spanish. CHIS's linguistic adaptation enables it to include more fully immigrant population groups that tend to have low incomes and poor access to private health insurance and public programs. In CHIS 2001, 10.7% of all adult interviews and 20.1% of all interviews with the sample child's "most knowledgeable parent" were conducted in a language other than English. The great majority of these were in Spanish, thus including many Latino immigrants who, as a group, have high uninsured rates. Thus, offering the CHIS interview in multiple languages would be likely to include more uninsured persons, lowering CHIS's estimates of health insurance coverage relative to the CPS.

40 Estimates of telephone coverage are from the UCLA Center for Health Policy Research's analyses of the March 2001 Current Population Survey.

**Response Rate and Adjustment for Nonresponse.** Telephone survey response rates are defined as the ratio of completed interviews to eligible (residential) telephone numbers. Telephone numbers in the sample that end up with an unknown eligibility are classified as either eligible or ineligible based on a method of assigning a statistical likelihood that they are residential or not. In CHIS 2001 there are two levels of response rates which, when multiplied together, produces the overall survey response rate. The first level, the "screener" response rate, is the response to an interviewer contacting a telephone number, determining eligibility (is it a residence and thus eligible, or is it a nonresidential or nonworking number?), explaining the study, and selecting a respondent. The overall screener response rate for CHIS 2001 was 59.2%. The second level, the "completed interview" response rate, is the rate of success in having the selected respondents actually complete the CHIS interview. The completed interview response rate was 63.7%. Therefore, the overall survey response rate for CHIS 2001 is 37.7%, the product of 59.2% multiplied by 63.7%.

Comparing the CHIS 2001 response rate of 37.7% with other telephone surveys is not a straightforward process. Not all surveys handle the incorporation of eligibility status of nonresponding telephone numbers in exactly the same way nor do they all collect and record the information on telephone numbers in their sample with the same level of detail that CHIS did. The CHIS computational approach is one that professional survey organizations set as the preferred method. Also, response rates differ based on differences in the type of organization that is sponsoring them; CHIS informs respondents that UCLA is sponsoring the survey. Response rates also differ depending on the amount of time respondents must spend completing an interview; CHIS requires more time to complete than most other telephone surveys. CHIS is unique in that it requires multiple interviews per household when adolescents and/or children are also present.

California is one of the more difficult states in which to obtain "high" response rates. The 2000 California Behavioral Risk Factor Surveillance System (BRFSS) survey reported a response rate of 43.4% (average 20 minutes, only English and Spanish language households are eligible). The 1999 National Survey of America's Families (NSAF), which included a monetary incentive, had a response rate of 51.7% for adults in the California RDD sample. Although NSAF had the same computational approach as CHIS, the monetary incentive — something CHIS did not offer — is largely responsible for this higher response rate. Accounting for the differences between CHIS and BRFSS, the response rates for these two surveys are similar and thus usual for a California survey.

As an additional effort to reduce nonresponse bias in CHIS 2001, several nonresponse adjustments were made to the CHIS sample in the CHIS weighting scheme. The weighting adjusts for such factors as the age and gender of respondents who did not complete the interview, refused to do the interview, or were just not available to start the interview, and several other adjustments based on information in the sample were designed to reduce nonresponse bias.

**Imputation of Missing Values.** The item nonresponse rate (a result of the respondent refusing to answer or replying with "Don't know" to a question) in CHIS 2001 is relatively low: with a few exceptions, less than 0.5 percent for the majority of questions. The household income item has the highest nonresponse rate at about 15 percent, a rate comparable to many national surveys for their questions on

household income. The second highest item nonresponse rate in CHIS 2001 is for the race question, at about 3 percent. For the CHIS 2001 insurance questions, the item nonresponse rate ranges from a low of less than 0.1 percent to a high of 0.9 percent.

Missing values (nonresponses) were imputed for selected variables used in this report. Three different methods were used in the imputation: logical, relational, and statistical imputations. Logical imputation was used to deduce the information for a variable from other information provided by a particular respondent. In relational imputation, an imputed value of a variable was obtained or deduced from a related respondent (e.g., using a parent's information to impute that of a child). The method of "hot-decking" was used in statistical imputation in which respondents were grouped through modeling and then in each group separating donors (nonmissing) and receivers (missing). Values were then randomly drawn from donors of the same group (with replacement) and were assigned to receivers.

**Weighting of the Sample.** In order for the CHIS sample to accurately represent the California population, the sample is weighted using data from the 2000 Census. A number of sample adjustments are made for such effects as selection probability, nonresponse, and nontelephone coverage. Correcting for the sample design, the data are statistically weighted to reflect the correct proportions of gender, age, race, and ethnicity as reported in the 2000 Census. When the weights are applied, the CHIS population estimates made will have been correctly adjusted to make the CHIS data identical to the 2000 Census proportion across all these dimensions.

The closer the unweighted sample is to the Census proportions, the smaller are the required adjustments. As an example, on the dimensions of race and ethnicity, the CHIS sample is remarkably similar to the race and ethnic distribution of the 2000 Census. In CHIS, the proportion of respondents reporting Hispanic or Latino origin was 21.4%, virtually identical to the expected 21.2% in the 2000 Census data (adjusted for the CHIS stratified sample design).

**EXHIBIT A-3. PERCENT COMPARISONS OF THE UNWEIGHTED CHIS SAMPLE TO THE 2000 CENSUS* FOR SEVEN RACE CATEGORIES**

| GROUP | CHIS RDD SAMPLE | 2000 CENSUS |
|---|---|---|
| WHITE | 69.9 | 70.4 |
| OTHER | 11.6 | 10.7 |
| ASIAN | 7.1 | 8.1 |
| AFRICAN AMERICAN | 4.7 | 5.9 |
| TWO OR MORE RACES REPORTED | 4.5 | 3.5 |
| AMERICAN INDIAN & ALASKA NATIVE | 1.7 | 1.1 |
| NATIVE HAWAIIAN & OTHER PACIFIC ISLANDER | 0.4 | 0.2 |
| **TOTAL** | **100%** | **100%** |

* Census distributions adjusted for the CHIS stratified sample design.

Source: 2001 California Health Interview Survey and Employment Development Department, Labor Market Information Division

**EXHIBIT A-4. HEALTH INSURANCE COVERAGE ESTIMATES FOR CHILDREN AND NONELDERLY ADULTS FOR 2001 CALIFORNIA HEALTH INTERVIEW SURVEY, MARCH 2000 AND 2001 CURRENT POPULATION SURVEYS, AND 1999 NATIONAL SURVEY OF AMERICA'S FAMILIES, CALIFORNIA**

| | UNINSURED | MEDI-CAL/ HEALTHY FAMILIES | JOB-BASED INSURANCE | PRIVATELY PURCHASED | OTHER | TOTAL |
|---|---|---|---|---|---|---|
| **AGES 0-17** | | | | | | |
| CHIS 2001 | 9.6 | 27.6 | 58.9 | 2.9 | 1.2 | 100% |
| CPS 2001 | 15.4 | 24.7 | 55.4 | 3.0 | 1.5 | 100% |
| CPS 2000 | 16.8 | 23.8 | 52.5 | 4.5 | 2.4 | 100% |
| NSAF 1999 | 13.2 | 20.7 | 60.1 | * | 6.0 | 100% |
| **AGES 18-64** | | | | | | |
| CHIS 2001 | 17.7 | 10.4 | 65.1 | 5.6 | 1.2 | 100% |
| CPS 2001 | 22.1 | 7.7 | 63.2 | 4.7 | 2.3 | 100% |
| CPS 2000 | 22.9 | 8.0 | 61.8 | 4.9 | 2.5 | 100% |
| NSAF 1999 | 18.8 | 11.1 | 63.4 | * | 6.8 | 100% |

* Included in "Other" estimate

Source: 2001 California Health Interview Survey; March 2000 and 2001 Current Population Survey (analyses by UCLA Center for Health Policy Research) and The Urban Institute (Haley JM, Fragale M. "Health Insurance, Access, and Use: California," Assessing the New Federalism Program, December 2001)

Exhibit A-3 shows how well CHIS approximated the reported single race distribution plus the "two or more" race category when compared to the 2000 Census proportions. These unweighted results show an excellent response to CHIS across all groups. Because these distributions are so similar, only small race and ethnicity weighting adjustments are required for the CHIS sample to reflect California's diverse population. It should be noted that the large "other" and "two or more races" categories include some persons who, on the basis of additional information provided by respondents, were classified into more descriptive categories such as Latino, Asian, and African American.

## SUMMING UP: COMPARING ESTIMATES FROM CHIS, CPS, AND NSAF

Health insurance coverage estimates from CHIS 2001 differ from those of the March 2000 and 2001 Current Population Surveys and the 1999 National Survey of America's Families, which is conducted by Westat for The Urban Institute. In Exhibit A-4, we compare estimates from these surveys for uninsurance and coverage through Medi-Cal, the Healthy Families Program, employment-based health insurance, privately purchased health insurance, and other public programs for children and adults. This exhibit demonstrates that different estimates are related, at least in part, to differences in survey methods, questions, and year of

**EXHIBIT A-5. STATE SURVEY'S POINT-IN-TIME AND THE CPS'S ANNUAL ESTIMATES OF UNINSURANCE**

| STATE | STATE SURVEY YEAR | STATE SURVEY POINT-IN-TIME ESTIMATE | CPS ESTIMATE FROM STATE SURVEY YEAR |
|---|---|---|---|
| MASSACHUSETTS | 1998 | 8.1% | 10.3% |
| MINNESOTA | 1998 | 5.3% | 8.0% |
| WISCONSIN | 1998 | 6.0% | 11.8% |

Source: State Health Access Data Assistance Center (University of Minnesota School of Public Health), "State Health Insurance Coverage Estimates: Why State-Survey Estimates Differ from CPS," Issue Brief 3, July 2001

administration. The 1999 NSAF was administered by telephone at a time when employment was not as strong as it was when most of the CHIS interviews were conducted; the NSAF was conducted earlier in the period of rapid growth in enrollment in Medi-Cal and the Healthy Families Program. Despite these temporal differences, the 1999 NSAF estimates and those of CHIS 2001 are closer to each other than either is to those of the 2000 or 2001 CPS — most likely a result of the greater similarity in NSAF and CHIS questions on health insurance coverage.

## A FINAL COMPARISON: CPS AND OTHER STATE SURVEYS

A final comparison is worth noting: most state surveys find lower uninsured rates than are generated from the CPS samples for that state. This pattern is demonstrated in Exhibit A-5, which compares three state surveys from 1998, all asking about coverage at a point in time, with estimates from the March 1999 CPS for the year of the state survey.

Thus, the differences between CHIS's estimates of uninsurance and those drawn from the CPS reflect a variety of methodological differences between the surveys. The reader can have confidence in the CHIS estimates because of the detail and precision of the questions, the inclusiveness of the sample, and the care with which the estimates have been produced.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